AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS RUC RECOMMENDATIONS FOR 2013 MFS CMS REQUESTS

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February 28, 2011

Jonathan Blum Deputy Administrator and Director Center for Medicare Centers for Medicare and Medicaid Services 7500 Security Boulevard Baltimore, MD 21244-1850

Subject: RUC Recommendations

Dear Mr. Blum:

The American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) submits the enclosed recommendations for work and direct practice expense inputs to the Centers for Medicare and Medicaid Services (CMS). The RUC is a committee of physician volunteers utilizing their first amendment right to petition CMS to consider a number of improvements to the Resource-Based Relative Value Scale (RBRVS). These recommendations are a component of the RUC's consideration of services that were identified as potentially misvalued. The RUC is fully committed to this ongoing effort to improve relativity in the work, practice expense, and professional liability insurance values.

February 2011 RUC Recommendations

The enclosed recommendations result from the RUC's review of physicians' services from the February 3-5, 2011 meeting and include:

- *Fourth Five-Year Review of the RBRVS* The RUC submitted a comprehensive set of recommendations in October 2010 and requested that 29 codes be deferred until the February meeting. The RUC has now completed the review of these codes. With the exception of issues deferred to the CPT Editorial Panel, the RUC has concluded the review of codes identified for the Fourth Five-Year Review.
- *Harvard Valued, Utilization greater than 100,000* The RUC submits recommendations for five high volume services (vascular injections and special stains) that were previously reviewed under the Harvard research in the 1980s.
- *New Technology* The RUC initiated its review of codes previously identified as new technology at the October 2010 meeting and requested a re-survey of stereotactic radiosurgery. The RUC submits revisions to the work and/or direct practice expense costs for these two services.

Site of Service Anomalies – The RUC has completed its re-review of physician services identified as "site-of-service anomalies" and submits recommendations for 20 services. The Medicare claims data for these services reflect that the patient is in the outpatient hospital setting, while nearly all of these 20 services typically require an overnight stay (23+ hours). To the physician and the patient, the experience is the same, the patient is in a hospital bed and visits and discharge planning services are performed. The hospitals, under increased pressure due to CMS recovery audit contractors, are using a black box software package to determine admission status. The RUC strongly recommends that CMS consider evidence from the specialties and the RUC that visits and discharge management are typical and should be included as work proxies in the surgical global period.

As stated in our December 20, 2010 comment letter to the CMS Final Rule for the 2011 Medicare Physician Payment Schedule, the RUC urges CMS to reconsider its decision to value subsequent observation visits lower than subsequent hospital visits. We are hopeful that the refinement panel will restore equity between these services. The subsequent observation visits (99224 – 99226) and the observation discharge (99217) represent the appropriate proxy for these 23+ hour services. In 2006 rulemaking regarding Evaluation and Management (E/M), CMS developed policy that E/M services in surgical global periods were equivalent in work to stand alone E/M services. Therefore, we ask that you reconsider any policy that would remove pre- and postservice work from observation visits performed by physicians within a procedure's global period.

The RUC originated the review of services where the site-of-service had migrated from the inpatient setting to the outpatient setting. However, the RUC had assumed that this would represent services that are truly outpatient. Some of the codes identified recently were still 47% to 48% inpatient in one year and then 50% or 51% in the next. Coding or data errors could misclassify a code as an outpatient service. The RUC recommends that moving forward, we consider three consecutive years of data indicating 50% or fewer inpatients each year before indentifying a site of service anomaly. This would avoid misclassification due to annual fluctuations in the claims data.

• *Moderate Sedation* – At the request of the specialty societies representing gastroenterology, a workgroup was formed to consider whether the existing practice expense inputs related to moderate sedation are appropriate. The RUC suggests the addition of additional monitoring equipment as discussed in the enclosed recommendations.

Cost estimates for medical supplies and equipment not listed on the "CMS Labor, Supply, an Equipment List for the Year 2011" are based on provided source(s) as noted, such as manufacturer's catalogue prices and may not reflect the wholesale prices, quantity, or cash discounts, prices for used equipment or any other factors that may alter the cost estimates. The RUC shares this information with CMS without making specific recommendations on the pricing for supplies and equipment. For example, the RUC identified 77373 *Stereotactic body radiation therapy* as a new technology when initially reviewed in 2005. This technology has now matured and the RUC recommends revisions in the work and practice expense. The RUC requested that the specialty share with CMS invoices for all vendors of the SRS system to reflect updated pricing information.

Update on Progress of the Relativity Assessment Workgroup

The RUC has reviewed nearly 800 physicians services identified under one or more objective screens as potentially misvalued. The implementation of these RUC recommendations to improve the relativity within the RBRVS began in 2009, continued in 2010, with significant impact in 2011. The cumulative impact of the three years of effort is \$1.5 billion in redistribution. The practice and professional liability redistribution occurs within the relative values, while the work value redistribution was implemented with minor increases to the Medicare conversion factor in 2009 and 2010 and a 0.4% increase in 2011.

The significance of the RUC's work should not be underestimated. This work would not be possible without the contributions of the volunteer physicians on the RUC and the medical specialty societies. Many specialty societies have shepherded through coding changes, surveys, and relative value recommendations that ultimately result in payment reductions for their members. The individuals in this process have done so as organized medicine understands that ensuring the relativity within the RBRVS is important. This volunteer effort should be recognized by CMS and other policymakers, not only in descriptions within rulemaking, but also in methods of implementation and expectations regarding ongoing review. For example, the RUC has called on CMS to transition the practice expense data implementation into services that were newly bundled. Additionally, specialties that are undergoing significant redistribution and changes in coding should be afforded the opportunity to address these modifications in a deliberate manner. Finally, we urge CMS to refrain from arbitrary adjustments through multiple procedure reductions or other policies. A process that allows for a comparison of today's practice to the original valuation history, with input of the individuals that perform the service, is imperative to maintaining a fair resource-based system.

In rulemaking for the 2011 Medicare Physician Payment Schedule, CMS identified additional screens to identify mis-valued services. The RUC has developed objective screens over the past five years and welcomes any ideas related to these or other screens. At the most recent RUC meetings, the Relativity Assessment Workgroup has reviewed the services identified in the CMS screens. Our recommendations on each of these screens are attached to this letter. The RUC's review of these services is ongoing. The screens include:

- *Codes with Low Work RVUs/Billed with Multiple Units* CMS identified 12 services that are billed in multiples of 5 or more per day, with work RVUs of less than or equal to 0.50. In subsequent review of claims data provided to the RUC, it was determined that most of these 12 services are actually performed in multiples of less than 5 per day. Nevertheless, the RUC has now reviewed each of these codes to ensure that the typical number of units per Medicare claims data is consistent with the number of units assumed by the RUC during original valuation. The RUC has requested re-survey, practice expense review, or CPT referral for four of the 12 codes. These recommendations will follow by May 2011. The RUC is interested in obtaining claims data regarding number of units performed and the AMA is working to incorporate this data into the RUC database. A retrospective review to ensure that correct assumptions were made in original valuation is reasonable and warranted.
- Low Value/High Volume Codes CMS requested that the RUC review 24 services that have low work RVUs (less than or equal to 0.25) and high utilization (over 1 million). It is not clear that the assignment of a low work relative value has any relationship to misvaluation. However, the RUC expanded the query to ensure that all codes with a work value of 0.50 and over 1 million were discussed. The RUC reviewed this list in February and determined that any low value code reviewed by the RUC should not be reconsidered as the valuation, combined with a review of the time data, is unlikely to be modified. However, the RUC has requested that specialties survey codes that have not yet been reviewed by the RUC. These services are noted as crosswalked by CMS (CMS/Other source). In reviewing the more comprehensive query the RUC identified CPT code 93971 *Extremity study*; G0101 *CA screen, pelvic/breast exam*; and G0283 *Elect. Stim other than wound.* The RUC requests that CMS indicate whether a review of G0101 and G0283 is desired by the agency. The RUC has previously reviewed G codes, but only at the request of CMS. A detailed list of the RUC recommendations and status update is included in the enclosed materials.

The RUC review of this screen resulted in a request of complete list of all codes that were valued by neither the RUC or the Harvard study (ie, CMS/Other source). The RUC has reviewed all Harvard codes with utilization greater than 30,000.

Before any identification to review additional Harvard codes with lower volume thresholds, the CMS/Other codes with high volume should be addressed. The RUC will review the list of these codes to determine next steps at the April 2011 meeting.

Multi-Specialty Points of Comparison (MPC) List – In the rulemaking for the 2011 Medicare Physician Payment Schedule, CMS requested review of 33 services, ranked by utilization and charges, included on the RUC's MPC list. In our comments to the rulemaking, we informed CMS that the RUC is engaged in a systematic review and restructuring of the MPC list. The RUC requested that CMS allow this review to continue without the requirement to resurvey key codes during the process. At the February meeting, the RUC reviewed the list of 33 codes and determined that 6 codes were identified by another screen and have either been very recently reviewed or are undergoing a review. An additional 17 codes have been reviewed by the RUC in the past six years. In the Final Rule for 2011, CMS indicated that the agency had screened for codes that had not been reviewed in the past six years. The RUC agrees that a review of stable codes describing matured technology would not likely result in a different valuation. The RUC, therefore, requests that CMS remove these codes from the screen. The remaining 10 codes have been referred to specialty societies to either survey for April 2011 presentation or develop an action plan to survey for September 2011. Action plans were needed for several services as the code can't be reviewed in isolation from a larger family of services. A list of the RUC's recommendations and status for these 33 codes is included in the enclosed materials.

Thank you for your careful consideration of the RUC's recommendations. We look forward to continued opportunities to offer recommendations to improve the RBRVS.

Sincerely,

Barbara Jeng No

Barbara S. Levy, MD

cc: Carol Bazell, MD Edith Hambrick, MD Marc Hartstein Ryan Howe Ken Simon, MD Elizabeth Truong RUC Participants

CPT Code	Descriptor	RUC Recommenda tion	Site of Service Screen	Codes Reported Together	Harvard Valued - Util Over 100,000	4th Five- Year Review	New Technology
27792	Open treatment of distal fibular fracture (lateral	Reaffirmed	Х			Х	
	malleolus), includes internal fixation, when performed	9.71					
28120	Partial excision (craterization, saucerization,	Reaffirmed	Х			Х	
	sequestrectomy, or diaphysectomy) bone (eg,	8.27					
00400	osteomyelitis or bossing); talus or calcaneus	Destination	X			V	
28122	Partial excision (craterization, saucerization,	Reattirmed	X			X	
	sequestrectomy, of diaphysectomy) bone (eg,	1.12					
	bone except talus or calcaneus						
28725	Arthrodesis; subtalar	Reaffirmed	Х				
	, ,	12.18					
28730	Arthrodesis, midtarsal or tarsometatarsal,	Reaffirmed	Х				
	multiple or transverse;	12.42					
28825	Amputation, toe; interphalangeal joint	Reaffirmed	Х			Х	
		6.01 and					
		Request					
		Global					
		change to					
20826	Arthroscopy shoulder surgical:	Survey April		Y		Y	
23020	decompression of subacromial space with	2011		~		^	
	partial acromioplasty with or without	2011					
	coracoacromial release						
32405	Biopsy, lung or mediastinum, percutaneous	Review of				Х	
	needle	PE Only					
		(1.93 Oct					
		2010 Rec)					
33977	Removal of ventricular assist device;	20.86				Х	
00070	extracorporeal, single ventricle	25.00				V	
33970	extracorporeal biventricular	25.00				^	
33980	Removal of ventricular assist device	40.00				X	
00000	implantable intracorporeal, single ventricle	10.00					
36200	Introduction of catheter, aorta	Reaffirmed				Х	
		3.02					
36246	Selective catheter placement, arterial system;	Reaffirmed			Х	Х	
	initial second order abdominal, pelvic, or lower	5.27					
	extremity artery branch, within a vascular family						
26247	Selective extrator placement, orterial evetem:	Deeffirmed			v	v	
30247	initial third order or more selective abdominal				^	^	
	nelvic or lower extremity artery branch within a	7.00					
	vascular family						
36821	Arteriovenous anastomosis, open; direct, any	Reaffirmed	Х			Х	
	site (eg, Cimino type) (separate procedure)	12.11					
36825		Pooffirmod	X				
	Creation of arteriovenous fistula by other than	Realinneu	~				
1	direct arteriovenous anastomosis (separate	15.13	Λ				
40=	direct arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft	15.13	X				
42415	Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft Excision of parotid tumor or parotid gland;	15.13 Reaffirmed	X			X	

CPT Code	Descriptor	RUC Recommenda tion	Site of Service Screen	Codes Reported Together	Harvard Valued - Util Over	4th Five- Year Review	New Technology
42420	Excision of parotid tumor or parotid gland: total	Reaffirmed	X		100,000		
42420	with dissection and preservation of facial nerve	21.00	~				
47000	Biopsy of liver, needle; percutaneous	Review of PE Only (1.90 Oct 2010 Rec)				X	
49507	Repair initial inguinal hernia, age 5 years or older: incarcerated or strangulated	Reaffirmed 10.05	Х			Х	
49521	Repair recurrent inguinal hernia, any age; incarcerated or strangulated	Reaffirmed 12.44	Х				
49587	Repair umbilical hernia, age 5 years or older; incarcerated or strangulated	Reaffirmed 8.04	Х			Х	
49652	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible	Reaffirmed 12.88	Х			Х	
49653	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated	Reaffirmed 16.21	Х			Х	
49654	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible	Reaffirmed 15.03	Х			Х	
49655	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated	Reaffirmed 18.11	Х			Х	
53445	Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff	13.00	Х				
54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session	Reaffirmed 15.18	Х				
65825	Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue	16.00	Х				
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	PE Only					Х
77435	Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	11.87					X
88312	Special stains; Group I for microorganisms (eg, Gridley, acid fast, methenamine silver), including interpretation and report. each	Reaffirmed 0.54			X		
88313	Special stains; Group II, all other (eg, iron, trichrome), except immunocytochemistry and immunoperoxidase stains, including interpretation and report, each	Reaffirmed 0.24			Х		

CPT Code	Descriptor	RUC Recommenda tion	Site of Service Screen	Codes Reported Together	Harvard Valued - Util Over 100,000	4th Five- Year Review	New Technology
88314	Special stains; histochemical staining with	Reaffirmed			Х		
	frozen section(s), including interpretation and	0.45					
	report (List separately in addition to code for						
	primary procedure)						
88319	Determinative histochemistry or cytochemistry	Reaffirmed			Х		
	to identify enzyme constituents, each	0.53					
98925	body regions involved	0.50			Х	X	
98926	Osteopathic manipulative treatment (OMT); 3-4	0.75			Х	Х	
	body regions involved						
98927	Osteopathic manipulative treatment (OMT); 5-6	1.00			Х	Х	
	body regions involved						
98928	Osteopathic manipulative treatment (OMT); 7-8	1.25			Х	Х	
	body regions involved						
98929	Osteopathic manipulative treatment (OMT); 9-	1.50			Х	Х	
	10 body regions involved	D "				N/	
99234	Observation or inpatient hospital care, for the	Reaffirmed				Х	
	evaluation and management of a patient	2.56					
	Including admission and discharge on the						
	same date, which requires these 5 key						
	bistory: A detailed or comprehensive						
	examination: and Medical decision making that						
	is straightforward or of low complexity						
	Counseling and/or coordination of care with						
	other providers or agencies are provided						
	consistent with the nature of the problem(s)						
	and the patient's and/or family's needs. Usually						
	the presenting problem(s) requiring admission						
	are of low severity.						
99235	Observation or inpatient hospital care, for the	3.24				Х	
	evaluation and management of a patient						
	including admission and discharge on the						
	same date, 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)						
	the properting problem(c) requiring admission						
	are of moderate severity						
	are or moderate sevenity.						

CPT Code	Descriptor	RUC Recommenda tion	Site of Service Screen	Codes Reported Together	Harvard Valued - Util Over 100,000	4th Five- Year Review	New Technology
99236	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, 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	4.2				X	
	and/or family's needs. Usually the presenting problem(s) requiring admission are of high severity.						

Febru	ary 2011 R	UC Meeting	g Physicia	n Time								
	Pre	Pre-	Dress	Intra-	Immediate							
СРТ	Evaluation	Positioning	Scrub and	Service	Post Service	99238/					Total	
Code	Time	Time	Wait Time	Time	Time	99217	99224	99225	99212	99213	Time	Origination
27792	33	10	15	60	20	1	1		2	2	274	Site of Service Anomaly Screen/Fourth Five Year Review
28120	33	10	15	50	20	1	1		3	2	280	Site of Service Anomaly Screen/Fourth Five Year Review
28122	33	10	15	45	20	1	1		2	2	259	Site of Service Anomaly Screen/Fourth Five Year Review
28725	33	10	15	90	20	1	1		2	3	327	Site of Service Anomaly
28730	33	10	15	100	20	1	1		2	3	337	Site of Service Anomaly
28825	33	10	15	30	20	1			2	2	224	Site of Service Anomaly Screen/Fourth Five Year Review
33977	60	15	20	180	60						335	Fourth Five-Year Review
33978	60	15	20	200	60						355	Fourth Five-Year Review
33980	60	15	20	300	90						485	Fourth Five-Year Review
36200	33	3	5	30	20						91	Fourth Five-Year Review
36246	33	3	5	45	20						106	Harvard Valued Utilization over 100,000 Screen/Fourth Five-Year Review
36247	33	3	5	60	30						131	Harvard Valued - Utilization over 100,000 Screen/Fourth Five-Year Review
36821	33	10	10	90	20	0.5			2	1	237	Site of Service Anomaly Screen/Fourth Five Year Review
36825	40	10	20	120	30	1	1		1	2	340	Site of Service Anomaly Screen/Fourth Five Year Review
42415	40	12	20	150	20	1	1		1	2	362	Site of Service Anomaly Screen/Fourth Five Year Review
42420	40	12	20	180	20	1	1	1	1	2	447	Site of Service Anomaly Screen/Fourth Five Year Review
49507	40	3	20	70	30	1	1		1	1	260	Site of Service Anomaly Screen/Fourth Five Year Review
49521	40	3	20	90	30	1	1		1	1	280	Site of Service Anomaly Screen/Fourth Five Year Review
49587	40	3	20	60	30	1	1		1	1	250	Site of Service Anomaly Screen/Fourth Five Year Review
49652	40	15	15	90	30	1	1		1	1	287	Site of Service Anomaly Screen/Fourth Five Year Review
49653	40	15	15	120	30	1	2		2	1	353	Site of Service Anomaly Screen/Fourth Five Year Review
49654	40	15	15	120	30	1	2		1	1	337	Site of Service Anomaly Screen/Fourth Five Year Review
49655	40	15	15	150	30	1	2		2	1	383	Site of Service Anomaly Screen/Fourth Five Year Review
53445	50	15	20	90	25	1	1		1	3	343	Site of Service Anomaly
54410	40	10	15	120	30	1	1		1	3	358	Site of Service Anomaly
65285	30	10	20	90	30	1			1	6	372	Site of Service Anomaly
77435	20	0	0	210	20						250	New Technology List
88312	0	0	0	24	0						24	Harvard Valued - Utilization over 100,000 Screen/Fourth Five-Year Review
88313	0	0	0	13	0						13	Harvard Valued - Utilization over 100,000 Screen/Fourth Five-Year Review
88314	0	0	0	13	0						13	Harvard Valued - Utilization over 100,000 Screen/Fourth Five-Year Review
88319	0	0	0	18	0						18	Harvard Valued - Utilization over 100,000 Screen/Fourth Five-Year Review
98925	2	1	0	10	3						16	Fourth Five-Year Review/RAW Harvard Valued – Utilization Over 100,000
98926	2	1	0	15	3						21	Fourth Five-Year Review/RAW Harvard Valued – Utilization Over 100,000
98927	2	1	0	20	3						26	Fourth Five-Year Review/RAW Harvard Valued – Utilization Over 100,000
98928	2	1	0	25	3						31	Fourth Five-Year Review/RAW Harvard Valued – Utilization Over 100,000
98929	2	1	0	30	3				ļ		36	Fourth Five-Year Review/RAW Harvard Valued – Utilization Over 100,000
99234	14	0	0	40	15						69	Fourth Five-Year Review
99235	14	0	0	50	19.5						83.5	Fourth Five-Year Review
99236	19	0	0	55	20						94	Fourth Five-Year Review

Summary of Direct Practice Expense Inputs Changes RUC Recommendations for CMS Requests - February 2011																								
Summary of Direct Fractice Expense inputs changes RUC Recommendations for CMS Requests - February 2011 Previous Time Data Current Recommendation Change in Practice Expense Components																								
Broviou	ie Timo Dr								Current	Pocommon	datio	<u> </u>				Change in	Dract	co Ex	none		nono	nte		
Fleviou		lla							Current	Recommen						Change III	FIACL	CeEX	pens		ipone	nis		
CPT Code	Clinical Labor Assist	Intra Service Time	99238	99239	99212	99213	99214	99215	Clinical Labor Assist	Intra- Service	99238	99212	99213	99214	99215	Intra Service Change in Clinical Labor Time	99238	99239	99212	99213	99214	99215	Change in Post-Op Visits	Change in Clinical Labor Time from Change in Post-Op Visits
27792		60	1		2	2				60	1	2	2											
28120	67	50	1		3	2			50	50	1	3	2			-17								
28122	50	50	1		2	2			45	45	1	2	2			-5								
28725		90	1		2	3				90	1	2	3											
28730		100	1		2	3				100	1	2	3											
28825	36	30	1		2	2			30	30	1	2	2			-6								
33977		150				2		1		180										-2		-1	Yes	-135
33978		180				2		1		200										-2		-1	Yes	-135
33980		360		1		2	3			300								-1		-2	-3		Yes	-246
36200		39								30														
36246	72	72							45	45						-27								
36247	86	86							60	60						-26								
36821		90	1		2	1				90	0.5	2	1				-0.5						Yes	-6
36825		120	1		1	2				120	1	1	2											
42415		150	1		1	2				150	1	1	2											
42420		180	1		1	2				180	1	1	2											
49507		70	1		1	1				70	1	1	1											
49521		90	1		1	1				90	1	1	1											
49587		60	1		1	1				60	1	1	1											
49652		90	1		1	1		1		90	1	1	1											
49653		120	1		2	1				120	1	2	1											
49654		120	1		1	1		1		120	1	1	1											
49655		150	1		2	1		1		150	1	2	1											
53445		90	1		1	3				90	1	1	3											
54410		120	1		1	3		1		120	1	1	3											
65285		79	1			6		1		90	1	1	6						1	0.5			Yes	45
99234		60								40														
99235		75								50														
99236		110								55														

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

							Pre-					2009	
СРТ		RUC		Work	Pre-	Pre-	Posi	Intra-	Post-			Medicare	
Code	Short descriptor	Review	Global	RVU	Eval	S/D/W	tion	Svc	Svc	Visits	IWPUT	Utilization	RUC Recommendation
11056	Trim skin lesions, 2 to 4	Apr-97	000	0.61	2			8	5		0.0567	1,687,654	Action plan for April 2011
													Reaffirm RUC recommendation, has been RUC reviewed in
11100	Biopsy, skin lesion	Aug-05	000	0.81	5			12	5		0.0488	2,579,687	the past 6 years
11721	Debride nail, 6 or mor	Apr-96	000	0.54	5			8	5		0.0395	7,539,975	Action plan for April 2011
													Reaffirm RUC recommendation, has been RUC reviewed in
17000	Destruct premalg lesion	Aug-05	010	0.65	4			3	2	99212=1	0.0119	4,730,673	the past 6 years
													Reaffirm RUC recommendation, has been RUC reviewed in
20610	Drain/inject, joint/burs	Oct-10	000	0.79	5	1	5	5	5		0.10062	5,847,320	the past 6 years
31231	Nasal endoscopy, dx	June-93	000	1.10	10			10	10		0.0652	361,190	Action plan for April 2011
													Reaffirm RUC recommendation, has been RUC reviewed in
31575	Diagnostic laryngoscopy	Sep-05	000	1.10	5	5	5	8	5		0.0904	557,616	the past 6 years
													Reaffirm RUC recommendation, has been RUC reviewed in
43235	Uppr gi endoscopy, diagnosis	Aug-05	000	2.39	18	5	5	20	15		0.0749	408,630	the past 6 years
43239	Upper GI endoscopy, biopsy	Aug-00	000	2.87	27			34	23.5		0.0511	1,419,531	Action plan for April 2011
45380	Colonoscopy and biopsy	Aug-00	000	4.43	45			51.5	22		0.0569	799,816	Action plan for April 2011
45385	Lesion removal colonoscopy	Jun-93	000	5.3	16			43	15		0.1071	641,691	Action plan for April 2011
													Reaffirm RUC recommendation, has been RUC reviewed in
52000	Cystoscopy	Aug-05	000	2.23	10	5	2	15	10		0.1131	920,676	the past 6 years
													Reaffirm RUC recommendation, has been RUC reviewed in
66821	After cataract laser surgery	Aug-05	090	3.42	15			11	10	99213=2	0.0836	566,092	the past 6 years
66984	Cataract surg w/iol, 1 stage	Aug-05	090	10.52	10	10	5	30	10	99212=2			Reaffirm RUC recommendation, has been RUC reviewed in
										99213=2	0.0440	4 07 4 000	the past 6 years. RUC to review again Sept 2011, High
										99238=0.5	0.2113	1,674,939	IWPUT screen
74000		A		0.00				0			0.0504	40 740 000	Reaffirm RUC recommendation, has been RUC reviewed in
71020	Chest x-ray	Aug-05	XXX	0.22	1			3	1		0.0584	13,740,080	the past 6 years
													Reamirm RUC recommendation, has been RUC reviewed in
71075	Ct angiography chost	Eab 01	~~~	1 02	0.5			20	10		0.0404	502 55G	the past 6 years. RUC to review again Sept 2011, CMS
71273	Ariat of hur outro w/o dwo			1.92	9.5			30	10		0.0494	595,556	Pastest Growing screen
13121	Min jnt of lwr extre w/o dye	Apr-01	~~~	1.35				20			0.0675	610,825	Action plan for April 2011
74160	Ct abdomon w/dvo	Eab 08	~~~	1 27	2			15	Б		0.0727	2 210 502	the past 6 years
74100		Feb-00	~~~	1.27	3			15	5		0.0727	2,219,595	The past o years.
76700	Lis exam abdom complete	Aug-05	XXX	0.81	3			10	1		0.0653	1 030 /10	the past 6 years
77003	Eluoroquide for spine inject	May_00		0.60	10			20	5		0.0000	2 185 916	Action plan for April 2011
11005		Ividy-33	7.777	0.00	10			20	5		0.0132	2,105,510	Reaffirm RUC recommendation, has been RUC reviewed in
77290	Set radiation therapy field	Aug-05	XXX	1 56				70			0.0223	339 258	the past 6 years
11200		, .ug 00	,,,,,	1.00				.0			0.0220	000,200	Reaffirm RUC recommendation has been RUC reviewed in
77300	Radiation therapy dose plan	Aug-05	XXX	0.62				15			0.0413	1.638.636	the past 6 years
				0.02							0.0110	.,200,000	Reaffirm RUC recommendation, has been RUC reviewed in
77334	Radiation treatment aid(s)	Aug-05	XXX	1.24				35			0.0354	1,476,951	the past 6 years

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

ODT						D	Pre-		Dest			2009	
CPT		RUC		WORK	Pre-	Pre-	Posi	Intra-	Post-			Medicare	
Code	Short descriptor	Review	Global	RVU	Eval	S/D/W	tion	Svc	Svc	VISItS	IWPUT	Utilization	RUC Recommendation
													Reaffirm RUC recommendation, has been RUC reviewed in
78815	Pet image w/ct, skull-thigh	Apr-07	XXX	0.00	15			35	15		-0.0192	487,518	the past 6 years
													Reaffirm RUC recommendation, has been RUC reviewed in
92083	Visual field examination(s)	Aug-05	XXX	0.5	3			10			0.0433	2,580,775	the past 6 years
													Reaffirm RUC recommendation, has been RUC reviewed in
92250	Eye exam with photos	Aug-05	XXX	0.44				9	5		0.0364	2,175,839	the past 6 years
92980	Insert intracoronary stent	May-94	000	14.82	45			120	60		0.1039	320,072	Survey for April 2011
													Reaffirm RUC recommendation, has been RUC reviewed in
93010	Electrocardiogram report	Aug-05	XXX	0.17				4	1		0.0369	19,334,268	the past 6 years
94060	Evaluation of wheezing	Aug-95	XXX	0.31	5			10	5		0.0086	1,231,072	Action plan for April 2011
													Reaffirm RUC recommendation, has been RUC reviewed in
95165	Antigen therapy services	Feb-06	XXX	0.06				3			0.0200	5,412,909	the past 6 years
													Reaffirm RUC recommendation, has been RUC reviewed in
95810	Polysomnography, 4 or more	Apr-10	XXX	2.50	15			36.5	15		0.0501	311,495	the past 6 years
													Reaffirm RUC recommendation, has been RUC reviewed in
95900	Motor nerve conduction test	Aug-05	XXX	0.42	4			6	4		0.0401	1,371,085	the past 6 years
													Reaffirm RUC recommendation, has been RUC reviewed in
97110	Therapeutic exercises	Apr-10	XXX	0.45	1			15	2		0.0255	40,440,714	the past 6 years

TABLE 10 - Codes with	Low Work RVUs/Billed	in Multiple Units

ODT	Shert	BUG	RUC	CMS	4	2	2		E	6.		2011	Dro	Intro	Dect			
Code	Descriptor	Review	Units	of Units	Unit	∠ Units	ہ Units	4 Units	ວ Units	0+ Units	Global	RVU	Svc	Svc	Svc	2009	RUC Rec	RUC Rationale
11101	Biopsy, skin	Aug-95	2	1.5	68%	20%	7%	3%	1%	1%	ZZZ	0.41		10		1,120,739	Reaffirm	The RUC assumed number of units whether the second se
	add-on																	services are the same or similar to the of units. Additionally, this service is no times or more per day, 98% of the time or less. Therefore, this code did not mo screen as indicated.
17003	Destruct premalg les, 2–14	Aug-05	4	4.4	25%	15%	12%	10%	8%	31%	ZZZ	0.07		2		15,004,060	Reaffirm	The RUC assumed number of units wh services are the same or similar to the of units. Additionally, this service is no times or more per day, 62% of the time or less. Therefore, this code did not me screen as indicated.
76000	Fluoroscope examination	CMS/ Other	1	1.1	95%	5%	0%	0%	0%	0%	XXX	0.17		5		44,391	Maintain	The RUC assumed number of units wh services are the same or similar to the of units. This service is not commonly per day, 100% of the time it is hilled in
76000	-26			1.0	99%	1%	0%	0%	0%	0%	XXX	0.17				97,466		Therefore, this code did not meet the C
76000	ТС			1.5	66%	13%	20%	0%	0%	0%	XXX	0.00				9,108		indicated. 95% of the time this service per date of servce.
88300	Surgical path, gross	Apr-10	1	1.1	93%	6%	0%	0%	0%	0%	XXX	0.08		10		18,992	Reaffirm	The RUC assumed number of units wh services are the same or similar to the of units. Additionally, this service is no
88300	-26			1.0	96%	3%	0%	0%	0%	0%	XXX	0.08				191,507		or less. Therefore, this code did not me
88300	TC			1.1	90%	7%	2%	0%	0%	0%	XXX	0.00				8,620		screen as indicated. More than 90% of is reported only once per date of service
95004	Percut allergy skin tests	Feb-07	40	50.1	1%	1%	1%	1%	0%	96%	XXX	0.01	0.125	0.125	0.125	7,281,377	Reaffirm	The RUC recommended comparison of divided by the number of RUC assume CMS mean number of units, 50, both r 0.01. Additionally, the RUC appropriat physician time by the typical number of
95010	Percut allergy titrate test	Aug-95	7	14.2	8%	6%	9%	8%	6%	61%	XXX	0.15	10	25	5	118,160	Survey for April 2011	Resurvey, as physician times are not r number of units typically performed an Assistant to publish an article to ensur
95015	Id allergy titrate- drug/bug	Aug-95	rationale= 7; intra svc=17	8.3	13%	8%	13%	10%	13%	43%	XXX	0.15	10	30	12	46,551	Survey for April 2011	Resurvey, as physician times are not r number of units typically performed an Assistant to publish an article to ensur
95024	Id allergy test, drug/bug	Feb-07	12	17.8	8%	8%	3%	2%	2%	77%	XXX	0.01		0.416	0.833	1,586,553	Reaffirm work RVU. Review PE April 2011.	The RUC recommendation established battery of 12 tests resulting in 0.01 wo 95004 and 95027). The specialty indic Workgroup agreed that it is reasonable RUC assumed typical number of tests valuation, an RVU of 0.17 would simila for the battery of tests still resulting in Additionally, the RUC appropriately div time by the typical number of units.
95027	ld allergy titrate- airborne	Feb-07	45	39.9	3%	7%	3%	2%	2%	83%	XXX	0.01	0.22	0.222	0.222	269,298	Reaffirm	The RUC recommended comparison of divided by the number of RUC assume CMS mean number of units, 40, both r 0.01. Additionally, the RUC appropriate physician time by the typical number of
95144	Antigen therapy services	Feb-06	6	6.8	5%	10%	0%	28%	15%	41%	XXX	0.06		3		231,886	Reaffirm	The RUC determined that the current F of units, 6, and CMS mean number of result in a different work RVU than the recommended work RVU of 0.06. Add time of 3 minutes is appropriate as this service is different than the battery of a
95148	Antigen therapy services	Harvard	N/A	2.5	79%	2%	0%	4%	7%	9%	XXX	0.06		2		14,281	Maintain	This service is not commonly billed 5 t 85% of the time it is billed in 4 units or code did not meet the CMS criteria scr of the time this service is reported with
95904	Sense nerve	Aug-05		4.1	6%	24%	10%	29%	4%	27%	XXX	0.34	4	5	3	3,083,411	Refer to CPT	This service is currently being reviewe Reported Together 75% or More scree
95904	-26			3.7	10%	25%	13%	25%	6%	20%	XXX	0.34				512,126		commonly billed 5 times or more per c is billed in 4 units or less. Therefore, th the CMS criteria screen as indicated.
95904				4.1	1%	20%	10%	32%	3%	29%	XXX	0.00				127,805		reaffirms its previous recommendaton CPT.

hen valuing these e CMS mean number ot commonly billed 5 ne it is billed in 4 units neet the CMS criteria hen valuing these e CMS mean number ot commonly billed 5 ne it is billed in 4 units eet the CMS criteria hen valuing these e CMS mean number billed 5 times or more n 3 units or less. CMS criteria screen as e is reported only once hen valuing these e CMS mean number ot commonly billed 5 ne it is billed in 3 units neet the CMS criteria of the time, this service ice. code 99212 (0.48) ed units, 40, or the result in a work RVU of tely divided the of units. representative of the nd Refer to CPT ire proper coding. representative of the nd Refer to CPT re proper coding. d an RVU of 0.12 for a ork RVU (identical to cated and the le to suggest that if the were 17 at the time of larly been established n a work RVU of 0.01. ivided the physician code 99212 (0.48) ed units, 45, or the result in a work RVU of tely divided the of units. RUC assumed number f units, 6.8, would not e recent RUC litionally, the physician his is antigen therapy allergy tests. times or more per day, r less. Therefore, this reen as indicated. 79% th a single unit. red through the Code en and has been ally, this service is not day, 69% of the time it his code did not meet

However, the RUC n to refer this service to

Table 11: Low Value/High Volume Codes

				2011					2009		
СРТ				Work	Pre	Intra	Post		Medicare		
Code	Decriptor	RUC Mtg Date	Global	RVU	Time	Time	Time	Source	Utilization	Screen	RUC Recommendation
11719	Trim nail(s)	Apr97 (HCPAC)	000	0.17	2	2	5	RUC	1,472,007		Reaffirm RUC recommendation
71010	Chest x-ray	Aug-05	XXX	0.18	1	3	1	RUC	18,889,676		Reaffirm RUC recommendation
72040	X-ray exam of neck, spine	Aug-95	XXX	0.22		6		CMS/Other	572,449		Survey for April 2011
										Harvard Valued -	
										Utilization over	Identified by another screen: RUC
72100	X-ray exam of lower spine	Feb-11	XXX	0.22	0	6	0	CMS/Other	1,824,948	100,000	reviewed Feb 2011
72170	X-ray exam of pelvis	Aug-95	XXX	0.17	0	5	0	CMS/Other	1,683,045		Survey for April 2011
73030	X-ray exam of shoulder	Aug-95	XXX	0.18	0	5	0	CMS/Other	2,137,263		Survey for April 2011
73110	X-ray exam of wrist	Aug-05	XXX	0.17	1	3	1	RUC	857,179		Reaffirm RUC recommendation
73130	X-ray exam of hand	Aug-05	XXX	0.17	1	3	1	RUC	890,262		Reaffirm RUC recommendation
											Identified by another screen: RUC
73510	X-ray exam of hip	Apr-10	XXX	0.21	0	5	0	RUC	2,424,907	Top 9 Harvard	reviewed Apr 2010
73560	X-ray exam of knee 1 or 2	May-98	XXX	0.17	0	3	0	RUC	2,137,514		Reaffirm RUC recommendation
73562	X-ray exam of knee 3	May-98	XXX	0.18	0	4	0	RUC	1,747,709		Reaffirm RUC recommendation
73564	X-ray exam knee 4 or more	May-98	XXX	0.22	0	5	0	RUC	1,025,955		Reaffirm RUC recommendation
											Identified by another screen: RUC
73610	X-ray exam of ankle	Oct-09	XXX	0.17	1	3	1	RUC	1,121,102	Top 9 Harvard	reviewed Oct 2009
73620	X-ray exam of foot	Aug-95	XXX	0.16		5		CMS/Other	865,846		Survey for April 2011
											Identified by another screen: RUC
73630	X-ray exam of foot	Oct-09	XXX	0.17	1	3	1	RUC	2,066,436	Top 9 Harvard	reviewed Oct 2009
74000	X-ray exam of abdomen	Aug-05	XXX	0.18	1	3	1	RUC	1,886,517		Reaffirm RUC recommendation
77052	Comp screen mammogram add-on	Sep-03	ZZZ	0.06	0	1	0	RUC	4,688,454		Reaffirm RUC recommendation
										4th Five-Year	Identified by another screen: RUC
88304	Tissue exam by pathologist	Apr-10	XXX	0.22	0	15	0	RUC	1,105,302	Review	reviewed Apr 2010 and Oct 2010
											Identified by another screen: RUC
88313	Special stains group 2	Feb-11	XXX	0.24	0	11	0	Harvard	1,273,054	Top 9 Harvard	reviewed Feb 2011
										Codes Reported	Identified by another screen: RUC
92543	Caloric vestibular test	Apr-09	XXX	0.10		10		CMS/Other	469,356	Together	reviewed Apr 2009
		·								Codes Reported	-
										Together 95% or	Identified by another screen: RUC
92567	Tympanometry	Apr-09	XXX	0.20	1	4	1	RUC	1,015,010	More	reviewed Apr 2009
											Remove from Screen, work RVU is
											0.00 and does not meet criteria for
93701	Bioimpedance, cv analysis	Feb-09	XXX	0.00					416,300		screen.
93971	Extremity study	Aug-95	XXX	0.45	0	16	0	CMS/Other	1,419,577		Survey for April 2011
94010	Breathing capacity test	Aug-05	XXX	0.17	0	5	2	RUC	1,256,953		Reaffirm RUC recommendation
97035	Ultrasound therapy	May94 (HCPAC)	XXX	0.21	1	12	2	RUC	4,491,827		Reaffirm RUC recommendation
		· · · · · · · · · · · · · · · · · · ·							· ·		Letter to CMS - questioning RUC
G0101	CA screen;pelvic/breast exam		xxx	0.45	0	0	o	CMS/Other	1,094.967		review
					-	-			, - ,		Letter to CMS - questioning RUC
G0283	Elec stim other than wound		xxx	0.18	0	0	o	CMS/Other	6,153,297		review
00100			7000	0110	•	•	•		€,100,201		



The RUC Relativity Assessment Workgroup Progress Report

In 2006, the RUC established the Five-Year Identification Workgroup (now referred to as the Relativity Assessment Workgroup) to identify potentially misvalued services using objective mechanisms for reevaluation prior to the next Five-Year Review. The RUC formed this Workgroup in response to criticisms that, despite reducing the work RVUs for nearly 400 services in the past, the process contains "bias in the 5-year review in favor of undervalued codes as compared to overvalued codes."¹ Since the inception of the Relativity Assessment Workgroup, the Workgroup and CMS have identified over 900 services through eleven different screening criteria for further review by the RUC. Additionally, the RUC charged the Workgroup with maintaining the "new technology" list of services that will be re-reviewed by the RUC as reporting and cost data become available.

New Technology

As the RUC identifies new technology services that should be re-reviewed, a list of these services is maintained and forwarded to CMS. Currently, codes are identified as new technology based on recommendations from the specialty society and consensus among RUC members at the time of the RUC review for these services. RUC members consider several factors to evaluate potential new technology services, including: recent FDA-approval, newness or novelty of the service, use of an existing service in a new or novel way, and migration of the service from a Category III to Category I CPT code. The Workgroup maintains and develops all standards and procedures associated with the list, which contains 187 services. In September 2010, the re-review cycle began and the RUC recommended that 2 of the first 32 services be re-examined. The remaining services are rarely performed (ie, less than 500 times per year in the Medicare population) and will not be re-examined. The Workgroup will continue to review the remaining 155 services every September after three years of Medicare claims data is available for each service.

Site of Service Anomalies

The Workgroup initiated its effort by reviewing services with anomalous sites of service when compared to Medicare utilization data. Specifically, these services are performed less than 50% of the time in the inpatient setting, yet include inpatient hospital Evaluation and Management services within their global period.

The RUC identified 194 services through the site of service anomaly screen. The RUC required the specialties to resurvey 129 services to capture the appropriate physician work involved. These services were reviewed by the RUC between April 2008 and February 2011. CMS implemented 124 of these recommendations in the 2009, 2010 and 2011 Medicare Physician Payment Schedules. The RUC submitted another 5 recommendations to CMS for the 2012 Medicare Physician Payment Schedule.

Of the remaining 65 services that were not re-surveyed, the RUC modified the discharge day management for 46 services and removed 2 codes from the screen as the typical patient was not a Medicare beneficiary and would be an inpatient. The CPT Editorial Panel deleted 11 codes and

¹ MedPAC comments to CMS regarding the 2008 Medicare Physician Payment Schedule proposed rule, submitted August 30, 2007.



will review another 3 services in the CPT 2012 cycle. The RUC will review an additional 3 codes for the 2012 Medicare Physician Payment Schedule.

During this review, the RUC uncovered several services that are reported in the outpatient setting, yet, according to several expert panels and survey data from physicians who performed the procedure, the service, typically requires a hospital stay of greater than 23 hours. The RUC maintains that physician work that is typically performed, such as visits on the date of service and discharge work the following day, should be included within the overall valuation. Subsequent observation day visits and discharge day management service as appropriate proxies for this work.

High Volume Growth

The Workgroup assembled a list of all services with a total Medicare utilization of 1,000 or more that have increased by at least 100% from 2004 through 2006. The query resulted in the identification of 81 services, expanded by 15 services to include the family of services. Specialty societies submitted comments to the Workgroup in April 2008 to provide feedback or explanations for the growth in reporting. Following this review, the RUC required the specialties to survey 35 services to capture the appropriate work effort and/or practice expense inputs. These services were reviewed by the RUC between February 2009 and April 2010.

The RUC recommended that 20 services be removed from the screen as the volume growth did not impact the resources required to provide the service. The CPT Editorial Panel deleted 14 codes and will review another 10 services in the CPT 2012 cycle. The RUC will review 17 services after two years of utilization data are collected. Review of these services will begin at the September 2011 meeting.

CMS Fastest Growing

In 2008, CMS developed the Fastest Growing Screen to identify all services with growth of at least 10% per year over the course of 3 years from 2005-2007. Through this screen, CMS identified 114 fastest growing services and the RUC expanded this screen by an additional 62 services to include the family of services, totaling 176. The RUC required the specialties to survey 70 services to capture the appropriate work effort and/or practice expense inputs. These services were reviewed by the RUC between February 2008 to April 2010 and submitted to CMS for the Medicare Physician Payment Schedule.

The RUC recommended that 43 services be removed from the screen as the volume growth did not impact the resources required to provide the service. The CPT Editorial Panel deleted 16 codes and will review another 11 services in the CPT 2013 cycle. The RUC will review 2 services in April 2011 and 34 services in September 2011.

High IWPUT

The Workgroup assembled a list of all services with a total Medicare utilization of 1,000 or more that have an intra-service work per unit of time (IWPUT) calculation greater than 0.14, indicating an outlier intensity. The query resulted in identification of 32 services. Specialty societies submitted comments to the Workgroup in April 2008 for these services. As a result of this screen, the RUC has reviewed and submitted recommendations to CMS for 26 codes. The RUC also recommended 2 services be reviewed in September 2011 and 4 services be removed from the screen as the IWPUT was considered appropriate.



Services Surveyed by One Specialty – Now Performed by A Different Specialty

Services that were originally surveyed by one specialty, but now performed predominantly by other specialties were identified and reviewed. The RUC identified 21 services by this screen, adding 10 services to address various families of codes. The majority of these services required clarification within CPT. To date, the CPT Editorial Panel has deleted 2 codes and will review 21 codes in the CPT 2012 cycle. The RUC submitted 1 recommendation to CMS for the 2011 Medicare Physician Payment Schedule and will submit 7 recommendations for physician work and practice expense for the 2012 Medicare Physician Payment Schedule.

Harvard Valued

Utilization over 1 Million

CMS requested that the RUC pay specific attention to Harvard valued codes that have a high utilization. The RUC identified 9 Harvard valued services with high utilization (performed over 1 million times per year). The RUC also incorporated an additional 12 Harvard valued codes within the initial family of services identified. The CPT Editorial Panel deleted 1 code. The RUC submitted 20 relative value work recommendations to CMS for the 2011 and 2012 Medicare Physician Payment Schedule.

Utilization over 100,000

The RUC continued to review Harvard-only valued codes with significant utilization. The Relativity Assessment Workgroup expanded the review of Harvard codes to those with utilization over 100,000 which totaled 38 services and the RUC expanded by the screen by 99 services to include the family of services, totaling 137 services. The CPT Editorial Panel deleted 26 codes and will review 8 services in the CPT 2012 cycle. The RUC submitted 101 recommendations to CMS for the 2011 and 2012 Medicare Physician Payment Schedule. The RUC will review will review 2 codes in September 2012.

Bundled CPT Services

Reported 95% or More Together

The Relativity Assessment Workgroup solicited data from CMS regarding services inherently performed by the same physician on the same date of service (95% of the time) in an attempt to identify pairings of services that should be bundled together. To that end, the RUC and CPT Editorial Panel created a joint workgroup to discuss the complex coding issues and to ensure that all resource efficiencies are accounted. The Joint Workgroup report to the RUC and CPT Editorial Panel, which was approved by both bodies, called for CPT coding change proposals to collapse code pairings into fewer bundled services. The CPT Editorial Panel deleted 31 codes. The RUC surveyed, reviewed the work and practice expense, and submitted recommendations to CMS for 53 services to account for efficiencies achieved through bundling. The RUC completed review for services identified under this screen.

Reported 75% or More Together

In February 2010, the Workgroup continued review of services provided on the same day by the same provider at a lower threshold. The Workgroup analyzed code pairs provided on the same day by the same physician. The Relativity Assessment Workgroup reviewed the Medicare claims data for these services and found 151 relevant code pairs. These codes were divided into similar "groups" and the 20 code groups, totaling 80 codes with the highest allowed charges were sent to specialty societies to solicit action plans for consideration at the April 2010 RUC meeting. Nine (9) additional codes were added as part of the family of services, totaling 89 services. The CPT



Editorial Panel deleted 5 codes and will consider 49 of codes in the CPT 2013 cycle. The RUC reviewed the work and practice expense, and will submit recommendations to CMS for 32 services to account for efficiencies when performed together, for the 2012 Medicare Physician Payment Schedule. The RUC will review an additional 3 services for the 2013 Medicare Physician Payment Schedule.

Low Value/Billed in Multiple Units

CMS has requested that services with low work RVUs that are commonly billed with multiple units in a single encounter be reviewed. CMS identified services that are reported in multiples of 5 or more per day, with work RVUs of less than or equal to 0.50 RVUs.

In October 2010, the Workgroup reviewed 12 CMS identified services and determined that 6 of the codes were improperly identified as the services was either not reported in multiple units or was reported in a few units, but that was assumed in original valuation. The RUC will provide recommendations for the remaining 6 services for the 2012 Medicare Physician Payment Schedule.

Low Value/High Volume Codes

CMS has requested that services with low work RVUs and high utilization be reviewed. CMS has requested that the RUC review 24 services that have low work RVUs (less than or equal to 0.25) and high utilization. The RUC questioned the criteria CMS used to identify these services as it appeared some codes were missing from the screen criteria indicated. The RUC identified codes with a work RVU ranging from 0.01 - 0.50 and Medicare utilization greater than one million. In February 2011, the RUC reviewed the codes identified by this criteria added 3 codes to review under this screen, totaling 27. The RUC will provide recommendations for all 27 services for the 2012 Medicare Physician Payment Schedule.

Multi-Specialty Points of Comparison List

CMS requested that services on the Multi-Specialty Points of Comparison (MPC) list should be reviewed. CMS prioritized the review of the MPC list to 33 codes, ranking the codes by allowed service units and charges based on CY 2009 claims data and as well as those services reviewed by the RUC more than six years ago. The RUC submitted recommendations for 24 codes for the 2012 Medicare Physician Payment Schedule and have requested specialty societies to develop action plans for the remaining 9 codes so the RUC may address for the 2013 Medicare Physician Payment Schedule.

Other Issues

In addition to the above screening criteria, the Relativity Assessment Workgroup performed an exhaustive search of the RUC database for services indicated by the RUC to be re-reviewed at a later date. Three codes were found that had not yet been re-reviewed. The RUC recommended a work RVU decrease for 2 codes and to maintain the work RVU for another code.

CMS also identified 72 services that required further practice expense review. The RUC submitted practice expense recommendations on 67 services and the CPT Editorial Panel deleted 5 services. The RUC also reviewed special requests for 19 audiology and speech-language pathology services, which the RUC submitted recommendations for 10 services for the 2010 Medicare Physician Payment Schedule and the remaining 9 services for the 2011 Medicare Physician Payment Schedule.



CMS Requests and RUC Relativity Assessment Workgroup Code Status

Total Number of Codes Identified**					
Codes Completed	766				
Work and PE Maintained	254				
Work Increased	50				
Work Decreased*	246				
Direct Practice Expense Revised (beyond work changes)*	119				
Deleted from CPT	97				
Codes Under Review	171				
Referred to CPT	81				
RUC to Review April 2011	33				
Action Plan to the RUC in April 2011	8				
Re-Review in September 2011 or September 2012	49				

*Approximately \$400 million was redistributed to the 2011 Medicare conversion factor (0.4% increase) to account for the efforts on the work relative values. This lead to \$40 million redistribution within the PLI RVUs and combined with other recommendations, \$730 million redistribution within the practice expense RVUs, for a total overall redistribution of **\$1.2 billion** in 2011.

In 2009 and 2010 minor increases to the conversion factor and redistribution within the PLI and PE RVUs also occurred. The RUC's efforts for 2009-2011 have resulted in at least \$1.5 billion in redistribution.

**The total number of codes identified will not equal the number of codes from each screen as some codes have been identified in more than one screen.

AMA/Specialty Society RVS Update Committee Summary of Recommendations Identified through the Site of Service Anomaly Screen and the Fourth Five Year Review

February 2011

Treatment of Ankle Fracture

CPT code 27792 was reviewed by the RUC as part of the Internal or External Fixation Services in 2007 utilizing a survey instrument that contained questions regarding site of service. Following the RUC's recommendation, in 2009, CMS identified CPT code 27792 as part of the 4th Five-Year Review through their site of service anomaly screen. In response to this request made by CMS, the RUC re-reviewed the survey data presented by the specialty societies and assessed the previous RUC recommendation for work RVUs.

The specialty societies presented their survey data including physician times and the RUC agreed that these times accurately reflected the service performed by the physician. Importantly, the RUC noted that the work involved in monitoring the typical patient post-operatively on the day of surgery is the same Evaluation and Management work whether the patient's status ends up inpatient or outpatient. Adjustments to the allocation of post-operative visits are used as proxies and do not constitute changes to the physician work relative value of the service which was determined by magnitude estimation and physician specialty survey data during the last RUC review.

In the previous RUC recommendation for this service, the specialty societies, utilizing magnitude estimation, compared this service to 28299 *Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy* (Work RVU=11.57). The RUC noted that the intraservice time of 27792 is significantly less than the intra-service time of the reference code, 60 minutes and 90 minutes, respectively. The RUC also noted that the care for this type of fracture is slightly more complex than 27784 *Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performed* (RUC Recommended Value=9.67). In 2008, with the lower amount of intra-service time of the surveyed code in comparison to the reference code and maintaining the proper rank order between the surveyed code and 27784, the RUC agreed that the median of the survey, 10.50 RVUs appropriately places this code in comparison to the reference codes. However, despite the compelling evidence provided, CMS applied work neutrality to the group of fracture codes, resulting in 9.55 Work RVUs, a 9% reduction in the work compared with the RUC recommendation. This value was then increased in 2010 to 9.71 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. Therefore, based on this history and magnitude estimation comparison to the reference codes, the specialty societies agree and the RUC recommends that the current value of this service be maintained. **The RUC recommends 9.71 work RVUs for CPT code 27792.**

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
27792		Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed (For treatment of tibia and fibula shaft fractures, see 27750-27759)	090	9.71 (No Change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code:27792 Tracking Number

Original Specialty Recommended RVU: 9.71 Presented Recommended RVU: 9.71 RUC Recommended RVU: 9.71

Global Period: 090

CPT Descriptor: Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old male misses the last step and falls, sustaining a displaced fracture of the lateral malleolus requiring open reduction and internal fixation.

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 42%, Kept overnight (less than 24 hours) 44%, Admitted (more than 24 hours) 13%

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: Write preadmission orders for preoperative medications. Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs. Perform H&P. Assure appropriate selection, timing, and administration of antibiotic. Meet with patient and family to review planned procedure and post-operative management. Review informed consent with patient. Verify that all required instruments and supplies are available. Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes. Assess position of the extremities and head, adjust as needed. The patient's leg is placed on the table and elevated with proper bolstering to aid surgical exposure. Indicate areas of skin to be prepped and mark surgical incisions. A tourniquet is placed on the proximal thigh. The leg is prepped and draped. The pneumatic tourniquet is inflated. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Under anesthesia, a lateral incision is made over the distal fibula with care to protect branches of the superficial peroneal and sural nerve. The fracture hematoma is irrigated and the joint inspected from the lateral side for loose debris. The fracture is reduced and held with a bone holding forceps. An interfragmentary screw is inserted. An appropriate sized plate is chosen and fixed with screws. Stability of the syndesmosis is confirmed by trying to disrupt the distal tibio-fibular junction. The wound is irrigated and closed in layers. The tourniquet is let down and hemostasis is confirmed.

Description of Post-Service Work:

Immediate Post op [after wound closure through discharge from recovery room]:

CPT Code: 27792

Application of a dressing and short leg splint. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia. Continue prophylaxis for DVT. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to orthopaedic floor and discuss ongoing care with floor nurses.

Hospital Visit [operative day after discharge from recovery room]:

Review interval chart notes. Discuss ongoing care with floor nurses. Discuss management of medical co-morbidities with medical physician. Evaluate vital signs and intake/output. Examine patient, assess for bleeding and drain output. Assess circulation, sensation, and motor function of the operated extremity, Assess pain scores and adequacy of analgesia; adjust medication as needed. Discuss operative findings, procedure, and plan with patient and/or family; answer patient and family questions. Answer nursing/other staff questions. Chart patient progress notes.

Hospital Discharge Management [day after surgery, IF patient is stable and can safely be discharged]:

Review interval chart notes. Evaluate vital signs and intake/output. Assess dressing or splint/cast for bleeding. Assess drain output; remove drain. Evaluate the circulation, sensation, and motor function of the operated extremity. Assess pain scores and adequacy of analgesia; adjust medication as needed. Assess progress with mobilization, ambulation, and physical therapy. Discuss management of medical co-morbidities with medical physician. Home restrictions (ie, activity, bathing) are discussed with the patient and family members. Chart patient progress notes. Write prescriptions for medications needed post-discharge. Coordinate follow-up appointment with patient or family and office staff. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Office

Review interval chart notes. Examine and talk with patient. Answer patient/family questions. Remove splint/dressings. Assess wound. Assess of circulation, sensation, and motor function of the operated extremity. Assess pain scores and adequacy of analgesia. Remove staples or sutures and drain, when appropriate. Redress wound. Order physical therapy. Monitor progress of rehabilitation. Discuss progress with referring physician(s) (verbal and written). Dictate progress notes for medical chart. Order and review radiographs to assess fixation and bone healing.

							-					
SURVEY DATA												
RUC Meeting Date (mm/yyyy) 02/2011												
Presenter(s):	William Creev	Nilliam Creevy, MD; Tye Ouzounian, MD;										
Specialty(s):	AAOS; AOFA	AAOS; AOFAS; OTA										
CPT Code:	27792	27792										
Sample Size:	250 R	esp N:	53	53 Response: 21.2 %								
Sample Type:	Random	Random Additional Sample Information:										
			Low	25 th pctl	Median*	75th pctl	<u>High</u>					
Service Perform	nance Rate		0.00	6.00	15.00	20.00	100.00					
Survey RVW:			8.00	9.00	10.50	13.00	25.00					
Pre-Service Evalu	uation Time:				40.00							
Pre-Service Posit	tioning Time:				10.00							
Pre-Service Scru	b, Dress, Wait Ti	me:			15.00							
Intra-Service Ti	me:		30.00	45.00	60.00	60.00	90.00					
Immediate Post	Service-Time:	<u>20.00</u>										
Post Operative	<u>Visits</u>	Total Min**	CPT Cod	e and Num	ber of Visit	S						
Critical Care tin	ne/visit(s):	<u>0.00</u>	99291x 0	. 00 99292	2x 0.00							
Other Hospital	time/visit(s):	<u>20.00</u>	99231x 1	. 00 99232	2x 0.00 9	9233x 0.00						
Discharge Day	Mgmt:	<u>38.00</u>	99238x 1	.00 99239x	0.00							
Office time/visit	t(s):	78.00	99211x 0	.00 12x 2.0	0 13x 2.00 1	4x 0.00 15x	0.00					
Prolonged Serv	ices:	0.00	99354x 0	.00 55x C).00 56x 0	.00 57x 0.0)0					
Sub Obs Care:		<u>0.00</u>	99224x 0	.00 99225	5x 0.00 9	9226x 0.00						

**Physician standard total <u>minutes per E/M visit</u>: 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:	27792		Recommended Physician Work RVU: 9.71						
			Specialty Specialty Recommended Recommended Pre-Service Time Pre Time Packag		Adjustments to Pre-Service Time				
Pre-Service Evaluation T	ime:		33.00	33.00	0.00				
Pre-Service Positioning 1	Time:		10.00	3.00	7.00				
Pre-Service Scrub, Dress	, Wait Tim	ie:	15.00	15.00	0.00				
Intra-Service Time:			60.00						
Immediate Post Servic	e-Time:	<u>20.00</u>							
Post Operative Visits		<u>Total Min**</u>	CPT Code and Nu	<u>mber of Visits</u>					
Critical Care time/visit	(s):	<u>0.00</u>	99291x 0.00 992	92x 0.00					
Other Hospital time/vis	sit(s):	<u>0.00</u>	99231x 0.00 992	32x 0.00 99233x	0.00				
Discharge Day Mgmt:		<u>38.00</u>	99238x 1.0 99239>	< 0.0					
Office time/visit(s):		<u>78.00</u>	99211x 0.00 12x 2	.00 13x 2.00 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:		20.00	99224x 1.00 992	25x 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 S	ERVICE:			
<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	
28299	090	11.57	RUC Time	

CPT Descriptor Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy

KEY MPC COMPARISON CODES:

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

				Most Recent
MPC CPT Code 1	<u>Global</u> V	<u>Vork RVU</u>	Time Source	Medicare Utilization
14060	090	9.23	RUC Time	98,372
CPT Descriptor 1 Adjacen	t tissue transfer o	or rearrangement,	eyelids, nose, ears	and/or lips; defect 10 sq cm or less
				Most Recent
MPC CPT Code 2	<u>Global</u>	Work RVU	Time Source	Medicare Utilization
50590	090	9.77	RUC Time	53,325

CPT Descriptor 2 Lithotripsy, extracorporeal shock wave

Other Reference CPT Code	<u>Global</u>	Work RVU	Time Source
27784	090	9.67	RUC Time

CPT Descriptor Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performed

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including existing time 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: 13.2 %

<u>TIME ESTIMATES (Median)</u>	CPT Code: 27792	Key Reference CPT Code: <u>28299</u>	Source of Time RUC Time
Median Pre-Service Time	58.00	75.00	
Median Intra-Service Time	60.00	90.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	38.0	19.00	
Median Office Visit Time	78.0	85.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	20.0	0.00	
Median Total Time	274.00	299.00	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

(of those that selected Key Reference code)

<u>Mental Effort and Judgment (Mean)</u>		
The number of possible diagnosis and/or the number of	3.00	3.00
management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests,	3.43	3.20
and/or other information that must be reviewed and analyzed		
Urgency of medical decision making	3.00	3.20
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.29	3.20
Physical effort required	346	3 40
	0.40	5.40
Psychological Stress (IVICAII)		
The risk of significant complications, morbidity and/or mortality	3.00	3.20
Outcome depends on the skill and judgment of physician	3.00	3.40
Sucome depends on the skin and judgment of physician	5.00	5.40
Estimated risk of malpractice suit with poor outcome	3.00	3.20
INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference
		Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.86	3.00
Intra-Service intensity/complexity	3.14	3.40
De et Comise intervier/es multiple	2.40	2.0
Post-Service Intensity/complexity	343	L 2.0U

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 Code: 27792

As part of the third 5-year-review process in 2005, the AAOS commented to CMS that there was compelling evidence for examining the work RVU for a group of fracture treatment codes where incorrect assumptions were made due to lack of clarity of the CPT descriptor. The 5YR ID Workgroup recommended AAOS review the codes at CPT prior to surveying as part of the third 5YR.

Code 27792 was revised and reviewed by the RUC in 2007. The RUC reviewed the compelling evidence presented including a lack of clarity in CPT descriptors and an Abt study that was performed in 1992 for RUC consideration. The Abt study produced percentage relationships to key reference codes, but not surveyed time and visit data. Some of the recommendations in this 1992 study were accepted by the RUC and HCFA (CMS) and others were adjusted up or down, but no changes were made to the Harvard time and visit data, if available. At the 2007 RUC meeting, the AAOS argued that there was little, if any, relationship between the Harvard database information and the current work RVUs because of all the changes made to work RVUs based on the Abt study. Change in technology (ie, the ability to treat more complex repairs) was also presented as compelling evidence at the 2007 RUC meeting. The RUC accepted compelling evidence (under the 3rd 5YR) and recommended 10.50 work RVUs for code 27792.

CMS disregarded the compelling evidence that was presented and instead applied work neutrality to the group of fracture codes that were reviewed, <u>resulting in a 9% reduction</u> in the work RVU compared with the RUC recommendation and the survey data. No reference code(s) to support the value were offered.

Recently, CMS has indicated that the site of service for 27792 has changed from inpatient to outpatient in the Medicare database. The 2009 Medicare data indicate <u>49.4%</u> inpatient. CMS requested the RUC review code 27792 as a code with a site of service anomaly.

Our consensus panel believes <u>that the procedure has not changed over time.</u> We also question CMS's request for review of a procedure that is not typically provided to Medicare patients or where the Medicare percentage of inpatient is so close to 50%. If we remove the nearly 100 claims from specialties that (in our opinion) represent erroneous reporting (eg, family practice, general practice, ophthalmology), the Medicare percentage of inpatient claims for 2009 is 50.2%, instead of 49.4%. We note that the type and severity of fractures resulting from trauma are not static from year to year. Separately, we would note that the Relativity Assessment Workgroup will discuss modifying the criteria for the site-ofservice screen going forward to require three complete years of consecutive data showing 45% or less inpatient before requiring review of a code under that screen. Separately, we hope there will also be a discussion reinforcing typical national patient versus typical Medicare patient.

It is the clinical opinion of our expert panel that the typical patients requiring 27792 would be kept *at least* one night in the hospital. Patients requiring this repair are not typically Medicare-aged. These patients are typically trauma patients, including multiple traumas. Neurovascular injury may occur with this type of fracture, requiring close monitoring of the circulation, sensation, and motor function of the involved extremity. Hospital admission criteria programs may designate the patient's stay as outpatient instead of inpatient, but the physician work to review the patient chart, take down dressings, examine the patient, write subsequent orders, and talk to the floor staff and the family is the same, regardless of facility status. Then, the next day, <u>after</u> reviewing the patient's chart and examining the patient, the surgeon will determine if it is safe to discharge the patient. Some patients will be discharged on the second day and others will remain additional days in the hospital (either admitted to inpatient status or maintained under outpatient status).

CURRENT RECOMMENDATION

The AAOS, AOFAS, and OTA recommend maintaining the current RVW as published for CY 2011 (9.71).

We believe the total physician work has not changed for 27792. We believe the total physician work has not changed for 27792 and recommend maintaining a discrete evaluation and management visit on the day of surgery as indicated by our survey data and clinical rationale. We respectfully request to defer our recommendation for the designation of the postop evaluation and management code until the RUC approves a policy and/or rules regarding correct coding for this physician work.

The table below compares the survey code to many other RUC reviewed codes, providing further support that the current value for 27792 is not overvalued. In this table, we have utilized the RUC's current proxy of 99231 for the post-op in-hospital E/M visit.

RUC				Total					Immed		31/	38/		
Year	CPT	RVW	IWPUT	Time	eval	posit	s,d,w	INTRA	Post-op	32	<mark>24</mark>	<mark>17</mark>	13	12

			-		-		-	-				Joue.	<u> 1192</u>	
RUC Year	СРТ	RVW	IWPUT	Total Time	eval	posit	s.d.w	INTRA	Immed Post-op	32	31/ <mark>24</mark>	38/ <mark>17</mark>	13	12
2009	37761	9.13	0.074	224	33	10	15	60	25			0.5	2	1
2008	27690	9.17	0.052	258	33	10	15	60	20			0.5	3	2
2007	29905	9.18	0.058	244	40	15	10	60	15			0.5	3	1
2000	35701	9.19	0.053	262	55			60	30	1		1.0	1	1
2008	27650	9.21	0.057	239	19	15	5	60	20			0.5	3	2
2008	14060	9.23	0.090	183	15	10	5	60	15				2	2
2008	23415	9.23	0.065	247	40	15	15	60	20			0.5	2	2
2000	49501	9.36	0.070	232	45			60	30		1	1.0	1	1
1996	44970	9.45	0.055	242	45			73	20		1	1.0	2	
2007	28555	9.65	0.050	281	40	10	15	60	20		1	1.0	2	2
2003	37766	9.66	0.066	231	33	10	15	90	25			0.5	1	1
2007	27784	9.67	0.051	281	40	10	15	60	20		1	1.0	2	2
2007	27792	9.71	0.051	281	40	10	15	60	20		1	<mark>1.0</mark>	2	2
2005	50590	9.77	0.080	234	35	15	13	60	30			0.5	2	1
2000	49553	9.92	0.063	247	45			75	30		1	1.0	1	1
1997	53850	10.08	0.064	241	60			90	45				2	
2009	26117	10.13	0.058	271	40	12	20	75	20			0.5	3	1
2007	27769	10.14	0.065	279	45	15	15	60	15		1	1.0	1	3
2007	27832	10.17	0.046	301	45	10	15	75	20		1	1.0	2	2
1997	49323	10.23	0.043	299	75			90	30		1	1.0	2	
2000	54522	10.25	0.080	211	45			75	25		1		2	
2005	15240	10.41	0.053	288	45	10	10	60	20			0.5	4	2
2005	66984	10.52	0.211	162	10	5	10	30	10			0.5	2	2
2001	28299	11.57	0.058	299	75			90	30			0.5	3	1

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) 27792

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 orthopaedic surgery		How often? Sometimes
Specialty	How often?	
Specialty	How often?	

Estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. national frequency not available, but typical patient is not Medicare age

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? 6,096 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate. 2009 Medicare Data

Specialty orthopaedic surgery		Frequency 5619	Percentage 92.17 %	
Specialty	Frequency	Percentage	%	
Specialty	Frequency	Percentage	%	

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 27792

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

AMA/Specialty Society RVS Update Committee Summary of Recommendations Identified through the Site of Service Anomaly Screen and the Fourth Five-Year Review

February 2011

Removal of Foot Bone

In September 2007, the RUC's Relativity Assessment Workgroup identified CPT codes 28120 and 28122 as potentially misvalued through the Siteof-Service Anomaly screen. In 2008, the American Academy of Orthopaedic Surgery, the American Orthopaedic Foot and Ankle Society and the American Podiatric Medical Association conducted a RUC survey for these services. The RUC deferred review of these services until the RUC survey instrument could be modified to capture information about typical site of service. In 2009, the specialties presented code 28120 and 28122 using data from a modified RUC survey instrument that included a question regarding site-of-service and visits on the day of the procedure. Following the RUC's recommendation, CMS included code 28120 and 28122 as part of the 4th Five-Year Review and in Table 16 of the 2011 Proposed Rule to re-review these services. In response to this request by CMS, the RUC re-reviewed the survey data presented by the specialty societies and assessed the previous RUC recommendation for work RVUs.

The specialty societies presented their survey data including physician times and the RUC agreed that these times accurately reflected the service performed by the physician. Importantly, the RUC noted that the work involved in monitoring the typical patient post-operatively on the day of surgery is the same Evaluation and Management work whether the patient's status ends up inpatient or outpatient. Adjustments to the allocation of post-operative visits are used as proxies and do not constitute changes to the physician work relative value of the service which was determined by magnitude estimation and physician specialty survey data during the last RUC review.

28120

In the previous RUC recommendation for this service, the specialty societies utilizing magnitude estimation, compared this service to two reference codes, 15100 *Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)* (work RVU = 9.89) and 49505 *Repair initial inguinal hernia, age 5 years or older; reducible* (work RVU = 7.96). The RUC noted that the surveyed code has less total service time in comparison to 15100, 260 minutes and 281 minutes, respectively. Further, the RUC noted that the surveyed code has more total service time in comparison to 49505, 260 minutes and 198 minutes, respectively. In 2009, based on magnitude estimation, the RUC agreed that the survey's 25th percentile, 8.08 RVUs. CMS accepted the RUC recommended value for this service for 2010. Further, for 2010, this value was increased to 8.27 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. Therefore based on this history and magnitude estimation comparisons to the reference codes, the specialty societies agree and the RUC recommends that the current value of this service be maintained. **The RUC recommends 8.27 Work RVUs for CPT code 28120**.

28122

In the previous RUC recommendation for this service, the RUC discussed the proposed work RVU and agreed that there was no compelling evidence to change the work RVU from its current value. To justify the current value of this service, the specialty societies utilizing magnitude estimation, compared this service to two reference codes, 33207, *Insertion or replacement of permanent pacemaker with transvenous electrode(s); ventricular* (work RVU = 8.05) and 49505 *Repair initial inguinal hernia, age 5 years or older; reducible* (work RVU = 7.96). The RUC noted that the surveyed code has less intra-service time in comparison to 33207, 45 minutes and 60 minutes, respectively. Further, the RUC noted that the surveyed code has less intra-service time in comparison to 49505, 45 minutes and 70 minutes, respectively. Based on these comparisons, the RUC recommended that the current value of 28122, 7.56 work RVUs should be maintained. CMS accepted the RUC recommended value for this service for 2010. Further, for 2010, this value was increased to 7.72 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. Therefore based on this history and magnitude estimation comparisons to the reference codes, the specialty societies agree and the RUC recommends that the current value of this service be maintained. **The RUC recommends 7.72 Work RVUs for CPT code 28122**.

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommenda- tion
28120		Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus	090	8.27
				(No Change)
28122		tarsal or metatarsal bone, except talus or calcaneus	090	7.72
		(For partial excision of talus or calcaneus, use 28120)		(No Change)
		(For cheilectomy for hallux rigidus, use 28289)		

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code:28120 Tracking Number

Original Specialty Recommended RVU: **8.27** Presented Recommended RVU: **8.27** RUC Recommended RVU: **8.27**

Global Period: 090

CPT Descriptor: Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 62-year-old insulin-dependent diabetic female presents with a chronic, trophic ulcer on the posterior aspect of her right heel. A sinus tract leads to the calcaneus, and bone scans are positive for osteomyelitis. She requires resection of the posterior-inferior aspect of the right calcaneus.

Percentage of Survey Respondents who found Vignette to be Typical: 74%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 87%, In the ASC 13%, 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 16%, Kept overnight (less than 24 hours) 18%, Admitted (more than 24 hours) 67%

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 88%

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:

Select and order the appropriate antibiotic(s) and confirm timing and administration. Assure appropriate selection, timing, and administration of DVT prophylaxis. Review results of preadmission testing including labs, X-rays, CT scans, bone scan, and/or MRIs. Perform H&P. Meet with patient and family to review planned procedure and post-operative management. Review informed consent with patient. Verify that all required instruments and supplies are available. Monitor/assist with patient PRONE positioning; padding of bony prominences; and application of thermal regulation drapes. Assess position of the extremities and head, adjust as needed. The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure. Indicate areas of skin to be prepped and mark surgical incisions. The leg is prepped and draped. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Under anesthesia, two semi-elliptical incisions are made on the posterior aspect of the right heel, encompassing a 1 cm diameter ulcer. The insertion of the Achilles tendon is identified and protected. Using bone rongeurs and bone curettes, a portion of the posterior-inferior aspect of the calcaneus is resected and sent for culture and pathology. The remaining healthy bone is rasped smooth. The wound is inspected and irrigated. The wound is packed open.

CPT Code: 28120

Application of a dressing and short leg splint. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia. Continue prophylaxis for DVT. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to orthopaedic floor and discuss ongoing care with floor nurses.

Hospital Visit [operative day after discharge from recovery room]:

Review interval chart notes. Discuss ongoing care with floor nurses. Discuss management of medical co-morbidities with medical physician. Evaluate vital signs and intake/output. Examine patient, assess for bleeding and drain output. Assess circulation, sensation, and motor function of the operated extremity, Assess pain scores and adequacy of analgesia; adjust medication as needed, including antibiotic therapy. Discuss operative findings, procedure, and plan with patient and/or family; answer patient and family questions. Answer nursing/other staff questions. Chart patient progress notes.

Hospital Discharge Management [day after surgery, IF patient is stable and can safely be discharged]:

Review interval chart notes. Evaluate vital signs and intake/output. Assess dressing or splint/cast for bleeding. Assess drain output; remove drain. Evaluate the circulation, sensation, and motor function of the operated extremity. Assess pain scores and adequacy of analgesia; adjust medication as needed. Assess progress with mobilization, ambulation, and physical therapy. Discuss management of medical co-morbidities with medical physician. Home restrictions (ie, activity, bathing) are discussed with the patient and family members. Chart patient progress notes. Write prescriptions for medications needed post-discharge. Coordinate follow-up appointment with patient or family and office staff. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Office

Review interval chart notes. Examine and talk with patient. Answer patient/family questions. Remove splint/dressings. Assess wound. Assess of circulation, sensation, and motor function of the operated extremity. Assess pain scores and adequacy of analgesia. Remove staples or sutures and drain, when appropriate. Redress wound. Order physical therapy. Monitor progress of rehabilitation. Discuss progress with referring physician(s) (verbal and written). Dictate progress notes for medical chart. Order and review radiographs to assess fixation and bone healing.

SURVEY DAT	ГА						
RUC Meeting Da	ate (mm/yyyy)	02/2011					
Presenter(s):	William Cree	William Creevy, MD; Tye Ouzounian, MD; Seth Rubenstein, DPM; Timothy Tillo, DPM					
Specialty(s):	AAOS; AOF	AAOS; AOFAS; APMA					
CPT Code:	28120	28120					
Sample Size:	300	Resp N:	52	Response: 17.3 %			
Sample Type:	Random	Additional Sa	mple Info	rmation:			
			Low	25 th pctl	Median*	75th pctl	<u>High</u>
Service Performance Rate		0.00	3.00	5.00	13.00	60.00	
Survey RVW:			4.00	8.08	8.89	10.55	18.00
Pre-Service Evaluation Time:				45.00			
Pre-Service Positioning Time:				10.00			
Pre-Service Scrub, Dress, Wait Time:				15.00			
Intra-Service Time:		15.00	45.00	50.00	75.00	120.00	
Immediate Post Service-Time: 20.00					· · ·		
Post Operative	<u>Visits</u>	Total Min**	n** CPT Code and Number of Visits				
Critical Care tim	ne/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00				
Other Hospital t	time/visit(s):	<u>20.00</u>	99231x 1.00 99232x 0.00 99233x 0.00				
Discharge Day	Mgmt:	<u>38.00</u>	99238x 1.00 99239x 0.00				
Office time/visit	:(s):	<u>94.00</u>	99211x 0.00 12x 3.00 13x 2.00 14x 0.00 15x 0.00				
Prolonged Serv	ices:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00				
Sub Obs Care:		0.00	99224x 0	.00 99225	5x 0.00 9	9226x 0.00	

**Physician standard total <u>minutes per E/M visit</u>: 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:	28120		Recommended Physician Work RVU: 8.27			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time		
Pre-Service Evaluation Time:		33.00	33.00	0.00		
Pre-Service Positioning Time:		10.00	3.00	7.00		
Pre-Service Scrub, Dress, Wait Time:		15.00	15.00	0.00		
Intra-Service Time:		50.00				
Immediate Post Service	e-Time:	<u>20.00</u>				
Post Operative Visits		<u>Total Min**</u>	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00			
Other Hospital time/vis	it(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:		<u>38.00</u>	99238x 1.0 99239x 0.0			
Office time/visit(s):		<u>94.00</u>	99211x 0.00 12x 3.00 13x 2.00 14x 0.00 15x 0.00			
Prolonged Services:		<u>0.00</u>	99354x 0.00 55x	0.00 56x 0.00	57x 0.00	
Sub Obs Care:		<u>20.00</u>	99224x 1.00 992	25x 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 SER	VICE:							
Key CPT Code 28289	<u>Global</u> 090			<u>Work RV</u> 8.31	<u>Tim</u> RU	e Source C Time		
<u>CPT Descriptor</u> Hallux metatarsophalangeal joint	rigidus corre	ection with che	eilectomy,	debridement	and capsular	release of	the	first
KEY MPC COMPARISON CODES: Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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 So	ource	Medicare U	tilization		
67904	090	7.97	RUC	C Time	50,099	· · · · · · · · · · · · · · · · · · ·		
CPT Descriptor 1 Repair of	f blepharoptosi	s; (tarso) levator	resection or	advancement	, external approa	ach t Recent		
MPC CPT Code 2	Global	Work RVU	Time Sou	ırce	Medicare U	Itilization		
50590	090	9.77	RUC Ti	ime	53,325			
<u>CPT Descriptor 2</u> Lithotripsy, extracorporeal shock wave								
Other Reference CPT Code	<u>Global</u>	<u>Work F</u> 0.00	<u>RVU</u>	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: 11 % of respondents: 21.1 %

<u>TIME ESTIMATES (Median)</u>	CPT Code: 28120	Key Reference CPT Code: <u>28289</u>	Source of Time RUC Time
Median Pre-Service Time	58.00	30.00	
Median Intra-Service Time	50.00	45.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	38.0	0.00	
Median Office Visit Time	94.0	92.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	20.0	0.00	
Median Total Time	280.00	197.00	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

(of those that selected Key Reference code)

<u>Mental Effort and Judgment (Mean)</u>		
The number of possible diagnosis and/or the number of	3.38	3.08
management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests,	3.85	3.08
and/or other information that must be reviewed and analyzed		
г		
Urgency of medical decision making	3.46	2.77
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.31	3.38
Physical effort required	3.08	3 15
De la la choir required	0.00	0.10
<u>Psychological Stress (Ivicali)</u>		
The risk of significant complications, morbidity and/or mortality	3.54	3.38
Outcome depends on the skill and judgment of physician	3.38	3.38
	0.05	0.00
Estimated risk of malpractice suit with poor outcome	3.85	3.38
INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference
		<u>Service 1</u>
Time Segments (Mean)		
Pre-Service intensity/complexity	3.75	3.18
Intra-Service intensity/complexity	3.42	3.18
Post-Service intensity/complexity	3.50	3.36

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 Code: 28120 CPT code 28120 was a Harvard valued code that was identified by the RUC 5YR ID WG in 2007 as potentially misvalued through a site-of-service anomaly screen. The RUC recommended 28120 be surveyed. In 2008, AAOS, AOFAS, and APMA conducted a RUC survey and presented data that indicated 28120 was not same-day surgery. The specialties argued that patients require close monitoring on the day of the procedure and are admitted for continued monitoring at least overnight. These patients typically have many co-morbidities including diabetes. They require close observation of their medical status as well as wound inspection and monitoring of lower extremity neurovascular status. The next day, after examining the patient and reviewing the chart, the surgeon would determine if it was safe to discharge the patient. Some patients would be discharged and others would remain additional days in the hospital. After hearing these arguments, the RUC deferred review of 28120 until the RUC survey instrument could be modified to capture information about typical site of service.

The AAOS, AOFAS, and APMA conducted another RUC survey in 2009 using a modified RUC survey instrument that included a question regarding site-of-service and visits on the day of the procedure. The RUC reviewed and accepted compelling evidence to review the code for a change in work. After consideration of the survey data and reference codes the RUC recommended the survey 25th percentile work RVU.

Recently, CMS requested the RUC review 28120 again as a code with a site of service anomaly.

Our consensus panel believes that the procedure has not changed over time. The Harvard intra-time from nine orthopaedic surgeons was 67 minutes. The current survey intra-time from 52 podiatrists and orthopaedic surgeons is 50 minutes. Further, we also believe the post-operative work has not changed, other than physicians are now treating more complex patients who may be older and have more co-morbidities, resulting in more intense and complex work.

Patients require close monitoring on the day of the procedure and are kept in the hospital for continued monitoring at least overnight. These patients require wound inspection and monitoring of lower extremity neurovascular status. Then, the next day, <u>after</u> reviewing the patient's chart and examining the patient, the surgeon will determine if it is safe to discharge the patient. Some patients will be discharged on the second day and others will remain additional days in the hospital (either admitted to inpatient status or maintained under outpatient or observation care status). The hospital admission criteria program may designate this outpatient instead of inpatient, but the physician work to review the patient chart, take down dressings, examine the patient, write subsequent orders, and talk to the floor staff and the family is the same, regardless of inpatient or outpatient status.

CURRENT RECOMMENDATION

The AAOS, AOFAS, and APMA recommend maintaining the current RVW as published for CY 2011 (8.27).

We believe the total physician work has not changed for 28120. We believe the total physician work has not changed for 28120 and recommend maintaining a discrete evaluation and management visit on the day of surgery as indicated by our survey data and clinical rationale. We respectfully request to defer our recommendation for the designation of the postop evaluation and management code until the RUC approves a policy and/or rules regarding correct coding for this physician work.

The table below compares the survey code to many other RUC reviewed codes, providing further support that the current value for 28120 is not overvalued. In this table, we have utilized the RUC's current proxy of 99231 for the post-op in-hospital E/M visit.

RUC Year	СРТ	RVW	IWPUT	Total Time	eval	posit	s,d,w	INTRA	Immed Post-op	32	31/ <mark>24</mark>	38/ <mark>17</mark>	13	12
2009	21556	7.66	0.046	234	33	20	15	60	25			0.5	2	1
2003	37765	7.71	0.066	201	33	10	15	60	25			0.5	1	1
2007	27766	7.89	0.028	266	40	10	15	45	20		1	1.0	2	2
2000	46262	7.91	0.089	179	40			45	20			0.5	1	2
2005	49505	7.96	0.065	198	20	15	15	70	20			0.5	1	1
2005	67904	7.97	0.089	185	10	10	15	45	15			0.5	1	3
2007	33207	8.05	0.049	239	15	13	20	60	30	1		1.0	1	
2008	25310	8.08	0.056	235	40	10	15	60	20			0.5	1	3
2009	45171	8.13	0.076	209	33	15	15	45	20			0.5	2	1
2008	52500	8.14	0.058	231	45	10	15	45	28			0.5	3	

											OF L	Coue.	20120)
RUC Year	СРТ	RVW	IWPUT	Total Time	eval	posit	s,d,w	INTRA	Immed Post-op	32	31/ <mark>24</mark>	38/ <mark>17</mark>	13	12
2009	28120	8.27	0.026	280	33	10	15	50	20		1	<mark>1.0</mark>	2	3
2006	25606	8.31	0.042	260	40	10	15	45	30			0.5	3	2
1998	28289	8.31	0.069	197	30			45	30				4	
2008	54530	8.46	0.060	247	58	10	15	60	30			0.5	1	2
2005	45020	8.56	0.051	255	30	15	15	45	30		1	1.0	2	1
2000	35741	8.69	0.037	272	50			75	30	1		1.0	1	1
2005	33208	8.77	0.061	236	15	15	15	60	30	1		1.0	1	
2007	24635	8.80	0.032	291	40	10	15	60	30		1	1.0	2	2
2005	22524	8.86	0.092	196	30	15	15	55	20			1.0	1	
2005	67966	8.97	0.084	200	10	10	15	60	15			0.5	1	3
2007	24359	8.98	0.083	213	30	10	10	60	20			0.5		4
1993	24566	9.06	0.047	257	60			60	45				4	
2005	50590	9.77	0.080	234	35	15	13	60	30			0.5	2	1

CDT Code, 20120

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) 28120

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 podiatry	How often? Sometimes				
Specialty orthopaedic surgery		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 <u>percentage</u> for each specialty. Please explain the rationale for this estimate. national frequency not available

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,977 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate. 2009 Medicare data

Specialty podiatry	Frequer	ncy 2026		Percentage	0.00 %
Specialty orthopaedic su	rgery	Frequency 1591		Percentage	0.00 %
Specialty	Frequency		Percenta	age 9	0

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 28120

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code:28122 Tracking Number

Original Specialty Recommended RVU: 7.72 Presented Recommended RVU: 7.72 RUC Recommended RVU: 7.72

Global Period: 090

CPT Descriptor: Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 62 year-old insulin-dependent diabetic female presents with a chronic, trophic ulcer on the plantar aspect of her right cuboid. A sinus tract leads to the cuboid, and bone scans are positive for osteomyelitis. She requires resection of the inferior aspect of the right cuboid.

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 83%, In the ASC 17%, 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 12%, Kept overnight (less than 24 hours) 30%, Admitted (more than 24 hours) 58%

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 92%

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:

Select and order the appropriate antibiotic(s) and confirm timing and administration. Assure appropriate selection, timing, and administration of DVT prophylaxis. Review results of preadmission testing including labs, X-rays, CT scans, bone scan, and/or MRIs. Perform H&P. Meet with patient and family to review planned procedure and post-operative management. Review informed consent with patient. Verify that all required instruments and supplies are available. Monitor/assist with patient PRONE positioning; padding of bony prominences; and application of thermal regulation drapes. Assess position of the extremities and head, adjust as needed. The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure. Indicate areas of skin to be prepped and mark surgical incisions. The leg is prepped and draped. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work:

Under anesthesia, two semi-elliptical incisions are made on the plantar aspect of the cuboid, encompassing a 1 cm diameter ulcer. Using bone rongeurs and bone curettes, a portion of the cuboid is resected and sent for culture and pathology. The remaining healthy bone is rasped smooth. The wound is inspected and irrigated. The wound is packed open.

Description of Post-Service Work:

Immediate Post op [after wound closure through discharge from recovery room]:

CPT Code: 28122

Application of a dressing and short leg splint. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia. Continue prophylaxis for DVT. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to orthopaedic floor and discuss ongoing care with floor nurses.

Hospital Visit [operative day after discharge from recovery room]:

Review interval chart notes. Discuss ongoing care with floor nurses. Discuss management of medical co-morbidities with medical physician. Evaluate vital signs and intake/output. Examine patient, assess for bleeding and drain output. Assess circulation, sensation, and motor function of the operated extremity, Assess pain scores and adequacy of analgesia; adjust medication as needed, including antibiotic therapy. Discuss operative findings, procedure, and plan with patient and/or family; answer patient and family questions. Answer nursing/other staff questions. Chart patient progress notes.

Hospital Discharge Management [day after surgery, IF patient is stable and can safely be discharged]:

Review interval chart notes. Evaluate vital signs and intake/output. Assess dressing or splint/cast for bleeding. Assess drain output; remove drain. Evaluate the circulation, sensation, and motor function of the operated extremity. Assess pain scores and adequacy of analgesia; adjust medication as needed. Assess progress with mobilization, ambulation, and physical therapy. Discuss management of medical co-morbidities with medical physician. Home restrictions (ie, activity, bathing) are discussed with the patient and family members. Chart patient progress notes. Write prescriptions for medications needed post-discharge. Coordinate follow-up appointment with patient or family and office staff. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Office

Review interval chart notes. Examine and talk with patient. Answer patient/family questions. Remove splint/dressings. Assess wound. Assess of circulation, sensation, and motor function of the operated extremity. Assess pain scores and adequacy of analgesia. Remove staples or sutures and drain, when appropriate. Redress wound. Order physical therapy. Monitor progress of rehabilitation. Discuss progress with referring physician(s) (verbal and written). Dictate progress notes for medical chart. Order and review radiographs to assess fixation and bone healing.

SURVEY DAT	ГА								
RUC Meeting Date (mm/yyyy) 02/2011									
Presenter(s):	William Cree	William Creevy, MD; Tye Ouzounian, MD; Seth Rubenstein, DPM; Timothy Tillo, DPM							
Specialty(s):	AAOS; AOF	AOS; AOFAS; APMA							
CPT Code:	28122	28122							
Sample Size:	300 F	Resp N:	52	52 Response: 17.3 %					
Sample Type:	Random	Additional Sa	mple Info	rmation:					
			Low	25 th pctl	Median*	75th pctl	<u>High</u>		
Service Perform	nance Rate		0.00	3.00	6.00	15.00	50.00		
Survey RVW:			4.00	7.88	8.35	10.13	17.00		
Pre-Service Evaluation Time:					45.00				
Pre-Service Posit	ioning Time:				10.00				
Pre-Service Scrul	b, Dress, Wait T	ime:			15.00				
Intra-Service Ti	me:		15.00	44.00	45.00	60.00	120.00		
Immediate Post	Service-Time	: <u>20.00</u>							
Post Operative	<u>Visits</u>	Total Min**	CPT Cod	e and Num	ber of Visit	<u>S</u>			
Critical Care tim	ne/visit(s):	<u>0.00</u>	99291x 0	. 00 99292	2x 0.00				
Other Hospital t	time/visit(s):	<u>20.00</u>	99231x 1	.00 99232	2x 0.00 9	9233x 0.00			
Discharge Day Mgmt: <u>38.00</u>			99238x 1	. 00 99239x	0.00				
Office time/visit	99211x 0	.00 12x 2.0	0 13x 2.00 1	4x 0.00 15x	0.00				
Prolonged Serv	99354x 0	.00 55x C	.00 56x 0	.00 57x 0.0	00				
Sub Obs Care:		0.00	99224x 0	.00 99225	5x 0.00 9	9226x 0.00			

**Physician standard total <u>minutes per E/M visit</u>: 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:	28122		Recommended Physician Work RVU: 7.72				
			Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time		
Pre-Service Evaluation Time:			33.00	33.00	0.00		
Pre-Service Positioning T	ime:		10.00	3.00	7.00		
Pre-Service Scrub, Dress, Wait Time:			15.00	15.00	0.00		
Intra-Service Time:			45.00				
Immediate Post Service	e-Time:	<u>20.00</u>					
Post Operative Visits		<u>Total Min**</u>	CPT Code and Nu	umber of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 992	92x 0.00			
Other Hospital time/vis	it(s):	<u>0.00</u>	99231x 0.00 992	32x 0.00 99233x	0.00		
Discharge Day Mgmt:		<u>38.00</u>	99238x 1.0 99239	× 0.0			
Office time/visit(s):		<u>78.00</u>	99211x 0.00 12x 2.00 13x 2.00 14x 0.00 15x 0.00				
Prolonged Services:		<u>0.00</u>	99354x 0.00 55x	0.00 56x 0.00	57x 0.00		
Sub Obs Care:		20.00	99224x 1.00 992	25x 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:							
<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	Time Source				
28288	090	5.81	RUC Time				

CPT Descriptor Ostectomy, partial, exostectomy or condylectomy, metatarsal head, each metatarsal head

KEY MPC COMPARISON CODES:

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

				Most Recent
MPC CPT Code 1	<u>Global</u>	Work RVU	Time Source	Medicare Utilization
67904	090	7.97	RUC Time	50,099
CPT Descriptor 1 Repair	of blepharoptosis	; (tarso) levator re	esection or advanceme	ent, external approach
				Most Recent
MPC CPT Code 2	Global	Work RVU	Time Source	Medicare Utilization
46262	090	7.91	RUC Time	226

<u>CPT Descriptor 2</u> Hemorrhoidectomy, internal and external, 2 or more columns/groups; with fistulectomy, including fissurectomy, when performed

Other Reference CPT Code	<u>Global</u>	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: 25.0 %

<u>TIME ESTIMATES (Median)</u>	CPT Code: 28122	Key Reference CPT Code: <u>28288</u>	Source of Time RUC Time
Median Pre-Service Time	58.00	20.00	
Median Intra-Service Time	45.00	30.00	
Median Immediate Post-service Time	20.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	38.0	0.00	
Median Office Visit Time	78.0	99.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	20.0	0.00	
Median Total Time	259.00	169.00	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

(of those that selected Key Reference code)

<u>Mental Effort and Judgment (Mean)</u>		
The number of possible diagnosis and/or the number of	3.56	2.78
management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests,	3.78	2.89
and/or other information that must be reviewed and analyzed		
Urgency of medical decision making	3.78	3.11
Technical Skill/Physical Effort (Mean)		
	·	
Technical skill required	3.33	3.11
Physical effort required	3.00	2.78
Psychological Stross (Mean)		
r sychological stress (ivicall)		
The risk of significant complications, morbidity and/or mortality	3.89	2.89
Outcome depends on the skill and judgment of physician	3 78	3 33
Sucome depends on the skin and judgment of physician	0.10	0.00
Estimated risk of malpractice suit with poor outcome	3.73	3.22
INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference
	0110040	Service 1
Time Sermente (Moon)		
Pre-Service intensity/complexity	3.89	3.11
Intra-Service intensity/complexity	3 33	2 78
mua-service mensity/complexity	0.00	2.10
Post-Service intensity/complexity	3.33	2.78

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 Code: 28122 CPT code 28122 was a Harvard valued code that was identified by the RUC 5YR ID WG in 2007 as potentially misvalued through a site-of-service anomaly screen. The RUC recommended 28122 be surveyed. In 2008, AAOS, AOFAS, and APMA conducted a RUC survey and presented data that indicated 28122 was not same-day surgery. The specialties argued that patients require close monitoring on the day of the procedure and are admitted for continued monitoring at least overnight. These patients typically have many co-morbidities including diabetes. They require close observation of their medical status as well as wound inspection and monitoring of lower extremity neurovascular status. The next day, after examining the patient and reviewing the chart, the surgeon would determine if it was safe to discharge the patient. Some patients would be discharged and others would remain additional days in the hospital. After hearing these arguments, the RUC deferred review of 28122 until the RUC survey instrument could be modified to capture information about typical site of service.

The AAOS, AOFAS, and APMA conducted another RUC survey in 2009 using a modified RUC survey instrument that included a question regarding site-of-service and visits on the day of the procedure. The RUC reviewed and rejected compelling evidence to review the code for a change in work. After consideration of the survey data and reference codes the RUC recommended maintaining the current work RVU.

Recently, CMS requested the RUC review 28122 again as a code with a site of service anomaly.

Our consensus panel believes that the procedure has not changed over time. The Harvard intra-time from nine orthopaedic surgeons was 51 minutes. The current survey intra-time from 52 podiatrists and orthopaedic surgeons is 50 minutes. Further, we also believe the post-operative work has not changed, other than physicians are now treating more complex patients who may be older and have more co-morbidities, resulting in more intense and complex work.

Patients require close monitoring on the day of the procedure and are kept in the hospital for continued monitoring at least overnight. These patients require wound inspection and monitoring of lower extremity neurovascular status. Then, the next day, <u>after</u> reviewing the patient's chart and examining the patient, the surgeon will determine if it is safe to discharge the patient. Some patients will be discharged on the second day and others will remain additional days in the hospital (either admitted to inpatient status or maintained under outpatient or observation care status). The hospital admission criteria program may designate this outpatient instead of inpatient, but the physician work to review the patient chart, take down dressings, examine the patient, write subsequent orders, and talk to the floor staff and the family is the same, regardless of inpatient or outpatient status.

CURRENT RECOMMENDATION

The AAOS, AOFAS, and APMA recommend maintaining the current RVW as published for CY 2011 (7.72).

We believe the total physician work has not changed for 28122. We believe the total physician work has not changed for 28122 and recommend maintaining a discrete evaluation and management visit on the day of surgery as indicated by our survey data and clinical rationale. We respectfully request to defer our recommendation for the designation of the postop evaluation and management code until the RUC approves a policy and/or rules regarding correct coding for this physician work.

The table below compares the survey code to many other RUC reviewed codes, providing further support that the current value for 28122 is not overvalued. In this table, we have utilized the RUC's current proxy of 99231 for the post-op in-hospital E/M visit.

RUC Year	СРТ	RVW	IWPUT	Total Time	eval	posit	s,d,w	INTRA	Immed Post-op	32	31/ <mark>24</mark>	38/ <mark>17</mark>	13	12
2009	21556	7.66	0.046	234	33	20	15	60	25			0.5	2	1
2003	37765	7.71	0.066	201	33	10	15	60	25			0.5	1	1
2007	27766	7.89	0.028	266	40	10	15	45	20		1	1.0	2	2
2000	46262	7.91	0.089	179	40			45	20			0.5	1	2
2005	49505	7.96	0.065	198	20	15	15	70	20			0.5	1	1
2005	67904	7.97	0.089	185	10	10	15	45	15			0.5	1	3
2007	33207	8.05	0.049	239	15	13	20	60	30	1		1.0	1	
1993	54670	6.65	0.030	230	30			60	42		1	1.0		2.5
2002	49419	7.08	0.034	231	60			60	30		1	1.0	1	
2004	58565	7.12	0.074	191	35	10	15	50	30			0.5		2

				1								1 0000	. 201	~~
RUC				Total	_		_		Immed		31/	38/		
Year	СРТ	RVW	IWPUT	Time	eval	posit	s,d,w	INTRA	Post-op	32	<mark>24</mark>	<mark>17</mark>	13	12
2005	37718	7.13	0.078	178	35	10	10	45	20			0.5	1	1
1992	55550	7.20	0.048	196	45			75	30				2	
2007	28505	7.44	0.049	227	40	10	15	45	20			0.5	2	2
2008	56620	7.53	0.035	239	45	10	5	45	30			0.5	3	1
2008	25116	7.56	0.031	249	40	10	15	60	20			0.5	3	1
2009	21556	7.66	0.046	234	33	20	15	60	25			0.5	2	1
2003	37765	7.71	0.066	201	33	10	15	60	25			0.5	1	1
2009	28122	7.72	0.025	264	33	10	15	50	20		1	<mark>1.0</mark>	2	2
2007	27766	7.89	0.028	266	40	10	15	45	20		1	1.0	2	2
2000	46262	7.91	0.089	179	40			45	20			0.5	1	2
2005	49505	7.96	0.065	198	20	15	15	70	20			0.5	1	1
2005	67904	7.97	0.089	185	10	10	15	45	15			0.5	1	3
2007	33207	8.05	0.049	239	15	13	20	60	30	1		1.0	1	
2008	25310	8.08	0.056	235	40	10	15	60	20			0.5	1	3
2009	45171	8.13	0.076	209	33	15	15	45	20			0.5	2	1
2008	52500	8.14	0.058	231	45	10	15	45	28			0.5	3	
2006	25606	8.31	0.042	260	40	10	15	45	30			0.5	3	2
2008	54530	8.46	0.060	247	58	10	15	60	30			0.5	1	2
2005	45020	8.56	0.051	255	30	15	15	45	30		1	1.0	2	1
2000	35741	8.69	0.037	272	50			75	30	1		1.0	1	1

CDT Code, 20122

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) 28122

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 podiatry

How often? Sometimes

Specialty orthopaedic surgery

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 <u>percentage</u> for each specialty. Please explain the rationale for this estimate. national frequency not available

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 10,767 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate. 2009 Medicare data

Specialty podiatry	Frequ	ency 8121	Percent	tage 75.42 %
Specialty orthopaedic su	rgery	Frequency 2188	Percent	tage 20.32 %
Specialty	Frequency	Per	centage	%

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 <u>will not</u> change, enter the surveyed existing CPT code number 28122

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

AMA/Specialty Society RVS Update Committee Summary of Recommendations Identified through the Site of Service Anomaly Screen

February 2011

Foot Arthrodesis

In September 2007, the RUC's Relativity Assessment Workgroup identified CPT codes 28725 and 28730 as potentially misvalued through the Siteof-Service Anomaly screen. In 2008, the American Academy of Orthopaedic Surgery, the American Orthopaedic Foot and Ankle Society and the American Podiatric Medical Association conducted a RUC survey for these services. The RUC deferred review of these services until the RUC survey instrument could be modified to capture information about typical site of service. In 2009, the specialties presented code 28725 and 28730 using data from a modified RUC survey instrument that included a question regarding site-of-service and visits on the day of the procedure. Following the RUC's recommendation, CMS included code 28120 and 28122 in Table 16 of the 2011 Proposed Rule to re-review these services. In response to this request by CMS, the RUC re-reviewed the survey data presented by the specialty societies and assessed the previous RUC recommendation for work RVUs.

The specialty societies presented their survey data including physician times and the RUC agreed that these times accurately reflected the service performed by the physician. Importantly, the RUC noted that the work involved in monitoring the typical patient post-operatively on the day of surgery is the same Evaluation and Management work whether the patient's status ends up inpatient or outpatient. Adjustments to the allocation of post-operative visits are used as proxies and do not constitute changes to the physician work relative value of the service which was determined by magnitude estimation and physician specialty survey data during the last RUC review.

28725

In the previous RUC recommendation for this service, based on its review of the survey data, the RUC agreed that the current work RVU was the appropriate valuation of the work involved in the service. The RUC noted that the current work RVU is below the survey 25th percentile work RVU. The RUC utilizing magnitude estimation, also reviewed several reference codes to support the 2009 work RVU of 11.97 for 28725 including CPT code 28261, *Capsulotomy, midfoot; with tendon lengthening*, (work RVU = 13.11) and 47562, *Laparoscopy, surgical; cholecystectomy*, (work RVU=11.76). The RUC noted that the surveyed code requires less intra-service time as compared to 28261, 90 minutes and 103 minutes, respectively. Further, the RUC noted that the surveyed code requires more intra-service time as compared to 47562, 90 minutes and 80 minutes, respectively. In 2009, the RUC recommended maintaining the current work RVU of 11.97 for CPT code 28725. CMS accepted the RUC recommended value for this service for 2010. Further, for 2010, this value was increased to 12.18 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. Therefore, based on this history and magnitude estimation comparisons to the reference codes, the specialty societies agree and the RUC recommends that the current value of this service be maintained. **The RUC recommends 12.18 RVUs for CPT code 28725**.

28730

In the previous RUC recommendation for this service, based on its review of the survey data, the RUC agreed that the current work RVU was the appropriate valuation of the work involved in the service. The RUC also noted that the current work RVU is below the survey 25th percentile work RVU. The RUC also reviewed several reference codes to support the 2009 work RVU of 12.21 for 28730 including CPT codes 28309, *Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; multiple (eg, Swanson type cavus foot procedure)* (work RVU = 14.16) and 29862, *Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum* (work RVU = 11.17). The RUC noted that while the procedures are similar in intensity and complexity, 28730 required less total-service time than 28309, 317 minutes and 350 minutes, respectively. The RUC also commented that the surveyed code has more total-service time that 29862, 317 minutes and 297 minutes, respectively. In 2009, the RUC recommended maintaining the current work RVU of 12.21 for CPT code 28730, a value less than the 25th percentile of the survey data. CMS accepted the RUC recommended value for this service for 2010. Further, for 2010, this value was increased to 12.42 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. Therefore, based on this history and magnitude estimation comparisons to the reference codes, the specialty societies agree and the RUC recommends that the current value of this service be maintained. **The RUC recommends 12.42 RVUs for CPT code 28730**.

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommenda- tion
28725		Arthrodesis; subtalar	090	12.18
				(No Change)
28730		Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse;	090	12.42
				(No Change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code:28725 Tracking Number

Original Specialty Recommended RVU: **12.18** Presented Recommended RVU: **12.18** RUC Recommended RVU: **12.18**

Global Period: 090

CPT Descriptor: Arthrodesis; subtalar

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 36-year-old male presents with a chronic, painful foot secondary to an old calcaneal fracture. Clinical findings, X-rays and a CT scan reveal an arthritic subtalar joint. He undergoes a subtalar arthrodesis.

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 89%~ , In the ASC 11%, 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 17%, Kept overnight (less than 24 hours) 56%, Admitted (more than 24 hours) 27%

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 89%

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:

Select and order the appropriate antibiotic(s) and confirm timing and administration. Assure appropriate selection, timing, and administration of DVT prophylaxis. Review results of preadmission testing including labs, X-rays, CT scans, bone scan, and/or MRIs. Perform H&P. Meet with patient and family to review planned procedure and post-operative management. Review informed consent with patient. Verify that all required instruments and supplies are available. Monitor/assist with patient prone positioning (PRONE); padding of bony prominences; and application of thermal regulation drapes. Assess position of the extremities and head, adjust as needed. The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure. Indicate areas of skin to be prepped and mark surgical incisions. The leg is prepped and draped. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Under anesthesia, an incision is made over the lateral hindfoot. Neurovascular structures are identified and protected. The incision is carried down through the sinus tarsi to the subtalar joint. The articular cartilage in the subtalar joint is removed down to bleeding bone. Loose fragments are irrigated and removed. The foot is placed in a functional position and the fusion is fixed with internal fixation. Position is verified using fluoroscopy. The wound is inspected and irrigated. Bone graft is inserted as necessary. A hemovac drain is placed. The wound is closed in layers.

Description of Post-Service Work:

Immediate Post op [after wound closure through discharge from recovery room]:

CPT Code: 28725

Application of a dressing and short leg splint. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia. Continue prophylaxis for DVT. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to orthopaedic floor and discuss ongoing care with floor nurses.

Hospital Visit [operative day after discharge from recovery room]:

Review interval chart notes. Discuss ongoing care with floor nurses. Discuss management of medical co-morbidities with medical physician. Evaluate vital signs and intake/output. Examine patient, assess for bleeding and drain output. Assess circulation, sensation, and motor function of the operated extremity, Assess pain scores and adequacy of analgesia; adjust medication as needed. Discuss operative findings, procedure, and plan with patient and/or family; answer patient and family questions. Answer nursing/other staff questions. Chart patient progress notes.

Hospital Discharge Management [day after surgery, IF patient is stable and can safely be discharged]:

Review interval chart notes. Evaluate vital signs and intake/output. Assess dressing or splint/cast for bleeding. Assess drain output; remove drain. Evaluate the circulation, sensation, and motor function of the operated extremity. Assess pain scores and adequacy of analgesia; adjust medication as needed. Assess progress with mobilization, ambulation, and physical therapy. Discuss management of medical co-morbidities with medical physician. Home restrictions (ie, activity, bathing) are discussed with the patient and family members. Chart patient progress notes. Write prescriptions for medications needed post-discharge. Coordinate follow-up appointment with patient or family and office staff. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Office

Review interval chart notes. Examine and talk with patient. Answer patient/family questions. Remove splint/dressings. Assess wound. Assess of circulation, sensation, and motor function of the operated extremity. Assess pain scores and adequacy of analgesia. Remove staples or sutures and drain, when appropriate. Redress wound. Order physical therapy. Monitor progress of rehabilitation. Discuss progress with referring physician(s) (verbal and written). Dictate progress notes for medical chart. Order and review radiographs to assess fixation and bone healing.

SURVEY DAT	ΓΑ									
RUC Meeting Da	RUC Meeting Date (mm/yyyy) 02/2011									
Presenter(s):	William Creevy, MD; Tye Ouzounian, MD; Seth Rubenstein, DPM; Timothy Tillo, DPM									
Specialty(s):	AAOS; AOFA	AOS; AOFAS; APMA								
PT Code: 28725										
Sample Size:	300 F	300 Resp N: 71 Response: 23.6 %								
Sample Type:	Random	Additional Sa	mple Info	rmation:						
			Low	25 th pctl	Median*	75th pctl	<u>High</u>			
Service Perform	ance Rate		0.00	3.00	6.00	15.00	100.00			
Survey RVW:			8.30	16.50	15.00	16.00	30.00			
Pre-Service Evalu	ation Time:				45.00					
Pre-Service Posit	ioning Time:				10.00					
Pre-Service Scrut	o, Dress, Wait Ti	me:			15.00					
Intra-Service Tir	ne:		35.00	70.00	90.00	120.00	300.00			
Immediate Post	Service-Time:	<u>20.00</u>								
Post Operative	Visits	Total Min**	CPT Cod	e and Num	ber of Visit	S				
Critical Care tim	e/visit(s):	<u>0.00</u>	99291x 0	. 00 99292	2x 0.00					
Other Hospital t	ime/visit(s):	<u>20.00</u>	99231x 1	.00 99232	2x 0.00 9	9233x 0.00				
Discharge Day I	Ngmt:	<u>38.00</u>	99238x 1	. 00 99239x	0.00					
Office time/visit(s): 101.00 99211x 0.00 12x 2.00 13x 3.00 14x 0.00 15						4x 0.00 15x	0.00			
Prolonged Serv	ices:	0.00	99354x 0	.00 55x C).00 56x 0	.00 57x 0.0	00			
Sub Obs Care: 0.00 99224x 0.00 99225x 0.00 99226x 0.00										

**Physician standard total <u>minutes per E/M visit</u>: 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:	28725		Recommended Physician Work RVU: 12.18				
			Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time		
Pre-Service Evaluation Ti	ime:		33.00	33.00	0.00		
Pre-Service Positioning T	Time:		10.00	3.00	7.00		
Pre-Service Scrub, Dress	, Wait Tim	ie:	15.00 15.00 0.0				
Intra-Service Time:			90.00				
Immediate Post Servic	e-Time:	<u>20.00</u>					
Post Operative Visits		<u>Total Min**</u>	CPT Code and Nu	<u>Imber of Visits</u>			
Critical Care time/visit	(s):	<u>0.00</u>	99291x 0.00 992	92x 0.00			
Other Hospital time/vis	sit(s):	<u>0.00</u>	99231x 0.00 992	32x 0.00 99233x	0.00		
Discharge Day Mgmt:		<u>38.00</u>	99238x 1.0 99239	< 0.0			
Office time/visit(s):		<u>101.00</u>	99211x 0.00 12x 2	.00 13x 3.00 14x 0	.00 15x 0.00		
Prolonged Services:		<u>0.00</u>	99354x 0.00 55x	0.00 56x 0.00	57x 0.00		
Sub Obs Care:		<u>20.00</u>	99224x 1.00 992	25x 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 SER	VICE:						
<u>Key CPT Code</u> 27870	<u>Global</u> 090		<u>W</u>	<u>/ork RVU</u> 15.41	Time Source RUC Time		
CPT Descriptor Arthrodes	is, ankle, open						
KEY MPC COMPARIS	ON CODES:						
Compare the surveyed coor appropriate that have relation	le to codes on ve values high	the RUC's MPC er and lower than t	List. Reference the requested relation	codes from t tive values fo	he MPC list should be chosen, or the code under review. Most Recent		
MPC CPT Code 1	Global	Work RVU	Time Source	M	Iedicare Utilization		
49560	090	11.92	RUC Time		33,997		
CPT Descriptor 1 Repair in	nitial incisional	or ventral hernia;	reducible				
					Most Recent		
MPC CPT Code 2	<u>Global</u>	Work RVU	Time Source	<u>N</u>	Medicare Utilization		
60220	090	12.37	RUC Time		9,133		
CPT Descriptor 2 Total thyroid lobectomy, unilateral; with or without isthmusectomy							
Other Reference CPT Cod	<u>e Global</u>	<u>Work R</u> 0.00	<u>VU</u> <u>Time S</u>	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: 45

% of respondents: 63.3 %

<u>TIME ESTIMATES (Median)</u>	CPT Code: 28725	Key Reference CPT Code: <u>27870</u>	Source of Time RUC Time
Median Pre-Service Time	58.00	60.00]
Median Intra-Service Time	90.00	140.00]
Median Immediate Post-service Time	20.00	30.00]
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	40.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	101.0	92.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	20.0	0.00	
Median Total Time	327.00	400.00	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

(of those that selected Key Reference code)

<u>Mental Effort and Judgment (Mean)</u>		
The number of possible diagnosis and/or the number of	3.56	3.63
management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests,	3.53	3.56
and/or other information that must be reviewed and analyzed		
Urgency of medical decision making	2.43	2.51
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.16	4.15
Physical effort required	3.82	3.83
Psychological Stress (Mean)		
	,	·
The risk of significant complications, morbidity and/or mortality	3.71	3.85
Outcome depends on the skill and judgment of physician	4.24	4.20
1 5 1 5		
Estimated risk of malpractice suit with poor outcome	3.68	3.71
INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference
		Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.64	3.61
· · ·	L]	
		4.07
Intra-Service intensity/complexity	4.11	4.07
Post-Service intensity/complexity	3.31	3.32

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 Code: 28725 CPT code 28725 was a Harvard valued code that was identified by the RUC 5YR ID WG in 2007 as potentially misvalued through a site-of-service anomaly screen. The RUC recommended 28725 be surveyed. In 2008, AAOS, AOFAS, and APMA conducted a RUC survey and presented data that indicated 28725 was not same-day surgery. The specialties argued that patients require close monitoring on the day of the procedure and are admitted for continued monitoring at least overnight for wound inspection and monitoring of lower extremity neurovascular status. The next day, after examining the patient and reviewing the chart, the surgeon would determine if it was safe to discharge the patient. Some patients would be discharged and others would remain additional days in the hospital. After hearing these arguments, the RUC deferred review of 28725 until the RUC survey instrument could be modified to capture information about typical site of service.

The AAOS, AOFAS, and APMA conducted another RUC survey in 2009 using a modified RUC survey instrument that included a question regarding site-of-service and visits on the day of the procedure. After review of the code, the RUC recommended maintaining the work RVU.

Recently, CMS requested the RUC review 28725 again as a code with a site of service anomaly.

Our consensus panel believes that the procedure has not changed over time. The Harvard intra-time was 89 minutes. The current survey intra-time is 90 minutes. Further, we also believe the post-operative work has not changed, except that physicians are now treating more complex patients who may be older and have more co-morbidities, resulting in more intense and complex work.

Patients require close monitoring on the day of the procedure and are kept in the hospital for continued monitoring at least overnight. These patients require wound inspection and monitoring of lower extremity neurovascular status. Then, the next day, <u>after</u> reviewing the patient's chart and examining the patient, the surgeon will determine if it is safe to discharge the patient. Some patients will be discharged on the second day and others will remain additional days in the hospital (either admitted to inpatient status or maintained under outpatient or observation care status). The hospital admission criteria program may designate this outpatient instead of inpatient, but the physician work to review the patient chart, take down dressings, examine the patient, write subsequent orders, and talk to the floor staff and the family is the same, regardless of inpatient or outpatient status.

CURRENT RECOMMENDATION

The AAOS, AOFAS, and APMA recommend maintaining the current RVW as published for CY 2011 (12.18).

We believe the total physician work has not changed for 28725. We believe the total physician work has not changed for 28725 and recommend maintaining a discrete evaluation and management visit on the day of surgery as indicated by our survey data and clinical rationale. We respectfully request to defer our recommendation for the designation of the postop evaluation and management code until the RUC approves a policy and/or rules regarding correct coding for this physician work.

The table below compares the survey code to many other RUC reviewed codes, providing further support that the current value for 28725 is not overvalued. In this table, we have utilized the RUC's current proxy of 99231 for the post-op in-hospital E/M visit.

RUC Year	СРТ	RVW	IWPUT	Total Time	eval	posit	s,d,w	INTRA	Immed Post-op	32	31/ <mark>24</mark>	38/ <mark>17</mark>	13	12	11
2007	27540	11.30	0.053	334	60	15	15	75	20	1		1.0	1	3	
2008	23410	11.39	0.067	277	40	15	15	90	20			0.5	2	2	
2007	24579	11.44	0.043	338	45	15	15	90	30		1	1.0	3	1	
2001	28299	11.57	0.058	299	75			90	30			0.5	3	1	
2000	49557	11.62	0.072	262	45			90	30		1	1.0	1	1	
1997	54690	11.70	0.052	329	75			90	60		1	1.0	2		
2005	47562	11.76	0.088	246	30	15	15	80	25			0.5	2	1	
2000	29883	11.77	0.058	311	75			90	30			1.0	2	2	
2005	42120	11.86	0.064	306	30	15	15	80	30		1	1.0	2	2	
2000	49560	11.92	0.091	223	45			90	30			0.5	1	1	
2009	45172	12.13	0.078	290	40	15	20	75	20		1	1.0	2	1	
2005	58720	12.16	0.062	309	37	5	10	90	30	1	1	1.0	1	1	

	CPT Code: 28725														
RUC Year	СРТ	RVW	IWPUT	Total Time	eval	posit	s,d,w	INTRA	Immed Post-op	32	31/ <mark>24</mark>	38/ <mark>17</mark>	13	12	11
2009	28725	12.18	0.053	327	33	10	15	90	20		1	<mark>1.0</mark>	3	2	
2007	23670	12.28	0.059	326	40	15	15	90	30		1	1.0	2	2	
2007	25575	12.29	0.054	342	45	10	15	90	30		1	1.0	2	3	
2007	23615	12.30	0.053	338	45	15	15	90	30		1	1.0	3	1	
2008	60220	12.37	0.077	275	63			90	25		1	1.0	1	1	
1995	58925	12.43	0.055	329	60			90	35	1	1	1.0	2		
1995	42200	12.53	0.053	330	60			120	30		1	1.0	1	2	1
2005	49000	12.54	0.064	304	60			90	30		2	1.0	2		
2009	14301	12.65	0.070	287	33	10	15	100	25			0.5	3	1	
2005	38700	12.81	0.073	300	30	15	15	90	30		1	1.0	2	1	
2007	49652	12.88	0.081	292	45	15	15	90	30		1	1.0	1	1	
2001	54406	12.89	0.070	295	50			95	30		1	1.0	2	1	
2007	27556	13.00	0.055	369	60	15	15	90	20	1	1	1.0	1	3	
2002	53500	13.00	0.075	289	50			90	29		1	1.0	2	1	
2007	23680	13.15	0.051	361	45	15	15	120	30		1	1.0	2	2	
1995	63030	13.18	0.057	342	75			90	30		2	1.0	3		

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.



2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one 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) 28725

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 podiatry

How often? Sometimes

Specialty orthopaedic surgery

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 <u>percentage</u> for each specialty. Please explain the rationale for this estimate. national frequency not available

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,007 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate. 2009

Specialty podiatry	Freque	ency 986	Perce	Percentage 32.79 %				
Specialty orthopaedic	surgery	Frequency	1803	Percentage 59.9	96 %			
Specialty	Frequency 0	Per	rcentage 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 <u>will not</u> change, enter the surveyed existing CPT code number 28725

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code:28730 Tracking Number

Original Specialty Recommended RVU: 12.42 Presented Recommended RVU: 12.42 RUC Recommended RVU: 12.42

Global Period: 090

CPT Descriptor: Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse;

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old female presents with foot pain secondary to rheumatoid arthritis. X-rays and CT scan reveal severely arthritic tarsometatarsal joints. She requires arthrodesis of the tarsometatarsal joints.

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 92% , In the ASC 8%, 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 15%, Kept overnight (less than 24 hours) 55%, Admitted (more than 24 hours) 29%

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 80%

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:

Select and order the appropriate antibiotic(s) and confirm timing and administration. Assure appropriate selection, timing, and administration of DVT prophylaxis. Review results of preadmission testing including labs, X-rays, CT scans, bone scan, and/or MRIs. Perform H&P. Meet with patient and family to review planned procedure and post-operative management. Review informed consent with patient. Verify that all required instruments and supplies are available. Monitor/assist with patient prone positioning; padding of bony prominences; and application of thermal regulation drapes. Assess position of the extremities and head, adjust as needed. The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure. Indicate areas of skin to be prepped and mark surgical incisions. The leg is prepped and draped. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Under anesthesia, two incisions are made over the medial first and dorsal third tarsometatarsal joints. Neurovascular structures are identified and protected. The incision is carried down to bone and the tarsometatarsal joints are exposed. The articular cartilage is removed down to bleeding bone. Loose fragments are irrigated and removed. The foot is placed in a functional position and the fusion is fixed with internal fixation. Position is verified using fluoroscopy. The wound is inspected and irrigated. Bone graft is inserted as necessary. A hemovac drain is placed. The wound is closed in layers.

Description of Post-Service Work: Immediate Post op [after wound closure through discharge from recovery room]:

CPT Code: 28730

Application of a dressing and short leg splint. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia. Continue prophylaxis for DVT. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to orthopaedic floor and discuss ongoing care with floor nurses.

Hospital Visit [operative day after discharge from recovery room]:

Review interval chart notes. Discuss ongoing care with floor nurses. Discuss management of medical co-morbidities with medical physician. Evaluate vital signs and intake/output. Examine patient, assess for bleeding and drain output. Assess circulation, sensation, and motor function of the operated extremity, Assess pain scores and adequacy of analgesia; adjust medication as needed. Discuss operative findings, procedure, and plan with patient and/or family; answer patient and family questions. Answer nursing/other staff questions. Chart patient progress notes.

Hospital Discharge Management [day after surgery, IF patient is stable and can safely be discharged]:

Review interval chart notes. Evaluate vital signs and intake/output. Assess dressing or splint/cast for bleeding. Assess drain output; remove drain. Evaluate the circulation, sensation, and motor function of the operated extremity. Assess pain scores and adequacy of analgesia; adjust medication as needed. Assess progress with mobilization, ambulation, and physical therapy. Discuss management of medical co-morbidities with medical physician. Home restrictions (ie, activity, bathing) are discussed with the patient and family members. Chart patient progress notes. Write prescriptions for medications needed post-discharge. Coordinate follow-up appointment with patient or family and office staff. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Office

Review interval chart notes. Examine and talk with patient. Answer patient/family questions. Remove splint/dressings. Assess wound. Assess of circulation, sensation, and motor function of the operated extremity. Assess pain scores and adequacy of analgesia. Remove staples or sutures and drain, when appropriate. Redress wound. Order physical therapy. Monitor progress of rehabilitation. Discuss progress with referring physician(s) (verbal and written). Dictate progress notes for medical chart. Order and review radiographs to assess fixation and bone healing.

SURVEY DAT	ΓΑ						
RUC Meeting Da	ate (mm/yyyy)	02/2011					
Presenter(s):	William Cree	vy, MD; Tye Ou	uzounian, I	MD; Seth Ru	ibenstein, D	PM; Timothy	Tillo, DPM
Specialty(s):	AAOS; AOFA	S; APMA					
CPT Code:	28730						
Sample Size:	300 F	tesp N:	71	Respo	onse: 23.6 %	, D	
Sample Type:	Random	Additional Sa	mple Info	rmation:			
			Low	25 th pctl	Median*	75th pctl	High
Service Perform	ance Rate		0.00	2.00	5.00	12.00	35.00
Survey RVW:			9.30	14.00	15.00	17.00	25.00
Pre-Service Evalu	ation Time:				45.00		
Pre-Service Posit	ioning Time:				10.00		
Pre-Service Scrut	o, Dress, Wait T	ime:			15.00		
Intra-Service Tir	ne:		45.00	90.00	100.00	120.00	280.00
Immediate Post	Service-Time	<u>20.00</u>					
Post Operative	Visits	Total Min**	CPT Cod	e and Num	ber of Visit	S	
Critical Care tim	ne/visit(s):	<u>0.00</u>	99291x 0	. 00 99292	2x 0.00		
Other Hospital t	ime/visit(s):	<u>20.00</u>	99231x 1	.00 99232	2x 0.00 9	9233x 0.00	
Discharge Day I	Ngmt:	<u>38.00</u>	99238x 1	. 00 99239x	0.00		
Office time/visit	(s):	<u>101.00</u>	99211x 0	.00 12x 2.0	0 13x 3.00 1	4x 0.00 15x	0.00
Prolonged Serv	ices:	<u>0.00</u>	99354x 0	.00 55x C).00 56x 0	.00 57x 0.0	00
Sub Obs Care:		0.00	99224x 0	.00 99225	5x 0.00 9	9226x 0.00	

**Physician standard total <u>minutes per E/M visit</u>: 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:	28730		Recommended Physician Work RVU: 12.42							
			Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time					
Pre-Service Evaluation Ti	ime:		33.00	33.00	0.00					
Pre-Service Positioning T	Time:		10.00	3.00	7.00					
Pre-Service Scrub, Dress	, Wait Tim	ie:	15.00	15.00	0.00					
Intra-Service Time:			100.00							
Immediate Post Servic	e-Time:	<u>20.00</u>								
Post Operative Visits		<u>Total Min**</u>	CPT Code and Nu	<u>Imber of Visits</u>						
Critical Care time/visit	(s):	<u>0.00</u>	99291x 0.00 992	92x 0.00						
Other Hospital time/vis	sit(s):	<u>0.00</u>	99231x 0.00 992	32x 0.00 99233x	0.00					
Discharge Day Mgmt:		<u>38.00</u>	99238x 1.0 99239	< 0.0						
Office time/visit(s):		<u>101.00</u>	99211x 0.00 12x 2	.00 13x 3.00 14x 0	.00 15x 0.00					
Prolonged Services:		<u>0.00</u>	99354x 0.00 55x	0.00 56x 0.00	57x 0.00					
Sub Obs Care:		20.00	99224x 1.00 992	25x 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 SER	VICE:										
<u>Key CPT Code</u> 27870	<u>Global</u> 090			<u>Work RVU</u> 15.21	Time Source RUC Time						
<u>CPT Descriptor</u> Arthrodesis, ankle, open											
KEY MPC COMPARISO Compare the surveyed cod appropriate that have relative	DN CODES: le to codes on t ve values highe	he RUC's MPC r and lower than t	List. Reference the requested re	e codes from lative values f	the MPC list should be chosen, if for the code under review.						
MPC CPT Code 1 Global Work RVU Time Source Medicare Utilization 49560 090 11.92 RUC Time 33,997											
<u>MPC CPT Code 2</u> 60220	<u>Global</u> 090	Work RVU 12.37	<u>Time Source</u> RUC Time		Most Recent Medicare Utilization 9,133						
<u>CPT Descriptor 2</u> Total thy	roid lobectomy	, unilateral; with	or without isthn	nusectomy							
Other Reference CPT Code	<u>Global</u>	<u>Work R</u> 0.00	<u>VU</u> <u>Time</u>	e 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: 23

% of respondents: 32.3 %

<u>TIME ESTIMATES (Median)</u>	CPT Code: 28730	Key Reference CPT Code: <u>27870</u>	Source of Time RUC Time
Median Pre-Service Time	58.00	60.00]
Median Intra-Service Time	100.00	140.00]
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	40.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	101.0	92.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	20.0	0.00	
Median Total Time	337.00	400.00	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

(of those that selected Key Reference code)

<u>Mental Effort and Judgment (Mean)</u>		
The number of possible diagnosis and/or the number of	3.68	3.64
management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests,	3.82	3.86
and/or other information that must be reviewed and analyzed		
I Turner of an align the initial methics	2.50	2.64
Orgency of medical decision making	2.39	5.04
<u>Technical Skill/Physical Effort (Mean)</u>		
Technical skill required	4.68	4.32
		[]
Physical effort required	3.86	3.82
<u>Psychological Stress (Mean)</u>		
The risk of significant complications, morbidity and/or mortality	4.14	4.00
Outcome depends on the skill and judgment of physician	4.50	4.22
Outcome depends on the skin and judgment of physician	4.50	4.23
	,	
Estimated risk of malpractice suit with poor outcome	3.73	3.56
INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference
		Service 1
Time Segments (Mean)		
	2.70	2.0
Pre-Service intensity/complexity	3.70	3.68
Intra-Service intensity/complexity	4.57	4.41
Post-Service intensity/complexity	3 52	3 55

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 code 28730 was a Harvard valued code that was identified by the RUC 5YR ID WG in 2007 as potentially misvalued through a site-of-service anomaly screen. The RUC recommended 28730 be surveyed. In 2008, AAOS, AOFAS, and APMA conducted a RUC survey and presented data that indicated 28730 was not same-day surgery. The specialties argued that patients require close monitoring on the day of the procedure and are admitted for continued monitoring at least overnight for wound inspection and monitoring of lower extremity neurovascular status. The next day, after examining the patient and reviewing the chart, the surgeon would determine if it was safe to discharge the patient. Some patients would be discharged and others would remain additional days in the hospital. After hearing these arguments, the RUC deferred review of 28730 until the RUC survey instrument could be modified to capture information about typical site of service.

The AAOS, AOFAS, and APMA conducted another RUC survey in 2009 using a modified RUC survey instrument that included a question regarding site-of-service and visits on the day of the procedure. After review of the code, the RUC recommended maintaining the work RVU.

Recently, CMS requested the RUC review 28730 again as a code with a site of service anomaly.

Our consensus panel believes that the procedure has not changed over time. The Harvard intra-time was 90 minutes. The current survey intra-time is 100 minutes. Further, we also believe the post-operative work has not changed, other than physicians are now treating more complex patients who may be older and have more co-morbidities, resulting in more intense and complex work.

Patients require close monitoring on the day of the procedure and are kept in the hospital for continued monitoring at least overnight. These patients require wound inspection and monitoring of lower extremity neurovascular status. Then, the next day, <u>after</u> reviewing the patient's chart and examining the patient, the surgeon will determine if it is safe to discharge the patient. Some patients will be discharged on the second day and others will remain additional days in the hospital (either admitted to inpatient status or maintained under outpatient or observation care status). The hospital admission criteria program may designate this outpatient instead of inpatient, but the physician work to review the patient chart, take down dressings, examine the patient, write subsequent orders, and talk to the floor staff and the family is the same, regardless of inpatient or outpatient status.

CURRENT RECOMMENDATION

The AAOS, AOFAS, and APMA recommend maintaining the current RVW as published for CY 2011 (12.42).

We believe the total physician work has not changed for 28730. We believe the total physician work has not changed for 28730 and recommend maintaining a discrete evaluation and management visit on the day of surgery as indicated by our survey data and clinical rationale. We respectfully request to defer our recommendation for the designation of the postop evaluation and management code until the RUC approves a policy and/or rules regarding correct coding for this physician work.

The table below compares the survey code to many other RUC reviewed codes, providing further support that the current value for 28730 is not overvalued. In this table, we have utilized the RUC's current proxy of 99231 for the post-op in-hospital E/M visit.

RUC Year	СРТ	RVW	IWPUT	Total Time	eval	posit	s,d,w	INTRA	Immed Post-op	32	31/ <mark>24</mark>	38/ <mark>17</mark>	13	12	11
2007	27540	11.30	0.053	334	60	15	15	75	20	1		1.0	1	3	
2008	23410	11.39	0.067	277	40	15	15	90	20			0.5	2	2	
2007	24579	11.44	0.043	338	45	15	15	90	30		1	1.0	3	1	
2001	28299	11.57	0.058	299	75			90	30			0.5	3	1	
2000	49557	11.62	0.072	262	45			90	30		1	1.0	1	1	
1997	54690	11.70	0.052	329	75			90	60		1	1.0	2		
2005	47562	11.76	0.088	246	30	15	15	80	25			0.5	2	1	
2000	29883	11.77	0.058	311	75			90	30			1.0	2	2	
2005	42120	11.86	0.064	306	30	15	15	80	30		1	1.0	2	2	
2000	49560	11.92	0.091	223	45			90	30			0.5	1	1	
2009	45172	12.13	0.078	290	40	15	20	75	20		1	1.0	2	1	

												1 000	40.20	100	
RUC				Total	_				Immed		31/	38/			
Year	СРТ	RVW	IWPUT	Time	eval	posit	s,d,w	INTRA	Post-op	32	<mark>24</mark>	<mark>17</mark>	13	12	11
2005	58720	12.16	0.062	309	37	5	10	90	30	1	1	1.0	1	1	
2007	23670	12.28	0.059	326	40	15	15	90	30		1	1.0	2	2	
2007	25575	12.29	0.054	342	45	10	15	90	30		1	1.0	2	3	
2007	23615	12.30	0.053	338	45	15	15	90	30		1	1.0	3	1	
2008	60220	12.37	0.077	275	63			90	25		1	1.0	1	1	
2009	28730	12.42	0.051	330	33	3	15	100	20		1	<mark>1.0</mark>	3	2	
1995	58925	12.43	0.055	329	60			90	35	1	1	1.0	2		
1995	42200	12.53	0.053	330	60			120	30		1	1.0	1	2	1
2005	49000	12.54	0.064	304	60			90	30		2	1.0	2		
2009	14301	12.65	0.070	287	33	10	15	100	25			0.5	3	1	
2005	38700	12.81	0.073	300	30	15	15	90	30		1	1.0	2	1	
2007	49652	12.88	0.081	292	45	15	15	90	30		1	1.0	1	1	
2001	54406	12.89	0.070	295	50			95	30		1	1.0	2	1	
2007	27556	13.00	0.055	369	60	15	15	90	20	1	1	1.0	1	3	
2002	53500	13.00	0.075	289	50			90	29		1	1.0	2	1	
2007	23680	13.15	0.051	361	45	15	15	120	30		1	1.0	2	2	
1995	63030	13.18	0.057	342	75			90	30		2	1.0	3		

CDT Code, 20720

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)

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 podiatry

How often? Sometimes

Specialty orthopaedic surgery

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 <u>percentage</u> for each specialty. Please explain the rationale for this estimate. national frequency not available

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,918 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate. 2009 Medicare data

Specialty podiatry	Frequ	ency 577	Perce	ntage 30.08 %	1
Specialty orthopaedi	c surgery	Frequency 1	054	Percentage	54.95 %
Specialty	Frequency 0	Perc	centage 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 <u>will not</u> change, enter the surveyed existing CPT code number 28730

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

AMA/Specialty Society RVS Update Committee Summary of Recommendations Identified through the Site of Service Anomaly Screen and Fourth Five-Year Review

February 2011

Partial Amputation of Toe

CPT code 28825, *Amputation, toe; interphalangeal joint*, was identified by the RUC's Five-Year Review Identification Workgroup in 2007 as potentially misvalued through the Site-of-Service Anomaly screen.. CMS agreed with the RUC that this service should be evaluated. The involved specialties argued that the typical patient requiring 28825 would be variable (co-morbidities) and bi-modal (inpatient vs outpatient), and that the correct global period to account for this variability would be 0-day.. Based on the 2009 Medicare utilization data, the service is performed approximately 41% in the inpatient hospital setting, about 51% in the outpatient hospital and ambulatory surgery center settings, and about 7% in the physician office. The service is performed by a wide variety of specialties including podiatry, orthopaedic surgery, vascular surgery, and general surgery, further supporting a bi-modal distribution. The typical patient is bi-modal and requires amputation because of either diabetes or gangrene resulting from peripheral vascular disease. The specialties, based on their own survey data which indicated a bi-modal distribution and the Medicare utilization data, recommended that the service be resurveyed with a 000 day global period to more accurately include the work given the bi-modal distribution. The RUC agreed and further noted that a change in CPT descriptor will not resolve the issue, but a change in global period would. The RUC recommended that CMS change the global period for 28825 to 000 day global period and the specialty societies to resurvey for the April 2008 RUC meeting. CMS responded that the 090 day global will be maintained. **Based on the aforementioned arguments, the RUC reiterates its requests that the global period for 28825 be changed to a 000 day global. If CMS agrees with this recommendation, the RUC would review the code again with the new global period**.

In 2008, the American Academy of Orthopaedic Surgery, the American College of Surgeons, the American Podiatric Medical Association, and Society for Vascular Surgery conducted a RUC survey for these services. The specialties presented code 28825 using data from a modified RUC survey instrument that included a question regarding site-of-service and visits on the day of the procedure. CMS accepted the RUC's recommendation for this service. Following the RUC's recommendation, CMS included code 28825 as part of the 4th Five-Year Review. In response to this request by CMS, the RUC re-reviewed the survey data presented by the specialty societies and assessed the previous RUC recommendation for work RVUs.

The specialty society commented that as the physician work for this service has not changed since its last review, the current value, 6.01 RVUs should be maintained. The specialty society presented two reference services that are similar procedures and that have the same intra-time and require similar total work: 28288, *Ostectomy, partial, exostectomy or condylectomy, metatarsal head, each metatarsal head* (work RVU = 6.02, intra-service time = 30 minutes) and 26951, *Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure* (work RVU = 6.04, intra-service time = 30 minutes). The RUC agrees with the specialties that the current value for 28825, 6.01 RVUs is appropriate and relative to these other two similar services. Therefore, based on the magnitude estimation comparisons to the reference codes, the specialty societies agree and the RUC recommends that the current value of this service be maintained.

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

Additionally, the RUC further analyzed the site-of-service data and post-operative visit data. Code 28825 is not typically same day surgery. Diabetic patients requiring 28825 are sick with multiple co-morbidities. Amputation of an appendage is a last resort for patients who have failed medical management of their disease. Patients require close monitoring of the wound and co-morbid disease(s) on the day of the procedure and are kept in the hospital for continued monitoring at least overnight. The surgeon would: Review interval chart notes. Discuss ongoing care with floor nurses. Evaluate vital signs and intake/output. Examine patient, check wounds and drain, and change dressings. Assess circulation, sensation, and motor function of the operated extremity, along with anticoagulation therapy. Continue prophylaxis for DVT and antibiotic therapy. Assess pain scores and adequacy of analgesia. Review nursing/other staff patient chart notes. Coordinate care as necessary with endocrinology, infectious disease, and possibly the PCP. Answer patient and family questions. Answer nursing/other staff questions. Then, the next day or several days later, after reviewing the patient's chart and examining the patient, the surgeon will determine if it is safe to discharge the patient. Some patients will be discharged on the second day and others will remain additional days in the hospital (either admitted to inpatient status or maintained under outpatient or observation care status). This was substantiated by the survey data which shows that the typical patient receives this procedure in the hospital (84%), stays at least overnight in the hospital following surgery (63%) and receives an Evaluation and Management service on the same date (53%). Given this data, the RUC enacted its policy to allocate the appropriate proxy for the post-operative visits. Importantly, the RUC noted that whether the hospital admission criteria program designates this service outpatient or inpatient, the physician work at the bed of a patient in a hospital surgical ward to review the patient chart, take down dressings, examine the patient, write subsequent orders, and talk to the floor staff and the family is the same. Adjustments to the allocation of post-operative visits are used as proxies and do not constitute changes to the physician work relative value of the service which was determined by magnitude estimation and physician specialty survey data during the last RUC review. The RUC recommends a work RVU of 6.01 for CPT code 28825.

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommenda- tion
28825		Amputation, toe; interphalangeal joint	090	6.01
		(For amputation of tuft of distal phalanx, use 11752)		(No Change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code:28825 Tracking Number

Original Specialty Recommended RVU: 6.01 Presented Recommended RVU: 6.01 RUC Recommended RVU: 6.01

Global Period: 090

CPT Descriptor: Amputation, toe; interphalangeal joint

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 62-year-old insulin-dependent diabetic male presents with a chronic, trophic ulcer on the dorsal aspect of the great toe of his left foot. A sinus tract leads to the middle phalanx and bone scans are positive for osteomyelitis. The patient requires amputation of a portion of the toe at the level of the proximal interphalangeal joint.

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 84%, In the ASC 16%, 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 36%, Kept overnight (less than 24 hours) 11%, Admitted (more than 24 hours) 52%

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 64%

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: Write preadmission orders for preoperative medications. Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs. Perform H&P. Meet with patient and family to review planned procedure and post-operative management. Review informed consent with patient. Verify that all required instruments and supplies are available. Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes. Assess position of the extremities and head, adjust as needed. The patient's leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure. Indicate areas of skin to be prepped and mark surgical incisions. An ankle tourniquet is placed. The leg and foot are prepped. Scrub and gown. The leg and foot are draped. The leg is elevated and exsanguinated. The pneumatic tourniquet is inflated. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work:

A tennis racket type incision is performed over the proximal interphalangeal joint in an appropriate location to allow for adequate plastic closure. The incision in carried deep at the site down through soft tissue structures including tendon and joint capsule. After the capsulotomy is performed the joint is then disarticulated and the amputated portion of the toe is removed and sent to pathology. Any redundant soft tissue is excised in preparation for closure. At the surgeon's election, the head of the proximal phalanx may also be excised from the surgical site. The wound is inspected and irrigated. The tourniquet is let down and any bleeders are cauterized. A drain is placed. The wound is closed.

Description of Post-Service Work:

Immediate Post op [after wound closure through discharge from recovery room]:

CPT Code: 28825

Application of a dressing and short leg splint. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia. Continue prophylaxis for DVT. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to orthopaedic floor and discuss ongoing care with floor nurses.

Hospital Visit [operative day after discharge from recovery room]:

Review interval chart notes. Discuss ongoing care with floor nurses. Discuss management of medical co-morbidities with medical physician. Evaluate vital signs and intake/output. Examine patient, assess for bleeding and drain output. Assess circulation, sensation, and motor function of the operated extremity. Assess pain scores and adequacy of analgesia; adjust medication as needed. Discuss operative findings, procedure, and plan with patient and/or family; answer patient and family questions. Coordinate care as necessary with other physicians (eg, endocrinology, PCP). Answer nursing/other staff questions. Chart patient progress notes.

Hospital Discharge Management [day after surgery, IF patient is stable and can safely be discharged]:

Review interval chart notes. Evaluate vital signs and intake/output. Assess dressing or splint/cast for bleeding. Assess drain output; remove drain. Evaluate the circulation, sensation, and motor function of the operated extremity. Assess pain scores and adequacy of analgesia; adjust medication as needed. Assess progress with mobilization, ambulation, and physical therapy. Discuss management of medical co-morbidities with medical physician. Home restrictions (ie, activity, bathing) are discussed with the patient and family members. Chart patient progress notes. Write prescriptions for medications needed post-discharge. Coordinate follow-up appointment with patient or family and office staff. Coordinate care as necessary with other physicians (eg, endocrinology, PCP). All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Office

Review interval chart notes. Examine and talk with patient. Answer patient/family questions. Remove splint/dressings. Assess wound. Assess of circulation, sensation, and motor function of the operated extremity. Assess pain scores and adequacy of analgesia. Remove staples or sutures and drain, when appropriate. Redress wound. Order physical therapy. Monitor progress of rehabilitation. Discuss progress with referring physician(s) (verbal and written). Dictate progress notes for medical chart. Order and review radiographs to assess fixation and bone healing.

SURVEY DA	ГА						
RUC Meeting Da	ate (mm/yyyy)	02/2011					
Presenter(s):	Seth Rubens MD, FACS; C Creevy, MD;	Seth Rubenstein, DPM; Timothy Tillo, DPM; Gary Seabrook, MD, FACS; Robert Zwolak, MD, FACS; Christopher Senkowski, MD FACS; Charles Mabry, MD FACS; William Creevy, MD; Tye Ouzounian, MD					
Specialty(s):	APMA, ACS,	APMA, ACS, SVS, AAOS, AOFAS					
CPT Code:	28825						
Sample Size:	300 F	esp N:	44	Response: 14.6 %			
Sample Type:	Random	Additional Sa	mple Info	rmation:			
			Low	25 th pctl	Median*	75th pctl	High
Service Performance Rate			0.00	5.00	6.00	12.00	40.00
Survey RVW:			3.50	5.89	6.11	8.29	15.00
Pre-Service Evaluation Time:					45.00		
Pre-Service Positioning Time:					10.00		
Pre-Service Scrub, Dress, Wait Time:					15.00		
Intra-Service Time:			15.00	25.00	30.00	45.00	75.00
Immediate Post	t Service-Time:	20.00					
Post Operative	<u>Visits</u>	Total Min**	CPT Cod	e and Num	ber of Visit	s	
Critical Care tin	ne/visit(s):	<u>0.00</u>	99291x C	. 00 99292	2x 0.00		
Other Hospital time/visit(s): <u>60.00</u>			99231x 1.00 99232x 1.00 99233x 0.00				
Discharge Day Mgmt: <u>38.00</u>			99238x 1.00 99239x 0.00				
Office time/visit	t(s):	<u>78.00</u>	99211x C	0.00 12x 2.0	0 13x 2.00 1	4x 0.00 15x	0.00
Prolonged Serv	vices:	0.00	99354x C	.00 55x ().00 56x 0	0.00 57x 0.0	00
Sub Obs Care:		0.00	99224x C	.00 99225	5x 0.00 9	99226x 0.00	

**Physician standard total <u>minutes per E/M visit</u>: 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: 2	28825		Recommended Physician Work RVU: 6.01			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time		
Pre-Service Evaluation Time:		33.00	33.00	0.00		
Pre-Service Positioning Time:			10.00	3.00	7.00	
Pre-Service Scrub, Dress, Wait Time:		15.00	15.00	0.00		
Intra-Service Time:			30.00			
Immediate Post Service	e-Time:	<u>20.00</u>				
Post Operative Visits		<u>Total Min**</u>	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00			
Other Hospital time/vis	it(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:		<u>38.00</u>	99238x 1.0 99239x 0.0			
Office time/visit(s):		<u>78.00</u>	99211x 0.00 12x 2.00 13x 2.00 14x 0.00 15x 0.00			
Prolonged Services:		<u>0.00</u>	99354x 0.00 55x	0.00 56x 0.00	57x 0.00	
Sub Obs Care:		<u>0.00</u>	99224x 0.00 992	25x 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 Time Source Work RVU 090 28288 6.02 **RUC Time** CPT Descriptor Ostectomy, partial, exostectomy or condylectomy, metatarsal head, each metatarsal head **KEY MPC COMPARISON CODES:** Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review. Most Recent MPC CPT Code 1 Global Work RVU Time Source Medicare Utilization 0.00 CPT Descriptor 1 Most Recent MPC CPT Code 2 Global Work RVU Time Source Medicare Utilization 0.00 CPT Descriptor 2 Other Reference CPT Code Global Work RVU Time Source 26951 090 6.04 **RUC** Time

<u>CPT Descriptor</u> Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure

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

Number of respondents who choose Key Reference Code: 18

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

% of respondents: 40.9 %

TIME ESTIMATES (Median) Key Reference Source of Time **CPT Code: CPT Code: RUC** Time 28825 28288 20.00 Median Pre-Service Time 58.00 Median Intra-Service Time 30.00 30.00 Median Immediate Post-service Time 20.00 20.00 Median Critical Care Time 0.0 0.00 Median Other Hospital Visit Time 0.0 0.00 Median Discharge Day Management Time 0.00 38.0 Median Office Visit Time 78.0 99.00 0.00 Prolonged Services Time 0.0 Median Subsequent Observation Care Time 0.0 0.00 224.00 169.00 **Median Total Time**

Other time if appropriate	

<u>INTENSITY/COMPLEXITY MEASURES (Mean)</u>	(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	3.11	2.81		
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	2.88		
Urgency of medical decision making	3.44	2.56		
Technical Skill/Physical Effort (Mean)				
Technical skill required	3.06	2.94		
Physical effort required	2.50	2.56		
Psychological Stress (Mean)				
The risk of significant complications, morbidity and/or mortality	3.61	3.06		
Outcome depends on the skill and judgment of physician	3.17	2.81		
Estimated risk of malpractice suit with poor outcome	3.44	3.13		
INTENSITY/COMPLEXITY MEASURES	<u>CPT Code</u>	<u>Reference</u> <u>Service 1</u>		
Time Segments (Mean)				
Pre-Service intensity/complexity	3.29	3.25		
Intra-Service intensity/complexity	2.82	3.00		
Post-Service intensity/complexity	3.06	2.94		

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 code 28825 was a Harvard valued code that was identified by the RUC 5YR ID WG in 2007 as potentially misvalued through a site-of-service anomaly screen. The involved specialties argued that the typical patient requiring 28825 would be variable (co-morbidities) and bi-modal (inpatient vs outpatient), and that the correct global period to account for this variability would be 0-day. CMS rejected this recommendation and maintained a 90-day global for 28825. The RUC recommended 28825 be surveyed. In 2008, APMA, SVS, ACS, AAOS, and AOFAS conducted a RUC survey. The survey summary data and specialty distribution are presented below.

SPEC	Resp	Median RVW	EVAL	POSIT	SDW	Med Intra	P-SD	99232	99231	99238	99214	99213	99212
ALL	44	6.11	45	10	15	30	20	1	1	1		2	2
Surg	21	6.00	50	10	15	30	20		1	1	1	1	2
Pod	23	6.50	45	10	15	30	20	1	1	1		2	2

Although the survey from all involved specialties indicated multiple hospital visits, the societies presented that there is extreme variability of the patient, diagnoses and providers – resulting in extreme variability in facility status (inpatient vs outpatient) and length of hospital stay. The societies also noted the majority of patients would be admitted to a hospital at least overnight (ie, 23-hr stay), but probably for several days. However, the multi-specialty group agreed to no visit on the day of the procedure. In hindsight, this is not reflective of the survey data, our expert opinion, or the equal split in (Medicare) patient status of 41% inpatient versus 39% outpatient. Discussions at RUC meetings subsequent to this recommendation allowed for the possibility to request 99231 as a proxy for the discrete E/M visit, which was included in the previous SoR post-service description and is shown again in this SoR's post-service description.

After review of the code, along with significant compelling evidence that the previous Harvard review was flawed because the intra-work was negative, the RUC recommended a new work RVU relative to the reference codes 28288 (Ostectomy, partial, exostectomy or condylectomy, metatarsal head, each metatarsal head) and 26951 (Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure).

Recently, CMS requested the RUC review 28825 again.

Our consensus panel believes <u>that the procedure has not changed over time</u>. The Harvard geometric mean intra-time was 36 minutes. The current survey median intra-time is 30 minutes. Further, we also believe the post-operative work has not changed, with the exception that physicians are now treating more complex patients who may be older and have more co-morbidities, resulting in more intense and complex post-operative work.

Diabetic patients requiring 28825 are sick with multiple co-morbidities. Amputation of an appendage is a last resort for patients who have failed medical management of their disease. Patients require close monitoring of the wound and co-morbid disease(s) on the day of the procedure and are kept in the hospital for continued monitoring at least overnight. The surgeon would: Review interval chart notes. Discuss ongoing care with floor nurses. Evaluate vital signs and intake/output. Examine patient, check wounds and drain, and change dressings. Assess circulation, sensation, and motor function of the operated extremity, along with anticoagulation therapy. Continue prophylaxis for DVT and antibiotic therapy. Assess pain scores and adequacy of analgesia. Review nursing/other staff patient chart notes. Coordinate care as necessary with endocrinology, infectious disease, and possibly the PCP. Answer patient and family questions. Answer nursing/other staff questions. Then, the next day or several days later, <u>after</u> reviewing the patient's chart and examining the patient, the surgeon will determine if it is safe to discharge the patient. Some patients will be discharged on the second day and others will remain additional days in the hospital (either admitted to inpatient status or maintained under outpatient or observation care status). The hospital admission criteria program may designate this outpatient or inpatient, but the physician work to review the patient chart, take down dressings, examine the patient, write subsequent orders, and talk to the floor staff, the family, and other caregivers is the same, regardless of facility inpatient or outpatient status.

CURRENT RECOMMENDATION

We continue to believe the correct global period for this code should be 0-day. With a 90-day global period, the code is significantly undervalued for the amount of physician work required to manage this patient post-operatively. Without a same-day post-op E/M included in the total work, the intra-op intensity is 0.010; essentially nothing. If a same-day post-op E/M is included in the total work, the intra-op intensity is negative. Without recourse, the APMA, SVS, ACS, AAOS, and AOFAS recommend maintaining the current RVW as published for CY 2011 (6.01).

CPT Code: 28825 We believe the total physician work has not changed for 28825. We also believe it is correct to include a discrete evaluation and management visit on the day of surgery as indicated by our survey data and clinical rationale. We respectfully request to defer our recommendation for the designation of the post-op evaluation and management code until the RUC approves a policy and/or rules regarding correct coding for this physician 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) 28825

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 podiatry	How often? Commonly
Specialty surgery	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 <u>percentage</u> for each specialty. Please explain the rationale for this estimate. national frequency not available

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 9,308 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate. 2009 Medicare data

Specialty podiatry

Specialty surgery (gener	Frequency 3958		CPT Code: 28825 Percentage 42.52 %		
Specialty	Frequency	Percentage	%		

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 28825

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

AMA/Specialty Society RVS Update Committee Summary of Recommendations Identified through the Fourth Five-Year Review and Codes Reported 75% or More Together Screen

February 2011

Shoulder Arthroscopy- Practice Expense Only

In February 2010, the following services were identified in the 4th Five-Year Review through CMS' screen for Harvard valued services with utilization over 30,000 and Codes Reported 75% or More Together Screen as being frequently billed together:

29824 Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)(Work RVU = 8.98, 090 day global)

29826 Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with or without coracoacromial release (Work RVU = 8.98, 090 day global)

29827 Arthroscopy, shoulder, surgical; with rotator cuff repair (Work RVU = 15.59, 090 day global)

29828 Arthroscopy, shoulder, surgical; biceps tenodesis (Work RVU = 13.16, 090 day global)

The RUC reviewed the physician work for CPT Code 29826 in October 2010 and review of practice expense for this service was deferred to the February 2011 meeting. The RUC acknowledged that 29826 when performed with other endoscopic services is subject to the Endoscopic Multiple Procedure Reduction. CPT Code 29826 is reported as a stand alone procedure less than 8% of time in the Medicare population. However, in younger populations it is often a procedure provided independent of other surgeries. The RUC understood that the specialty submitted a coding proposal to the CPT Editorial Panel for consideration at the February 2011 meeting, which outlined the bundling of 29826 when performed with 29824 *Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)*, or 29827 *Arthroscopy, shoulder, surgical; with rotator cuff repair* or 29828 *Arthroscopy, shoulder, surgical; biceps Tenodesis*. The RUC deferred the review of the practice expense inputs until these codes are revised by the CPT Editorial Panel and will therefore be placed on the April 2011 RUC agenda.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation			
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with or without coracoacromial release (For open procedure, use 23130 or 23415))	090	Deferred to April 2011 RUC Meeting			
Surgical endoscopy/arthroscopy always includes a diagnostic endoscopy/arthroscopy. When arthroscopy is performed in conjunction with arthrotomy, add modifier 51.						

AMA/Specialty Society RVS Update Committee Summary of Recommendations Identified through the Fourth Five-Year Review

February 2011

Biopsy Lung or Mediastinum – Practice Expense Only

In the 4th Five-Year Review of the RBRVS, CMS identified CPT code 32405 *Biopsy, lung or mediastinum, percutaneous needle* as potentially misvalued through the Harvard Valued - Utilization over 30,000 Screen. The RUC carefully reviewed the work relative value of this service in October 2010 and recommended its value be maintained. In addition, at that time, the specialties explained that the survey data supported the fact that moderate sedation is an inherent component of this service. The RUC recommended that CPT Code 32405 be referred to the CPT Editorial Panel to be included in Appendix G. The inclusion of 32405 in CPT's Appendix G necessitates the inclusion of the direct practice expense inputs associated with moderate sedation, and therefore the RUC scheduled a review of the inputs at its February 2011 meeting.

In February 2011, the RUC carefully reviewed the specialty recommended typical clinical labor, medial supplies, and equipment for CPT code 32405, and agreed upon the presented direct practice expense inputs associated with the performance of moderate sedation. The RUC recommends the attached direct practice expense inputs for code 32405.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
32405	Biopsy, lung or mediastinum, percutaneous needle (For radiological supervision and interpretation, see 76942, 77002, 77012, 77021)	000	Practice Expense Recommendation
	(For fine needle aspiration, use 10022) (For evaluation of fine needle aspirate, see 88172, 88173)		

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

CPT Long Descriptor: Biopsy, lung or mediastinum, percutaneous needle

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:

The SIR and ACR convened a panel that included a number of experts familiar with this service to evaluate the direct practice expense inputs for this recently surveyed biopsy code. This percutaneous biopsy code was identified by CMS as part of the Fourth Five Year Review as a Harvard valued code with utilization over 30,000 services reported in Medicare and was presented at the October 2010 RUC meeting. At that time, it was determined to be appropriate to develop NF practice expense inputs for this procedure, including conscious sedation inputs. As such, we are presenting direct practice inputs for this service.

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

We selected the recently RUC'ed abdominal paracentesis code (4908x1) as our comparison code. The procedures are performed similarly and the resources used are comparable.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Provide pre-service education/ obtain consent
- Follow-up phone calls and prescriptions

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

• Conduct phone calls /call in prescriptions

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

CPT Long Descriptor: Biopsy, lung or mediastinum, percutaneous needle

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:

The SIR and ACR convened a panel that included a number of experts familiar with this service to evaluate the direct practice expense inputs for this recently surveyed biopsy code. This percutaneous biopsy code was identified by CMS as part of the Fourth Five Year Review as a Harvard valued code with utilization over 30,000 services reported in Medicare and was presented at the October 2010 RUC meeting. At that time, it was determined to be appropriate to develop NF practice expense inputs for this procedure, including conscious sedation inputs. As such, we are presenting direct practice inputs for this service.

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

We selected the recently RUC'ed abdominal paracentesis code (4908x1) as our comparison code. The procedures are performed similarly and the resources used are comparable.

Please describe in detail the clinical activities of your staff:

<u>Pre-Service</u> Clinical Labor Activities: Complete pre-service diagnostic and referral forms Coordinate pre-surgery services

Intra-Service Clinical Labor Activities:

The patient is greeted, gowning is provided and patient is escorted to procedure room. Registered Technologist (RT) takes the vital signs. RT interviews the patient for allergies, medications and coagulopathy. Procedure is explained and informed consent is witnessed. RT consults with the M.D regarding the type of needle to be used. RT prepares the tray including betadine, lidocaine, and biopsy needle. IV access is established with intracatheter and hep lock, flushed. RT positions the patient and may prep the skin under physician supervision. RN administers conscious sedation. RT assists the M.D. performing biopsy, including providing additional needles, lidocaine etc., collects specimen in appropriate solution. Following completion of biopsy, RT cleans betadine from the skin, applies Bandaid or dressing to the biopsy site. The patient is escorted to the observation area. RN performs sequential vital signs over 4 hour observation. RT fills out the pathology request for the lab. RT cleans up the biopsy tray with appropriate disposal of sharps. The biopsy site is checked for discharge and gives the patient complete discharge instructions.

<u>Post-Service</u> Clinical Labor Activities: Conduct phone calls /call in prescriptions

	Α	В	С	D	E	F	G
	Meeting Date: February 2011			470	200		105
1				4/0		324	+05
				Biopsy of IN	ver, needle;	Biopsy,	lung or
	AMA/Specialty Society RVS Update Committee			percuta	ineous	mediastinum, percutane	
2	Recommendation	CMS	Staff			nee	ale
2	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility
1				0	0	0	0
5	TOTAL CLINICAL LABOR TIME			132.0	20.0	152.0	20.0
5	TOTAL DDE SEDV CLINICAL LABOD TIME			132.0	17.0	132.0	17.0
6	TOTAL TRE-SERV CLINICAL LADOR TIME			4.0	17.0	4.0	17.0
1	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	1.0075		125.0	0.0	145.0	0.0
8		L037D	RN/LPN/MTA				
9		L041B	RT	43.0		53.0	
10		L051A	RN	82.0		92.0	
11	TOTAL POST-SERV CLINICAL LABOR TIME			3.0	3.0	3.0	3.0
12	PRE-SERVICE						
13	Start: Following visit when decision for surgery or procedur	re made					
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3	3	3	3
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA	1	1	1	1
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA		5		5
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3		3
19	Other Clinical Activity (Retrieve films/hang)	L041B	RT				
20	End: When patient enters office/facility for surgery/procedur	e					
21	SERVICE PERIOD						
22	Start: When patient enters office/facility for surgery/procedu	re: Servi	ces Prior to Procedur	e			
	Greet patient, provide gowning, ensure appropriate medical						
23	records are available	L041B	RT	3		3	
24	Obtain vital signs	L041B	RT	3		3	
25	Provide pre-service education/obtain consent	L041B	RT	3		3	
26	Prepare room, equipment, supplies	L041B	RT	2		2	
27	Setup scope (non facility setting only)						
28	Prepare and position patient/ monitor patient/ set up IV	L041B	RT	3		3	
29	Sedate/apply anesthesia	L051A	RN	2		2	
30	Intra-service						
31	Assist physician in performing procedure	L041B	RT	20		30	
32	Monitor drainage of fluid	L037D	RN/LPN/MTA				
33	Assist physician in performing procedure (CS)	L051A	RN	20		30	
34	Post-Service						
35	Monitor pt. following service/check tubes, monitors, drains	L051A	RN	60		60	
36	Clean room/equipment by physician staff	L041B	RT	3		3	
37	Clean Scope						
38	Clean Surgical Instrument Package						
39	Complete diagnostic forms, lab & X-ray requisitions	L041B	RT	3		3	
40	Review/read X-ray, lab, and pathology reports						
	Check dressings & wound/ home care instructions /coordinate						
41	office visits /prescriptions	L041B	RT	3		3	
42	Other Clinical Activity (process films)						
43	End: Patient leaves office						
44	POST-SERVICE Period						
45	Start: Patient leaves office/facility						
46	Conduct phone calls/call in prescriptions	L041B	RT	3	3	3	3
47	Other Activity (please specify)						
48	End: with last office visit before end of global period						
49	MEDICAL SUPPLIES	0.4.0.45	Unit				
50	pack, minimum multi-specialty	SA048	pack	1		1	
51	Conscious Sedation Pack	SA044	kit	1		1	
52	Bandaid	SG021	item	1		1	
53	Beradine	SJ041	mi	30		30	
54		SB024	pair	2		2	
55	Heparin lock	SC012	Item	1		1	
56		SH047	mi	10		10	
57	INeedle, Uniba	SC035	each			3	
58	Ineedie, 186	50029	item	1		1	
59	Pre-set biopsy tray	SAU61	Item	1		1	
60 61	Saline Flush	SH065	mi ita	10		10	
61	Spring loaded needle, 18G (blopsy gun)	SC033	item			1	
62		50057	item	Ĩ		1	
63		EL 007		00		40	
64				30		40	
65	Sileicher Chair ECC. 2 channol (with SpO2, NIPD, town, room)	EF019 E0014		202		212	
67	$\mathbb{I}_{\mathcal{V}}$ influsion pump	EQ011		202		212	
01				202		212	

AMA Specialty Society Recommendation

AMA/Specialty Society RVS Update Committee Summary of Recommendations Fourth Five-Year Review

February 2011

Ventricular Assist Device (VAD) Removal

In the 4th Five-Year Review of the RBRVS, the Society of Thoracic Surgeons (STS) identified services including ventricular assist device (VAD) removal codes, VAD insertion and replacement codes, lung transplant codes, pulmonary artery embolectomy codes, descending thoracic aorta repair codes and congenital cardiac codes. In October 2010, the RUC reviewed the VAD insertion and replacement codes, which have an XXX global period. To be consistent with the insertion and replacement VAD codes, the RUC requested that CMS consider an XXX global period for CPT codes 33977 *Removal of ventricular assist device; extracorporeal, single ventricle,* 33978 *Removal of ventricular assist device; extracorporeal, single ventricle,* single ventricle. CMS approved this global change request and the specialty society re-surveyed the VAD removal codes with an XXX global period and provided recommendations at the February 2011 RUC meeting.

The RUC agreed with the specialty society that there is compelling evidence that the patient population has changed because the complexity of patients has increased as many have been on cardiopulmonary bypass. Additionally, although the RUC is recommending slight increases for 33977 and 33978, the previous 090 global work RVU of this code did not include any post-operative hospital visits and therefore was valued incorrectly.

33977 Removal of ventricular assist device; extracorporeal, single ventricle

The RUC reviewed the survey results of 44 cardiothoracic surgeons and determined that he survey 25th percentile work RVU of 20.86 appropriately accounts for the work required to perform this procedure and places it in the proper rank order with other VAD procedures. Additionally, the pre-service time of 95 minutes, intra-service time of 180 minutes and immediate post-service time of 60 minutes appropriately accounts for the physician work required to this service compared to the VAD insertion and replacement services. The RUC compared 33977 to the key reference service (adjusted for the XXX global period for comparison) 33548 *Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR, SAVER, Dor procedures)* (XXX work = 30.26, intra-service time = 217) and MPC code 33405 *Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve* (XXX work RVU = 23.53, intra-service time = 180 minutes) and agreed with the survey respondents that the physician work and time for 33977 is less as the reference codes include cardiopulmonary bypass and 33977 does not. Therefore, **the RUC recommends a work RVU of 20.86 for CPT code 33977**.

33978 Removal of ventricular assist device; extracorporeal, biventricular

The RUC reviewed the survey results of 44 cardiothoracic surgeons and determined that he survey 25th percentile work RVU of 25.00 appropriately accounts for the work required to perform this procedure and places it in the proper rank order with other VAD procedures. Additionally, the pre-service time of 95 minutes, intra-service time of 200 minutes and immediate post-service time of 60 minutes appropriately

1

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accounts for the physician work required to this service compared to the VAD insertion and replacement services. The RUC compared 33978 to the key reference service (adjusted for the XXX global period for comparison) 33548 *Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR, SAVER, Dor procedures)* (XXX work = 30.26, intra-service time = 217) and MPC code 33426 *Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring* (XXX work RVU = 25.49, intra-service time = 205 minutes) and agreed with the survey respondents that the physician work and time for 33978 is less as the reference codes include cardiopulmonary bypass and 33978 does not. Therefore, **the RUC recommends a work RVU of 25.00 for CPT code 33978**.

33980 Removal of ventricular assist device, implantable intracorporeal, single ventricle

The RUC reviewed the survey results of 44 cardiothoracic surgeons and determined that he survey median work RVU of 40.00 appropriately accounts for the work required to perform this procedure and places it in the proper rank order with other VAD procedures. Additionally, the preservice time of 95 minutes, intra-service time of 300 minutes and immediate post-service time of 90 minutes appropriately accounts for the physician work required to this service compared to the VAD insertion and replacement services. The RUC determined that the median survey work RVU was appropriate for code 33980 because the physician time and work for the intracorporeal removal, 300 minutes intra-service time, is significantly more than for the extracorporeal removal codes 33977, 180 minutes intra-service time, and 33978, 200 minutes intra-service time.

The RUC also compared 33980 to the key reference service (adjusted for the XXX global period for comparison) 43123 *Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)* (XXX work = 49.95, intra-service time = 442) and agreed with the survey respondents that 33980 was more intense, but required less physician time. The RUC also compared 33780 to MPC code 47130 *Hepatectomy, resection of liver; total right lobectomy* (XXX work RVU = 34.80, intra-service time = 240 minutes) and determined that 33780 requires more physician work and time to perform. Therefore, **the RUC recommends a work RVU of 40.00 for CPT code 33980**.

Additional Information:

Please note that the October 2010 summary of recommendation forms which include survey responses based on a 090-day global period are attached as requested by CMS.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
33977	Removal of ventricular assist device; extracorporeal, single ventricle	090 XXX	20.86
33978	extracorporeal, biventricular	090 XXX	25.00

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CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
33980	Removal of ventricular assist device, implantable intracorporeal, single ventricle	090 XXX	40.00

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS 2010 FIVE YEAR REVIEW SUMMARY OF RECOMMENDATION

CPT Code:33977 Tracking Number Global Period: XXX Specialty Society Recommended RVU: 20.86 RUC Recommended RVU: 20.86

CPT Descriptor: Removal of ventricular assist device; extracorporeal, single ventricle

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 51 year-old man failed to weaned from cardiopulmonary bypass following coronary artery bypass grafting and required insertion of an extracorporeal left ventricular assist device as a bridge to survival. He is now 5 days postop, and appears to have sufficient recovery of LV function to allow removal of his assist device and its inflow and outflow cannulae.

Percentage of Survey Respondents who found Vignette to be Typical: 63%

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: Physician performs a complete or interval history and physical exam, comprehensive medical decision making, writes pre-operative orders for pre-operative medications, reviews pre-operative work-up including review of information from other physicians, and relevant tests/data/labs, reviews incision and procedure, talks with patient and family and answers any questions, obtains informed consent, confirms O.R. start time. The physician changes into scrubs, and must accompany the patient during transport from the ICU to the OR as the extracorporeal device must be monitored during this transport. The physician reviews with anesthesia, waits for anesthetic induction, intubation, placement of arterial and central lines, positions and pads patient, places defibrillator pads on the chest and back, scrubs, gloves, preps and drapes patient. The physician must ensure that during prep and drape the extracorporeal cannulae are well protected and will not be dislodged or accidently removed. Just prior to incision, a comprehensive "Time Out" procedure is undertaken by the entire operating room team.

Description of Intra-Service Work: A standard re-operative median sternotomy incision is performed and the cannulation sites for the extracorporeal device are mobilized and exposed. The physcian then weans the device - ensuring optimal hemodynamics, monitoring intracardiac filling pressures and adjusting inotropes and vasoactive drugs accordingly. When the patient is stabilized off device, the cannulae are removed and the cannulation sites secured with suture closure. The chest cavity is then thoroughly irrigated with antibiotic saline and closed.

Description of Post-Service Work: The physician evaluates and manages the patient's hemodynamics and bleeding while preparing the patient for transport from the operating room to the intensive care unit. Once appropriate transfer monitoring

CPT Code: 33977

is established, and the physician determines that there is sufficient stability, the physician accompanies the patient to the intensive care unit and participates in the transfer of direct care from anesthesiology to intensive care nursing. Particular attention is paid to the ventilatory status to optimize intra-thoracic pressure in view of typically impaired right ventricular performance. Because the typical patient is not stable, multiple adjustments of inotropic/vasoactive agents and volume status as well as characteristics of intra-aortic balloon pump triggering are determined minute to minute. In addition, the physician talks to family, talks to and coordinates care with other physicians, writes orders, writes an operative note, discusses outcome with patient and family during this time.

SURVEY DAT	ГА						
RUC Meeting Da	ate (mm/yyyy)	02/2011					
Presenter(s):	Joseph Clev	veland, MD; Ste	phen Lahey	, MD; Verdi [DiSesa, MD		
Specialty(s):	cardiothorad	cic surgery					
CPT Code:	33977						
Sample Size: 250 Resp N:			44	Response	9: 17.6 %		
Sample Type:	Convenienc	e Addition	al Sample I	nformation:			
			Low	25 th %	Median*	<u>75th %</u>	High
Service Perform	nance Rate		0.00	2.00	3.00	7.00	30.00
Survey RVW:			12.75	20.86	27.20	30.00	45.00
Pre-Service Evalu	ation Time:				60.00		
Pre-Service Posit	ioning Time:				25.00		
Pre-Service Scrul	o, Dress, Wait	Time:			20.00		
Intra-Service Ti	me:		70.00	120.00	180.00	180.00	360.00
Immediate Post	Service-Time	e: <u>60.00</u>			·		
Post Operative	<u>Visits</u>	Total Min**	CPT Code	and Numbe	er of Visits		
Critical Care tim	ne/visit(s):	<u>0.00</u>	99291x 0.0	0 99292x	0.00		
Other Hospital t	ime/visit(s):	<u>0.00</u>	99231x 0.0	0 99232x	0.00 99233x	0.00	
Discharge Day	Mgmt:	<u>0.00</u>	99238x 0.0	0 99239x 0 .	.00		
Office time/visit	(s):	<u>0.00</u>	99211x 0.0	0 12x 0.00	13x 0.00 14x 0.0	0 15x 0.00	
Prolonged Serv	ices:	<u>0.00</u>	99354x 0.0	0 55x 0.00	56x 0.00 57x	0.00	
Sub Obs Care:		0.00	99224x 0.0	0 99225x	0.00 99226x	0.00	

**Physician standard total <u>minutes per E/M visit</u>: 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: 4 - FAC Difficult Patient/Difficult Procedure

CPT	33077		Recomm	nended Phy	ysician Work RVU:	20.86
Code:	55911				1	
			Spe	cialty	Specialty Recommended	Adjustments to
			Pre-Ser	vice Time	Pre Time Package	Pre-Service Time
Pre-Service Evaluation	Time:		60	0.00	40.00	20.00
Pre-Service Positioning	Time:		1	5.00	3.00	12.00
Pre-Service Scrub, Dres	s, Wait Tim	ie:	20	0.00	20.00	0.00
Intra-Service Time:			18	0.00		
Immediate Post Servi	ce-Time:	<u>60.00</u>				
Post Operative Visits		<u>Total Min**</u>	CPT Cod	de and Nu	<u>Imber of Visits</u>	
Critical Care time/visi	t(s):	<u>0.00</u>	99291x	0.00 992	92x 0.00	
Other Hospital time/vi	sit(s):	<u>0.00</u>	99231x	0.00 992	32x 0.00 99233	× 0.00
Discharge Day Mgmt:		<u>0.00</u>	99238x	0.0 99239>	< 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 57	× 0.00
Sub Obs Care:		0.00	99224x	0.00 992	25x 0.00 99226	× 0.00

KEY REFERENCE SERVICE:

Key CPT Code 33548	<u>Global</u> XXX		<u>Work RVU</u> 28.16	<u>Time Source</u> RUC Time
<u>CPT Descriptor</u> Surgical ver remodeling, SVR, SAVER, D Code is adjusted from 90 day used in the RSL for this surve	ntricular restor or procedures to represet XX y	ration procedure,) XX global work or	includes prosthetic pate	ch, when performed (eg, ventricular ed by the Research subcommittee and
KEY MPC COMPARISON	CODES:			
Compare the surveyed code t appropriate that have relative	o codes on th values higher	e RUC's MPC L and lower than the	1st. Reference codes from e requested relative value	om the MPC list should be chosen, if es for the code under review.
<u>MPC CPT Code 1</u> 22554 <u>CPT Descriptor 1</u> Arthrodesi than for decompression); cerv	Global W XXX s, anterior int ical below C2	<u>/ork RVU</u> 12.11 erbody technique	<u>Time Source</u> RUC Time e, including minimal dise	Most Recent <u>Medicare Utilization</u> 32,339 cectomy to prepare interspace (other
RVW IS ADJUSTED TO RE	PRESENT XX	XX WORK ONL	Y	
<u>MPC CPT Code 2</u> 33405	<u>Global</u> XXX	<u>Work RVU</u> 23.53	Time Source RUC Time	Most Recent <u>Medicare Utilization</u> 31,270
<u>CPT Descriptor 2</u> eplacement stentless valve RVW IS ADJUSTED TO RE	t, aortic valve	, with cardiopulm	nonary bypass; with pros Y	sthetic valve other than homograft or
Other Reference CPT Code 33405	<u>Global</u> XXX	<u>Work RV</u> 23.53	U <u>Time Source</u> RUC Time	
<u>CPT Descriptor</u> Replacement stentless valve Code is adjusted from 90 day used in the RSL for this surve	, aortic valve, to represet XX y	, with cardiopulm XX global work or	nonary bypass; with pros	thetic valve other than homograft or ed by the Research subcommittee and

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including existing time 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 %

<u>TIME ESTIMATES (Median)</u>	CPT Code: 33977	Key Reference CPT Code: <u>33548</u>	Source of Time RUC Time
Median Pre-Service Time	95.00	95.00	
Median Intra-Service Time	180.00	217.00	
Median Immediate Post-service Time	60.00	40.00	
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	335.00	352.00
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

(of those that selected Key Reference code)

<u>Mental Effort and Judgment (Mean)</u>		
The number of possible diagnosis and/or the number of	4.14	3.28
management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests,	4.26	3.51
and/or other information that must be reviewed and analyzed		
Urganay of modical desicion making	4 20	2 40
orgency of medical decision making	4.30	5.40
<u>Technical Skill/Physical Effort (Mean)</u>		
Technical skill required	3.63	3.65
Physical effort required	3.79	3.58
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.53	3.70
Outcome depends on the skill and judgment of physician	4.58	3.88
Estimated risk of malpractice suit with poor outcome	3.93	3.40
INTENSITY/COMPLEXITY MEASURES	<u>CPT Code</u>	<u>Reference</u> Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.26	3.42
Intra-Service intensity/complexity	3.63	3.37
Post-Service intensity/complexity	4.23	3.14

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 Code: 33977

COMPELLING EVIDENCE FOR THE FAMILY OF VAD CODES WAS ACCEPTED BY THE FULL RUC AT THE OCTOBER, 2010 RUC MEETING.

The arguments for compelling evidence that were previously submitted and approved by the RUC are included in this section for reference.

Why is this code being reviewed?

This code is submitted as part of the VAD family of codes. Ventricular Assist Devices are undergoing rapid evolution of technology effecting both extracorporeal and intracorporeal devices, and a transition from stroke volume devices to continuous flow devices. With more effective devices, the physician work of implantation is changing, and the patient population served is becoming more challenging. Additionally, as survival on device has improved, device durability now factors into this family of codes. Device durability is somewhat better, but not unlimited. This situation necessitated the development of pump replacement (changeout) codes (33981-33983), which could not be properly valued without revaluing the entire family.

Compelling evidence

The VAD codes were recently reviewed in October 2010 and the RUC accepted compelling evidence for the entire family (including 33977). With regards to code 33977, postcardiotomy shock (PCCS) remains a highly complex and lethal entity. Estimates for its incidence range from 0.2%- 6% following cardiac operations. This wide range is the result of a nonuniform definition of PCCS; however, it is noteworthy that at best, recent literature suggests that at best only 25-40% of patients survive until discharge (1). Despite the advent of newer third generation centrifugal devices (such as the CentriMag) blood pump, good outcomes for PCCS still lag far behind other device outcomes. While outcomes for PCCS have improved modestly over the past decade, the morbidity rates of bleeding, stroke, infection, and prolonged ventilation have not changed (see table below). The reason for these continued high rates of morbidity are related almost entirely to patient status at implant (cardiogenic shock with end organ malperfusion) and timing of implantation. These patients remain extraordinarily challenging to successfully judge device weaning, timing of explantation, and then resolution of PCCS to successful discharge.

TABLE 3. Unadjusted Outcomes

	January 1995–June 1997	July 1997-December 1999	January 2000-June 2002	July 2002-December 2004	
	(n—1255), %	(n—1119), %	(n—1776), %	(n-1585), %	P
Mortality	61.5	54.2	34.1	40.8	< 0.001
Mortality/morbidity	77.7	74.3	54.6	62.8	< 0.001
Reoperation for bleeding	23.4	23.6	17.5	19.7	< 0.001
Stroke	6.6	5.4	4.0	4.9	< 0.001
Renal failure	24.9	25.4	18.3	21.8	< 0.001
Infection (deep sternum)	1.3	1.4	1.1	1.8	< 0.001
Infection (sepsis)	6.2	5.7	5.2	7.0	< 0.001
Prolonged ventilation	37.4	40.8	31.2	39.2	< 0.001

Probability values are for trend across columns, determined via the Jonckheere-Terpstra (nonparametric) test for trend.

Table from: Hernandez, et al. A decade of short-term outcomes in postcardiac surgery ventricular assist device implantation: Data from the Society of Thoracic Surgeons's National Cardiac Database. Circulation 2007;116:606-612.

References

(1)Sylvin EA, Stern DR, Goldstein DJ. Mechanical Circulatory Support for Postcardiotomy Cardiogenic Shock: Has Progress Been Made? J Card Surg 2010;25:442-454.

Five-year-review specific questions and discussion

Change in Work

Eighty-two percent of the respondents indicated that the patients for this procedure have become more complex, consistent with general changes in the cardiac surgical patient population and advances in ventricular assist device design that have broadened the indications. 58% of the respondents felt that there the physician work has changed, and has increased. None of the other 5-year-review questions indicated a significant (typical) statistic.

Work RVU Recommendation

We are recommending the 25^h percentile work RVU of 20.86. The IWPUT of the recommendation is 0.098 which is consistent with the complexity of cardiac and VAD procedures in general and this procedure in particular. This value and its components are appropriate for this complex procedure and patient, and the intra-service work is suitably related to that of the reference code and selected MPC codes.

Pre-time

Pre-time package 4 (facility- difficult patient/difficult procedure) is appropriate for this procedure.

<u>Evaluation:</u> Add 20 minutes. This is supported by the survey, and the critical nature of the decision making when removing a ventricular assist device. In addition to preparing the patient for a major cardiac procedure, the patient's hemodynamic status and biventricular function is completely reassessed in the operating room immediately prior to skin preparation. This evaluation includes the interpretation of transesophageal echocardiographic images and central pulmonary artery pressures as final trial weaning of the assist device is performed. Consideration is given to the patient's ability to tolerate the planned removal, and the potential necessity to utilize temporary cardiopulmonary bypass support to accomplish the transition from device to the absence of mechanical support.

<u>Positioning</u>: Add 12 minutes. This is supported by the survey. This accounts for the additional time involved in coordinating the positioning of the assist device console and lines for the support device in place, placement of additional EKG electrodes to be used to trigger the intra-aortic balloon pump to account for positioning of the patient with typically an intra-aortic balloon pump which is often necessary, and coordination of the placement of these devices with the cardiopulmonary bypass machine which may also be required. Since the patient is a re-operative patient with limited immediate cardiac exposure, R2 external defibrillating pads must also be appropriately positioned for patient rescue from sustained ventricular arrhythmia.

Scrub, dress, wait: No change

Comparison to key reference code

33548 - Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR, SAVER, Dor procedures)

	RVW	IWPUT	Total	Eval	Postit	SDW	Intra	IM-	91	92	33	32	31	38	39	15	14	13	12
			Time					post											
33548	54.14	.117	928	60	15	20	217	40	2	1	3	2	1		1		1	2	
90																			
glob																			
time																			
33548	28.16	.117	352	60	15	20	217	40											
XXX																			
adj																			
time																			
33977	20.86	0.098	335	60	15	20	180	60											

Comparison to other key reference code

33945	5 - Heart tr	ransplant, w	ith or witl	10ut reci	pient card	iectomy													
	RVW	IWPUT	Total	Eval	Postit	SDW	Intra	IM-	91	92	33	32	31	38	39	15	14	13	12
			Time					post											
33405	41.32	0.105	769	60	15	20	198	40	1		3	2	1	1			1	1	
90																			
glob																			
time																			
33405	23.53	0.105	333	60	15	20	198	40											
XXX																			
adj																			
time																			
33977	20.86	0.098	335	60	15	20	180	60											

Comparison to MPC codes

22554 - Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2 33405 - Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve

		,					-,				8								
	RVW	IWPUT	Total	Eval	Postit	SDW	Intra	IM-	91	92	33	32	31	38	39	15	14	13	12
			Time					post											
22554	12.11	0.1058	185	60	20	15	90	30											
XXX																			
adj																			
time																			
33405	23.53	0.105	333	60	15	20	198	40											
XXX																			
adj																			
time																			
33977	20.86	0.098	335	60	15	20	180	60											

Additional requested statistics

CPT		Min	5 ^{th %}	25 th %	Med	75 th %	95 th %	Max	Arith Mean	Geo Mean	Mode
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CPT Cod	le: 33977
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22077	Work RVU	12.75	13.55	20.86	27.20	30.00	40.68	20.86	30.00	40.68	45.00
33977	Intra Time	70	90	120	180	180	240	360	167	156	180

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.

Professional Liability Insurance Information (PLI)

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

If no, please select another crosswalk and provide a brief rationale. 33977

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

Compelling Evidence

The RUC operates with the initial presumption that the current values assigned to the codes under review are correct. The argument for a change must be substantial and meet the RUC's compelling evidence standards listed in the Instructions Document. Please list your compelling evidence below (if appropriate).

Compelling evidence for 33977 is included in the Rationale Section Above.

Five-Year Review Specific Questions

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

Has the work of performing this service changed in the past 5 years? Yes 58% No 42% A. This service represents new technology? Yes 63% No 37%

Of survey respondents, who said yes, the new technology affected the work:

Less Work: 0% Same Work: 48% More Work: 52%

- B. This service reflects new technology that has become more familiar: Yes 58% No 42%
- C. Patients requiring this service are now: More complex (more work) 82% Less complex (less work) 0% No change in complexity 18%
- D. The typical site-of-service has changed:

From outpatient to inpatient 0% From inpatient to outpatient 0% No change 100%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS 2010 FIVE YEAR REVIEW SUMMARY OF RECOMMENDATION

CPT Code:33978 Tracking Number Global Period: XXX Specialty Society Recommended RVU: 25.00 RUC Recommended RVU: 25.00

CPT Descriptor: Removal of ventricular assist device; extracorporeal, biventricular

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 51 year-old man failed to weaned from cardiopulmonary bypass following coronary artery bypass grafting and required insertion of an extracorporeal left and right ventricular assist devices to bridge to survival. He is now 5 days postop, and appears to have sufficient recovery of biventricular function to allow removal of both devices and associated inflow and outflow cannulae.

Percentage of Survey Respondents who found Vignette to be Typical: 56%

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: Physician performs a complete or interval history and physical exam, comprehensive medical decision making, writes pre-operative orders for pre-operative medications, reviews pre-operative work-up including review of information from other physicians, and relevant tests/data/labs, reviews incision and procedure, talks with patient and family and answers any questions, obtains informed consent, confirms O.R. start time. The physician changes into scrubs, and must accompany the patient during transport from the ICU to the OR as the extracorporeal device must be monitored during this transport. The physician reviews with anesthesia, waits for anesthetic induction, intubation, placement of arterial and central lines, positions and pads patient, places defibrillator pads on the chest and back, scrubs, gloves, preps and drapes patient. The physician must ensure that during prep and drape that the extracorporeal cannulae are well protected and will not be dislodged or accidently removed. Just prior to incision, a comprehensive "Time Out" procedure is undertaken by the entire operating room team.

Description of Intra-Service Work: A standard re-operative median sternotomy incision is performed and the cannulation sites for the extracorporeal devices are mobilized and exposed. The physcian then weans both devices - ensuring optimal hemodynamics, monitoring intracardiac filling pressures and adjusting inotropes and vasoactive drugs accordingly. When the patient is stabilized off both devices, the cannulae are removed and the cannulation sites secured with suture closure. The chest cavity is then thoroughly irrigated with antibiotic saline and closed.

Description of Post-Service Work: The physician evaluates and manages the patient's hemodynamics and bleeding while preparing the patient for transport from the operating room to the intensive care unit. Once appropriate transfer monitoring

CPT Code: 33978

is established, and the physician determines that there is sufficient stability, the physician accompanies the patient to the intensive care unit and participates in the transfer of direct care from anesthesiology to intensive care nursing. Particular attention is paid to the ventilatory status to optimize intra-thoracic pressure in view of typically impaired right ventricular performance. Because the typical patient is not stable, multiple adjustments of inotropic/vasoactive agents and volume status as well as characteristics of intra-aortic balloon pump triggering are determined minute to minute. In addition, the physician talks to family, talks to and coordinates care with other physicians, writes orders, writes an operative note, discusses outcome with patient and family during this time.

SURVEY DAT	ГА						
RUC Meeting Da	ate (mm/yyyy)	02/2011					
Presenter(s):	Joseph Clev	/eland, MD; Ste	phen Lahey	, MD; Verdi D	iSesa, MD		
Specialty(s):	cardiothora	cic surgery					
CPT Code:	33978						
Sample Size:	250	Resp N:	44	Response	: 17.6 %		
Sample Type:	Convenienc	e Addition	al Sample I	nformation:			
			Low	25 th %	Median*	75th %	High
Service Perform	nance Rate		0.00	1.00	3.00	4.00	10.00
Survey RVW:			12.91	25.00	30.00	39.50	50.00
Pre-Service Evalu	ation Time:				60.00		
Pre-Service Posit	ioning Time:				25.00		
Pre-Service Scrul	o, Dress, Wait	Time:			20.00		
Intra-Service Ti	me:		90.00	180.00	200.00	240.00	420.00
Immediate Post	Service-Time	e: <u>60.00</u>					
Post Operative	<u>Visits</u>	Total Min**	CPT Code	and Numbe	er of Visits		
Critical Care tim	ne/visit(s):	<u>0.00</u>	99291x 0.0	0 99292x	0.00		
Other Hospital t	ime/visit(s):	<u>0.00</u>	99231x 0.0	0 99232x	0.00 99233x	0.00	
Discharge Day	Mgmt:	<u>0.00</u>	99238x 0.0	0 99239x 0.0	00		
Office time/visit	(s):	<u>0.00</u>	99211x 0.0	0 12x 0.00 1	3x 0.00 14x 0.0	0 15x 0.00	
Prolonged Serv	ices:	<u>0.00</u>	99354x 0.0	0 55x 0.00	56x 0.00 57x	0.00	
Sub Obs Care:		0.00	99224x 0.0	0 99225x	0.00 99226x	0.00	

**Physician standard total <u>minutes per E/M visit</u>: 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: 4 - FAC Difficult Patient/Difficult Procedure

CPT	33078		Recomme	ended Phy	ysician Wo	rk RVU:	25.00
Code:	33910						
			Spec Recomn	ialty nended	Specia Recomm	alty ended	Adjustments to
			Pre-Servi	ice Time	Pre Time P	ackage	Pre-Service Time
Pre-Service Evaluation	Time:		60.	00	40.0	0	20.00
Pre-Service Positioning	Time:		15.	00	3.00)	12.00
Pre-Service Scrub, Dres	s, Wait Tim	ie:	20.	00	20.0	0	0.00
Intra-Service Time:			200	.00			
Immediate Post Servi	ce-Time:	<u>60.00</u>					
Post Operative Visits		<u>Total Min**</u>	CPT Code	and Nu	mber of Vis	<u>sits</u>	
Critical Care time/visi	t(s):	<u>0.00</u>	99291x 0 .	00 992	92x 0.00		
Other Hospital time/vi	isit(s):	<u>0.00</u>	99231x 0 .	00 992	32x 0.00	99233x	0.00
Discharge Day Mgmt:		<u>0.00</u>	99238x 0 .	0 99239>	< 0.0		
Office time/visit(s):		<u>0.00</u>	99211x 0 .	00 12x 0	.00 13x 0.0	0 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 .	00 992	25x 0.00	99226x	0.00

KEY REFERENCE SERVICE:

Key CPT Code	<u>Global</u>	Work RVU	Time Source
33548	XXX	28.16	RUC Time

<u>CPT Descriptor</u> Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR, SAVER, Dor procedures)

Code is adjusted from 90 day to represet XXX global work only - method was approved by the Research subcommittee and used in the RSL for this survey

KEY MPC COMPARISON CODES:

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

				Most Recent
MPC CPT Code 1	<u>Global</u> V	Work RVU	Time Source	Medicare Utilization
61698	XXX	44.77	RUC Time	58
CPT Descriptor 1 Surge	ry of complex intra	acranial aneurysm	n, intracranial approac	h; vertebrobasilar circulation
RVW IS ADJUSTED T	O REPRESENT X	XX WORK ON	LY	
				Most Recent
MPC CPT Code 2	<u>Global</u>	Work RVU	Time Source	Medicare Utilization
33426	XXX	25.49	RUC Time	6.392

<u>CPT Descriptor 2</u> Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring RVW IS ADJUSTED TO REPRESENT XXX WORK ONLY

Other Reference CPT Code	Global	Work RVU	Time Source
33945	XXX	44.88	RUC Time

CPT Descriptor Heart transplant, with or without recipient cardiectomy

Number of respondents who choose Key Reference Code: 8

Code is adjusted from 90 day to represet XXX global work only - method was approved by the Research subcommittee and used in the RSL for this survey

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

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

% of respondents: 18.1 %

Source of Time **TIME ESTIMATES (Median) Key Reference CPT Code: RUC Time CPT Code:** 33978 33548 Median Pre-Service Time 95.00 95.00 Median Intra-Service Time 200.00 217.00 Median Immediate Post-service Time 40.00 60.00 Median Critical Care Time 0.0 0.00 Median Other Hospital Visit Time 0.0 0.00 Median Discharge Day Management Time 0.0 0.00Median Office Visit Time 0.0 0.00 0.0 Prolonged Services Time 0.00 Median Subsequent Observation Care Time 0.0 0.00**Median Total Time** 355.00 352.00

Other time if appropriate	

<u>INTENSITY/COMPLEXITY MEASURES (Mean)</u>	(of those the Refere	at selected Key ence code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.37	3.49
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.47	3.67
Urgency of medical decision making	4.37	3.49
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.91	3.84
Physical effort required	4.00	3.74
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.63	3.70
Outcome depends on the skill and judgment of physician	4.60	3.88
Estimated risk of malpractice suit with poor outcome	3.95	3.58
INTENSITY/COMPLEXITY MEASURES	<u>CPT Code</u>	<u>Reference</u> Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.47	3.44
Intra-Service intensity/complexity	4.02	3.65
Post-Service intensity/complexity	4.35	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.*

COMPELLING EVIDENCE FOR THE FAMILY OF VAD CODES WAS ACCEPTED BY THE FULL RUC AT THE OCTOBER, 2010 RUC MEETING.

The arguments for compelling evidence that were previously submitted and approved by the RUC are included in this section for your reference.

Why is this code being reviewed?

This code is submitted as part of the VAD family of codes. Ventricular Assist Devices are undergoing rapid evolution of technology effecting both extracorporeal and intracorporeal devices, and a transition from stroke volume devices to continuous flow devices. With more effective devices, the physician work of implantation is changing, and the patient population served is becoming more challenging. Additionally, as survival on device has improved, device durability now factors into this family of codes. Device durability is somewhat better, but not unlimited. This situation necessitated the development of pump replacement (changeout) codes (33981-33983), which could not be properly valued without revaluing the entire family. Also, CMS requested review of this code (33978) as part of the fourth 5-Year-Review process.

Compelling evidence

The VAD codes were recently reviewed in October 2010 and the RUC accepted compelling evidence for the entire family (including 33978). With regards to code 33978, postcardiotomy shock (PCCS) remains a highly complex and lethal entity. Estimates for its incidence range from 0.2%- 6% following cardiac operations. This wide range is the result of a nonuniform definition of PCCS; however, it is noteworthy that at best, recent literature suggests that at best only 25-40% of patients survive until discharge (1). Despite the advent of newer third generation centrifugal devices (such as the CentriMag) blood pump, good outcomes for PCCS still lag far behind other device outcomes. While outcomes for PCCS have improved modestly over the past decade, the morbidity rates of bleeding, stroke, infection, and prolonged ventilation have not changed (see table below). The reason for these continued high rates of morbidity are related almost entirely to patient status at implant (cardiogenic shock with end organ malperfusion) and timing of implantation. These patients remain extraordinarily challenging to successfully judge device weaning, timing of explantation, and then resolution of PCCS to successful discharge.

TABLE 3. Unadjusted Outcomes

	January 1995–June 1997 (n=1255), %	July 1997–December 1999 (n-1119), %	January 2000–June 2002 (n–1776), %	July 2002-December 2004 (n-1585), %	Р
Mortality	61.5	54.2	34.1	40.8	< 0.001
Mortality/morbidity	77.7	74.3	54.6	62.8	< 0.001
Reoperation for bleeding	23.4	23.6	17.5	19.7	< 0.001
Stroke	6.6	5.4	4.0	4.9	< 0.001
Renal failure	24.9	25.4	18.3	21.8	< 0.001
Infection (deep sternum)	1.3	1.4	1.1	1.8	< 0.001
Infection (sepsis)	6.2	5.7	5.2	7.0	< 0.001
Prolonged ventilation	37.4	40.8	31.2	39.2	< 0.001

Probability values are for trend across columns, determined via the Jonckheere-Terpstra (nonparametric) test for trend.

Table from: Hernandez, et al. A decade of short-term outcomes in postcardiac surgery ventricular assist device implantation: Data from the Society of Thoracic Surgeons's National Cardiac Database. Circulation 2007;116:606-612.

References

(1)Sylvin EA, Stern DR, Goldstein DJ. Mechanical Circulatory Support for Postcardiotomy Cardiogenic Shock: Has Progress Been Made? J Card Surg 2010;25:442-454.

Five-year-review specific questions and discussion

Change in Work

Eighty-two percent of the respondents indicated that the patients for this procedure have become more complex, consistent with general changes in the cardiac surgical patient population and advances in ventricular assist device design that have broadened the indications. 58% of the respondents felt that there the physician work has changed, and has increased. None of the other 5-year-review questions indicated a significant (typical) statistic.

Work RVU Recommendation

We are recommending the 25^h percentile work RVU of 25.00. The additional work units for this code compared to 33977 reflect having to deal with biventricular dysfunction as well as the additional intraprocedure time of dealing with 4 cannulation sites instead of two. Additionally, patients requiring BIVAD support at any time are much more compromised. The IWPUT of the recommendation is 0.109 which is consistent with the complexity of cardiac and VAD procedures in general and this procedure in particular. This value is appropriate for this complex procedure and patient, and is suitably related to the intra-service work of the reference codes and selected MPC codes.

Pre-time

Pre-time package 4 (facility- difficult patient/difficult procedure) is appropriate for this procedure.

Evaluation: Add 20 minutes. This is supported by the survey, and the critical nature of the decision making when removing left and right ventricular assist devices. In addition to preparing the patient for a major cardiac procedure, the patient's hemodynamic status and biventricular function is completely reassessed in the operating room immediately prior to skin preparation. This evaluation includes the interpretation of transesophageal echocardiographic images and central pulmonary artery pressures as final trial weaning of the assist device is performed. Consideration is given to the patient's ability to tolerate the planned removal, and the potential necessity to utilize temporary cardiopulmonary bypass support to accomplish the transition from device to the absence of mechanical support.

Positioning: Add 12 minutes. This is supported by the survey. This accounts for the additional time involved in coordinating the positioning of the assist device consoles and lines for the support devices in place, placement of additional EKG electrodes to be used to trigger the intra-aortic balloon pump to account for positioning of the patient with typically an intra-aortic balloon pump which is often necessary, and coordination of the placement of these devices with the cardiopulmonary bypass machine which may also be required. Since the patient is a re-operative patient with limited immediate cardiac exposure, R2 external defibrillating pads must also be appropriately positioned for patient rescue from sustained ventricular arrhythmia.

Scrub, dress, wait: No change

Comparison to key reference code

33548 - Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR, SAVER, Dor procedures)

	RVW	IWPUT	Total	Eval	Postit	SDW	Intra	IM-	91	92	33	32	31	38	39	15	14	13	12
			Time					post											
33548	54.14	0.117	928	60	15	20	217	40	2	1	3	2	1		1		1	2	
90																			
glob																			
time																			
33548	28.16	0.117	352	60	15	20	217	40											
XXX																			
adj																			
time																			
33978	25.00	0.109	355	60	15	20	200	60											

Comparison to other key reference code

33945	5 - Heart ti	ansplant, w	ith or with	nout reci	pient card	iectomy													
	RVW	IWPUT	Total	Eval	Postit	SDW	Intra	IM-	91	92	33	32	31	38	39	15	14	13	12
			Time					post											
33945	89.50	0.117	1716	167	15	90	325	85	3	1	5	6	1		1	1	2	3	
90																			
glob																			
time																			
33945	44.88	0.117	682	167	15	90	325	85											
XXX																			
adj			1 1																
time																			
33978	25.00	0.109	355	60	15	20	200	60											

Comparison to MPC codes

61698 - Surgery of complex intracranial aneurysm, intracranial approach; vertebrobasilar circulation

33426	o - Valvulo	oplasty, miti	ral valve,	with care	lıopulmor	iary bypa	ss; with p	prosthetic	c ring										
	RVW	IWPUT	Total	Eval	Postit	SDW	Intra	IM-	91	92	33	32	31	38	39	15	14	13	12
			Time					post											
61698	44.77	0.1147	525	60	40	15	360	50											
XXX																			
adj																			
time																			
33426	25.49	0.110	340	60	15	20	205	40											
XXX																			
adj																			
time																			
33978	25.00	0.109	355	60	15	20	200	60											

Additional requested statistics

CPT	Min	5th %	25th %	Med	75th %	95th %	Max	Arith	Geo	Mode

									Mean	Mean	
33978	Work RVU	12.91	17.28	25.00	30.00	39.50	45.00	50.00	39.50	45.00	50.00
	Intra Time	90	102	180	200	240	300	420	240	300	420

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.

Professional Liability Insurance Information (PLI)

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

If no, please select another crosswalk and provide a brief rationale. 33978

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

Compelling Evidence

The RUC operates with the initial presumption that the current values assigned to the codes under review are correct. The argument for a change must be substantial and meet the RUC's compelling evidence standards listed in the Instructions Document. Please list your compelling evidence below (if appropriate).

Compelling evidence for 33978 is included in the Rationale Section Above.

Five-Year Review Specific Questions

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

Has the work of performing this service changed in the past 5 years? Yes 58% No 42% A. This service represents new technology? Yes 63% No 37%

Of survey respondents, who said yes, the new technology affected the work: Less Work: 0% Same Work: 43% More Work: 57%

- B. This service reflects new technology that has become more familiar: Yes 58% No 42%
- C. Patients requiring this service are now: More complex (more work) 82% Less complex (less work) 0% No change in complexity 18%

D. The typical site-of-service has changed:

From outpatient to inpatient 0% From inpatient to outpatient 0% No change 100%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS 2010 FIVE YEAR REVIEW SUMMARY OF RECOMMENDATION

CPT Code:33980 Tracking Number Global Period: XXX Specialty Society Recommended RVU: **40.00** RUC Recommended RVU: **40.00**

CPT Descriptor: Removal of ventricular assist device, implantable intracorporeal, single ventricle

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35-year-old man who had presented with cardiogenic shock secondary to acute viral myocarditis is one-month status post placement of an implantable, intracorporeal left ventricular assist device as a bridge to recovery or to transplant. His biventricular function has improved with medical therapy and mechanical support and he has suffered no irreversible device related complications. It is recommended that device removal will provide his best prospect for long-term survival.

Percentage of Survey Respondents who found Vignette to be Typical: 72%

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: Physician performs a complete or interval history and physical exam, comprehensive medical decision making, writes pre-operative orders for pre-operative medications, reviews pre-operative work-up including review of information from other physicians, and relevant tests/data/labs, reviews procedure, talks with patient and family and answers any questions, obtains informed consent, and confirms procedure start time. The physician scrubs, gloves, preps and drapes patient. The physician must ensure that during prep and drape that the driveline and system controller fro the LVAD are well protected and will not be compromised during the prep. Just prior to incision, a comprehensive "Time Out" procedure is undertaken by the entire operating room team.

Description of Intra-Service Work: A standard re-operative median sternotomy incision is performed and the patient and the ascending aorta and right atrium are dissected free from adhesions in preparation for cannulation for cardiopulmonary bypass. The patient is systemically heparinized with 300 units/kg heparin and cannulated for cardiopulmonary bypass with central aortic cannulation and right atrial cannulation. Cardiopulmonary bypass is initiated, the intracorporeal VAD is switched off, and the remainder of the dissection is completed with the patient systemically heparinized with an activated clotting time of greater than 450 seconds. The VAD outflow and inflow cannulae are exposed. During this re-operative dissection, avoiding injury to either of the VAD cannulae - particularly the outflow cannula is essential to avoid exsanguination of the patient. The VAD inflow cannula site (the left ventricular apex) is reconstructed with a series of pledgeted sutures and a Dacron patch after the VAD inflow cannula has been removed from the LV apex.. The VAD outflow graft is clamped approximately 1 cm above its attachment to the ascending aorta. The VAD outflow graft is

CPT Code: 33980

divided and oversewn with a running monofilament suture. The VAD is removed from the operative field. Hemodynamics are optimized with inotropes and then cardiopulmonary bypass is weaned. Protamine is given to reverse heparin and mediastinal hemostasis is aggressively sought. It is typical that these patients will have a coagulopathy secondary to the re-operative status and the dissection of the VAD from the mediastinum using cardiopulmonary bypass. The coagulopathy is addressed with blood products and once corrected, the physician can close the sternum with wires. Skin is closed with suture.

Description of Post-Service Work: The physician evaluates and manages the patient's hemodynamics and bleeding while preparing the patient for transport from the operating room to the intensive care unit. Once appropriate transfer monitoring is established, and the physician determines that there is sufficient stability, the physician accompanies the patient to the intensive care unit and participates in the transfer of direct care from anesthesiology to intensive care nursing. Particular attention is paid to the ventilatory status to optimize intra-thoracic pressure in view of typically impaired right ventricular performance. Because the typical patient is not stable, multiple adjustments of inotropic/vasoactive agents and volume status as well as characteristics of intra-aortic balloon pump triggering are determined minute to minute. In addition, the physician talks to family, talks to and coordinates care with other physicians, writes orders, writes an operative note, discusses outcome with patient and family during this time.

SURVEY DAT	ГА						
RUC Meeting Da	02/2011						
Presenter(s):	Joseph Clev	Joseph Cleveland,MD; Stephen Lahey, MD; Verdi DiSesa, MD					
Specialty(s):	cardiothora	cardiothoracic surgery					
CPT Code: 33980							
Sample Size: 250 Resp N:			44	44 Response: 17.6 %			
Sample Type:	Convenienc	e Addition	al Sample I	nformation:			
			Low	25 th %	Median*	75th %	High
Service Perforn	nance Rate		0.00	1.00	2.00	5.00	25.00
Survey RVW:			20.00	33.50	40.00	47.00	60.00
Pre-Service Evalu	uation Time:				60.00		
Pre-Service Posit	tioning Time:				25.00		
Pre-Service Scru	b, Dress, Wait	Time:			20.00		
Intra-Service Ti	me:		90.00	240.00	300.00	300.00	480.00
Immediate Post	Service-Tim	e: <u>90.00</u>					
Post Operative	<u>Visits</u>	Total Min**	CPT Code	and Numbe	er of Visits		
Critical Care tin	ne/visit(s):	<u>0.00</u>	99291x 0.0	0 99292x	0.00		
Other Hospital time/visit(s): 0.00			99231x 0.0	0 99232x	0.00 99233x	0.00	
Discharge Day Mgmt: <u>0.00</u>			99238x 0.0	0 99239x 0 .	00		
Office time/visit(s): <u>0.00</u>			99211x 0.0	0 12x 0.00 1	3x 0.00 14x 0.0	0 15x 0.00	
Prolonged Services: <u>0.00</u>			99354x 0.0	0 55x 0.00	56x 0.00 57x	0.00	
Sub Obs Care:		0.00	99224x 0.0	0 99225x	0.00 99226x	0.00	

**Physician standard total <u>minutes per E/M visit</u>: 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: 4 - FAC Difficult Patient/Difficult Procedure

CPT 33980			Recommended Physician Work RVU: 40.00			
Code:	00000					
			Specialty Recommende Pre-Service Tir	d ne F	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation T	60.00		40.00	20.00		
Pre-Service Positioning 1	Fime:		15.00		3.00	12.00
Pre-Service Scrub, Dress	20.00		20.00	0.00		
Intra-Service Time:			300.00			
Immediate Post Servic	e-Time:	<u>90.00</u>				
Post Operative Visits		<u>Total Min**</u>	CPT Code and	Nun	<u>nber of Visits</u>	
Critical Care time/visit	(s):	<u>0.00</u>	99291x 0.00	99292	2x 0.00	
Other Hospital time/vis	sit(s):	0.00	99231x 0.00	9923	2x 0.00 99233x	0.00
Discharge Day Mgmt: <u>0.00</u>			99238x 0.0 99239x 0.0			
Office time/visit(s):		0.00	99211x 0.00 12	x 0.0	0 13x 0.00 14x 0	.00 15x 0.00
Prolonged Services:		0.00	99354x 0.00 5	5x 0 .	00 56x 0.00 57x	0.00
Sub Obs Care:		0.00	99224x 0.00	9922	5x 0.00 99226x	0.00

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
43123	XXX	51.07	RUC Time

<u>CPT Descriptor</u> Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es) Code is adjusted from 90 day to represet XXX global work only - method was approved by the Research subcommittee and used in the RSL for this survey

KEY MPC COMPARISON CODES:

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

				Most Recent
MPC CPT Code 1	<u>Global</u> W	/ork RVU	Time Source	Medicare Utilization
47130	XXX	34.80	RUC Time	519
CPT Descriptor 1 Hepate	ectomy, resection of	f liver; total righ	t lobectomy	
RVW IS ADJUSTED TO	O REPRESENT XX	XX WORK ONI	LY	
				Most Recent
MPC CPT Code 2	<u>Global</u>	Work RVU	Time Source	Medicare Utilization
33681	XXX	23.06	RUC Time	129
33681	XXX	23.06	RUC Time	129

<u>CPT Descriptor 2</u> Closure of single ventricular septal defect, with or without patch; RVW IS ADJUSTED TO REPRESENT XXX WORK ONLY

Other Reference CPT Code	<u>Global</u>	Work RVU	Time Source
33548	XXX	28.16	RUC Time

<u>CPT Descriptor</u> Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR, SAVER, Dor procedures)

Code is adjusted from 90 day to represet XXX global work only - method was approved by the Research subcommittee and used in the RSL for this survey

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

Number of respondents who choose Key Reference Code: 7

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

% of respondents: 15.9 %

Source of Time TIME ESTIMATES (Median) **Key Reference ČPT Code: CPT Code: RUC** Time 33980 <u>43123</u> Median Pre-Service Time 95.00 95.00 Median Intra-Service Time 300.00 442.00 Median Immediate Post-service Time 90.00 40.00 Median Critical Care Time 0.0 0.00 Median Other Hospital Visit Time 0.0 0.00 Median Discharge Day Management Time 0.00 0.0 Median Office Visit Time 0.0 0.00 Prolonged Services Time 0.00 0.0 0.0 Median Subsequent Observation Care Time 0.00

Median Total Time	485.00	577.00	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

(of those that selected Key Reference code)

<u>Mental Effort and Judgment (Mean)</u>		
The number of possible diagnosis and/or the number of	4.51	3.74
management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests,	4.72	3.98
and/or other information that must be reviewed and analyzed		
Uncourse of modical desision making	4.16	2.70
Orgency of medical decision making	4.10	5.70
<u>Technical Skill/Physical Effort (Mean)</u>		
Technical skill required	4.56	4.19
<u>^</u>		
	1.00	4.00
Physical effort required	4.60	4.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.79	4.07
Outcome depends on the skill and judgment of physician	4.84	4.19
Estimated risk of malpractice suit with poor outcome	4.02	3.60
INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference
		Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.70	3.88
Intra-Service intensity/complexity	4 56	4.00
indu-service intensity/complexity	т.50	4.00
	۱	·
Post-Service intensity/complexity	4.53	3.74

Additional Rationale and Comments

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

COMPELLING EVIDENCE FOR THE FAMILY OF VAD CODES WAS ACCEPTED BY THE FULL RUC AT THE OCTOBER, 2010 RUC MEETING.
CPT Code: 33980 The arguments for compelling evidence that were previously submitted and approved by the RUC are included in this section for your reference.

Why is this code being reviewed?

This code is submitted as part of the VAD family of codes. Ventricular Assist Devices are undergoing rapid evolution of technology effecting both extracorporeal and intracorporeal devices, and a transition from stroke volume devices to continuous flow devices. With more effective devices, the physician work of implantation is changing, and the patient population served is becoming more challenging. Additionally, as survival on device has improved, device durability now factors into this family of codes. Device durability is somewhat better, but not unlimited. This situation necessitated the development of pump replacement (changeout) codes (33981-33983), which could not be properly valued without revaluing the entire family. Also, CMS requested review of this code (33980) as part of the fourth 5-Year-Review process.

Compelling evidence

The VAD codes were recently reviewed in October 2010 and the RUC accepted compelling evidence for the entire family (including 33980). With regards to 33980:

Evidence that technology has changed physician work (diffusion of technology)

The prospect of utilizing ventricular assist devices (VADs) for myocardial recovery remains quite promising. While the experience with recovery to date remains limited, there exist increasing reports of successful recovery for carefully selected and evaluated patients. Indeed, patients with acute, severe myocarditis are most likely to experience myocardial recovery which allows for device explantation. However, experience with device removal for patients with dilated cardiomyopathy or ischemic cardiomyopathy continues to slowly grow. The overall success rate for device weaning in patients varies from 5% (1) to over 73% in a highly selected group of non-ischemic cardiomyopathic patients (2). Clearly, with such disparate results, differences in protocols for recovery are operant and the ideal protocol is still actively being sought. In addition, the Birks group (2) utilized an aggressive pharmacological strategy which was implemented over several weeks prior to device removal. Currently, an LVAD working group representing 7 US institutions interested in device recovery is undertaking additional studies to determine which patients should undergo device explantation for recovery. The influence of newer generation axial and centrifugal flow devices remains largely unknown, but promising upon the prospect of VAD insertion with subsequent removal for recovery.

References:

- (1) Mancini DM, Beniaminovitz A, Levin H, et al. Low incidence of myocardial recovery after left ventricular assist device implantation in patients with chronic heart failure. Circulation 1998;98:2383-89.
- (2) Birks EJ, Tansley PD, Hardy J, et al. Left ventricular assist device and drug therapy for the reversal of heart failure. New Engl J Med 2006;355(18):1873-84.
- (3) Maybaum S, Mancini DM, Xydas S, et al. Cardiac improvement during mechanical circulatory support a prospective multicentre study of the LVAD working group. Circulation 2007;115:2497-2505.

Five-year-review specific questions and discussion

Change in Work

Eighty-two percent of the respondents indicated that the patients for this procedure have become more complex, consistent with general changes in the cardiac surgical patient population and advances in ventricular assist device design that have broadened the indications. 65% of the respondents felt that there the physician work has changed, and 57% felt that the work has increased. None of the other 5-year-review questions indicated a significant (typical) statistic.

Work RVU Recommendation

We are recommending the median survey work RVU of 40.00. The IWPUT of the recommendation is 0.120 which is consistent with the complexity of cardiac and VAD procedures in general and this procedure in particular which is a redo operation usually done at a time (1-4 months) at which adhesions are difficult and highly vascular. Thus the surgical dissection is more difficult and hazardous. The proposed work value is appropriate for this complex procedure and patient, and is suitably related to the reference codes and selected MPC codes. This is further illustrated by the relationship of this recommendation to the intra-service work of Cardiac Surgery codes valued 2005 or later.

Pre-time

Pre-time package 4 (facility- difficult patient/difficult procedure) is appropriate for this procedure.

Evaluation: Add 20 minutes. This is supported by the survey, and the critical nature of the decision making when removing a ventricular assist device. In addition to preparing the patient for a major cardiac procedure, the patient's hemodynamic status and biventricular function is completely reassessed in the operating room immediately prior to skin preparation. This evaluation includes the interpretation of transesophageal echocardiographic images and central pulmonary artery pressures as final trial weaning of the assist device is performed. Consideration is given to the patient's ability to tolerate the planned removal, and the potential necessity to utilize temporary cardiopulmonary bypass support to accomplish the transition from device to the absence of mechanical support.

Positioning: Add 12 minutes. This is supported by the survey. This accounts for the additional time involved in coordinating the positioning of the assist device console and lines for the support device in place, placement of additional EKG electrodes to be used to trigger the intra-aortic balloon pump to account for positioning of the patient with typically an intra-aortic balloon pump which is often necessary, and coordination of the placement of these devices with the cardiopulmonary bypass machine which may also be required. Since the patient is a re-operative patient with limited immediate cardiac exposure, R2 external defibrillating pads must also be appropriately positioned for patient rescue from sustained ventricular arrhythmia.

Scrub, dress, wait: No change

Comparison to key reference code

43123 - Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)

	RVW	IWPUT	Total	Eval	Postit	SDW	Intra	IM-	91	92	33	32	31	38	39	15	14	13	12
			Time					post											
43123	83.12	0.109	1419	60	15	20	442	40	1		5	8	1		1		1	2	1
90																			
glob																			
time																			
43123	51.07	0.109	577	60	15	20	442	40											
XXX																			
adj																			
time																			
33980	40.00	0.120	485	60	15	20	300	90											

Comparison to other key reference code

33548 - Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR, SAVER, Dor procedures)

	8				,			,						,	,		/		
	RVW	IWPUT	Total	Eval	Postit	SDW	Intra	IM-	91	92	33	32	31	38	39	15	14	13	12
			Time					post											
33548	54.14	0.117	928	60	15	20	217	40	2	1	3	2	1		1		1	2	
90																			ĺ
glob																			ĺ
time																			ĺ
33548	28.16	0.117	352	60	15	20	217	40											
XXX																			ĺ
adj																			ĺ
time																			ĺ
33980	40.00	0.120	485	60	15	20	300	90											

Comparison to MPC codes

47130 - Hepatectomy, resection of liver; total right lobectomy

33681 - Closure of single ventricular septal defect, with or without patch;

	RVW	IWPUT	Total	Eval	Postit	SDW	Intra	IM-	91	92	33	32	31	38	39	15	14	13	12
			Time					post											
47130	34.80	0.1338	360	75			240	45											
XXX																			
adj																			
time																			
33681	23.06	0.1369	262.5	52.5			150	60											
XXX																			
adj																			
time																			
33980	40.00	0.120	485	60	15	20	300	90											

Additional requested statistics

CPT		Min	5 th %	25 th %	Med	75 th %	95 th %	Max	Arith Mean	Geo Mean	Mode
22080	Work RVU	20.00	28.20	33.50	40.00	47.00	55.68	60.00	47.00	55.68	60.00
33980	Intra Time	90	180	240	300	300	360	480	300	360	480

Multiple procedure payment comparison

CPT	Description	Global	Work RVW	Pre-	Intra-	IM Post	HV time	OV
Code	-			time	time	time		time
33945	Heart transplant	90	89.50	202	325	85	830	204
33980	Intracorporeal VAD	XXX	40.00@50%	95	300	90	0	0
	removal		_					
	Totals		109.50	297	625	175	830	204

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) Intracorporeal VAD are removed and a heart transplant performed in more than 50% of the patients, in the same setting. However, there is a significant population of patients who have removal for survival as described by this code and others where other assist devices may be inserted rather than transplantation. Additionally, heart transplantation is a stand-alone procedure, typically without a prior assist device. These factors make it more useful to have separate codes to describe these procedures, with the 50% reduction being appropriate when performed together. Since this is an XXX code, there is little overlap with the 090 and the amount of reduction is more than adequate.

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

Professional Liability Insurance Information (PLI)

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

If no, please select another crosswalk and provide a brief rationale. 33980

Compelling Evidence

The RUC operates with the initial presumption that the current values assigned to the codes under review are correct. The argument for a change must be substantial and meet the RUC's compelling evidence standards listed in the Instructions Document. Please list your compelling evidence below (if appropriate).

Compelling evidence for 33980 is included in the Rationale Section Above.

Five-Year Review Specific Questions

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

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

A. This service represents new technology? Yes 63% No 37%

Of survey respondents, who said yes, the new technology affected the work: Less Work: 0% Same Work: 43% More Work: 57%

- B. This service reflects new technology that has become more familiar: Yes 63% No 37%
- C. Patients requiring this service are now:
- More complex (more work) 82% Less complex (less work) 0% No change in complexity 18%

D. The typical site-of-service has changed: From outpatient to inpatient 0% From inpatient to outpatient 0% No change 100%

VAD REMOVAL XXX FEB 2011 RECOMMENDATIONS

(33977 - VAD removal, extracorporeal, single; 33978 - VAD removal, extracorporeal biventricular; 33980 - VAD removal intracorporeal)

СРТ	REC	IWPUT	RVW	Total Time	Pre Eval	Pre pos	s,d,w	Intra Time	P-SD	Current 90 day	Intra Work	XXX Work	XXX Time	LOS
33977	REC 25th	0.098	20.86	335	60	15	20	180	60	20.28	17.67	20.86	335	19
33978	REC 25th	0.109	25.00	355	60	15	20	200	60	22.72	21.81	25	355	21
33980	REC Med	0.120	40.00	485	60	15	20	300	90	65.2	36.14	40	485	21

FOR REFERENCE: REST OF VAD XXX FAMILY WITH RUC APPROVED VALUES FROM OCTOBER 2010 MEETING

VAD XXX (33975 - VAD insertion extracorporeal, single; 33976 - VAD insertion extracorporeal, biventricular; 33979 -VAD insertion, iimplantable intracorporeal; 33981 - Replacement, pump extracorporal; 33982 - Replacement pump intracorporeal w/o bypass; 33983 - replacement pump intracorporeal w bypass)

СРТ	REC	IWPUT	RVW	Total Time	Pre Eval	Pre pos	s,d,w	Intra Time	P-SD	Current Value	Intra Work	XXX Work	XXX Time	LOS
33975	REC 25th	0.114	25.00	395	60	15	20	180	120	20.97	20.47	25	395	0
33976	REC 25th	0.109	30.75	455	60	15	20	240	120	22.97	26.22	30.75	455	0
33979	REC 25th	0.118	37.50	495	60	15	20	280	120	45.93	32.97	37.5	495	0
33981	REC 25th	0.108	16.11	275	60	15	20	120	60	0	12.92	16.11	275	0
33982	REC 25th	0.116	37.86	495	60	15	20	290	110	0	33.55	37.86	495	0
33983	REC 25th	0.116	44.54	560	60	15	20	345	120	0	40.01	44.54	560	0

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS 2010 FIVE YEAR REVIEW SUMMARY OF RECOMMENDATION

CPT Code:33977 Tracking Number Global Period: 090 Specialty Society Recommended RVU: 54.75 RUC Recommended RVU:

CPT Descriptor: Removal of ventricular assist device; extracorporeal, single ventricle

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 51 year-old man failed to weaned from cardiopulmonary bypass following coronary artery bypass grafting and required insertion of an extracorporeal left ventricular assist device as a bridge to survival. He is now 5 days postop, and appears to have sufficient recovery of LV function to allow removal of his assist device and its inflow and outflow cannulae.

Percentage of Survey Respondents who found Vignette to be Typical: 79%

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? 2%

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: Physician performs a complete or interval history and physical exam, comprehensive medical decision making, writes pre-operative orders for pre-operative medications, reviews pre-operative work-up including review of information from other physicians, and relevant tests/data/labs, reviews incision and procedure, talks with patient and family and answers any questions, obtains informed consent, confirms O.R. start time. The physician changes into scrubs, and must accompany the patient during transport from the ICU to the OR as the extracorporeal device must be monitored during this transport. The physician reviews with anesthesia, waits for anesthetic induction, intubation, placement/ or of arterial and central lines, positions and pads patient, places defibrillator pads on the chest and back, scrubs, gloves, preps and drapes patient. Just prior to incision, a comprehensive "Time Out" procedure is undertaken by the entire operating room team.

Description of Intra-Service Work: A standard re-operative median sternotomy incision is performed and the cannulation sites for the extracorporeal device are mobilized and exposed. The physician then weans the device - ensuring optimal hemodynamics, monitoring intracardiac filling pressures and adjusting inotropes and vasoactive drugs accordingly. When the patient is stabilized off device, the cannulae are removed and the cannulation sites secured with sutire closure. The chest cavity is then thoroughly irrigated with antibiotic saline and closed.

Description of Post-Service Work: The physician stabilizes the patient in the ICU and provides critical care during the initial post-operative period and over multiple days and visits. The initial post-operative course after extracorporeal VAD removal is highly complex, long (days to weeks), and requires intensive post-operative management. While recovery of

CPT Code: 33977

the ventricle has permitted VAD removal, ventricular function is never completely normal, which will strongly negatively impact upon the post-operative course. Inotropic support is required for several days and judicious weaning of inotropes to optimize ventricular function is necessary. Once inotropes have been weaned, than a medical regimen for heart fialure with an appropriate medical regimen must be individualized to each patient. Further, end-organ dysfunction - such as renal failure, hepatic insufficiency, and nutritional compromise will frequently be encountered and must be managed by the physician. Infectious complications also are highly prevalent as these patients remain in the intensive care unit setting with multiple potential sources of infection such as invasive catheters and ventilators. The physician also talks to family, talks to and coordinates care with other physicians, writes orders, writes daily progress notes, an operative note, discusses outcome with patient and family, and discharges the patient from hospital, and provides follow-up with patient as necessary once discharged from hospital.

SURVEY DAT	TA						
RUC Meeting Da	ite (mm/yyyy)	10/2010					
Presenter(s):	Joseph Clev	/eland, MD, Jar	nes Levett, N	ИD			
Specialty(s):	cardiothora	cic surgery					
CPT Code:	33977						
Sample Size:	350	Resp N:	42	Response:	12.0 %		
Sample Type:	Random	Additional Sa	ample Infori	mation:			
			Low	25 th %	Median*	<u>75th %</u>	<u>High</u>
Service Perform	ance Rate		0.00	1.00	2.00	4.00	12.00
Survey RVW:			15.00	34.90	45.00	54.75	90.00
Pre-Service Evalu	ation Time:				90.00		
Pre-Service Posit	ioning Time:				15.00		
Pre-Service Scrub	o, Dress, Wait	Time:			21.00		
Intra-Service Tir	ne:		60.00	120.00	180.00	200.00	480.00
Immediate Post	Service-Tim	e: <u>60.00</u>					
Post Operative	<u>Visits</u>	Total Min**	CPT Code	and Number	r of Visits		
Critical Care tim	e/visit(s):	<u>170.00</u>	99291x 2.0	0 99292x ′	1.00		
Other Hospital t	ime/visit(s):	<u>555.00</u>	99231x 6.0	0 99232x 4	4.00 99233x	5.00	
Discharge Day I	Mgmt:	<u>38.00</u>	99238x 1.0	0 99239x 0.0	0		
Office time/visit	(s):	<u>63.00</u>	99211x 0.0	0 12x 0.00 13	3x 1.00 14x 1.0	0 15x 0.00	
Prolonged Serv	ices:	<u>0.00</u>	99354x 0.0	0 55x 0.00	56x 0.00 57x	0.00	

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	33977		Recommended Ph	ysician Work RVU:	54.75
			Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation T	ïme:		40.00	40.00	0.00
Pre-Service Positioning	Time:		3.00	3.00	0.00
Pre-Service Scrub, Dress	s, Wait Tim	ie:	20.00	20.00	0.00
Intra-Service Time:			180.00		·
Immediate Post Servic	e-Time:	<u>60.00</u>			
Post Operative Visits		<u>Total Min**</u>	CPT Code and Nu	umber of Visits	
Critical Care time/visit	(s):	<u>170.00</u>	99291x 2.00 992	92x 1.00	
Other Hospital time/vis	sit(s):	<u>555.00</u>	99231x 6.00 992	32x 4.00 99233x	5.00
Discharge Day Mgmt:		<u>38.00</u>	99238x 1.0 99239	× 0.0	
Office time/visit(s):		<u>63.00</u>	99211x 0.00 12x 0	.00 13x 1.00 14x 1	.00 15x 0.00
Prolonged Services:		<u>0.00</u>	99354x 0.00 55x	0.00 56x 0.00 57x	0.00

KEY REFERENCE SERVICE:

Key CPT Code	<u>Global</u>	Work RVU	Time Source
33548	090	54.14	RUC Time

<u>CPT Descriptor</u> Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR, SAVER, Dor procedures)

KEY MPC COMPARISON CODES:

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

				111000 1100 0110
MPC CPT Code 1	<u>Global</u> W	ork RVU	Time Source	Medicare Utilization
61518	090	39.89	RUC Time	1,157
CPT Descriptor 1 Crar	niectomy for excis	ion of brain tu	umor, infratentorial	or posterior fossa; except meningioma
cerebellopontine angle tu	umor, or midline tun	nor at base of sk	ull	
				Most Recent
MPC CPT Code 2	<u>Global</u>	Work RVU	Time Source	Medicare Utilization
44204	090	26.42	RUC Time	10.897

CPT Descriptor 2 Laparoscopy, surgical; colectomy, partial, with anastomosis

Other Reference CPT Code	<u>Global</u>	Work RVU	Time Source
33405	090	41.32	RUC Time

<u>CPT Descriptor</u> Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including existing time 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: 16.6 %

<u>TIME ESTIMATES (Median)</u>	CPT Code: 33977	Key Reference CPT Code: <u>33548</u>	Source of Time RUC Time
Median Pre-Service Time	63.00	95.00	
Median Intra-Service Time	180.00	217.00]
Median Immediate Post-service Time	60.00	40.00	
Median Critical Care Time	170.0	170.00	
Median Other Hospital Visit Time	555.0	265.00	
Median Discharge Day Management Time	38.0	55.00	
Median Office Visit Time	63.0	86.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	1129.00	928.00	
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	4.00	3.71
management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests,	4.00	4.14
and/or other information that must be reviewed and analyzed		
Urgency of medical decision making	4.00	3.14
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.57	4.29
Physical effort required	4.14	4.14
Psychological Stress (Mean)		L]
The risk of significant complications, morbidity and/or mortality	5.00	4.00
Outcome depends on the skill and judgment of physician	4.57	5.00
Estimated risk of malpractice suit with poor outcome	4.00	3.57
INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference
		<u>Service 1</u>
Time Segments (Mean)		
Pre-Service intensity/complexity	4 14	4 29
	۱	
Intra-Service intensity/complexity	3.86	4.43
Post-Service intensity/complexity	4 43	3.57
	1.10	0.0.

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.*

FOR ADDITIONAL RATIONALE, COMPELLING EVIDENCE AND OVERALL ARGUMENTS SEE CARDIOTHORACIC SURGERY COVER LETTER THAT WAS SUBMITTED WITH THE PROPOSAL

Why is this code being reviewed?

CPT Code: 33977

This code is submitted as part of the VAD family of codes. Ventricular Assist Devices are undergoing rapid evolution of technology effecting both extracorporeal and intracorporeal devices, and a transition from stroke volume devices to continuous flow devices. With more effective devices, the physician work of implantation is changing, and the patient population served is becoming more challenging. Additionally, survival has improved such that device durability (while also improved but is not unlimited. This necessitated the development of pump changeout codes (33981-33983), which could not be properly valued without revaluing the entire family.

Compelling evidence

Postcardiotomy shock (PCCS) remains a highly complex and lethal entity. Estimates for its incidence range from 0.2%-6% following cardiac operations. This wide range is the result of a non- uniform definition of PCCS; however, it is noteworthy that at best, recent literature suggests that at best only 25-40% of patients survive until discharge (1). Despite the advent of newer third generation centrifugal devices (such as the CentriMag) blood pump, good outcomes for PCCS still lag far behind other device outcomes. While outcomes for PCCS have improved modestly over the past decade, the morbidity rates of bleeding, stroke, infection, and prolonged ventilation have not changed (see table below). The reason for these continued high rates of morbidity are related almost entirely to patient status at implant (cardiogenic shock with end organ malperfusion) and timing of implantation. These patients remain extraordinarily challenging to successfully judge device weaning, timing of explantation, and then resolution of PCCS to successful discharge.

TABLE 3. Unadjusted Outcomes

	January 1995–June 1997 (n=1255), %	July 1997–December 1999 (n–1119), %	January 2000-June 2002 (n-1776), %	July 2002-December 2004 (n-1585), %	Р
Mortality	61.5	54.2	34.1	40.8	< 0.001
Mortality/morbidity	77.7	74.3	54.6	62.8	< 0.001
Reoperation for bleeding	23.4	23.6	17.5	19.7	< 0.001
Stroke	6.6	5.4	4.0	4.9	< 0.001
Renal failure	24.9	25.4	18.3	21.8	< 0.001
Infection (deep stemum)	1.3	1.4	1.1	1.8	< 0.001
Infection (sepsis)	6.2	5.7	5.2	7.0	< 0.001
Prolonged ventilation	37.4	40.8	31.2	39.2	< 0.001

Probability values are for trend across columns, determined via the Jonckheere-Terpstra (nonparametric) test for trend.

Table from: Hernandez, et al. A decade of short-term outcomes in postcardiac surgery ventricular assist device implantation: Data from the Society of Thoracic Surgeons's National Cardiac Database. Circulation 2007;116:606-612.

References

(1)Sylvin EA, Stern DR, Goldstein DJ. Mechanical Circulatory Support for Postcardiotomy Cardiogenic Shock: Has Progress Been Made? J Card Surg 2010;25:442-454.

Five-year-review specific questions and discussion

Change in Work

Eighty-one percent of the respondents indicated that the patients for this procedure have become more complex. This response reflects the fact that post-cardiotomy shock patients often undergo device implantation under extraordinarily challenging situations of severe impairment of all organ systems from shock and prolonged cardiopulmonary bypass. None of the other 5-year-review questions indicated a significant (typical) statistic.

Work RVU Recommendation

We are recommending the 75^h percentile work RVU of 54.75. The IWPUT of the recommendation is .0953 which is somewhat low but consistent with the complexity of cardiac and VAD procedures in general and this procedure in particular. The value of this code is dominated by the postoperative in-hospital care, which is consistent with a patient who one day needs a ventricular assist device to survive, and must do without. This value and its components are appropriate for this complex procedure and patient, and is suitably related to the reference codes and selected MPC codes. This is further illustrated by the relationship of this recommendation to Cardiac Surgery codes valued 2005 or later as follows. This relationship is also consistent with MPC 090 global code relationship of Total RUC Time to Total RVW, which inscribes the same regression line:



Pre-time

Pre-time package 4 (facility- difficult patient/difficult procedure) is appropriate for this procedure.

Evaluation: No change.

Positioning: No change

Scrub, dress, wait: No change

Comparison to key reference code

33548	33548 - Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR, SAVER, Dor procedures)																		
	RVW	IWPUT	Total	Eval	Postit	SDW	Intra	IM-	91	92	33	32	31	38	39	15	14	13	12
			Time					post											
33548	54.14	.117	928	60	15	20	217	40	2	1	3	2	1		1		1	2	
33977	54.75	0.095	1129	40	3	20	180	60	2	1	5	4	6	1			1	1	

Comparison to other code

33405 - Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve

	RVW	IWPUT	Total	Eval	Postit	SDW	Intra	IM-	91	92	33	32	31	38	39	15	14	13	12
			Time					post											
33405	41.32	0.105	769	60	15	20	198	49	1		3	2	1	1			1	1	
33977	54.75	0.095	1129	40	3	20	180	60	2	1	5	4	6	1			1	1	

Comparison to MPC codes

61518 - Craniectomy for excision of brain tumor, infratentorial or posterior fossa; except meningioma, cerebellopontine angle tumor, or midline tumor at base of skull 44204 - Laparoscopy, surgical; colectomy, partial, with anastomosis

	RVW	IWPUT	Total	Eval	Postit	SDW	Intra	IM-	91	92	33	32	31	38	39	15	14	13	12
			Time					post											
61518	39.89	0.0955	755	110			240	40			1	3	3	1			4		
44204	26.42	0.0965	455	45			180	30				1	3	1				2	1
33977	54.75	0.095	1129	40	3	20	180	60	2	1	5	4	6	1			1	1	

CPT Code: 33977

CPT		Min	5 ^{th %}	25 th %	Med	75 th %	95 th %	Max	Arith Mean	Geo Mean	Mode
22077	Work RVU	15.00	24.51	34.90	45.00	54.75	79.93	90.00	47.49	44.34	45.00
339//	Intra Time	60	90	120	180	200	298	480	177	163	180

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.

Professional Liability Insurance Information (PLI)

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

If no, please select another crosswalk and provide a brief rationale. adjust to 33977

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

Compelling Evidence

The RUC operates with the initial presumption that the current values assigned to the codes under review are correct. The argument for a change must be substantial and meet the RUC's compelling evidence standards listed in the Instructions Document. Please list your compelling evidence below (if appropriate).

FOR ADDITIONAL RATIONALE, COMPELLING EVIDENCE AND OVERALL ARGUMENTS SEE CARDIOTHORACIC SURGERY COVER LETTER THAT WAS SUBMITTED WITH THE PROPOSAL.

Compelling evidence for 33977 is included in the Rationale Section Above.

Five-Year Review Specific Questions

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

Has the work of performing this service changed in the past 5 years? Yes 43% No 57% A. This service represents new technology? Yes 43% No 57%

Of survey respondents, who said yes, the new technology affected the work: Less Work: 11% Same Work: 39% More Work: 50%

B. This service reflects new technology that has become more familiar: Yes 45% No 55%

C. Patients requiring this service are now:

More complex (more work) 81% Less complex (less work) 0% No change in complexity 19% D. The typical site-of-service has changed:

From outpatient to inpatient 0% From inpatient to outpatient 0% No change 100%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS 2010 FIVE YEAR REVIEW SUMMARY OF RECOMMENDATION

CPT Code:33978 Tracking Number Global Period: 090 Specialty Society Recommended RVU: 60.00 RUC Recommended RVU:

CPT Descriptor: Removal of ventricular assist device; extracorporeal, biventricular

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 51 year-old man failed to weaned from caridiopulmonary bypass following coronary artery bypass grafting and required insertion of an extracorporeal left and right ventricular assist devices to bridge to survival. He is now 5 days postop, and appears to have sufficient recovery of biventricular function to allow removal of both devices and associated inflow and outflow cannulae.

Percentage of Survey Respondents who found Vignette to be Typical: 74%

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? 2%

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: Physician performs a complete or interval history and physical exam, comprehensive medical decision making, writes pre-operative orders for pre-operative medications, reviews pre-operative work-up including review of information from other physicians, and relevant tests/data/labs, reviews incision and procedure, talks with patient and family and answers any questions, obtains informed consent, confirms O.R. start time. The physician changes into scrubs, and must accompany the patient during transport from the ICU to the OR as the extracorporeal device must be monitored during this transport. The physician reviews with anesthesia, waits for anesthetic induction, intubation, placement/ or of arterial and central lines, positions and pads patient, places defibrillator pads on the chest and back, scrubs, gloves, preps and drapes patient. Just prior to incision, a comprehensive "Time Out" procedure is undertaken by the entire operating room team.

Description of Intra-Service Work: A standard re-operative median sternotomy incision is performed and the cannulation sites for the extracorporeal device are mobilized and exposed. The physician then weans the device - ensuring optimal hemodynamics, monitoring intracardiac filling pressures and adjusting inotropes and vasoactive drugs accordingly. When the patient is stabilized off device, the cannulae are removed and the cannulation sites secured with sutire closure. The chest cavity is then thoroughly irrigated with antibiotic saline and closed.

Description of Post-Service Work: The physician stabilizes the patient in the ICU and provides critical care during the initial post-operative period and over multiple days and visits. The initial post-operative course after intracorporeal VAD removal is highly complex, long (days to weeks), and requires intensive post-operative management. While recovery of

CPT Code: 33978

the ventricle has permitted VAD removal, ventricular function is never completely normal, which will strongly negatively impact upon the post-operative course. Inotropic support is required for several days and judicious weaning of inotropes to optimize ventricular function is necessary. Once inotropes have been weaned, than a medical regimen for heart fialure with an appropriate medical regimen must be individualized to each patient. Further, end-organ dysfunction - such as renal failure, hepatic insufficiency, and nutritional compromise will frequently be encountered and must be managed by the physician. Infectious complications also are highly prevalent as these patients remain in the intensive care unit setting with multiple potential sources of infection such as invasive catheters and ventilators. The physician also talks to family, talks to and coordinates care with other physicians, writes orders, writes daily progress notes, an operative note, discusses outcome with patient and family, and discharges the patient from hospital, and provides follow-up with patient as necessary once discharged from hospital.

SURVEY DAT	Γ A									
RUC Meeting Da	ate (mm/yyyy)	10/2010								
Presenter(s):	Joseph Clev	/eland, MD, Jar	nes Levett, N	ИD						
Specialty(s):	cardiothora	cic surgery								
CPT Code:	33978									
Sample Size:	350	Resp N:	42	Response:	12.0 %					
Sample Type:	Random	Additional Sa	ample Inform	mation:						
			Low	25 th %	Median*	<u>75th %</u>	<u>High</u>			
Service Perform	nance Rate		0.00	1.00	2.00	3.00	15.00			
Survey RVW:			23.55	38.34	50.00	60.00	100.00			
Pre-Service Evalu	ation Time:				90.00					
Pre-Service Posit	ioning Time:				15.00					
Pre-Service Scrul	o, Dress, Wait	Time:			25.00					
Intra-Service Ti	me:		90.00	158.00	205.00	238.00	480.00			
Immediate Post	Service-Tim	e: <u>60.00</u>								
Post Operative	<u>Visits</u>	Total Min**	CPT Code	and Number	r of Visits					
Critical Care tim	ne/visit(s):	<u>170.00</u>	99291x 2.0	0 99292x 1	1.00					
Other Hospital t	ime/visit(s):	<u>595.00</u>	99231x 8.0	0 99232x 4	4.00 99233x	5.00				
Discharge Day I	Mgmt:	<u>38.00</u>	99238x 1.00 99239x 0.00							
Office time/visit	(s):	<u>63.00</u>	99211x 0.0	0 12x 0.00 13	Bx 1.00 14x 1.0	0 15x 0.00				
Prolonged Serv	ices:	<u>0.00</u>	99354x 0.0	0 55x 0.00	56x 0.00 57x	0.00				

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	33978		Recommended Ph	60.00	
			Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation T	ime:		40.00	40.00	0.00
Pre-Service Positioning	Time:		3.00	3.00	0.00
Pre-Service Scrub, Dress, Wait Time:			20.00	20.00	0.00
Intra-Service Time:			205.00		
Immediate Post Servic	e-Time:	60.00			
Post Operative Visits		<u>Total Min**</u>	CPT Code and Nu	umber of Visits	
Critical Care time/visit	(s):	<u>170.00</u>	99291x 2.00 992	92x 1.00	
Other Hospital time/vis	sit(s):	<u>595.00</u>	99231x 8.00 992	32x 4.00 99233x	5.00
Discharge Day Mgmt:		<u>38.00</u>	99238x 1.0 99239	× 0.0	
Office time/visit(s):		<u>63.00</u>	99211x 0.00 12x 0	.00 13x 1.00 14x 1	.00 15x 0.00
Prolonged Services:		0.00	99354x 0.00 55x	0.00 56x 0.00 57x	0.00

KEY REFERENCE SERVICE:

CPT	Code:	33978
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Key CPT Code	<u>Global</u>	Work RVU	Time Source
33545	090	57.06	RUC Time

<u>CPT Descriptor</u> Repair of postinfarction ventricular septal defect, with or without myocardial resection

KEY MPC COMPARISON CODES:

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

				Wost Recent
MPC CPT Code 1	<u>Global</u>	Work RVU	Time Source	Medicare Utilization
35631	090	36.03	RUC Time	1,037
CPT Descriptor 1 Bypas	ss graft, with other	than vein; aortoco	eliac, aortomesenteric	, aortorenal
				Most Recent
MPC CPT Code 2	Global	Work RVU	Time Source	Medicare Utilization
33512	090	0.00	RUC Time	4,018

<u>CPT Descriptor 2</u> Coronary artery bypass, vein only; 3 coronary venous grafts

Other Reference CPT Code	<u>Global</u>	Work RVU	Time Source
33945	090	89.50	RUC Time

CPT Descriptor Heart transplant, with or without recipient cardiectomy

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including existing time 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 %

<u>TIME ESTIMATES (Median)</u>	CPT Code: 33978	Key Reference CPT Code: <u>33545</u>	Source of Time RUC Time
Median Pre-Service Time	63.00	95.00	
Median Intra-Service Time	205.00	236.00	
Median Immediate Post-service Time	60.00	40.00	
Median Critical Care Time	170.0	170.00	
Median Other Hospital Visit Time	595.0	280.00	
Median Discharge Day Management Time	38.0	55.00	
Median Office Visit Time	63.0	63.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	1194.00	939.00	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

(of those that selected Key Reference code)

<u>Mental Effort and Judgment (Mean)</u>		
The number of possible diagnosis and/or the number of	4.63	4.00
management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests,	4.63	4.13
and/or other information that must be reviewed and analyzed		
Urgency of medical decision making	4.00	4.63
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.25	4.88
Physical effort required	4.38	4.50
Psychological Stress (Mean)		
	·	
The risk of significant complications, morbidity and/or mortality	5.00	5.00
Outcome depends on the skill and judgment of physician	4.38	4.63
		[]
Estimated risk of malpractice suit with poor outcome	4.13	3.88
INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference
		Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.63	4.13
		L]
Teter Comics interview lands	4.20	4.99
mua-service intensity/complexity	4.30	4.00
Post-Service intensity/complexity	4.63	4.50

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.*

FOR ADDITIONAL RATIONALE, COMPELLING EVIDENCE AND OVERALL ARGUMENTS SEE CARDIOTHORACIC SURGERY COVER LETTER THAT WAS SUBMITTED WITH THE PROPOSAL

Why is this code being reviewed?

CPT Code: 33978

Code 33978 as identified by STS as a low volume code that was not reviewed during the comprehensive review of cardiothoracic codes in 2000. CMS requested review of this code as part of the fourth 5-Year-Review process.

Compelling evidence

Postcardiotomy shock (PCCS) remains a highly complex and lethal entity. Estimates for its incidence range from 0.2%- 6% following cardiac operations. This wide range is the result of a non- uniform definition of PCCS; however, it is noteworthy that at best, recent literature suggests that at best only 25-40% of patients survive until discharge (1). Despite the advent of newer third generation centrifugal devices (such as the CentriMag) blood pump, good outcomes for PCCS still lag far behind other device outcomes. While outcomes for PCCS have improved modestly over the past decade, the morbidity rates of bleeding, stroke, infection, and prolonged ventilation have not changed (see table below). The reason for these continued high rates of morbidity are related almost entirely to patient status at implant (cardiogenic shock with end organ malperfusion) and timing of implantation. These patients remain extraordinarily challenging to successfully judge device weaning, timing of explantation, and then resolution of PCCS to successful discharge.

TABLE 3. Unadjusted Outcomes

	January 1995–June 1997 (n=1255), %	July 1997–December 1999 (n-1119), %	January 2000-June 2002 (n-1776), %	July 2002-December 2004 (n-1585), %	Р
Mortality	61.5	54.2	34.1	40.8	< 0.001
Mortality/morbidity	77.7	74.3	54.6	62.8	< 0.001
Reoperation for bleeding	23.4	23.6	17.5	19.7	< 0.001
Stroke	6.6	5.4	4.0	4.9	< 0.001
Renal failure	24.9	25.4	18.3	21.8	< 0.001
Infection (deep sternum)	1.3	1.4	1.1	1.8	< 0.001
Infection (sepsis)	6.2	5.7	5.2	7.0	< 0.001
Prolonged ventilation	37.4	40.8	31.2	39.2	< 0.001

Probability values are for trend across columns, determined via the Jonckheere-Terpstra (nonparametric) test for trend.

Table from: Hernandez, et al. A decade of short-term outcomes in postcardiac surgery ventricular assist device implantation: Data from the Society of Thoracic Surgeons's National Cardiac Database. Circulation 2007;116:606-612.

References

(1)Sylvin EA, Stern DR, Goldstein DJ. Mechanical Circulatory Support for Postcardiotomy Cardiogenic Shock: Has Progress Been Made? J Card Surg 2010;25:442-454.

Five-year-review specific questions and discussion

Change in Work

Eighty-five percent of the respondents indicated that the patients for this procedure have become more complex. This response reflects the fact that post-cardiotomy shock patients often undergo device implantation under extraordinarily challenging situations of severe impairment of all organ systems from shock and prolonged cardiopulmonary bypass. None of the other 5-year-review questions indicated a significant (typical) statistic.

Work RVU Recommendation

We are recommending the 75^h percentile work RVU of 60.00. The additional work units for this code compared to 33977 reflect having to deal with biventricular dysfunction as well as the additional intraprocedure time of dealing with 4 cannulation sites instead of two. Additionally, patients requiring BIVAD support at any time are much more compromised. The IWPUT of the recommendation is .1109 which is somewhat low but consistent with the complexity of cardiac and VAD procedures in general and this procedure in particular. As in 33977, the work value of this code is dominated by the postoperative care of a patient who requires biventricular support one day, and no VAD support the next. This value and its components are appropriate for this complex procedure and patient, and is suitably related to the reference codes and selected MPC codes. This is further illustrated by the relationship of this recommendation to Cardiac Surgery codes valued 2005 or later as follows. This relationship is also consistent with MPC 090 global code relationship of Total RUC Time to Total RVW, which inscribes the same regression line:



Pre-time

Pre-time package 4 (facility- difficult patient/difficult procedure) is appropriate for this procedure.

Evaluation: No change.

Positioning: No change

Scrub, dress, wait: No change

<u>Comparison to key reference code</u> 33545 - Repair of postinfarction ventricular septal defect, with or without myocardial resection

	RVW	IWPUT	Total Time	Eval	Postit	SDW	Intra	IM- post	91	92	33	32	31	38	39	15	14	13	12
33545	57.06	0.1210	939	60	15	20	236	40	2	1	3	1	1		1		1	1	
33978	60	0.102	1194	40	3	20	205	60	2	1	5	4	8	1			1	1	

Comparison to other code Heart transplant with

33945	- Heart tr	ansplant, w	ith or with	nout reci	pient card	iectomy													
	RVW	IWPUT	Total	Eval	Postit	SDW	Intra	IM-	91	92	33	32	31	38	39	15	14	13	12
			Time					post											
33945	89.50	0.117	1716	167	15	90	325	85	3	1	5	6	1		1	1	2	3	
33978	60	0.102	1194	40	3	20	205	60	2	1	5	4	8	1			1	1	

Comparison to MPC codes

35631 - Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal

33512 - Coronary artery bypass, vein only; 3 coronary venous grafts

	RVW	IWPUT	Total Time	Eval	Postit	SDW	Intra	IM- post	91	92	33	32	31	38	39	15	14	13	12
35631	36.03	0.1010	648	110			225	38			1	2	2	1				2	1
33512	43.98	0.1030	832	60	15	20	205	40	1		4	2	1	1			1		1
33978	60	0.102	1194	40	3	20	205	60	2	1	5	4	8	1			1	1	

Additional requested statistics

CPT		Min	5 ^{th %}	25 th %	Med	75 th %	95 th %	Max	Arith Mean	Geo Mean	Mode
22070	Work RVU	23.55	27.32	38.34	50.00	60.00	87.00	100.00	52.60	49.62	60.00
339/8	Intra Time	90	111	158	205	238	359	480	207	193	180

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.

Professional Liability Insurance Information (PLI)

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

If no, please select another crosswalk and provide a brief rationale. adjust to 33978

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

Compelling Evidence

The RUC operates with the initial presumption that the current values assigned to the codes under review are correct. The argument for a change must be substantial and meet the RUC's compelling evidence standards listed in the Instructions Document. Please list your compelling evidence below (if appropriate).

FOR ADDITIONAL RATIONALE, COMPELLING EVIDENCE AND OVERALL ARGUMENTS SEE CARDIOTHORACIC SURGERY COVER LETTER THAT WAS SUBMITTED WITH THE PROPOSAL.

Compelling evidence for 33978 is included in the Rationale Section Above.

Five-Year Review Specific Questions

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

Has the work of performing this service changed in the past 5 years? Yes 36% No 64% A. This service represents new technology? Yes 38% No 62%

Of survey respondents, who said yes, the new technology affected the work:

Less Work: 0% Same Work: 50% More Work: 50%

B. This service reflects new technology that has become more familiar: Yes 43% No 57%

- C. Patients requiring this service are now: More complex (more work) 85% L Less complex (less work) 0% No change in complexity 15% D. The typical site-of-service has changed:

From outpatient to inpatient 0% From inpatient to outpatient 0% No change 100%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS 2010 FIVE YEAR REVIEW SUMMARY OF RECOMMENDATION

CPT Code:33980 Tracking Number Global Period: 090 Specialty Society Recommended RVU: **75.00** RUC Recommended RVU:

CPT Descriptor: Removal of ventricular assist device, implantable intracorporeal, single ventricle

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35-year-old man who had presented with cardiogenic shock secondary to acute viral myocarditis is one-month status post placement of an implantable, intracorporeal left ventricular assist device as a bridge to recovery or to transplant. His biventricular function has improved with medical therapy and mechanical support and he has suffered no irreversible device related complications. It is recommended that device removal will provide his best prospect for long-term survival.

Percentage of Survey Respondents who found Vignette to be Typical: 67%

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? 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: Physician performs a complete or interval history and physical exam, comprehensive medical decision making, writes pre-operative orders for pre-operative medications, reviews pre-operative work-up including review of information from other physicians, and relevant tests/data/labs, reviews procedure, talks with patient and family and answers any questions, obtains informed consent, and confirms procedure start time. The physician scrubs, gloves, preps and drapes patient. Just prior to incision, a comprehensive "Time Out" procedure is undertaken by the entire operating room team.

Description of Intra-Service Work: A standard re-operative median sternotomy incision is performed and the patient and the ascending aorta and right atrium are dissected free from adhesions in preparation for cannulation for cardiopulmonary bypass. The patient is systemically heparinized with 300 units/kg heparin and cannulated for cardiopulmonary bypass with central aortic cannulation and right atrial cannulation. Cardiopulmonary bypass is initiated, the intracorporeal VAD is switched off, and the remainder of the dissection is completed with the patient systemically heparinized with an activated clotting time of greater than 450 seconds. The VAD outflow and inflow cannulae are exposed. During this re-operative dissection, avoiding injury to either of the VAD cannulae - particularly the outflow cannula is essential to avoid exsanguination of the patient. The VAD inflow cannula site is reconstructed with a series of pledgeted sutures and a Dacron patch after the VAD inflow cannula has been removed from the LV apex. The VAD outflow graft is clamped approximately 1 cm above its attachment to the ascending aorta. The VAD outflow graft is divided and oversewn with a running monofilament suture. The VAD is removed from the operative field. Hemodynamics are optimized with

CPT Code: 33980

inotropes and then cardiopulmonary bypass is weaned. Protamine is given to reverse heparin and mediastinal hemostasis is aggressively sought. It is typical that these patients will have a coagulopathy secondary to the re-operative status and the dissection of the VAD from the mediastinum using cardiopulmonary bypass. The coagulopathy is addressed with blood products and once corrected, the physician can close the sternum with wires. Skin is closed with suture.

Description of Post-Service Work: The physician stabilizes the patient in the ICU and provides critical care during the initial post-operative period and over multiple days and visits. The initial post-operative course after intracorporeal VAD removal is highly complex, long (days to weeks), and requires intensive post-operative management. While recovery of the ventricle has permitted VAD removal, ventricular function is never completely normal, which will strongly negatively impact upon the post-operative course. Inotropic support is required for several days and judicious weaning of inotropes to optimize ventricular function is necessary. Once inotropes have been weaned, than a medical regimen for heart fialure with an appropriate medical regimen must be individualized to each patient. Further, end-organ dysfunction - such as renal failure, hepatic insufficiency, and nutritional compromise will frequently be encountered and must be managed by the physician. Infectious complications also are highly prevalent as these patients remain in the intensive care unit setting with multiple potential sources of infection such as invasive catheters and ventilators. The physician also talks to family, talks to and coordinates care with other physicians, writes orders, writes daily progress notes, an operative note, discusses outcome with patient and family, and discharges the patient from hospital, and provides follow-up with patient as necessary once discharged from hospital.

CLIDVEN DAT										
SURVEY DAI	A									
RUC Meeting Da	te (mm/yyyy)	10/2010								
Presenter(s):	Joseph Clev	/eland, MD, Jar	nes Levett, N	ЛD						
Specialty(s):	cardiothora	cic surgery								
CPT Code:	33980									
Sample Size:	350	Resp N:	39	39 Response: 11.1 %						
Sample Type:	Random	Additional Sa	ample Inforr	mation:						
			Low	25 th %	Median*	<u>75th %</u>	<u>High</u>			
Service Perform	ance Rate		0.00	0.00	2.00	3.00	55.00			
Survey RVW:			35.00	55.97	75.00	89.54	115.00			
Pre-Service Evalu	ation Time:				100.00					
Pre-Service Posit	ioning Time:				15.00					
Pre-Service Scrul	o, Dress, Wait	Time:			20.00					
Intra-Service Ti	ne:		120.00	240.00	300.00	360.00	500.00			
Immediate Post	Service-Time	e: <u>90.00</u>								
Post Operative	<u>Visits</u>	Total Min**	CPT Code	and Number	r of Visits					
Critical Care tim	ne/visit(s):	<u>170.00</u>	99291x 2.0	0 99292x 1	1.00					
Other Hospital t	ime/visit(s):	<u>615.00</u>	99231x 7.0	0 99232x !	5.00 99233x	5.00				
Discharge Day I	Mgmt:	<u>38.00</u>	99238x 1.0	0 99239x 0.0	0					
Office time/visit	(s):	<u>79.00</u>	99211x 0.0	0 12x 1.00 13	Bx 1.00 14x 1.0	0 15x 0.00				
Prolonged Serv	ices:	<u>0.00</u>	99354x 0.0	0 55x 0.00	56x 0.00 57x	0.00				

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	33980		Recommended Physician Work RVU: 75.00				
			Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time		
Pre-Service Evaluation T	ïme:		40.00	40.00	0.00		
Pre-Service Positioning	Time:		3.00	3.00	0.00		
Pre-Service Scrub, Dress	s, Wait Tim	e:	20.00	20.00	0.00		
Intra-Service Time:			300.00				
Immediate Post Servic	e-Time:	<u>90.00</u>					
Post Operative Visits		<u>Total Min**</u>	CPT Code and Nu	umber of Visits			
Critical Care time/visit	(s):	<u>170.00</u>	99291x 2.00 992	92x 1.00			
Other Hospital time/vis	sit(s):	<u>615.00</u>	99231x 7.00 992	32x 5.00 99233x	5.00		
Discharge Day Mgmt:		<u>38.00</u>	99238x 1.0 99239	< 0.0			
Office time/visit(s):		<u>79.00</u>	99211x 0.00 12x 1	.00 13x 1.00 14x 1	.00 15x 0.00		
Prolonged Services:		<u>0.00</u>	99354x 0.00 55x	0.00 56x 0.00 57x	0.00		

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33945	090	89.50	RUC Time

CPT Descriptor Heart transplant, with or without recipient cardiectomy

KEY MPC COMPARISON CODES:

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

				Most Recent
MPC CPT Code 1	<u>Global</u> V	<u> Vork RVU</u>	Time Source	Medicare Utilization
61698	090	69.63	RUC Time	52
CPT Descriptor 1 Surger	ry of complex intra	cranial aneurysm	n, intracranial approac	h; vertebrobasilar circulation
				Most Recent
MPC CPT Code 2	<u>Global</u>	Work RVU	Time Source	Medicare Utilization
33426	090	43.28	RUC Time	6,554

CPT Descriptor 2 Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring

Other Reference CPT Code	<u>Global</u>	Work RVU	Time Source
33548	090	54.14	RUC Time

<u>CPT Descriptor</u> Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR, SAVER, Dor procedures)

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including existing time 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: 48.7 %

<u>TIME ESTIMATES (Median)</u>	CPT Code: 33980	Key Reference CPT Code: <u>33945</u>	Source of Time RUC Time
Median Pre-Service Time	63.00	272.00	
Median Intra-Service Time	300.00	325.00	
Median Immediate Post-service Time	90.00	85.00	
Median Critical Care Time	170.0	240.00	
Median Other Hospital Visit Time	615.0	535.00	
Median Discharge Day Management Time	38.0	55.00	
Median Office Visit Time	79.0	204.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	1355.00	1,716.0	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

(of those that selected Key Reference code)

<u>Mental Effort and Judgment (Mean)</u>		
The number of possible diagnosis and/or the number of	4.68	4.47
management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests,	4.95	4.79
and/or other information that must be reviewed and analyzed		
Urgency of medical decision making	4.32	4.11
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.79	4.53
Physical effort required	4.79	4.53
Psychological Stress (Mean)		II
The risk of significant complications, morbidity and/or mortality	4.89	4.68
Outcome depends on the skill and judgment of physician	4.84	4.53
		L
Estimated risk of malpractice suit with poor outcome	3.89	3.84
INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference
		<u>Service 1</u>
Time Segments (Mean)		
Pre-Service intensity/complexity	4.79	4.79
Intra-Service intensity/complexity	4.79	4.68
~ <u>*</u> *		
Post-Service intensity/complexity	5.00	4 74
1 ost out the intensity/complexity	5.00	

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.*

FOR ADDITIONAL RATIONALE, COMPELLING EVIDENCE AND OVERALL ARGUMENTS SEE CARDIOTHORACIC SURGERY COVER LETTER THAT WAS SUBMITTED WITH THE PROPOSAL

Why is this code being reviewed?

This code is submitted as part of the VAD family of codes. Ventricular Assist Devices are undergoing rapid evolution of technology effecting both extracorporeal and intracorporeal devices, and a transition from stroke volume devices to continuous flow devices. With more effective devices, the physician work of implantation is changing, and the patient population served is becoming more challenging. Additionally, survival has improved such that device durability (while also improved but is not unlimited. This necessitated the development of pump changeout codes (33981-33983), which could not be properly valued without revaluing the entire family.

Compelling evidence

Evidence that technology has changed physician work (diffusion of technology)

The prospect of utilizing ventricular assist devices (VADs) for myocardial recovery remains quite promising. While the experience with recovery to date remains limited, there exist increasing reports of successful recovery for carefully selected and evaluated patients. Indeed, patients with acute, severe myocarditis are most likely to experience myocardial recovery which allows for device explantation. However, experience with device removal for patients with dilated cardiomyopathy or ischemic cardiomyopathy continues to slowly grow. The overall success rate for device weaning in patients varies from 5% (1) to over 73% in a highly selected group of non-ischemic cardiomyopathic patients (2). Clearly, with such disparate results, differences in protocols for recovery are operant and the ideal protocol is still actively being sought. In addition, the Birks group (2) utilized an aggressive pharmacological strategy which was implemented over several weeks prior to device removal. Currently, an LVAD working group representing 7 US institutions interested in device recovery is undertaking additional studies to determine which patients should undergo device explantation for recovery. The influence of newer generation axial and centrifugal flow devices remains largely unknown, but promising upon the prospect of VAD insertion with subsequent removal for recovery.

References:

- (1) Mancini DM, Beniaminovitz A, Levin H, et al. Low incidence of myocardial recovery after left ventricular assist device implantation in patients with chronic heart failure. Circulation 1998;98:2383-89.
- (2) Birks EJ, Tansley PD, Hardy J, et al. Left ventricular assist device and drug therapy for the reversal of heart failure. New Engl J Med 2006;355(18):1873-84.
- (3) Maybaum S, Mancini DM, Xydas S, et al. Cardiac improvement during mechanical circulatory support a prospective multicentre study of the LVAD working group. Circulation 2007;115:2497-2505.

Five-year-review specific questions and discussion

Change in Work

Eighty-three percent of the respondents indicated that the patients for this procedure have become more complex. This response reflects the advances in VAD technology and payment policy that permit older (Medicare) and sicker patients to receive VADs. None of the other 5-year-review questions indicated a significant (typical) statistic.

Work RVU Recommendation

We are recommending the median survey work RVU of 75.00. The IWPUT of the recommendation is .1137 which is consistent with the complexity of cardiac and VAD procedures in general and this procedure in particular. This value and its components are appropriate for this complex procedure and patient, and is suitably related to the reference codes and selected MPC codes. This is further illustrated by the relationship of this recommendation to Cardiac Surgery codes valued 2005 or later as follows. This relationship is also consistent with MPC 090 global code relationship of Total RUC Time to Total RVW, which inscribes the same regression line:



Pre-time

Pre-time package 4 (facility- difficult patient/difficult procedure) is appropriate for this procedure.

Evaluation: No change.

Positioning: No change

Scrub, dress, wait: No change

Comparison to key reference code

	RVW	IWPUT	Total Time	Eval	Postit	SDW	Intra	IM- post	91	92	33	32	31	38	39	15	14	13	12
33945	89.50	0.117	1716	167	15	90	325	85	3	1	5	6	1		1	1	2	3	
33980	75.00	0.114	1355	40	3	20	300	90	2	1	5	5	7	1			1	1	1

Comparison to other code

33548	3548 - Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR, SAVER, Dor procedures)																		
	RVW	IWPUT	Total	Eval	Postit	SDW	Intra	IM-	91	92	33	32	31	38	39	15	14	13	12
			Time					post											
33548	54.14	0.117	928	60	15	20	217	40	2	1	3	2	1		1		1	2	
33980	75.00	0.114	1355	40	3	20	300	90	2	1	5	5	7	1			1	1	1

<u>Comparison to MPC codes</u> 61698 - Surgery of complex intracranial aneurysm, intracranial approach; vertebrobasilar circulation

22426 371 1	1	1 .1	1. 1 1	1.1	
33476 - Valvilloi	nlastv mitral v	alve with ca	ardioniilmonary h	wnass with i	prosthetic ring
55120 fulfulo	plasty, initial v	un , e, mun et	and optimition any c	jpubb, mini	Stobuletie Img

	RVW	IWPUT	Total	Eval	Postit	SDW	Intra	IM-	91	92	33	32	31	38	39	15	14	13	12
61698	69.63	0 1147	1209	60	40	15	360	50			4	6	5	1			1	2	
33426	43.28	0.1110	778	60	15	20	205	40	1		3	2	1	1			1	1	
33980	75.00	0.114	1355	40	3	20	300	90	2	1	5	5	7	1			1	1	1

Additional requested statistics

CPT		Min	5 ^{th %}	25 ^{th %}	Med	75 th %	95 th %	Max	Arith Mean	Geo Mean	Mode
22000	Work RVU	35.00	44.51	55.97	75.00	89.54	101.00	115.00	72.54	69.74	90.00
33980	Intra Time	120	180	240	300	360	480	500	302	290	300

Multiple procedure payment comparison

	13.87
	10.13@50%
Multiple procedure payment work RVU	17.07

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.

Professional Liability Insurance Information (PLI)

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

If no, please select another crosswalk and provide a brief rationale. adjust to 33980

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

Compelling Evidence

The RUC operates with the initial presumption that the current values assigned to the codes under review are correct. The argument for a change must be substantial and meet the RUC's compelling evidence standards listed in the Instructions Document. Please list your compelling evidence below (if appropriate).

FOR ADDITIONAL RATIONALE, COMPELLING EVIDENCE AND OVERALL ARGUMENTS SEE CARDIOTHORACIC SURGERY COVER LETTER THAT WAS SUBMITTED WITH THE PROPOSAL.

Compelling evidence for 33980 is included in the Rationale Section Above.

Five-Year Review Specific Questions

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

Has the work of performing this service changed in the past 5 years? Yes 46% No 54% A. This service represents new technology? Yes 44% No 56%

Of survey respondents, who said yes, the new technology affected the work: Less Work: 19% Same Work: 13% More Work: 69%

- B. This service reflects new technology that has become more familiar: Yes 44% No 56%
- C. Patients requiring this service are now:

More complex (more work) 83% Less complex (less work) 0% No change in complexity 17% D. The typical site-of-service has changed:

From outpatient to inpatient 0% From inpatient to outpatient 0% No change 100%

AMA/Specialty Society RVS Update Committee Summary of Recommendations Identified through the Harvard Valued – Utilization over 30,000 Screen and the Fourth Five-Year Review

February 2011

Vascular Injection Procedures

In the 4th Five-Year Review of the RBRVS, CMS identified CPT codes 36010, 36200, 36215, 36216, 36246, 36247, and 36471 as potentially misvalued through the Harvard Valued with Utilization Greater than 30,000 Screen. The specialty societies requested that CPT code 36470 be added to the 4th Five-Year Review.

During its October 2010 meeting, the RUC reviewed the physician work for CPT Codes 36470 *Injection of sclerosing solution; single vein* and 36471 *Injection of sclerosing solution; multiple veins, same leg*, as a subset of the large family of lower extremity revascularization services that describe complete therapy procedures for the revascularization of the lower extremities. The specialty societies explained that with the new CPT 2011 codes involving lower extremity revascularization becoming effective in January 2011, they anticipate utilization shifts for the remainder of the codes under this review of the vascular injection procedures. The specialty societies had difficulties surveying CPT codes 36200, 36246, and 36247 as the global period assignment of XXX appeared inappropriate for these surgical services. Therefore, the RUC recommended, and CMS agreed to change the global period for these services from an XXX -day global to a 000 global period, and survey for February 2011. The RUC also recommended CPT codes 36010, 36215, 36216, and 37620 be referred to the CPT Editorial Panel for revision based on the new and revised coding structure of the lower extremity revascularization services and better describe the services when these codes are reported together on the same date by the same physician.

The component non-selective code 36200 Introduction of catheter, aorta, and selective catheterization codes 36246 Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family and 36247 Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family describe those scenarios where a diagnostic study is performed without intervention or where angiography and intervention are performed outside of the lower extremities or carotid circulation.

The RUC's review of the vascular injection codes and catheterization codes was based on magnitude estimation as the amount of work and intensity is progressively greater as one moves from a short non-selective catheterization 36140 *Introduction of needle or intracatheter; extremity artery* (work RVU = 2.01), progressing to a deeper more invasive aortic catheterization (36200), progressing to a selective catheterization of the origin of a vessel 36245 *Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family* (work RVU = 4.67), its first named branch after a bifurcation (36246), and finally deep into a vascular bed in its second or third named branch often requiring a telescoping construct of base catheter, microcatheter, and microwire (36247).

36200 Introduction of catheter, aorta

The RUC reviewed the survey results from over 80 vascular surgeons, general surgeons, cardiologists, radiologists, interventional radiologists, and interventional cardiologists who perform this service and agreed with the specialty societies that the work has not changed for this service and the current work RVU of 3.02 should be maintained.

The specialties reported that only fourteen percent of the respondents indicated that there has been a change in work over the past five years. In addition, the specialties agreed that the time to perform 36200 has not changed in the past 5 years and there is no significant data to suggest a change in work. However, the intensity and complexity of this service certainly has increased similar to almost every other procedure and service in the physician fee schedule, as physicians are now treating more complex patients who may be older and have more co-morbidities.

The RUC compared the physician work of 36200 to recently RUC reviewed key reference service 93503 *Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes* (work RVU = 2.91). Code 93503 is typically performed on an ICU patient for cardiac and hemodynamic monitoring whereas code 36200 is typically performed on a vascular patient with associated co-morbidities, cardiac risks, and/or disease. The RUC agreed that the intra-service work portion of the key reference code and surveyed code are similar in that they both involve Seldinger technique, manipulation, and placement of a catheter. RUC members agreed that the inherent differences of working in the arterial vs. venous system, the length of the aorta, and presence of atherosclerosis and its complications, would account for the additional intra-service time required in 36200, 30 versus 15 minutes, respectively. The RUC noted the survey respondents indicated that code 36200 requires more intensity and complexity to perform than code 93503. The RUC determined that the lower pre- and post-time and physician work for 93503 are due to the fact that 93503 is modifier 51 exempt and the RUC reduced the physician time to be certain of no overlapping time with other work typically performed. Additionally, moderate sedation is not inherent to 93503 and thus requires less pre-time and pre-work than the survey deservice.

To further support maintaining the current work RVU of 3.02, the RUC compared the physician work of 36200 to CPT Code 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (work RVU = 2.70) and 45378 *Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)* (work RVU = 3.69). The RUC determined that MPC code 51102 requires similar physician work in that a Seldinger technique would be employed with needle, wire, and catheter placement. However, code 51102 does not include moderate sedation and therefore 51102 would have less pre-work. The RUC compared 36200 to MPC code 45378 and noted they have identical intra-service time and moderate sedation is inherent to both procedures and therefore should be valued similarly. Considering the specialties survey results and key reference service and cross specialty comparisons, the RUC agreed with the specialty that the physician work value for CPT code 36200 should be maintained at 3.02, which is supported by the survey's 25th percentile work RVU of 3.00. **The RUC recommends maintaining the current work RVU of 3.02 for CPT code 36200**.

36246 Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family

The RUC considered compelling evidence to increase the work value of this service. The RUC reviewed the survey results from 75 vascular surgeons, general surgeons, cardiologists, radiologists, interventional radiologists, and interventional cardiologists who perform this service and determined that the physician work for this service has not changed and the current work RVU of 5.27 should be maintained

The RUC agreed that the survey respondents did not indicate any change in physician work for code 36246 due to the creation of the new lower extremity revascularization codes. The RUC compared the physician work of 36246 to its key reference service 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (work RVU = 4.17) which is inherently less complex and intense than 36246 with 15 minutes less intra time. Both codes include moderate sedation as inherent. The survey's comparative intensity measures were much greater than the reference code supporting a higher RVW for 36246 compared with 32550.

To justify the current value of this service, the specialty societies utilizing magnitude estimation, compared this service to MPC codes 45385 *Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique* (work RVU = 5.30) and 43260 *Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (work RVU = 5.95) which are RUC reviewed 000-day global services. In comparison, the RUC agreed that the typical vascular patient undergoing second order angiography for the surveyed code is just as complex as the 45385 and 43260. Code 36246 requires multiple catheter exchanges and manipulations, carries the risk of radiation exposure to the operator throughout the procedure, and carries significant risk of life-threatening complications to the patient. Moderate sedation is inherent to all three codes. The RUC concurred that the current physician work value of 5.27 and intra service time for 36246 are in rank order with these similarly valued services. In addition, the RUC concurred that the current physician work value is supported by the specialty's median survey value of 5.50. **The RUC recommends a work RVU of 5.27 for CPT code 36246**.

36247 Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family

The RUC considered compelling evidence to increase the work value of this service based primarily on the fact that a very large percentage of patients in whom this code would have been used previously are now be reported with the new family of lower extremity intervention codes. The remaining cohort of patients for whom this code will be used are exemplified by the typical patient vignette, a clinical situation in which more physician work is required . Procedures now reported with 36247, as exemplified by the vignette, would be catheterization of the mesenteric vessels and renal vessels which are inherently more complex. The caliber of the vessels is smaller than the iliac and superficial femoral artery and the end-organs are much more susceptible to the complication of thrombo-embolic injury. Catheterization of second and third order branches of the mesentery have a definite higher failure rate than the lesser catheterizations reflecting the incrementally more difficult nature of this work.

The RUC agreed with the specialty's compelling evidence that the physician work of 36247 had increased. The RUC agreed that the when 36247 had been originally valued through the Harvard studies, the predominate provider was radiology, whereas now it is vascular surgery and cardiology. The RUC also agreed that there had been a change in the physician work for 36247 due to: patient population changes, the change in the global period change from XXX to 000, moderate sedation is now inherent, and the procedures that remain in 36247 after the creation of the lower extremity revascularization codes, are inherently more complex. In addition, the caliber of the vessels are smaller than the iliac and superficial femoral artery femoral artery and the end organs are much more susceptible to the complication of thrombo-embolic injury. The RUC accepted these arguments as compelling evidence to change the current value of code 36247.

The RUC reviewed the survey results from 74 vascular surgeons, general surgeons, cardiologists, radiologists, interventional radiologists, and interventional cardiologists who perform this service and determined that the survey median work RVU of 7.00 appropriately accounts for the work required to perform this service.

The RUC compared the physician work of 36247 to its key reference service 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (work RVU = 4.17) which is inherently less complex, and less intense than 36247 with 30 minutes less intra time. Both codes include moderate sedation as inherent. The survey's comparative intensity measures were much greater than the reference code supporting a higher RVW for 36246 compared with 32550.

The RUC also compared code 36147 Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection[s] of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava) (work RVU = 3.72) as a recently RUC reviewed bundled service that incorporates placement of a short catheter into the AV access (inherently less difficult) followed by imaging of the graft and central veins. A portion of the additional 25 minutes of intraservice time is in part due to the bundled imaging of the graft and the central veins. If this is reported separately with 75791, the work RVU = 1.71, with the surgical component value (derived) is equal to 2.01 as supported by RUC rationale for 36147. The surgical work of introducing the catheter into the AV graft is in rank order with other catheter placement procedures.

The specialty society explained to the RUC that 36247 was previously reported with a blend of services and 90% of that blend of services shifted to the new lower extremity revascularization (LER) services. The patients and services of that 90% shift represent less complex catheterization services and less intense patients. The RUC accepted this argument after reviewing the top diagnosis codes for 36247 prior to the creation of the new LER codes and compared it to the newly established vignette for the 36247 and recognized that the patients described by the top diagnosis codes was significantly less intense than the patient described in the newly created vignette. Based on this premise, the RUC reviewed the survey data for this service and compared it to several reference codes including; MPC codes 58560 *Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)* (work RVU = 6.99) and 31600 *Tracheostomy, planned (separate procedure* (work RVU = 7.17), code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral* (work RVU = 6.74), and code 43272 *Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique* (work RVU = 7.38). MPC code 58560 is a low Medicare volume 000-day global code, but has the same intra time of 60 minutes and almost identical work RVU, however, moderate sedation is inherent for code 36247, but not for 58560. Code 31600 requires 20 minutes less intra time, however would require more overall time, reflected in the higher work RVU. The additional pre-time for general anesthesia for 31600 and post-time are offset by the difference in intra-time, making the similarity in work RVU appropriate in terms of total physician work. CPT code 43272 was considered a comparable service to 36247, although the intensity of 43272 was considered a higher than 36247.

The RUC also compared 36247 to similar service, code 34812 *Open femoral artery cut-down for delivery of endovascular prosthetic device* (work RVU = 6.74), performed frequently by vascular surgeons, requires 15 minutes less intra-service time than the surveyed code and therefore has a lower work RVU. The concurred that survey median physician work value and intra service time for 36247 maintains the proper rank order with these comparable services. The RUC recommends a work RVU of 7.00 for CPT code 36247.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.
Referral to CPT Editorial Panel:

The specialties explained that the survey data supports that moderate sedation is an inherent component of these services. The RUC recommends that CPT Codes 36200, 36425, 36426, and 36247 be referred to the CPT Editorial Panel to be included in Appendix G.

Practice Expense

The RUC recommends the revised practice expense direct inputs, in order to account for the inherency of moderate sedation in CPT Codes 36200, 36245, 36426, and 36247.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
36200	Introduction of catheter, aorta	XXX 000	3.02
			(No Change)
36246	Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family	XXX 000	5.27
			(No Change)
36247	initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family	XXX 000	7.00

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS 2010 FIVE YEAR REVIEW SUMMARY OF RECOMMENDATION

CPT Code:36200 Tracking Number Global Period: 000 Specialty Society Recommended RVU: 3.02 RUC Recommended RVU: 3.02

CPT Descriptor: Introduction of catheter, aorta

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75-year-old female with peripheral arterial disease and history of aortobifemoral bypass presents with acute left buttock claudication and absent left femoral pulse. After review of the medical history, physical, labs, and imaging studies, she is brought to the angiography suite. Via right femoral approach, a catheter is introduced into her abdominal aorta for angiography. [When completing this survey, only consider the physician work related to the catheterization procedure. Radiological supervision and interpretation would be reported separately.]

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

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 80%

Is moderate sedation inherent to this procedure in the office setting? Yes Percent of survey respondents who stated moderate sedation is typical in the office setting? 53%

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: Based on patient symptoms, signs, physical findings and pre-procedural studies, estimate the range of catheters, sheaths, and guidewires required for procedure. Assess need for stand-by devices that might be needed emergently, such as balloons and covered stents should there by an unanticipated event. Review recent pertinent blood tests, including creatinine GFR, CBC, and coagulation studies to assure patient suitability for planned procedure. Discuss procedure detail plan, including alternatives and risks with patient and family. Obtain informed consent for procedure and moderate sedation. Ensure all technical personnel have been familiarized with the procedure and techniques and that they are fully familiar with all required devices. Check the interventional suite to ensure proper function and configuration of the imaging equipment including compliance with all radiation safety regulations. Ensure that appropriate intravenous access has been gained and that the patient is appropriately positioned on the table. Don radiation protection gear and ensure that all who will be in the interventional suite do likewise. Position patient. Mark acces site(s). Supervise sterile prep of interventional access site(s) and subsequent draping. Perform procedural "Time Out."

Description of Intra-Service Work: Administer or supervise administration of conscious sedation. The access vessel is palpated and local anesthesia is administered. Using Seldinger technique, the vessel is punctured, a guidewire is passed, and a vascular sheath is introduced into the artery. This is then flushed with sterile saline. Over guidewire, catheter and guidewire are manipulated into the diseased iliac vessels and then ultimately in to the diseased aorta. Sterile saline flush and test injection of contrast are performed to ensure intraluminal and safe position of catheter. Depending on imaging portion of procedure, the catheter may be repositioned, or exchanged over appropriate guidewire for different caliber or

CPT Code: 36200

shaped catheter to facilitate imaging and pressure measurement. Following the imaging portion of the procedure (performed and reported separately), manual compression or closure device are utilized for closure of the arteriotomy to achieve hemostasis.

Description of Post-Service Work: Apply sterile dressings. Assist team in moving patient to stretcher. Discuss postprocedure care with recovery area staff. Write post-procedure orders for care and pain medication. Write brief procedure note. Repeat patient exam and assessment of vital signs and perfusion of limb multiple times in recovery area. Monitor groin puncture site for hematoma. Discuss findings and treatment with family and patient (when awake). Write orders for follow-up labs, x-rays. Complete medical records. Communicate with referring physician. Provide discharge instructions. Depending on the preexisting comorbidities and operative course, the patient may require full hospital admission, overnight hospital stay, or same day discharge. The patient is transferred to the appropriate care setting when recovery area discharge criteria are met, with appropriate orders for follow-up labs, x-rays, and patient care.

SURVEY DAT	ГА									
RUC Meeting Da	ate (mm/yyyy)	02/2011								
Presenter(s):	Gary Seabro Kavinsky, MI Senkowski, I	ook, MD; Rober D; Richard Wri MD; Charles M	rt Zwolak, M ght, MD; Eze abry, MD	D; Sean Tuttoi equiel Silva, M	n, MD; Jerry Nie D; Geraldine M	edzwieck, MD cGinty, MD; (; Clifford Christopher			
Specialty(s):	vascular surg	ascular surgery, interventional radiology, interventional cardiology, radiology, cardiology, eneral surgery								
CPT Code:	36200	36200								
Sample Size:	970	Resp N:	83	Response:	8.5 %					
Sample Type:	Random	Random Additional Sample Information:								
			Low	25 th %	Median*	<u>75th %</u>	High			
Service Perform	nance Rate		3.00	28.00	50.00	100.00	500.00			
Survey RVW:			2.00	3.00	3.50	4.50	6.25			
Pre-Service Evalu	uation Time:				35.00					
Pre-Service Posit	tioning Time:				10.00					
Pre-Service Scru	b, Dress, Wait T	Time:			10.00					
Intra-Service Ti	me:		5.00	15.00	30.00	60.00	75.00			
Immediate Post	Service-Time	: <u>20.00</u>								
Post Operative	Visits	Total Min**	CPT Code	and Number	of Visits					
Critical Care tin	ne/visit(s):	<u>0.00</u>	99291x 0.0	00 99292x ().00					
Other Hospital	time/visit(s):	<u>0.00</u>	99231x 0.0) 0 99232x ().00 99233x	0.00				
Discharge Day	Mgmt:	<u>0.00</u>	99238x 0.0)0 99239x 0.0	0					
Office time/visit	t(s):	0.00	99211x 0.0	00 12x 0.00 13	3x 0.00 14x 0.0	0 15x 0.00				
Prolonged Serv	ices:	<u>0.00</u>	99354x 0.0	00 55x 0.00	56x 0.00 57x	0.00				
Sub Obs Care:		0.00	99224x 0.0	99225x (99226x	0.00				

**Physician standard total <u>minutes per E/M visit</u>: 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: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT 3620	0	Recommended Physician Work RVU: 3.02					
Code:	0						
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time			
Pre-Service Evaluation Time:		33.00	33.00	0.00			
Pre-Service Positioning Time:	:	3.00	1.00	2.00			
Pre-Service Scrub, Dress, Wa	it Time:	5.00	5.00	0.00			
Intra-Service Time:		30.00					
Immediate Post Service-Ti	me: <u>20.00</u>						
Post Operative Visits	Total Min**	CPT Code and Nu	umber of Visits				
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 992	292x 0.00				
Other Hospital time/visit(s)	: <u>0.00</u>	99231x 0.00 992	232x 0.00 99233x	. 0.00			
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0 99239	× 0.0				
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0	.00 13x 0.00 14x 0	.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x	0.00 56x 0.00 57x	0.00			
Sub Obs Care:	0.00	99224x 0.00 992	25x 0.00 99226x	0.00			

KEY REFERENCE SERVICE:

Key CPT Code	<u>Global</u>	Work RVU	Time Source
93503	000	2.91	RUC Time

CPT Descriptor Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes

KEY MPC COMPARISON CODES:

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

				Most Recent
MPC CPT Code 1	<u>Global</u> <u>V</u>	<u>Vork RVU</u>	Time Source	Medicare Utilization
51102	000	2.70	RUC Time	12,781
CPT Descriptor 1 Aspira	ation of bladder; wi	th insertion of su	prapubic catheter	
				Most Recent
MPC CPT Code 2	<u>Global</u>	Work RVU	Time Source	Medicare Utilization
45378	000	3.69	RUC Time	915,402

<u>CPT Descriptor 2</u> Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)

Other Reference CPT Code	<u>Global</u>	Work RVU	Time Source
36147	000	3.72	RUC Time

<u>CPT Descriptor</u> Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection[s] of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava)

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

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

Number of respondents who choose Key Reference Code: 25 % of respondents: 30.1 %

<u>TIME ESTIMATES (Median)</u>	CPT Code: 36200	Key Reference CPT Code: <u>93503</u>	Source of Time RUC Time
Median Pre-Service Time	41.00	12.00	
Median Intra-Service Time	30.00	15.00	
Median Immediate Post-service Time	20.00	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	91.00	37.00	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

(of those that selected Key Reference code)

<u>Mental Effort and Judgment (Mean)</u>		
The number of possible diagnosis and/or the number of	3.24	3.00
management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests,	3.24	3.25
and/or other information that must be reviewed and analyzed		
Urgency of medical decision making	3.20	3.17
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.24	3.13
		L]
Г		
Physical effort required	2.92	2.79
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.48	3.39
Outcome depends on the skill and judgment of physician	3 / 8	3/3
Sucome depends on the skin and Judgment of physician	0.40	0.40
Estimated risk of malpractice suit with poor outcome	3.76	3.74
INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference
		Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.83	2.70
Intra-Service intensity/complexity	3.08	2.91
]	L]
Dest Corrise intensity/semulavity	2.06	2.57
Post-Service intensity/complexity	2.90	2.37

Additional Rationale and Comments

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

Why is this code being reviewed?

Code 36200 was identified as part of the 4th Five-Year Review by CMS. The RUC requested that CMS consider a change from XXX global to 000 global period. CMS agreed and code 36200, which is Harvard based, was surveyed with a 000 global period.

The Big Picture: Component Codes vs. Bundled Codes

In October, the multi-specialty societies brought forth the 16 lower extremity revascularization codes that describe complete therapy procedures for the revascularization of the lower extremities. The component coded non-selective 36200, and selective catheterization codes 36245,-46,-47 remain intact to describe those scenarios where: a diagnostic study is performed without intervention or where angiography and intervention are performed outside of the lower extremities or carotid circulation.

The vascular injection codes or catheterization codes were based on magnitude estimation in that the amount of work and intensity is progressively greater as we move from a short non-selective catheterization (36140), progressing to a deeper more invasive aortic catheterization (36200), progressing to a selective catheterization of the origin of a vessel (36245), its first named branch after a bifurcation (36246), and finally deep into a vascular bed in its second or third named branch often requiring a telescoping construct of base catheter, microcatheter, and microwire.

Change in Work

Only fourteen percent of the respondents indicated that there has been a change in work over the past five years. The consensus panel of surgery, cardiology, and radiology agree that the **time** to perform 36200 has not changed in the past 5 years; there is no significant statistic in the series of 5YR questions to suggest a change in work for 36200. That is not to say that the **intensity/complexity** has not increased since the original review in the late 1980's during the Harvard study. As with almost every other procedure and service in the PFS, physicians are now treating more complex patients who may be older and have more co-morbidities, resulting in more intense and complex work.

Work RVU Recommendation

We are recommending maintaining the current work RVU of 3.02 for CPT code 36200.

Pre-time

Pre-time package 2b [Difficult Patient/Straightforward Procedure (With sedation/anesthesia care)] is appropriate, with the following modifications to the positioning package time. The societies request an additional 2 minutes of positioning time to account for placement of fluoro compatible arm boards and safety restraints to prevent patient from falling off narrow angiography table, and due to the need for orientation and test imaging of the angiographic field of interest. Radio-opaque material in the field must be repositioned prior to sterile draping.

Comparison to key reference code

Clinical Comparison with Key Reference - 93503

Key reference code 93503 (insertion of Swan-Ganz catheter) would typically be performed on an ICU patient for cardiac and hemodynamic monitoring. Procedure 36200 would be performed on a vascular patient with associated co-morbidities, cardiac risks, and/ or disease.

Work Comparison with Key Reference - 93503

The intraservice work portion of the key reference code and surveyed code are similar in that they both involve Seldinger technique, manipulation, and placement of a catheter. The multi-specialty expert panel and survey respondents agree that the inherent differences of working in the arterial vs. venous system, the length of the aorta, and presence of atherosclerosis and its complications, would account for the additional intraservice time required in 36200. Intensity of the pre-, intra-, and post-service times was deemed to be greater by survey respondents than that of the reference code. The lower pre- and post-time (and work) for 93503 are due to the fact that 93503 is modifier 51 exempt and the RUC reduced these times to be certain of no overlapping times with other work typically performed. Additionally, moderate sedation is not inherent to 93503, also accounting for a lower pre-time.

	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	Post
93503	2.91	0.166	37	5	2	5	15	10
36200	3.02	0.058	91	33	3	5	30	20

Comparison to MPC codes

Comparison with MPC List Code 1, CPT 51102

CPT Code 51102, aspiration of bladder; with suprapubic catheter, represents similar work in that a Seldinger technique would be employed with needle, wire, and catheter placement. Both codes could be reported with a separate S&I. Moderate sedation is not inherent to 51102, accounting for the differences in time.

Comparison with MPC List Code 2, CPT 45378

Codes 45378 Colonoscopy and 36200 have identical intraservice time. Moderate sedation is inherent to both procedures. For code 45378, the patient is straightforward (pre-time package 1B*), compared with 36200 (pre-time package 2B*).

			Total					
	RVW	IWPUT	Time	Eval	Posit	SDW	INTRA	Post
51102	2.70	0.094	60	19	1	5	20	15
36200	3.02	0.058	91	33	3	5	30	20
45378	3.69	0.092	75	20	5	5	30	15

Comparison To Other Reference Code - 36147

Code 36147 (access and evaluation of AV graft) is a recently RUC reviewed bundled service that incorporates placement of a short catheter into the AV access (inherently less difficult) followed by imaging of the graft and central veins. A portion of the additional 25 minutes of intraservice time is in part due to the bundled imaging of the graft and the central veins. If this is reported separately with 75791, the RVW = 1.71, with the surgical component value (derived) is equal to 2.01 as supported by RUC rationale for 36147. The surgical work of introducing the catheter into the AV graft is in rank order with other catheter placement procedures. The IWPUT of 36200 of (0.058) is in rank order with many of the other interventional radiology codes that have been recently reviewed.

	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	Post
36147	3.72	0.065	80	20			45	15
36200	3.02	0.058	91	33	3	5	30	20

Summary

Based on all the above data and comparisons, we believe the current work RVU of 3.02 for 36200 is justified.

Additional requested statistics

СРТ		Min	5th%	25th%	Med	75th%	95th%	Max	Arith Mean	Geo Mean	Mode
26200	Work RVU	2.00	2.03	3.00	3.50	4.50	6.00	6.25	3.71	3.56	3.50
30200	Intra Time	5	10	15	30	40	60	75	29	25	30

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.



CPT Code: 36200 Multiple codes allow flexibility to describe exactly what components the procedure included. Multiple codes are 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. Appropriate radiological S&I code would be reported separately (eg, 75625).

Professional Liability Insurance Information (PLI)

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

If no, please select another crosswalk and provide a brief rationale. 36200

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

Compelling Evidence

The RUC operates with the initial presumption that the current values assigned to the codes under review are correct. The argument for a change must be substantial and meet the RUC's compelling evidence standards listed in the Instructions Document. Please list your compelling evidence below (if appropriate). n/a

Five-Year Review Specific Questions

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

Has the work of performing this service changed in the past 5 years? Yes 14% No 86% A. This service represents new technology? Yes 7% No 93%

Of survey respondents, who said yes, the new technology affected the work: Less Work: 17% Same Work: 33% More Work: 50%

B. This service reflects new technology that has become more familiar: Yes 7% No 93%

C. Patients requiring this service are now:

More complex (more work) 46% Less complex (less work) 0% No change in complexity 54%

D. The typical site-of-service has changed:

From outpatient to inpatient 0% From inpatient to outpatient 13% No change 87%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS 2010 FIVE YEAR REVIEW SUMMARY OF RECOMMENDATION

CPT Code:36246 Tracking Number Global Period: 000 Specialty Society Recommended RVU: 5.50 RUC Recommended RVU: 5.27

CPT Descriptor: Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 74-year-old female with hypertension and a 2.5 cm splenic artery aneurysm presents for diagnostic angiogram for surgical or endovascular planning. After review of the medical history, physical, labs, and imaging studies, she is brought to the angiography suite. Via right femoral approach, a catheter is introduced into the aorta with selective catheterization of the celiac and splenic artery to define neck size and number of feeding vessels. [When completing this survey, only consider the physician work related to the catheterization procedure. Radiological supervision and interpretation would be reported separately.]

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 0%, In the ASC 0%, In the office 0%

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 82%

Is moderate sedation inherent to this procedure in the office setting? Yes Percent of survey respondents who stated moderate sedation is typical in the office setting? 50%

Is moderate sedation inherent in your reference code (Office setting)? Yes Is moderate sedation inherent in your reference code (Hospital/ASC setting)? Yes

Description of Pre-Service Work: Based on patient symptoms, signs, physical findings and pre-procedural studies, estimate the range of catheters, sheaths, and guidewires required for procedure. Assess need for stand-by devices that might be needed emergently, such as balloons and covered stents should there by an unanticipated event. Review recent pertinent blood tests, including creatinine GFR, CBC, and coagulation studies to assure patient suitability for planned procedure. Discuss procedure detail plan, including alternatives and risks with patient and family. Obtain informed consent for procedure and moderate sedation. Ensure all technical personnel have been familiarized with the procedure and techniques and that they are fully familiar with all required devices. Check the interventional suite to ensure proper function and configuration of the imaging equipment including compliance with all radiation safety regulations. Ensure that appropriate intravenous access has been gained and that the patient is appropriately positioned on the table. Don radiation protection gear and ensure that all who will be in the interventional suite do likewise. Position patient. Mark acces site(s). Supervise sterile prep of interventional access site(s) and subsequent draping. Perform procedural "Time Out."

Description of Intra-Service Work: Administer or supervise administration of conscious sedation. Palpate access vessel is palpated and local anesthesia is administered. Using Seldinger technique, the vessel is punctured, a guidewire is passed, and a catheter and guidewire are manipulated into the diseased aorta. After the non-selective imaging portion of the procedure is performed (separate), the catheter is exchanged over guidewire for appropriate selective catheter which is

CPT Code: 36246

manipulated under fluoroscopic guidance into the origin of the chosen branch vessel. Sterile saline flush and test injection of contrast are performed to ensure intraluminal and safe position of catheter. Using guidewire and catheter techniques, the catheter is advanced beyond the first branch point into the second order portion of the vessel (eg. splenic, common hepatic, left gastric). Flush and test injection are repeated throughout the procedure to ensure safe position and patency of catheter system. The catheter may be repositioned, or exchanged over appropriate guidewire to be seated safely in the vessel. Following the imaging portion of the procedure (performed and reported separately), manual compression or closure device are utilized for closure of the arteriotomy to achieve hemostasis.

Description of Post-Service Work: Apply sterile dressings. Assist team in moving patient to stretcher. Discuss postprocedure care with recovery area staff. Write post-procedure orders for care and pain medication. Write brief procedure note. Repeat patient exam and assessment of vital signs and perfusion of limb multiple times in recovery area. Monitor groin puncture site for hematoma. Discuss findings and treatment with family and patient (when awake). Write orders for follow-up labs, x-rays. Complete medical records. Communicate with referring physician. Provide discharge instructions. Depending on the preexisting comorbidities and operative course, the patient may require full hospital admission, overnight hospital stay, or same day discharge. The patient is transferred to the appropriate care setting when recovery area discharge criteria are met, with appropriate orders for follow-up labs, x-rays, and patient care.

SURVEY DAT	ГА									
RUC Meeting Da	ate (mm/yyyy)	02/2011								
Presenter(s):	Gary Seabro Kavinsky, MI Senkowski, I	Gary Seabrook, MD; Robert Zwolak, MD; Sean Tutton, MD; Jerry Niedzwieck, MD; Clifford Gavinsky, MD; Richard Wright, MD; Ezequiel Silva, MD; Geraldine McGinty, MD; Christopher Genkowski, MD; Charles Mabry, MD								
Specialty(s):	vascular suro general surg	ascular surgery, interventional radiology, interventional cardiology, radiology, cardiology, eneral surgery								
CPT Code:	36246	36246								
Sample Size:	970	Resp N:	75	Response	: 7.7 %					
Sample Type:	Random	Additional Sa	ample Infor	mation:						
			Low	25 th %	Median*	<u>75th %</u>	High			
Service Performance Rate			0.00	13.00	30.00	50.00	250.00			
Survey RVW:			2.50	4.40	5.50	6.83	10.00			
Pre-Service Evalu	uation Time:				35.00					
Pre-Service Posit	tioning Time:				10.00					
Pre-Service Scru	b, Dress, Wait T	ime:			10.00					
Intra-Service Ti	me:		10.00	30.00	45.00	60.00	90.00			
Immediate Post	Service-Time	: <u>20.00</u>								
Post Operative	<u>Visits</u>	Total Min**	CPT Code	and Numbe	er of Visits					
Critical Care tin	ne/visit(s):	<u>0.00</u>	99291x 0.0	0 99292x	0.00					
Other Hospital 1	time/visit(s):	<u>0.00</u>	99231x 0.0	9 9232x	0.00 99233x	0.00				
Discharge Day	Mgmt:	<u>0.00</u>	99238x 0.0	0 99239x 0 .	00					
Office time/visit	t(s):	0.00	99211x 0.0	00 12x 0.00 1	13x 0.00 14x 0.0	0 15x 0.00				
Prolonged Serv	ices:	0.00	99354x 0.0	00 55x 0.00	56x 0.00 57x	0.00				
Sub Obs Care:		0.00	99224x 0.0	99225x	0.00 99226x	0.00				

**Physician standard total <u>minutes per E/M visit</u>: 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: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

СРТ	36246		Recommended Physician Work RVU: 5.27				
Code:	00240						
			Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time		
Pre-Service Evaluation Time:			33.00	33.00	0.00		
Pre-Service Positioning Time:			3.00	1.00	2.00		
Pre-Service Scrub, Dress, Wait Time:			5.00	5.00	0.00		
Intra-Service Time:			45.00				
Immediate Post Servio	ce-Time:	<u>20.00</u>					
Post Operative Visits		Total Min**	CPT Code and Number of Visits				
Critical Care time/visit	t(s):	<u>0.00</u>	99291x 0.00 992	292x 0.00			
Other Hospital time/vi	sit(s):	<u>0.00</u>	99231x 0.00 992	232x 0.00 99233x	. 0.00		
Discharge Day Mgmt:		<u>0.00</u>	99238x 0.0 99239	x 0.0			
Office time/visit(s):		<u>0.00</u>	99211x 0.00 12x 0	0.00 13x 0.00 14x 0	.00 15x 0.00		
Prolonged Services:		<u>0.00</u>	99354x 0.00 55x	0.00 56x 0.00 57x	0.00		
Sub Obs Care:		<u>0.00</u>	99224x 0.00 992	225x 0.00 99226x	0.00		

KEY REFERENCE SE	ERVICE:					
Key CPT Code 32550	<u>Global</u> 000		<u>Work</u> 4.17	<u>RVU</u>	Time Source RUC Time	
CPT Descriptor Insertion	n of indwelling tunn	eled pleural cath	eter with cuff			
KEY MPC COMPARI Compare the surveyed of appropriate that have related	SON CODES: code to codes on the ative values higher a	e RUC's MPC I and lower than th	List. Reference code ne requested relative v	s from the values for t	MPC list should be he code under revie Most Recent	e chosen, if w.
<u>MPC CPT Code 1</u> 45385 <u>CPT Descriptor 1</u> Colon by spare technique	<u>Global</u> <u>W</u> 000 oscopy, flexible, pr	<u>ork RVU</u> 5.30 oximal to splenio	<u>Time Source</u> RUC Time e flexure; with remov	<u>Med</u> al of tumor	licare Utilization 680,494 r(s), polyp(s), or oth	ner lesion(s)
<u>MPC CPT Code 2</u> 43260	<u>Global</u> 000	<u>Work RVU</u> 5.95	<u>Time Source</u> RUC Time	Me	Most Recent dicare Utilization 14,520	
<u>CPT Descriptor 2</u> Endo specimen(s) by brushing	oscopic retrograde of or washing (separa	cholangiopancrea te procedure)	atography (ERCP); o	liagnostic,	with or without c	ollection of
Other Reference CPT Co	ode Global	Work RV	<u>U</u> Time Source	e		

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

000

% of respondents: 26.6 %

RUC Time

<u>TIME ESTIMATES (Median)</u>	CPT Co 36246	de: CPT Code: <u>32550</u>	Source of Time RUC Time
Median Pre-Service Time	41.00	40.00]
Median Intra-Service Time	45.00	30.00]
Median Immediate Post-service Time	20.00	20.00]
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	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	106.0	90.00	
Other time if appropriate			1

INTENSITY/COMPLEXITY MEASURES (Mean)

(of those that selected Key Reference code)

<u>Mental Effort and Judgment (Mean)</u>		
The number of possible diagnosis and/or the number of	3.55	3.10
management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests,	3.65	3.25
and/or other information that must be reviewed and analyzed		
Urgency of medical decision making	3.45	2.95
Technical Skill/Physical Effort (Mean)		
		[]
Technical skill required	3.85	3.25
Physical effort required	3.35	2.95
Psychological Stress (Mean)		II
The risk of significant complications, morbidity and/or mortality	3.50	2.95
Outcome depends on the skill and judgment of physician	3 75	3 25
Suconic depends on the skin and judgment of physician	0.70	0.20
Estimated risk of malpractice suit with poor outcome	3.75	3.00
INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference
INTENSITI/COMPLEXITI MEASORES		Service 1
lime Segments (Mean)		
Pre-Service intensity/complexity	3.30	2.95
Intra Sarrias intensity/complexity	2.80	2.40
intra-Service intensity/complexity	5.80	3.40
Post-Service intensity/complexity	3.25	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.

Why is this code being reviewed?

Code 36246 was identified as part of the 4th Five-Year Review by CMS. The RUC requested that CMS consider a change from XXX global to 000 global period. CMS agreed and code 36246, which is Harvard based, was surveyed with a 000-global period.

Compelling Evidence

1. Harvard valued by radiology – tied to radiology codes with a global of XXX (non-invasive procedure codes). The global period change and the addition of moderate sedation as inherent recognize additional physician work for this invasive procedure.

2. Significant change in specialty providing service from radiology to vascular surgery and cardiology

3. Significant change in patient population and physician work. The procedures that remain in 36246 after creation of the LER codes (catheterization of the mesenteric vessels and renal vessels), are inherently more complex. The caliber of the vessels is smaller than the iliac and SFA and the end organs are much more susceptible to the complication of thrombo-embolic injury.

Change in Work

The expert panel reviewed the survey and work understanding that a majority of the selective catheterizations of the iliac, SFA, and tibials are now extracted from 36246. The expert panel does not believe that respondents acknowledged the impact on 36246 of the new LER codes, given they were so recently created. In fact, this survey was conducted before the LER codes were published (January 2011). Only thirteen percent of the respondents indicated that there has been a change in work over the past five years. However, this statistic is misleading because of the new bundled codes for lower extremity vascularization that have changed the patient population and work represented by 36246. Even so, 67% of the respondents indicated that the work had changed - more work – which is reflective of the more complex patients undergoing this procedure. The remaining procedures performed and reported with 36246, as exemplified by the vignette, would be catheterization of the mesenteric vessels and renal vessels which is inherently more complex. The caliber of the vessels is smaller than the iliac and SFA and the end-organs are much more susceptible to the complication of thrombo-embolic injury. Catheterization of second and third order branches of the mesentery has a definite higher failure rate than the lesser catheterizations reflecting the incrementally difficult nature of this work

Work RVU Recommendation

The survey respondents, with 75 completed surveys, indicated a high level of agreement that the vignette reflected the typical patient. We are recommending the survey median work RVU of 5.50 for code 36246.

Pre-time

Pre-time package 2b [Difficult Patient/Straightforward Procedure (With sedation/anesthesia care)] is appropriate, with the following modifications to the positioning package time. The societies request an additional 2 minutes of positioning time to account for placement of fluoro compatible arm boards and safety restraints to prevent patient from falling off narrow angiography table, and due to the need for orientation and test imaging of the angiographic field of interest. Radio-opaque material in the field must be repositioned prior to sterile draping.

Comparison to Key Reference Code - 32550

Work Comparison with Key Reference

Key reference code 32550 (placement of indwelling tunneled peritoneal catheter) is inherently less complex, and less intense than 36246 with 15 minutes less intra time. The difference in pre-time can be accounted for by the fact that 32550 was surveyed prior to standardized pre-time packages. Both codes include moderate sedation as inherent. The survey's comparative intensity measures were much greater than the reference code supporting a higher RVW for 36246 compared with 32550.

	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	Post
36246	5.50	0.093	106	33	3	5	45	20
32550	4.17	0.101	90	15	10	15	30	20

Comparison to MPC Codes

Comparison with MPC Codes 45385 and 43260

Code 45385 (colonoscopy with polyp removal) and 43260 (ERCP) are RUC valued 000-day global services. In comparison, we believe that the typical vascular patient undergoing second order angiography is at least as complex. The procedure requires multiple catheter exchanges and manipulations, carries the risk of radiation exposure to the operator throughout the procedure, and carries significant risk of life-threatening complications to the patient. Moderate sedation is inherent to all three codes. Differences in pre-time can be attributed to surveys conducted before pre-time packages were standardized. The RVW and intraservice times for 36246 are in rank order with these MPC services and support our recommended value.

	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	Post
45385	5.30	0.107	75	16			43	15
36246	5.50	0.093	106	33	3	5	45	20
43260	5.95	0.110	86	20			46	20

<u>Summary</u>

Based on all the above data and comparisons, we believe the recommended survey median work RVU of 5.50 for 36246 is justified.

Additional requested statistics

СРТ		Min	5th%	25th%	Med	75th%	95th%	Max	Arith Mean	Geo Mean	Mode
26246	Work RVU	2.50	3.00	4.40	5.50	6.83	8.00	10.00	5.64	5.37	5.50
30240	Intra Time	10	15	30	45	60	75	90	46	40	60

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: 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. Appropriate radiological S&I code would be reported separately (eg, 75726).

Professional Liability Insurance Information (PLI)

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

If no, please select another crosswalk and provide a brief rationale. 36246

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

Compelling Evidence

The RUC operates with the initial presumption that the current values assigned to the codes under review are correct. The argument for a change must be substantial and meet the RUC's compelling evidence standards listed in the Instructions Document. Please list your compelling evidence below (if appropriate).

1. Harvard valued by radiology – tied to radiology codes with a global of XXX (non-invasive procedure codes). The global period change and the addition of moderate sedation as inherent recognize additional physician work for this invasive procedure.

2. Significant change in specialty providing service from radiology to vascular surgery and cardiology

3. Significant change in patient population and physician work. The procedures that remain in 36246 after creation of the LER codes (catheterization of the mesenteric vessels and renal vessels), are inherently more complex. The caliber of the vessels is smaller than the iliac and SFA and the end organs are much more susceptible to the complication of thrombo-embolic injury.

Five-Year Review Specific Questions

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

Has the work of performing this service changed in the past 5 years? Yes 13% No 87% A. This service represents new technology? Yes 8% No 92%

Of survey respondents, who said yes, the new technology affected the work: Less Work: 0% Same Work: 33% More Work: 67%

B. This service reflects new technology that has become more familiar: Yes 8% No 92%

C. Patients requiring this service are now:

More complex (more work) 36% Less complex (less work) 0% No change in complexity 64%

D. The typical site-of-service has changed:

From outpatient to inpatient 1% From inpatient to outpatient 11% No change 88%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS 2010 FIVE YEAR REVIEW SUMMARY OF RECOMMENDATION

CPT Code:36247 Tracking Number Global Period: 000 Specialty Society Recommended RVU: 7.00 RUC Recommended RVU: 7.00

CPT Descriptor: Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year-old female with history of pancreatitis presents with hematemesis, hypotension, and tachycardia. Endoscopy localizes the bleeding to the upper GI tract. After review of the medical history, physical, labs, and imaging studies, she is brought to the angiography suite. Via right femoral approach, a catheter is introduced into the aorta, celiac and common hepatic artery. Through the base catheter, a microcatheter is introduced into the gastroduodenal artery. Angiography is performed. [When completing this survey, only consider the physician work related to the catheterization procedure. Radiological supervision and interpretation would be reported separately.]

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? Yes Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 89%

Is moderate sedation inherent to this procedure in the office setting? Yes Percent of survey respondents who stated moderate sedation is typical in the office setting? 61%

Is moderate sedation inherent in your reference code (Office setting)? Yes Is moderate sedation inherent in your reference code (Hospital/ASC setting)? Yes

Description of Pre-Service Work: Based on patient symptoms, signs, physical findings and pre-procedural studies, estimate the range of catheters, sheaths, and guidewires required for procedure. Assess need for stand-by devices that might be needed emergently, such as balloons and covered stents should there by an unanticipated event. Review recent pertinent blood tests, including creatinine GFR, CBC, and coagulation studies to assure patient suitability for planned procedure. Discuss procedure detail plan, including alternatives and risks with patient and family. Obtain informed consent for procedure and moderate sedation. Ensure all technical personnel have been familiarized with the procedure and techniques and that they are fully familiar with all required devices. Check the interventional suite to ensure proper function and configuration of the imaging equipment including compliance with all radiation safety regulations. Ensure that appropriate intravenous access has been gained and that the patient is appropriately positioned on the table. Don radiation protection gear and ensure that all who will be in the interventional suite do likewise. Position patient. Mark acces site(s). Supervise sterile prep of interventional access site(s) and subsequent draping. Perform procedural "Time Out."

Description of Intra-Service Work: Administer or supervise administration of conscious sedation. The access vessel is palpated and local anesthesia is administered. Using Seldinger technique, the vessel is punctured, a guidewire is passed, and a catheter and guidewire are manipulated into the aorta. After the non-selective imaging portion of the procedure is performed (separately reported), the catheter is exchanged over guidewire for appropriate selective catheter which is

CPT Code: 36247

manipulated under fluoroscopic guidance into the origin of the chosen branch vessel. Sterile saline flush and test injection of contrast are performed to ensure intraluminal and safe position of catheter. Using guidewire and catheter techniques, the catheter is advanced beyond the first branch point into the second order portion of the vessel (eg. splenic, common hepatic, left gastric). Flush and test injection are repeated throughout the procedure to ensure safe position and patency of catheter systems. Through the base catheter (typically 4-5 Fr.), a second microcatheter (typically 3 Fr.) is prepared on the back sterile table with assistant. This microcatheter and wire are introduced into the base catheter with sterile pressurized heparin flush connected and infused. Microcatheter is advance under guidance into the third order branch vessel (GDA, proper hepatic). Following the imaging portion of the procedure (performed and reported separately), manual compression or closure device are utilized for closure of the arteriotomy to achieve hemostasis.

Description of Post-Service Work: Apply sterile dressings. Assist team in moving patient to stretcher. Discuss postprocedure care with recovery area staff. Write post-procedure orders for care and pain medication. Write brief procedure note. Repeat patient exam and assessment of vital signs and perfusion of limb multiple times in recovery area. Monitor groin puncture site for hematoma. Discuss findings and treatment with family and patient (when awake). Write orders for follow-up labs, x-rays. Complete medical records. Communicate with referring physician. Provide discharge instructions. Depending on the preexisting comorbidities and operative course, the patient may require full hospital admission, overnight hospital stay, or same day discharge. The patient is transferred to the appropriate care setting when recovery area discharge criteria are met, with appropriate orders for follow-up labs, x-rays, and patient care.

SURVEY DAT	ГА								
RUC Meeting Da	ate (mm/yyyy)	02/2011							
Presenter(s):	Gary Seabro Kavinsky, M Senkowski,	ary Seabrook, MD; Robert Zwolak, MD; Sean Tutton, MD; Jerry Niedzwieck, MD; Clifford avinsky, MD; Richard Wright, MD; Ezequiel Silva, MD; Geraldine McGinty, MD; Christopher enkowski, MD; Charles Mabry, MD							
Specialty(s):	vascular sur general surg	ascular surgery, interventional radiology, interventional cardiology, radiology, cardiology, eneral surgery							
CPT Code:	36247	36247							
Sample Size:	970	Resp N:	74	Response	: 7.6 %				
Sample Type: Random Additional Sample Information:									
		Low	25 th %	Median*	75th %	High			
Service Performance Rate			0.00	10.00	20.00	50.00	200.00		
Survey RVW:			3.20	5.41	7.00	8.88	14.00		
Pre-Service Evaluation Time:					40.00				
Pre-Service Posit	ioning Time:				10.00				
Pre-Service Scrul	b, Dress, Wait 1	Time:			15.00				
Intra-Service Ti	me:		15.00	40.00	60.00	75.00	120.00		
Immediate Post	Service-Time	e: <u>30.00</u>							
Post Operative	Visits	Total Min**	CPT Code	and Numbe	er of Visits				
Critical Care tim	ne/visit(s):	<u>0.00</u>	99291x 0.0	0 99292x	0.00				
Other Hospital t	time/visit(s):	<u>0.00</u>	99231x 0.0	9 9232x	0.00 99233x	0.00			
Discharge Day I	Mgmt:	<u>0.00</u>	99238x 0.0	0 99239x 0 .	00				
Office time/visit	(s):	0.00	99211x 0.0	00 12x 0.00 1	3x 0.00 14x 0.0	0 15x 0.00			
Prolonged Serv	ices:	<u>0.00</u>	99354x 0.0	00 55x 0.00	56x 0.00 57x	0.00			
Sub Obs Care:		0.00	99224x 0.0	9 9225x	0.00 99226x	0.00			

**Physician standard total <u>minutes per E/M visit</u>: 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: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT 36247		Recommended Physician Work RVU: 7.00					
Code:							
		Specialty Recommended	Specialty Becommonded	Adjustments to			
		Pre-Service Time	Pre Time Package	Pre-Service Time			
Pre-Service Evaluation Time:		33.00	33.00	0.00			
Pre-Service Positioning Time:		3.00	1.00	2.00			
Pre-Service Scrub, Dress, Wait	Time:	5.00	5.00	0.00			
Intra-Service Time:		60.00					
Immediate Post Service-Tim	e: <u>30.00</u>						
Post Operative Visits	Total Min**	CPT Code and Number of Visits					
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 992	292x 0.00				
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 992	232x 0.00 99233x	. 0.00			
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0 99239x 0.0					
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0	.00 13x 0.00 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 0.00 992	225x 0.00 99226x	0.00			

KEY REFERENCE SERVICE:									
Key CPT Code 32550	<u>Global</u> 000		<u>W</u>	<u>Vork RVU</u> 4.17	<u>Time Source</u> RUC Time				
CPT Descriptor Insertion of indwelling tunneled pleural catheter with cuff									
KEY MPC COMPARISON	N CODES:								
Compare the surveyed code appropriate that have relative	to codes on values high	the RUC's MPC er and lower than t	List. Reference the requested rela	codes from the tive values for t	e MPC list should be cho the code under review. Most Recent	sen, if			
MPC CPT Code 1	Global	Work RVU	Time Source	Med	dicare Utilization				
58560	000	6.99	RUC Time		72				
CPT Descriptor 1 Hysterosco	py, surgical	; with division or r	resection of intrau	iterine septum (any method)				
					Most Recent				
MPC CPT Code 2	<u>Global</u>	Work RVU	Time Source	Me	edicare Utilization				
31600	000	7.17	RUC Time		41,800				
<u>CPT Descriptor 2</u> Tracheostomy, planned (separate procedure);									
Other Reference CPT Code	<u>Global</u>	Work R	<u>VU</u> <u>Time</u>	Source					
34812	000	6.74	RUC 1	Гіте					

CPT Descriptor Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral

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

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

Number of respondents who choose Key Reference Code: 5

% of respondents: 6.7 %

<u>TIME ESTIMATES (Median)</u>	CPT Code: 36247	Key Reference CPT Code: <u>32550</u>	Source of Time RUC Time
Median Pre-Service Time	41.00	40.00	
Median Intra-Service Time	60.00	30.00	
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	131.00	90.00	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

(of those that selected Key Reference code)

<u>Mental Effort and Judgment (Mean)</u>		
The number of possible diagnosis and/or the number of	4.20	4.00
management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests,	4.00	3.80
and/or other information that must be reviewed and analyzed		
[]		
Urgency of medical decision making	3.80	3.20
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.20	3.40
Physical effort required	3.60	3 20
	5.00	5.20
<u>Psychological Stress (Mean)</u>		
The risk of significant complications, morbidity and/or mortality	4.20	3.60
Outcome depends on the skill and judgment of physician	4 20	3 40
Sucome depends on the skin and judgment of physician	4.20	5.40
Estimated risk of malpractice suit with poor outcome	3.80	3.60
INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference
		Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.80	3.80
Intra-Service intensity/complexity	4.00	3.60
De et Comine intervier/community	2.00	2.00
Post-Service intensity/complexity	3.00	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.

Why is this code being reviewed?

Code 36247 was identified as part of the 4th Five-Year Review by CMS. The RUC requested that CMS consider a change from XXX global to 000 global period. CMS agreed and code 36247, which is Harvard based, was surveyed with a 000-global period.

Compelling Evidence

1. Harvard valued by radiology – tied to radiology codes with a global of XXX (non-invasive procedure codes). The global period change and the addition of moderate sedation as inherent recognize additional physician work for this invasive procedure.

2. Significant change in specialty providing service from radiology to vascular surgery and cardiology

3. Significant change in patient population and physician work. The procedures that remain in 36247 after creation of the LER codes (catheterization of the mesenteric vessels and renal vessels), are inherently more complex. The caliber of the vessels is smaller than the iliac and SFA and the end organs are much more susceptible to the complication of thrombo-embolic injury.

Change in Work

The expert panel reviewed the survey and work understanding that a majority of the selective catheterizations of the iliac, SFA, and tibials are now extracted from 36247. The expert panel does not believe that respondents acknowledged the impact on 36247 of the new LER codes, given they were so recently created. In fact, this survey was conducted before the LER codes were published (January 2011). Only thirteen percent of the respondents indicated that there has been a change in work over the past five years. However, this statistic is misleading because of the new bundled codes for lower extremity vascularization that have changed the patient population and work represented by 36246. Even so, 37% of the respondents indicated that the work had changed - more work – which is reflective of the more complex patients undergoing this procedure. The remaining procedures performed and reported with 36247, as exemplified by the vignette, would be catheterization of the mesenteric vessels and renal vessels which is inherently more complex. The caliber of the vessels is smaller than the iliac and SFA and the end-organs are much more susceptible to the complication of thrombo-embolic injury. Catheterization of second and third order branches of the mesentery has a definite higher failure rate than the lesser catheterizations reflecting the incrementally difficult nature of this work

Work RVU Recommendation

We are recommending the survey median work RVU of 7.00 for code 36247.

<u>Pre-time</u>

Pre-time package 2b [Difficult Patient/Straightforward Procedure (With sedation/anesthesia care)] is appropriate, with the following modifications to the positioning package time. The societies request an additional 2 minutes of positioning time to account for placement of fluoro compatible arm boards and safety restraints to prevent patient from falling off narrow angiography table, and due to the need for orientation and test imaging of the angiographic field of interest. Radio-opaque material in the field must be repositioned prior to sterile draping.

Comparison to Key Reference Code - 32550

Work Comparison with Key Reference

Key reference code 32550 (placement of indwelling tunneled peritoneal catheter) is inherently less complex, and less intense than 36247 with 30 minutes less intra time. The difference in pre-time can be accounted for by the fact that 32550 was surveyed prior to standardized pre-time packages. Both codes include moderate sedation as inherent. The survey's comparative intensity measures were much greater than the reference code supporting a higher RVW for 36247 compared with 32550.

	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	Post
36247	7.00	0.091	131	33	3	5	60	30
32550	4.17	0.101	90	15	10	15	30	20

Comparison to MPC Codes

Comparison with MPC Code 1, CPT 58560

MPC code 58560 (Hysteroscopy with surgical division of intrauterine septum) is a low volume 000-day global code, but has the same intra time and almost identical work RVU. The difference in pre-time can be accounted for by the fact that 58560 was surveyed prior to standardized pre-time packages. Moderate sedation is inherent for code 36247, but not for 58560.

Comparison with MPC Code 2, CPT 31600

MPC code 31600 (Open tracheostomy) requires 20 minutes less intra time and would require more overall time, reflected in the higher work RVU, a differential that well understood by the surgical colleagues in our multi-specialty consensus group. The additional pre-time for general anesthesia and post-time are offset by the difference in intra-time, making the similarity in work RVU appropriate in terms of total physician work.

	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	Post
58560	6.99	0.092	125	40			60	25
36247	7.00	0.091	131	33	3	5	60	30
31600	7.17	0.114	156	50			40	66

Comparison to other reference code - 34812

Code 34812 (Open femoral artery cut-down for delivery of endovascular prosthetic device) is performed frequently by vascular surgeons. It compares favorably to 36247 with less intra time and corresponding lower work RVU. The vascular surgeons and IRs performing endograft repair of aneurysms have a large experience with these codes allowing confident comparison.

	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	Post
36247	7.00	0.091	131	33	3	5	60	30
34812	6.74	0.098	150	75			45	30

<u>Summary</u>

Based on all the above data and comparisons, we believe the recommended survey median work RVU of 7.00 for 36247 is justified.

Additional requested statistics

СРТ		Min	5th%	25th%	Med	75th%	95th%	Max	Arith Mean	Geo Mean	Mode
26247	Work RVU	3.20	3.80	5.41	7.00	8.88	11.70	14.00	7.46	6.96	8.00
36247	Intra Time	15	20	40	60	75	90	120	60	53	60

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

CPT Code: 36247
Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Appropriate radiological S&I code would be reported separately (eg, 75726).

Professional Liability Insurance Information (PLI)

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

If no, please select another crosswalk and provide a brief rationale. 36247

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

Compelling Evidence

The RUC operates with the initial presumption that the current values assigned to the codes under review are correct. The argument for a change must be substantial and meet the RUC's compelling evidence standards listed in the Instructions Document. Please list your compelling evidence below (if appropriate).

1. Harvard valued by radiology – tied to radiology codes with a global of XXX (non-invasive procedure codes). The global period change and the addition of moderate sedation as inherent recognize additional physician work for this invasive procedure.

2. Significant change in specialty providing service from radiology to vascular surgery and cardiology

3. Significant change in patient population and physician work. The procedures that remain in 36246 after creation of the LER codes (catheterization of the mesenteric vessels and renal vessels), are inherently more complex. The caliber of the vessels is smaller than the iliac and SFA and the end organs are much more susceptible to the complication of thrombo-embolic injury.

Five-Year Review Specific Questions

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

Has the work of performing this service changed in the past 5 years? Yes 20% No 80% A. This service represents new technology? Yes 11% No 89%

Of survey respondents, who said yes, the new technology affected the work: Less Work: 13% Same Work: 38% More Work: 50%

B. This service reflects new technology that has become more familiar: Yes 11% No 89%

C. Patients requiring this service are now: More complex (more work) 36% Less complex (less work) 0% No change in complexity 64%D. The typical site-of-service has changed:

From outpatient to inpatient 1% From inpatient to outpatient 5% No change 93%

A	В	С	D	E	F	G	Н	I	J	К
1 Vascular Injection Procedures			362	200	362	245	36	246	362	247
	1		Selective	catheter	Selective	catheter	Selective cathe	eter placement,	Selective cathe	ter placement,
	1		placemer	nt, arterial	placement, ar	terial system;	arterial system	; initial second	arterial system	n; initial third
	1		system; eac	n tirst order	each first orde	er abdominal,	order abdomi	inal, pelvic, or	abdominal pelvic or lower	
			abdominal	, peivic, or	pervic, or lower extremity		branch, within a vascular		extremity artery branch	
			branch with	in a vascular	vascula	r family	family		within a vas	cular family
2		MS Code	fan	nily	vascula	y		<i>y</i>		i Gilliny
				•	l		l			
			Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac
			000				000		000	000
	<u> </u>	1	000	000	<u> </u>	<u> </u>	000	000	000	000
			158	0	244	3	188	3	218	3
6 PRE-SERV CLINICAL LABOR TIME		RN/LPN/WITA	6	0	6	0	6	0	6	0
	L041B	RI	0	0	0	0	0	0	0	U
8 SERVICE PERIOD CLINICAL LABOR TIME	L041B	RI	8		8		8		8	-
9 SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	92	0	135	0	107	0	122	0
10 SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	49	0	92	0	64	0	79	0
11 POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	3	0	3	3	3	3	3	3
12 POST-SERV CLINICAL LABOR TIME	L041B	RT	0	0	0	0	0	0	0	0
13 POST-SERV CLINICAL LABOR TIME	L051A	RN	0	0	0	0	0	0	0	0
14 PRE-SERVICE										
15 Start: After visit when decision for procedure										
16 Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3		3		3		3	
17 Coordinate pre-surgery services	L037D	RN/LPN/MTA	3		3		3		3	
18 Schedule space and equipment in facility	ח מין									
Provido pro-convice education/obtain concert							┠			
20 Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3		3		3		3	
21 Other Clinical Activity:										
22 End: When pt enters site for procedure										
23 SERVICE PERIOD										
24 Start: When pt enters site for procedure										
25 Pre-service	1									
Greet patient, provide gowning, ensure appropriate			_		_		_		-	
26 medical records are available	L037D	KN/LPN/MTA	3		3		3		3	
27 Obtain vital signs	L037D	RN/LPN/MTA	5		5		5		5	
28 Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	5		5		5		5	
29 Prepare room, equipment, supplies	L041B	RT	4		4		4		4	
30 Prepare and position pt/ monitor pt/ set up IV	L041B	RT	2		2		2		2	
31 Sedate/apply anesthesia	L051A	RN	2		2		2		2	
32 Intra-service			_		_					
33 Assist MD in performing procedure	L051A	RN	30		73		45		60	
34 Post-Service										
Monitor pt_after moderately sedated service: check										
tubes monitors drains [For procedure in artery, 240	I 051A	RN	60		60		60		60	
35 minute total recovery time 1									00	
36 Clean room/equipment by physician staff	I 041B	RT	3		3		3		3	
27 Clean Surgical Instrument Package			5		5				5	
38 Complete diag forms, lab & X-ray requisitions										
39 Review/read X-ray, lab, and pathology reports										
Check dressings & wound/ home care instructions	I 037D		3		3		3		3	
40 /coordinate office visits /prescriptions	20072		Ű		Ŭ		<u> </u>			
41 Dischg day mgmt										
Other Clinical Activity: Pre-procedure doppler check			2		2		2		2	
42 in addition to initial vitals	LUSID		3		3		3		3	
43 Other Clinical Activity:										
44 End: Patient leaves office										
45 POST-SERVICE Period										
46 Start: Patient leaves office/facility										
Conduct phone calls/call in prescriptions 3 minutes	1.0077		_		_	_		_	~	^
47 added to facility for surgicals	L037D	KN/LPN/MTA	3		3	3	3	3	3	3
48 Office visits:										
49 List Number and Level of Office Visits										
50 99211 16 minutes	16									
51 99212 27 minutes	27									
52 99213 36 minutes	36									
53 99214 53 minutes	53									
54 99215 63 minutes	63									
55 Other	1									
00										
57 Total Office Visit Time										
58 Other Activity (please specify)										
59 End: end of global period										
60 MEDICAL SUPPLIES							ľ			
61 pack, minimum multi-specialty visit	SA048	pack	1		1		1		1	
62 gown, surgical, sterile	SB028	item	2		1		1		1	
63 gloves, sterile	SB024	pair	2		1		1		1	
64 mask, surgical, with face shield	SB034	item	2		2		2		2	
65 cap, surgical	SB002	item	2		2		2		2	
66 shoe covers, surgical	SB039	pair	2		2		2		2	
67 tray, shave prep	SA067	tray	1		1		1		1	
68 underpad 2ftx3ft (Chux)	SB044	item	2		1		1		1	
69 drape, sterile, femoral	SB009	item	1		1		1		1	
70 drape-towel, sterile 18inx26in	SB019	item	4		4		4		4	
71 povidone soln (Betadine)	SJ041	ml	60		60		60		60	
72 applicator, sponge-tipped	SG009	item	4		4		4		4	
73 lidocaine 1%-2% ini (Xvlocaine)	SH047	ml	10		10		10		10	
74 syringe w-needle. OSHA compliant (SafetvGlide)	SC058	item	2		2		2		2	
75 heparin 1.000 units-ml ini	SH039	ml			5		5		5	
76 sodium chloride 0.9% flush svringe	SH065	item			2		2		2	
77 closed flush system. angiography	SC010	item	1		1		1		1	
78 catheter, angiographic, pig-tail	SC008	item	1		1		1		1	

	A	В	С	D	E	F	G	Н	I	J	K	
1	Vascular Injection Procedures			362	200	362	245	36	246	36	247	
				Selective	e catheter	Selective	e catheter	Selective catheter placement		Selective catheter placement		
				placemer	nt, arterial	placement, ar	placement, arterial system;		arterial system; initial second		arterial system; initial third	
				system; eac	ch first order	each first ord	er abdominal,	order abdom	inal, pelvic, or	order or mo	re selective	
				abdomina	l, pelvic, or	pelvic, or lov	ver extremity	lower extre	emity artery	abdominal, p	elvic, or lower	
				lower extre	emity artery	artery bran	ch, within a	branch, with	in a vascular	extremity ar	tery branch,	
				branch, with		vascula	ir family	Tar	niiy	within a vas	cular family	
2		C	MS Code	Tan	niiy				1			
	LOCATION			Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	
3												
4	GLOBAL PERIOD	<u> </u>		000	000	XXX	XXX	000	000	000	000	
79	blade, surgical (Bard-Parker)	SF007	item	1		1		1		1		
80	kit, AccuStick II Introducer System with RO Marker	SA071	kit	1		1		1		1		
81	guidewire, hydrophilic (Glidewire)	SD089	item			1		1		1		
82	guidewire, cerebral (Bentson)	SD172	item			1		1		1		
83	guidewire (Transcend)	SD175	item							1		
84	microcatheter (Mass Transit)	SD154	item							1		
85	catheter (SIM2F1)	SD141	item			1		1		1		
86	steri-strip (6 strip uou)	SG074	item	2		1		1		1		
87	gauze, sterile 4in x 4in	SG055	item	6		2		2		2		
88	tape, surgical paper 1in (Micropore)	SG079	item			6		6		6		
89	Equipment - post procedure observation only											
90	exam lamp	EQ168		40		83		55		70		
91	stretcher chair	EF019		0		0		0		0		
92	Angiographic room minutes	EL011		40		83		55		70		
93	infusion pump	EQ032		272		315		287		302		
94	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011		272		315		287		302		
95	pulse oxymetry recording software (prolonged monitoring)	EQ212		0		0		0		0		
96	table, instrument, mobile	EF027		272		315		287		302		

	A	В	C	D	E	F	G	Н	I	J	K
1	Vascular Injection Procedures			362	200	362	245	36	246	36	247
				Selective	catheter	Selective	catheter	Selective cathe	eter placement,	Selective cathe	eter placement,
				placemen	nt, arterial	placement, ar	terial system;	arterial system	; initial second	arterial syste	m; initial third
				system; eac	h first order	each first orde	er abdominal,	order abdominal, pelvic, or		abdominal pelvic or lowe	
				abdominal	, peivic, or	peivic, or low	ver extremity	branch, within a vascular		abdominal, pe	eivic, or lower
				branch with	in a vascular	vascula	vascular family		family		cular family
2			MS Code	fan	nilv	Vascula	li ianny		illy illy	within a vas	
2					···· y				[
2	LOCATION			Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac
3				000	000	VVV	vvv	000	000	000	000
-				122	000	175	2	147	000	162	000
5				132	0	175		147	 	102	3
7	PRE-SERV CLINICAL LABOR TIME	L037D	DT	6	0	6	0	6	0	6	0
8			RN	30	0	73	0	45	0	60	0
q				13	0	13	0	13	0	13	0
10	POST-SERV CLINICAL LABOR TIME			3	0	3	3	3	3	3	3
11	POST-SERV CLINICAL LABOR TIME	L037 D	RT	3	0	3	0	3	0	3	0
12	POST-SERV CLINICAL LABOR TIME		RN	60	0	60	0	60	0	60	0
13		200171									•
14	Start: After visit when decision for procedure										
15	Complete pre-service diagnostic & referral forms	1 037D	RN/I PN/MTA	3		3		3		3	
10	Coordinate pre-surgery services			2		2		2		2	
16)		<u>з</u>		S		S	
17		L037D	KN/LPN/MTA								
18	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA								
19	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3		3		3		3	
20	Other Clinical Activity:										
21	End: When pt enters site for procedure										
22	SERVICE PERIOD										
23	Start: When pt enters site for procedure										
24	Pre-service										
	Greet patient, provide gowning, ensure appropriate	1 0270		2							
25	medical records are available			5		3		5		3	
26	Obtain vital signs	L037D	RN/LPN/MTA	5		5		5		5	
27	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	5		5		5		5	
28	Prepare room, equipment, supplies	L041B	RT	4		4		4		4	
29	Prepare and position pt/ monitor pt/ set up IV	L041B	RT	2		2		2		2	
30	Sedate/apply anesthesia	L051A	RN	2		2		2		2	
31	Intra-service										
32	Assist MD in performing procedure	L051A	RN	30		73		45		60	
33	Post-Service										
	Monitor pt. after moderately sedated service: check		DN	CO		60		<u>co</u>		<u> </u>	
24	minute total recovery time 1	LUSTA	RN	60		00		60		00	
34	Close ream/equipment by physician staff		рт	2		2		2		2	
35	Clean Formed Instrument Deckage		K I	ు		3		S		3	
36											
37	Complete diag forms, lab & X-ray requisitions										
38	Review/read X-ray, lab, and pathology reports										
	Check dressings & wound/ home care instructions			3		3		3		3	
39	/coordinate office visits /prescriptions	LUSID		5		5		5		5	
40	Dischg day mgmt										
	Other Clinical Activity: Pre-procedure doppler check			2		2		2		2	
41	in addition to initial vitals			ు		3		3		3	
42	Other Clinical Activity:										
43	End: Patient leaves office										
44	POST-SERVICE Period										
45	Start: Patient leaves office/facility										
	Conduct phone calls/call in prescriptions 3 minutes	L037D	RN/LPN/MTA	3		3	3	3	3	3	3
46	added to facility for surgicals	-		-		-	-	-	-	-	-
47											
48	List Number and Level of Office Visits	10									
49		10 27						l			
50	99213 36 minutes	21									
57	99214 53 minutes	53									
52	99215 63 minutes	63			<u> </u>		<u> </u>	l			
54	Other							l	<u> </u>		
55											
56	Total Office Visit Time										
57	Other Activity (please specify)										
58	End: end of global period										
59	MEDICAL SUPPLIES										
60	pack, minimum multi-specialty visit	SA048	pack	1		1		1		1	
61	gown, surgical, sterile	SB028	item	2		1		1		1	
62	gloves, sterile	SB024	pair	2		1		1	ļ	1	
63	mask, surgical, with face shield	SB034	litem	2		2		2		2	
64	Icap, surgical	SB002	Item	2		2		2		2	
65	snoe covers, surgical	28039	pair	2		2		2		2	
66	uray, snave prep	SAUGT	tray					1		1	
0/	drane sterilo fomoral	30044 80000	item	<u> </u>				1		1	
00 03	drape-towel sterile 18inv26in	SB009	item	<u> </u>		і л		і Л			
70	novidone soln (Retadine)	S 10/1	ml	+ 03		+ 60		4 60		4 60	
71	applicator sponge-tipped	SGNNO	item	4		<u> </u>		<u> </u>		<u> </u>	
72	lidocaine 1%-2% ini (Xvlocaine)	SH047	ml	10				10		10	
73	syringe w-needle. OSHA compliant (SafetvGlide)	SC058	item	2		2		2		2	
74	heparin 1,000 units-ml ini	SH039	ml	-		5		5		5	
75	sodium chloride 0.9% flush svringe	SH065	item			2		2		2	
76	closed flush system, angiography	SC010	item	1		1		1		1	
77	catheter, angiographic, pig-tail	SC008	item	1		1		1		1	
78	blade, surgical (Bard-Parker)	SF007	item	1		1		1		1	

	A	В	С	D	E	F	G	Н		J	К
1	Vascular Injection Procedures			362	200	36	245	36	246	362	247
				Selective	catheter	Selective	e catheter	Selective cath	eter placement,	, Selective catheter placement,	
				placemer	nt, arterial	placement, ar	terial system;	arterial system; initial second		arterial system; initial third	
				system; eac	h first order	each first ord	er abdominal,	order abdom	inal, pelvic, or	order or mo	ore selective
				abdomina	l, pelvic, or	pelvic, or lov	ver extremity	lower extre	emity artery	abdominal, p	elvic, or lower
				lower extre	emity artery	artery bran	ch, within a	branch, with	in a vascular	extremity ar	tery branch,
				branch, with	in a vascular	vascula	ir family	fai	nily	within a vas	cular family
2		C	MS Code	fan	niiy				-		
	LOCATION			Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac
3					1 40		1 40		1 40	Non i do	1 40
4	GLOBAL PERIOD			000	000	XXX	XXX	000	000	000	000
79	kit, AccuStick II Introducer System with RO Marker	SA071	kit	1		1		1		1	
80	guidewire, hydrophilic (Glidewire)	SD089	item			1		1		1	
81	guidewire, cerebral (Bentson)	SD172	item			1		1		1	
82	guidewire (Transcend)	SD175	item							1	
83	microcatheter (Mass Transit)	SD154	item							1	
84	catheter (SIM2F1)	SD141	item			1		1		1	
85	steri-strip (6 strip uou)	SG074	item	2		1		1		1	
86	gauze, sterile 4in x 4in	SG055	item	6		2		2		2	
87	tape, surgical paper 1in (Micropore)	SG079	item			6		6		6	
88	Equipment - post procedure observation only										
89	exam lamp	E30006		101		144		116		131	
90	stretcher chair	EF019		101		144		116		131	
91	Angiographic room minutes	E51082		41		84		56		71	
92	infusion pump	E91001		41		84		56		71	
93	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011		101		144		116		131	
94	pulse oxymetry recording software (prolonged monitoring)	EQ212		101		144		116		131	
95	table, instrument, mobile	EF027		41		84		56		71	

AMA/Specialty Society RVS Update Committee Summary of Recommendations Fourth Five-Year Review and Site of Service Anomaly Screen

February 2011

Open Arteriovenous Anastomosis

In September 2007, the RUC's Relativity Assessment Workgroup identified CPT codes 36821 and 36825 as potentially misvalued through the Siteof-Service Anomaly screen. In 2008, the American College of Surgeons (ACS) and Society for Vascular Surgery (SVS) conducted a RUC survey for these services. The specialty societies indicated and the RUC agreed that code 36821 is not an inpatient service. In February 2009, the specialties presented code 36825 using a modified RUC survey instrument that included a question regarding site-of-service and visits on the day of the procedure. Following the RUC's recommendation, CMS included code 36821 as part of the 4th Five-Year Review and code 36825 in Table 16 of the 2011 Proposed Rule to re-review these services.

36821 Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure)

The RUC reviewed the previous rationale and physician work survey data for CPT code 36821. The RUC noted that, in 2008, the RUC recommended the median survey work RVU, with strong support from reference services, specialty survey data and a three-fold compelling evidence argument: 1) flawed Harvard valuation; 2) physician work for this service changed; and 3) fistula performance is now a Quality Performance Indicator. At this time, the RUC finds no additional compelling evidence to further change the current physician work value of this service.

The RUC reviewed the survey data from 32 vascular surgeons for CPT code 36821. The RUC agreed with the previous recommended pre-service time package 2B, difficult patient/straightforward procedure. At that time the specialty recommended and the RUC agreed that the positioning and scrub, dress and wait times should be slightly higher than the package to account for the additional time required to position and prepare for the procedure, due to the intricate vein mapping required to ensure the patient has adequate length and caliber donor vein conduit. The RUC agreed that the procedure requires 10 minutes of pre-service positioning time and 10 minutes of pre-service scrub dress and wait time. To justify the current value of this service, the specialty societies utilizing magnitude estimation compared code 36821 to the key reference service 36819 *Arteriovenous anastomosis, open; by upper arm basilic vein transposition* (Work RVU=14.47, intra-service time = 120 minutes). The survey respondents noted that the intensities and complexities of the key reference service and the surveyed code are nearly identical. The RUC agreed that the difference in intra-service times between the two services appropriately accounts for the work RVU difference between these two services. For further support the RUC compared code 36821 to MPC reference code 60220 *Total thyroid lobectomy, unilateral; with or without isthmusectomy* (work RVU = 12.37) and determined that the physician work is very similar and the intra-service time required to perform these services is the same, 90 minutes.

In 2008, the RUC determined that the median survey work RVU of 12.00, was justified by magnitude estimation in comparison to these reference services. CMS accepted the RUC recommended value for this service. Further, for 2010, this value was increased to 12.11 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. Therefore, based on this history

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and magnitude estimation comparisons to the reference codes, the specialty societies agree and the RUC recommends that the current value of this service be maintained.

The RUC further analyzed the site-of-service data and post-operative visit data. The specialty societies and the RUC have always agreed that code 36821 is an outpatient procedure with same-day discharge. Although the RUC agreed with the specialty societies that significant discharge work is required, the RUC's formal policy for same-day discharge coding (0.5 x 99238) should be implemented. This proxy for work in the global period does not change the physician work relative value of the service which was determined by magnitude estimation and physician specialty survey data during the last RUC review. **The RUC recommends a work RVU of 12.11 for CPT code 36821**.

36825 Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft

The RUC reviewed the previous rationale and physician work survey data for CPT code 36825. The RUC reviewed the survey results from 31 vascular and general surgeons and noted that in 2009, the RUC previously recommended the survey 25th percentile work RVU, with strong support from reference services, specialty survey data, and a two-fold compelling evidence argument: 1) flawed Harvard valuation and 2) physician work for this service changed. At this time, the RUC finds no additional compelling evidence to further change the current physician work value of this service.

The RUC considered the survey data in comparison to the MPC reference code selected by the specialty, 36819, *Arteriovenous anastomosis, open; by upper arm basilic vein transposition*, (work RVU = 14.47). The RUC agreed that the survey median work RVU of 18.00 was too high, but that the survey 25th percentile work RVU was appropriate. The RUC reviewed 36819 and noted that the reference service and the surveyed code contain identical intra-service times of 120 minutes. The specialty noted that there are two differences between 36825 and 36819 that warrant a higher RVU for 36825: 1) Code 36825 requires a vein that is harvested from a remote location. As a result, it requires two anastomoses, one where the vein is sewn to the inflow artery and a second where it is attached to the outflow vein. 2) Code 36825 includes an additional 99213 office visit. As a result, the RUC agreed that the survey 25th percentile work RVU of 15.00 for 36825 was appropriate in comparison to 36819. Further, for 2010, this value was increased to 15.13 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. Therefore, based on this history and magnitude estimation comparisons to the reference codes, the specialty societies agree and the RUC recommends that the current value of this service be maintained.

The RUC further analyzed the site-of-service data and post-operative visit data. According to the survey, the typical patient undergoes this procedure in the hospital (100%), is admitted or stays at least overnight in the hospital following surgery (74%) and received an Evaluation and Management service on the same date (61%). Given this data, the RUC enacted its policy to allocate the appropriate proxy for post-operative visits. Importantly, the RUC noted that the work involved in monitoring the typical patient post-operatively on the day of surgery is the same Evaluation and Management work whether the patient's status ends up inpatient or outpatient. Adjustments to the allocation of post-operative visits are used as proxies and do not constitute changes to the physician work relative value of the service which was determined by magnitude estimation and physician specialty survey data during the last RUC review. **The RUC recommends a work RVU of 15.13 for CPT code 36825.**

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
36821	Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure)	090	12.11 (No Change)
36825	Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft	090	15.13 (No Change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code:36821 Tracking Number

Original Specialty Recommended RVU: 12.11 Presented Recommended RVU: 12.11 RUC Recommended RVU: 12.11

Global Period: 090

CPT Descriptor: Arteriovenous anastomosis, open; direct, any site (e.g. Cimino type) (separate procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 38-year-old, diabetic female requires hemodialysis for chronic renal failure due to diabetic nephropathy. Duplex ultrasound vein mapping demonstrates that the only vein of adequate size to perform a traditional arteriovenous Cimino-type fistula lies at the antecubital fossa. A direct brachial artery to cephalic vein arteriovenous fistula is recommended and performed adjacent to the antecubital skin crease

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? 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: Select and order the appropriate antibiotic(s) and confirm timing and administration. Assure appropriate selection, timing, and administration of DVT prophylaxis. Assess need for beta-blockers, order as required. Review preadmission work-up, with particular attention to potential cardiovascular risk factors, electrolytes, BUN, creatinine etc. in the ESRD patient. Reexamine patient to make sure that physical findings have not changed and update H&P. Meet with patient and family to review planned procedure and post-operative management. Review and obtain informed consent. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available Duplex vein mapping studies are reviewed to ensure patient has adequate length and caliber donor vein conduit, and discussions are held with OR nurses regarding appropriate draping to expose vein donor site and the implantation site. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Incise skin in antecubital region over artery and vein using curvilinear incision to minimize morbidity. Carefully dissect subcutaneous tissue until artery and vein are located. Ligate and divide all vein branches. Continue to carefully dissect until vein is free. Carefully dissect soft tissue surrounding artery. Pass soft rubber loops around vein for control. Pass soft rubber loops around artery for control. Administer intravenous anticoagulant (e.g. heparin) and wait for circulation. Ligate and divide vein, ensuring that sufficient length is present to reach artery while preventing twist. Extend vein to overlie artery. Apply vascular clamps to artery. Perform longitudinal arteriotomy. Bevel vein to match length of arteriotomy creating a cobra-head-shape. Suture anastomosis with fine vascular suture. Flush

CPT Code: 36821

anastomosis with proximal and distal bleeding before removing clamps. Place extra sutures as needed to stop leaks, remove clamps, and evaluate flow signals with Doppler. Irrigate wound with saline. Achieve final hemostasis. Irrigate with sterile saline and close subcutaneous tissue. Close skin incision. Evaluate distal and proximal pulses with Doppler. Perform neurovascular check of hand to ensure adequate perfusion.

Description of Post-Service Work:

Hospital: Apply sterile dressings. Monitor patient during reversal of anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s).

Depending on the preexisting comorbidities and operative course the patient may require full hospital admission, overnight hospital stay, or same day discharge. The patient is transferred to the appropriate care setting when recovery area discharge criteria are met.

If the patient is admitted to hospital or is required to remain in the facility overnight, an E&M service is provided at the end of the work day to assure that the patient is hemodynamically stable, to assess neurovascular status of the hand on the limb where the hemoaccess was created, and to assure there is no significant bleeding from either the arterial or venous anastomosis. Blood test evaluation and discussion with the nephrologist regarding need for hemodialysis is also typical.

Hospital Discharge Management: Review interval chart notes. Evaluate vital signs and intake/output. Discharge work also includes review of interval chart notes, a full neurovascular evaluation of the extremity, wound evaluation for potential hemorrhage, fistula evaluation to ensure patency, glycemic assessment, physical exam to ensure the IV fluid administered by anesthesia has not pushed patient into CHF, provision of wound care instructions, provision of warnings for vascular steal syndrome and/or vascular compromise of the hand, ensuring arrangements are made to reestablish outpatient hemodialysis, and finalization of many other details for this very sick subset of typically diabetic renal failure patients. Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy. Write prescriptions for medications needed post-discharge. Home restrictions and activity levels (ie, diet, bathing) are discussed with the patient, family members and discharging nurse. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Post-op Office Visits: Review interval chart notes. Examine and talk with patient. Remove staples or sutures and drain, when appropriate. Review activity and restrictions. Check for presence of post-operative hematoma/seroma and assess need for aspiration. Check for patency of fistula and adequacy of blood flow to hand. Write medication prescriptions. Post discharge labs/films are ordered and reviewed. Discuss progress with referring physician(s) (verbal and written). Dictate progress notes for medical chart. Review activity permission with patient and write appropriate permission.

SURVEY DAT	ГА						
RUC Meeting Da	ate (mm/yyyy)	02/2011					
Presenter(s):	Christopher S FACS, Robe	Senkowski, MD rt Zwolak, MD I	FACS; Cł FACS	narles Mabry	y, MD FACS;	; Gary Seabro	ook, MD
Specialty(s):	General Surç	jery, Vascular S	Surgery				
CPT Code:	36821						
Sample Size:	150 F	Resp N:	32	Respo	onse: 21.3 %	0	
Sample Type:	Random	Additional Sa	mple Info	rmation:			
			Low	25 th pctl	Median*	75th pctl	High
Service Perform	nance Rate		0.00	6.00	11.00	25.00	150.00
Survey RVW:			9.00	11.25	12.00	12.00	20.00
Pre-Service Evalu	uation Time:				45.00		
Pre-Service Posit	tioning Time:				10.00		
Pre-Service Scru	b, Dress, Wait T	ime:			15.00		
Intra-Service Ti	me:		45.00	60.00	90.00	90.00	150.00
Immediate Post	Service-Time	<u>20.00</u>					
Post Operative	<u>Visits</u>	Total Min**	CPT Cod	e and Num	ber of Visit	t <u>s</u>	
Critical Care tin	ne/visit(s):	<u>0.00</u>	99291x 0	.00 99292	2x 0.00		
Other Hospital	time/visit(s):	<u>0.00</u>	99231x 0	.00 99232	2x 0.00 9	99233x 0.00	
Discharge Day	Mgmt:	<u>38.00</u>	99238x 1	. 00 99239x	0.00		
Office time/visit	t(s):	<u>55.00</u>	99211x 0	0.00 12x 2.0	0 13x 1.00 1	4x 0.00 15x	0.00
Prolonged Serv	ices:	<u>0.00</u>	99354x 0).00 55x ().00 56x 0	0.00 57x 0.0)0
Sub Obs Care:		0.00	99224x 0	0.00 99225	5x 0.00 9	99226x 0.00	

**Physician standard total <u>minutes per E/M visit</u>: 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: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	36821		Recommended Physician Work RVU: 12.11					
			Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time			
Pre-Service Evaluation Ti	me:		33.00	33.00	0.00			
Pre-Service Positioning T	ime:		10.00 1.00					
Pre-Service Scrub, Dress	, Wait Tim	ie:	10.00	5.00	5.00			
Intra-Service Time:			90.00					
Immediate Post Service	e-Time:	<u>20.00</u>						
Post Operative Visits		Total Min**	CPT Code and Nu	umber of Visits				
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 992	92x 0.00				
Other Hospital time/vis	it(s):	<u>0.00</u>	99231x 0.00 992	32x 0.00 99233x	.0.00			
Discharge Day Mgmt:		<u>19.00</u>	99238x 0.5 99239	× 0.0				
Office time/visit(s):		<u>55.00</u>	99211x 0.00 12x 2	.00 13x 1.00 14x 0	.00 15x 0.00			
Prolonged Services:		<u>0.00</u>	99354x 0.00 55x	0.00 56x 0.00	57x 0.00			
Sub Obs Care:		<u>0.00</u>	99224x 0.00 992	25x 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:									
<u>Key CPT Code</u> 36819	<u>Global</u> 090		W	<u>′ork RVU</u> 14.47	Time Source RUC Time				
CPT Descriptor Arteriovo	enous anastomosis	s, open; by upper	arm basilic vein	transposition					
KEY MPC COMPARIS	SON CODES:			1 6 1		1			
Compare the surveyed co appropriate that have rela	ode to codes on the ode to codes on the ode to code the ode to code the ode to code to	he RUC's MPC and lower than t	List. Reference the requested related the requested related to the requested related to the request to the request of the requ	codes from the	r the code under review.	chosen, 1f			
	U		I		Most Recent				
MPC CPT Code 1	Global V	Work RVU	Time Source	M	edicare Utilization				
60220	090	12.37	RUC Time		9,133				
CPT Descriptor 1 Total th	hyroid lobectomy.	unilateral; with	or without isthmu	sectomy					
				2	Most Recent				
MPC CPT Code 2	Global	Work RVU	Time Source	N	Iedicare Utilization				
36819	090	14.47	RUC Time		11,884				
CPT Descriptor 2 Arterio	ovenous anastomo	sis, open; by upp	er arm basilic vei	n transposition	n				

Other Reference CPT Code	<u>Global</u>	Work RVU	Time Source
37605	090	14.28	RUC Time

<u>CPT Descriptor</u> Ligation; internal or common carotid artery

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

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

Number of respondents who choose Key Reference Code: 7

% of respondents: 21.8 %

<u>TIME ESTIMATES (Median)</u>	CPT Code: 36821	Key Reference CPT Code: <u>36819</u>	Source of Time RUC Time
Median Pre-Service Time	53.00	55.00	j
Median Intra-Service Time	90.00	120.00]
Median Immediate Post-service Time	20.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	20.00	
Median Discharge Day Management Time	19.0	38.00	
Median Office Visit Time	55.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	237.00	287.00	
Other time if appropriate			
INTENSITY/COMPLEXITY MEASURES (Mean)

(of those that selected Key Reference code)

<u>Mental Effort and Judgment (Mean)</u>		
The number of possible diagnosis and/or the number of	3.00	3.14
management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests,	2.71	3.00
and/or other information that must be reviewed and analyzed		
Urgency of medical decision making	2.71	2.71
Technical Skill/Physical Effort (Mean)		
Taskaisal drill manyingd	2.57	2.96
Technical skill required	3.57	3.00
Physical effort required	3.00	3.29
Psychological Stress (Mean)		
The risk of significant complications morbidity and/or mortality	3.00	3 14
The fish of significant complications, motorally and of motality	5.00	0.11
Outcome depends on the skill and judgment of physician	3.86	3.86
Estimated risk of malnearties suit with near outcome	2 00	2.00
Estimated fisk of maipractice suit with poor outcome	5.00	5.00
INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference
		<u>Service 1</u>
Time Segments (Mean)		
Pre-Service intensity/complexity	3.00	3 1/
Tie-Service intensity/complexity	5.00	0.14
Intra-Service intensity/complexity	3.29	3.71
Dest Service intersity/comments	2.96	2.00
rost-service intensity/complexity	2.00	5.00

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.*

Why is 36821 being Considered by the RUC Again?

April 2007: 36821 (creation of a native arteriovenous hemodialysis fistula) was identified by a site-of-service screen because Harvard inputs included an inpatient visit, but only 22-27% (depending on year) are reported as inpatient.

January 2008: RUC considered this code, agreed that compelling evidence existed for consideration of a new value, agreed that it is <u>not</u> an inpatient service, agreed on recommendation of 12.00 RVW, and agreed on one full 99238 discharge visit due to patient complexity. Code 36821 was then pulled due to disagreement regarding a different code in the family.

April 2008: RUC considered this code, agreed that compelling evidence existed for consideration of new value, agreed that it is <u>not</u> an inpatient service, agreed on recommendation of 12.00 RVW, and agreed on one full 99238 discharge visit due to patient complexity.

April 2008 RUC minutes state: "A full 99238 is appropriate given the intensity of discharge duties." See below for rationale.

November 2008: CMS 1402-FC 2009 Medicare Physician Fee Schedule Final rule display copy page 889 states 36821 AMA-RUC recommendation 12.00 RVUs, CMS Decision-Agree. 2009 work RVU = 12.00

April 2010 RUC Status Report on 4th 5-Year Review for 36821: "CMS 2009 claims indicate only 20% of 36821 are performed as inpatient. CMS requests re-review"

PLEASE NOTE: The presenting specialty societies have <u>never</u> recommended that 36821 is an inpatient service. In fact, each time this service was presented at the RUC we specifically stated that <u>36821 is an outpatient service</u>.

Therefore, the presenting societies request that the RUC:

- 1) Reaffirm compelling evidence as presented and approved in April 2008
- 2) Reaffirm April 2008 work RVU of 12.11 (up from original 12.00 due to E&M work adjustment)
- 3) Reaffirm that work includes a full 99238 discharge management visit as presented and approved in April 2008
- 4) Reaffirm that 36821 is not an overnight stay or 23-hour service

Five Year Review Compelling Evidence from April 2008 SoR:

1. Vascular and general surgery were systematically undervalued by Harvard: As outlined in detail by Hertzer and Noether, the Hsiao/Harvard team that developed the RBRVS failed to recognize peripheral vascular surgery as a distinct discipline.¹ The physician work RVWs for 170 vascular surgery codes were extrapolated from surveys of only two peripheral vascular operations in Harvard Phase 1 (infrarenal aortic aneurysm repair and carotid endarterectomy). Upon thorough analysis of the Harvard/Hsiao extrapolations it became clear that physicians evaluating the vascular surgery services were not even obligated to have a working knowledge of the services as a condition for participation. The lack of an adequate basis for setting relative value work units for vascular services has been a widely acknowledged problem, resulting in reconsideration of hundreds of vascular services during the first three 5-year reviews.

In the early phases of RBRVS development, peripheral vascular CPT codes were grouped with cardiac surgery. This was an especially unfortunate situation since cardiac operations (but not peripheral vascular procedures) had long been targets of critics who felt they were overcompensated. As a result, RVU assignments resulted in major reductions in Medicare payment, and there were many rank order anomalies. As an example of an overt rank order anomaly within the initial vascular RVWs, elective repair of an infrarenal aortic aneurysm extending into the iliac arteries and requiring a bifurcated prosthesis was assigned a lower RVW than tube graft repair of an aneurysm isolated to the infrarenal aorta.

Much the same is true for general surgery. The American College of Surgeons was not a participant in the Harvard studies that form the foundation of RBRVS. General surgery has therefore been working for 15-years, through three 5-year review processes to achieve parity. General surgeons have submitted literally hundreds of services for review in the five-year process, and it has been acknowledgment during each review that general surgery services were undervalued during the Harvard studies. The current service, 36821, is performed by general surgeons and vascular surgeons. While the RUC database states that this service was considered in 1995 during the first 5-year review, the service did not

¹ Hertzer NR, Noether MG. The resource-based relative value scale in vascular surgery. A report of the activities of the Joint Council of the Society for Vascular Surgery and the North American Chapter of the ISCVS. J Vasc Surg 1993; 18:692-701.

CPT Code: 36821 undergo RUC survey. Only very sketchy details are presented under RUC rationale. We propose that 36821 has not undergone RUC survey and that it meets the compelling evidence threshold to be considered from a 5-year review perspective.

2. The work of this service has changed. While we believe this service was not valued correctly by Harvard at the inception of RBRVS, it is also true that the work of 36821 has increased over the past decade. Numerous scientific publications have identified native autogenous hemodialysis access (such as 36821) as providing superior patency and greater protection against infection in ESRD patients. This has become so important to CMS that the Agency created the Fistula First Breakthrough Initiative (FFBI), an entity that has been extremely influential in pushing surgeons to perform native autogenous access in an increasing percentage of dialysis patients. The end result is that surgeons are performing more and more complex fistula operations to meet the CMS FFBI mandate. In earlier times, surgeons would perform native dialysis fistulas only in the healthiest patients who were found to have large veins and normal arteries. Currently, smaller and more diseased veins and arteries are being used to create native fistulas. This is reflected in greater skin-to-skin operative times and greater levels of complexity.

3. Fistula performance is now a Quality Performance Indicator. As indicated in the K-DOQI guidelines for hemodialysis access, and with support from the Fistula First Breakthrough Initiative, performance of native hemodialysis access fistulas such as 36821 is now a formal Quality Indicator based on consideration of the National Quality Foundation. This important step will push surgeons even more towards performing an increasing percentage of native fistulas with greater emphasis on functionality of the finished product. This all translates to more time, more intensity, and therefore, more work.

IWPUT= 0.082

Based on the median survey RVW and the time and visit pattern recommended above, the IWPUT of this service is 0.082. This is typical for arterial vascular surgery of moderate intensity.

This Service Requires a Full Discharge Day

A full discharge management visit (99238) is required for this service regardless of when the patient goes home. Discharge management work includes a full neurovascular evaluation of the extremity, wound examination for potential hemorrhage, fistula evaluation to ensure patency, acceptable discharge glycemic control, physical exam to ensure the IV fluid administered by anesthesia has not pushed patient into CHF, provision of wound care instructions, provision of warnings for steal syndrome and vascular compromise of the hand, ensuring arrangements are made to reestablish outpatient hemodialysis, and finalization of many other details for this very sick typical diabetic renal failure patient. Although the RUC convention is ½ discharge day for an outpatient service performed the same day, the RUC stated very clearly that if a full discharge day is justified, it can and should be assigned. We recommend one full 99238 for this service. Data supporting this contention includes the fact that no survey respondent indicated less than a full 99238, while 10% of respondents indicated a 99239 discharge visit.

Comparison with Key Reference 36819

Code 36821 has 30 minutes less intra-time than key reference service 36819. Code 36819 has an RVW of 14.47. We recommend the median survey of 12.00 (now 12.11) which appropriately accounts for the 30 minute difference in service time. The patients are otherwise similar. The calculation follows:

30 min less intra time at IWPUT 0.082 = 2.43.

RVW of 36819 is 14.47 14.47 minus 2.43 = 12.04 = estimate of RVW for 36821 based on 36819.

Comparison with MPC 60220

Code 60220 is a partial thyroidectomy that has the same 90-minute intra-service time as 36821. RVW of 60220 is 12.37. We believe the intensity and complexity of these two operations are similar, and this MPC value provides relative support for our recommended RVW of 12.11 for 36821.

Comparison with MPC 49560 (from April 2008 RUC SoR)

Code 49560 is a 90-day global incisional hernia repair which has the same 90-minute intra-service time as 36821. RVW of 49560 is 11.92. We believe the intensity and complexity of these two services to be nearly equal, and this comparison therefore also serves to justify an RVW of 12.11 for 36821.

Comparison with all RUC-surveyed 90-day global services with 90-minute intra-service time

There are 149 RUC-surveyed 90-day global services with a 90-minute intra-service time. The median RVW for these codes is 12.31, and the 25th percentile RVW is 10.15. Based on the significant intensity and complexity of creating a native fistula in the multiply co-morbid diabetic renal failure patient, we believe that 36821 readily deserves an RVW of 12.00.

Detailed Background

CPT code 36821 was a Harvard valued code that was identified by the RUC 5YR ID WG in 2007 as potentially misvalued through a site-of-service anomaly screen. The RUC recommended 36821 be surveyed. In 2008, SVS and ACS conducted a RUC survey and presented compelling evidence to review the work RVU for 36821. The specialties presented compelling evidence that the work involved in providing 36821 has evolved. Numerous scientific publications have identified native autogenous hemodialysis access (such as 36821) as providing superior patency and greater protection against infection in ESRD patients. This has become so important to CMS that the Agency created the Fistula First Breakthrough Initiative (FFBI), an entity that has been extremely influential in urging surgeons to perform native autogenous access in an increasing percentage of dialysis patients. The end result is that surgeons are performing more and more complex fistula operations to meet the CMS FFBI mandate. In earlier times, surgeons would perform native dialysis fistulas only in the healthiest patients who were found to have large veins and normal arteries. Currently, smaller and more diseased veins and arteries are being used to create native fistulas. This is reflected in greater skin-to-skin operative times and greater levels of complexity. Lastly, the specialties presented evidence that fistula performance is now a Quality Performance Indicator. This will push surgeons even more towards performing an increasing percentage of native fistulas with greater emphasis on functionality of the finished product, which results in greater time, intensity, and work. The RUC agreed that compelling evidence to review 36821 exists.

Only 47% of the survey respondents indicated a separate visit on the day of the procedure, so no same-day E/M visit code has ever been recommended. After reviewing the survey data with comparisons to reference codes, the RUC agreed in April 2008 that a full 99238 for discharge work is appropriate regardless of whether the patient goes home on the day of service, or the day afterwards. Discharge work for 36821 includes a full neurovascular evaluation of the extremity, wound examination for potential hemorrhage, fistula evaluation to ensure patency, acceptable discharge glycemic control, physical exam to ensure the IV fluid administered by anesthesia has not pushed patient into CHF, provision of wound care instructions, provision of warnings for steal syndrome and vascular compromise of the hand, ensuring arrangements are made to reestablish outpatient hemodialysis, and finalization of many other details for this very sick typical diabetic renal failure patient. The RUC recommended the survey median work RVU.

CURRENT RECOMMENDATION

The Society for Vascular Surgery and the American College of Surgeons recommend maintaining the current RVW as published for CY 2011 (12.11) and the current time and visit data, including 1.0 x 99238 for discharge day management work.

Why Reverse Building Block is Not Applicable to Code 36821

CMS has suggested that the RUC use a building block methodology to adjust site-of-service anomaly codes for the RVWs associated with changes in time and visits. More specifically, CMS proposes a "reverse" BBM that subtracts E/M code work RVUs from the current work RVU and reassignment of minutes to different categories. For example, post-operative E/M minutes should be reassigned to immediate post-operative care (ie, time from skin closure through discharge from recovery room).

When Harvard reviewed code 36821, estimates were provided by six general surgeons for intra-<u>time</u> in <u>minutes</u>. Preand post-time time was assigned by algorithm. Because E/M codes were under revision at CPT during the Harvard study, surveyees were asked to estimate <u>minutes</u> – not E/M codes. Many years later, for purposes of practice expense RVU refinement, a CMS contractor translated the Harvard minutes to E/M codes using an algorithm. Vascular surgery, a significant provider of this service, was not included in the final phases of the Harvard review of this code.

The E/M CPT codes assigned by algorithm were NOT part of the Harvard building blocks to develop the work RVU for code 36821 for the first PFS in 1992. Therefore, CMS' proposal to use a reverse BBM that subtracts RVWs for E/M codes is flawed because Harvard never used RVWs for E/M codes to "build" the value for 36821 in the first place. In addition, since the RUC voted twice that compelling evidence exists to revalue 36821, all assumptions and extrapolations from Harvard are rendered irrelevant, being replaced by the standard RUC survey process that has been in place for almost 20 years.

Comparison of 36821 to Other RUC Reviewed Codes

Finally, we believe the review of any code and subsequent recommendation requires a final review of <u>relativity</u> using magnitude estimation of <u>total</u> work. This review process was used by Harvard to create the fee schedule and has been used by the RUC for almost 2 decades to correctly rank procedures across all codes in the MPFS. The table below of RUC reviewed codes with similar work RVUs, similar IWPUT, and similar total time provides further support that the current <u>total work</u> value for 36821 is appropriate.

RUC Year	СРТ	RVW	IWPUT	Total Time	eval	posit	s.d.w	INTRA	Immed Post-op	32	31	38	13	12
2005	65850	11.39	0.111	233	15	10	13	60	18			1.0		5
2009	63664	11.52	0.069	273	33	15	15	90	20			1.0	2	1
2009	63655	11.56	0.069	273	33	15	15	90	20			1.0	2	1
2007	57285	11.60	0.092	267	45	10	5	60	30	1		1.0	1	1
2000	49557	11.62	0.072	262	45			90	30		1	1.0	1	1
2002	37500	11.67	0.073	261	60			90	30			0.5	2	1
2000	29883	11.77	0.058	311	75			90	30			1.0	2	2
2000	49560	11.92	0.091	223	45			90	30			0.5	1	1
2000	59151	12.11	0.094	235	60			80	30			0.5	2	
2008	36821	12.11	0.082	256	33	10	10	90	20			1.0	1	2
2009	45172	12.13	0.078	290	40	15	20	75	20		1	1.0	2	1
2008	57288	12.13	0.091	280	35	10	15	60	20	1		1.0	2	1
2000	59150	12.29	0.110	225	60			70	30			0.5	2	
2008	60220	12.37	0.077	275	63			90	25		1	1.0	1	1
2009	49521	12.44	0.079	280	40	3	20	90	30		1	1.0	1	1
2009	14301	12.65	0.070	287	33	10	15	100	25			0.5	3	1
2002	34825	12.80	0.091	307	80			60	30	1	1	1.0	1	1
2005	38700	12.81	0.073	300	30	15	15	90	30		1	1.0	2	1
2010	66174	12.85	0.131	215	10	1	5	60	10			0.5	2	4
2007	49652	12.88	0.081	292	45	15	15	90	30		1	1.0	1	1
2001	54406	12.89	0.070	295	50			95	30		1	1.0	2	1
2002	53500	13.00	0.075	289	50			90	29		1	1.0	2	1
2007	29828	13.16	0.104	262	40	15	15	75	20			0.5	2	2

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) 36821

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 vascular surgerey	How often? Commonly
Specialty general surgery	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 <u>percentage</u> for each specialty. Please explain the rationale for this estimate. national frequency not available

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 34,807 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate. 2009 Medicare data

Specialty vascular s	urgery	Frequency 14195	Percentage 40.78 %
Specialty general su	irgery	Frequency 16684	Percentage 47.93 %
Specialty	Frequency	Percentage	%

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 <u>will not</u> change, enter the surveyed existing CPT code number 36821

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code:36825 Tracking Number

Original Specialty Recommended RVU: **15.13** Presented Recommended RVU: **15.13** RUC Recommended RVU: **15.13**

Global Period: 090

CPT Descriptor: Creation of Arteriovenous fistula by other than direct arteriovenous anastomosis; autogenous graft

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75-year-old man undergoes chronic hemodialysis for longstanding renal failure due to renovascular occlusive disease. He has undergone 4 prior native arteriovenous fistulas over the last 8 years, all of which eventually failed. Placement of a new arteriovenous hemoaccess is undertaken in his forearm using greater saphenous vein. Note: the work of this procedure includes vein harvest. Vein harvest is not separately reportable.

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 26%, Kept overnight (less than 24 hours) 35%, Admitted (more than 24 hours) 39%

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 82%

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: Select and order the appropriate antibiotic(s) and confirm timing and administration. Assure appropriate selection, timing, and administration of DVT prophylaxis. Assess need for beta-blockers, order as required. Review preadmission work-up, with particular attention to potential cardiovascular risk factors, electrolytes, BUN, creatinine etc. in the ESRD patient. Reexamine patient to make sure that physical findings have not changed and update H&P. Meet with patient and family to review planned procedure and post-operative management. Review and obtain informed consent. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available Duplex vein mapping studies are reviewed to ensure patient has adequate length and caliber donor vein conduit, and discussions are held with OR nurses regarding appropriate draping to expose vein donor site and the implantation site. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work:

Incise skin overlying target inflow artery. Dissect soft tissue to expose artery, avoid injury to multiple nearby nerves and veins. Dissect soft tissue from artery for ~6 cm length. Pass soft loops around artery for control. Next, incise skin overlying previously identified outflow vein. Dissect soft tissue from around the vein, avoiding nerve/arterial injury. Pass soft rubber loops around artery for control. Create a tunnel from arterial dissection site to vein dissection site in subcutaneous tissue of the forearm. Next, turn attention to harvesting vein conduit. Incise skin of thigh/calf over donor conduit vein (typically greater saphenous vein). Identify vein. Dissect soft tissue from around vein for adequate length.

CPT Code: 36825

Ligate and divide all vein branches. Ligate and divide ends of vein after double-checking to ensure adequate length has been harvested, and remove vein from extremity. Test vein conduit for leaks and repair, as needed with 7-0 vascular suture. This is followed by the arterial anastomosis. Anticoagulate patient with IV heparin and wait for circulation time. Apply vascular clamps to arterial anastomosis site on inflow artery. Perform arteriotomy. Perform most of vein conduit to inflow artery anastomosis, remove arterial clamps. Open clamps transiently to flush system, remove air and debris. Complete anastomosis, remove arterial clamps. Apply additional sutures as needed to control hemorrhage. Pass vein conduit through tunnel to outflow vein anastomosis site with care to avoid twists/kinks. Next, turn attention to the venous outflow anastomosis. Stretch vein conduit to full length. Apply vascular clamps. Perform venotomy. Cut vein conduit to match length and size of venotomy. Perform most of vein-to-vein anastomosis with fine vascular sutures as required to achieve hemostasis. Listen with Doppler and palpate distal pulses to assure fistula patency and assure continued flow to hand after completing the fistula. Irrigate all incisions. Achieve final wound hemostasis. Close all incisions in multiple layers. Recheck pulses to assure patency prior to application of sterile dressings

Description of Post-Service Work:

Hospital [operative day through discharge from recovery room]: Apply sterile dressings. Monitor patient during reversal of anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to general surgical floor and discuss ongoing care with floor nurses.

Hospital Visit [operative day after discharge from recovery room]: Review interval chart notes, take an interval history, assure that the patient is hemodynamically stable, assess neurovascular status of the hand on the limb where the hemoaccess was created, and assure there is no significant bleeding from either the arterial or venous anastomosis. Blood test evaluation and discussion with the nephrologist regarding need for hemodialysis is also typical. Continue prophylaxis for DVT. Assess need for beta-blockers, order as required. Review nursing/other staff patient chart notes. Write orders for labs, films, medications, diet, and patient activity. Chart patient progress notes. Answer patient and family questions.

Hospital Discharge Management [day after surgery, IF patient is stable and can safely be discharged]: Review interval chart notes. Evaluate vital signs and intake/output. Discharge work also includes review of interval chart notes, a full neurovascular evaluation of the extremity, wound evaluation for potential hemorrhage, fistula evaluation to ensure patency, glycemic assessment, physical exam to ensure the IV fluid administered by anesthesia has not pushed patient into CHF, provision of wound care instructions, provision of warnings for vascular steal syndrome and/or vascular compromise of the hand, ensuring arrangements are made to reestablish outpatient hemodialysis, and finalization of many other details for this very sick subset of typically diabetic renal failure patients. Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy. Write prescriptions for medications needed post-discharge. Home restrictions and activity levels (ie, diet, bathing) are discussed with the patient, family members and discharging nurse. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Post-op Office Visits: Review interval chart notes. Examine and talk with patient. Remove staples or sutures and drain, when appropriate. Review activity and restrictions. Check for presence of post-operative hematoma/seroma and assess need for aspiration. Check for patency of fistula and adequacy of blood flow to hand. Write medication prescriptions. Post discharge labs/films are ordered and reviewed. Discuss progress with referring physician(s) (verbal and written). Dictate progress notes for medical chart. Review activity permission with patient and write appropriate permission.

SURVEY DATA											
RUC Meeting Da	ate (mm/yyyy)	02/2011									
Presenter(s):	Gary Seabroo FACS; Charle	ary Seabrook, MD, FACS; Robert Zwolak, MD, FACS; Christopher Senkowski, MD ACS; Charles Mabry, MD FACS;									
Specialty(s):	General Surg	ery, Vascular S	Surgery								
CPT Code:	36825										
Sample Size:	100 F	lesp N:	31	Respo	onse: 31.0 %	, D					
Sample Type:	Random	Additional Sa	mple Info	rmation:							
			Low	25 th pctl	Median*	75th pctl	High				
Service Perform	nance Rate		0.00	0.00	1.00	1.00	5.00				
Survey RVW:			14.00	15.00	18.00	22.25	28.00				
Pre-Service Evalu	uation Time:				65.00						
Pre-Service Posit	tioning Time:				15.00						
Pre-Service Scrul	b, Dress, Wait Ti	me:			15.00						
Intra-Service Ti	me:		90.00	110.00	120.00	150.00	210.00				
Immediate Post	Service-Time:	<u>30.00</u>									
Post Operative	Visits	Total Min**	CPT Cod	e and Num	ber of Visit	S					
Critical Care tim	ne/visit(s):	<u>0.00</u>	99291x 0	. 00 99292	2x 0.00						
Other Hospital t	time/visit(s):	<u>20.00</u>	99231x 1	.00 99232	2x 0.00 9	9233x 0.00					
Discharge Day	Mgmt:	<u>38.00</u>	99238x 1	. 00 99239x	0.00						
Office time/visit	t(s):	<u>62.00</u>	99211x 0	.00 12x 1.0	0 13x 2.00 1	4x 0.00 15x	0.00				
Prolonged Serv	ices:	<u>0.00</u>	99354x 0	. 00 55x 0).00 56x 0	.00 57x 0.0)0				
Sub Obs Care:		0.00	99224x 0	.00 99225	5x 0.00 9	9226x 0.00					

**Physician standard total <u>minutes per E/M visit</u>: 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: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	36825		Recommended Physician Work RVU: 15.13					
			Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time			
Pre-Service Evaluation T	ime:		40.00	40.00	0.00			
Pre-Service Positioning	Fime:		10.00	3.00	7.00			
Pre-Service Scrub, Dress	s, Wait Tim	ie:	20.00	20.00	0.00			
Intra-Service Time:			120.00					
Immediate Post Servic	e-Time:	<u>30.00</u>						
Post Operative Visits		Total Min**	CPT Code and Number of Visits					
Critical Care time/visit	(s):	<u>0.00</u>	99291x 0.00 992	92x 0.00				
Other Hospital time/vis	sit(s):	<u>0.00</u>	99231x 0.00 992	32x 0.00 99233x	0.00			
Discharge Day Mgmt:		<u>38.00</u>	99238x 1.0 99239	< 0.0				
Office time/visit(s):		<u>62.00</u>	99211x 0.00 12x 1.00 13x 2.00 14x 0.00 15x 0.00					
Prolonged Services:		<u>0.00</u>	99354x 0.00 55x	0.00 56x 0.00	57x 0.00			
Sub Obs Care:		<u>20.00</u>	99224x 1.00 992	25x 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 SEF	RVICE:					
Key CPT Code 35522	<u>Global</u> 090		<u>Worl</u> 23.	<u>k RVU</u> 15	<u>Time Source</u> RUC Time	
CPT Descriptor Bypass gr	aft, with vein; ax	killary-brachial				
KEY MPC COMPARIS Compare the surveyed co- appropriate that have relate	ON CODES: de to codes on t ive values higher	he RUC's MPC	List. Reference coo	les from the l e values for th	MPC list should l e code under revi Most Recent	be chosen, if ew.
<u>MPC CPT Code 1</u> 36819	<u>Global</u> 090	<u>Work RVU</u> 14.47	<u>Time Source</u> RUC Time	Medi	care Utilization 11,884	
CPT Descriptor 1 Arteriov	venous anastomo	sis, open; by upp	er arm basilic vein tr	ransposition	,	
<u>MPC CPT Code 2</u> 63047	<u>Global</u> 090	<u>Work RVU</u> 15.37	Time Source RUC Time	Med	Most Recent icare Utilization 79,295	

<u>CPT Descriptor 2</u> Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar

Other Reference CPT Code	<u>Global</u>	<u>Work RVU</u> 0.00	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: 16 % of respondents: 51.6 %

<u>TIME ESTIMATES (Median)</u>	CPT Code: 36825	Key Reference CPT Code: <u>35522</u>	Source of Time RUC Time
Median Pre-Service Time	70.00	103.00	
Median Intra-Service Time	120.00	180.00]
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	100.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	62.0	46.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	20.0	0.00	
Median Total Time	340.00	497.00	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

(of those that selected Key Reference code)

<u>Mental Effort and Judgment (Mean)</u>		
The number of possible diagnosis and/or the number of	3.42	3.08
management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests,	3.58	3.25
and/or other information that must be reviewed and analyzed		
		2.00
Urgency of medical decision making	3.08	3.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.50	4.25
Physical effort required	3.33	3.17
Psychological Stress (Mean)		L
The risk of significant complications, morbidity and/or mortality	3.92	3.67
Outcome depends on the skill and judgment of physician	4.33	4.08
Estimated rick of malarastics suit with poor outcome	2 50	3.42
Estimated fisk of maipractice suit with poor outcome	5.50	5.42
INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference
		<u>Service 1</u>
<u>Time Segments (Mean)</u>		
Pre-Service intensity/complexity	3.42	3.08
	0.70	
Intra-Service intensity/complexity	3.78	3.33
Post-Service intensity/complexity	2.92	2.75

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 Code: 36825

Code 36825 was identified by the RUC 5YR ID WG in 2007 as potentially misvalued through a site-of-service anomaly screen. The RUC recommended 36825 be surveyed. In 2008, SVS and ACS conducted a RUC survey and presented data that indicated 36825 was not same-day surgery. We argued that a majority of these patients require close monitoring on the day of the procedure and are kept overnight in the hospital for continued monitoring to ensure the dialysis graft is patent, the hand beyond the dialysis graft is not ischemic, and that all hemodynamic instability and electrolyte abnormalities have been avoided. Discharge most commonly occurs the day following surgery, but at least 35% of Medicare patients need to stay for several days in the hospital, therefore, next day discharge is not "imminent" or preplanned when a patient is scheduled for surgery, and the work in monitoring these patients post-operatively on the day of surgery is the same E/M work whether the patient's <u>facility</u> status is designated as inpatient or outpatient. After hearing these arguments, the RUC deferred review of 36825 until the RUC survey instrument could be modified to capture information about typical site of service and visits.

SVS and ACS conducted another RUC survey in 2009 using a modified RUC survey instrument that included a question regarding site-of-service and visits on the day of the procedure. The specialties presented compelling evidence that the work involved in providing 36825 has evolved. Numerous scientific publications have identified native autogenous hemodialysis access (such as 36825) as providing superior patency and greater protection against infection in ESRD patients. This has become so important to CMS that the Agency created the Fistula First Breakthrough Initiative (FFBI), an entity that has been extremely influential in urging surgeons to perform native autogenous access in an increasing percentage of dialysis patients. The end result is that surgeons are performing more and more complex fistula operations to meet the CMS FFBI mandate. In earlier times, surgeons would perform native dialysis fistulas only in the healthiest patients who were found to have large veins and normal arteries. Currently, smaller and more diseased veins and arteries are being used to create native fistulas. This is reflected in greater skin-to-skin operative times and greater levels of complexity. Lastly, the specialties presented evidence that fistula performance is now a Quality Performance Indicator. This will push surgeons even more towards performing an increasing percentage of native fistulas with greater emphasis on functionality of the finished product, which results in greater time, intensity, and work.

The RUC agreed that compelling evidence to review 36825 was met. The RUC reviewed the survey data in comparison to reference codes and recommended the survey 25th percentile work RVU as appropriate.

Why Reverse Building Block is Not Applicable to Code 36825

CMS has suggested that the RUC use a building block methodology to adjust site-of-service anomaly codes for the RVWs associated with changes in time and visits. More specifically, CMS proposes a "reverse" BBM that subtracts E/M code work RVUs from the current work RVU and reassignment of minutes to different categories. For example, post-operative E/M minutes should be reassigned to immediate post-operative care (ie, time from skin closure through discharge from recovery).

When Harvard reviewed code 36825, estimates were provided by six general surgeons for pre-, intra-, and post-time in <u>minutes</u>. Because E/M codes were under revision at CPT during the Harvard study, surveyees were asked to estimate <u>minutes</u> – not E/M codes. Many years later, for purposes of practice expense RVU refinement, a CMS contractor translated the Harvard minutes to E/M codes using an algorithm. Vascular surgery, a significant provider of this service, was not included in the final phases of the Harvard review of this code.

The E/M CPT codes assigned by algorithm were NOT part of the Harvard building blocks to develop the work RVU for code 36825 for the first PFS in 1992. Therefore, CMS' proposal to use a reverse BBM that subtracts RVWs for E/M codes is flawed because Harvard did not use RVWs for E/M codes to "build" the value for 36825 – minutes were used.

The RUC agreed with the SVS and ACS that the procedure itself had changed over time, requiring more time and more intense/complex physician work. The Harvard geometric mean intra-time of 81 minutes compared with the RUC survey median intra-time of 120 minutes, along with significantly greater post-operative time, supports this.

Discussion of Post-operative E/M Work

It is the clinical opinion of our expert panel that the typical patients undergoing 36825 require continued post-operative monitoring on the day of the procedure and on subsequent days until the patient is discharged. This operation is pretty much the end of the line in native fistula procedures for the ESRD patient. The typical patient has undergone multiple prior hemoaccess operations and is physiologically aged well beyond 75 chronologic years. This is not the patient you tip your hat to on the way out the door at night. He or she requires a substantial assessment to review interval chart notes, take an interval history, assure that the patient is hemodynamically stable, assess neurovascular status of the hand on the limb where the hemoaccess was created, and assure there is no significant bleeding from either the arterial or venous anastomosis. Blood test evaluation and discussion with the nephrologist regarding need for hemodialysis is also typical. Some patients will be discharged on the day after surgery and others will remain additional days in the hospital (either admitted to inpatient status or maintained under outpatient status). The hospital admission criteria program may designate outpatient instead of inpatient, but the physician work to review the patient chart, take down dressings, examine the patient, write subsequent orders, and talk to the floor staff and the family is the same, regardless of inpatient or outpatient status. As stated above, many of these patients will need to stay for several days in the hospital, therefore, next day discharge is not "imminent" or pre-planned when a patient is scheduled for surgery and the work in managing these patients post-operatively on the day of surgery is the same evaluation and management work whether the patient's status ends up inpatient or outpatient on the following day.

CURRENT RECOMMENDATION

The Society for Vascular Surgery and the American College of Surgeons recommend maintaining the current RVW as published for CY 2011 (15.13). We believe the total physician work has not changed for 36825 and recommend maintaining a discrete evaluation and management visit on the day of surgery as indicated by our survey data and, more importantly by the clinical rationale. We respectfully request to defer our recommendation for the designation of the post-op evaluation and management code until the RUC approves a policy and/or rules regarding correct coding for this physician work.

RUC	ODT			Total					Immed Post-	20	24	20		40	40
1ear	20040	11.00		11me	eval		s,a,w		op	32	31	30	14	13	12
2004	30010	11.09	0.009	230	35	10	10	90	30			0.5		1	1
2008	36821	12.11	0.082	256	33	10	10	90	20			1.0		1	2
2009	28173	14.16	0.072	304	19	3	5	110	30		1	1.0	1	1	1
2008	29888	14.30	0.089	295	45	15	15	98	25			0.5		2	2
2009	57426	14.30	0.061	360	40	3	20	110	40	1		1.0		3	
2007	27726	14.34	0.081	319	40	15	15	100	20		1	1.0		1	3
2006	64911	14.39	0.075	294	25	10	15	120	20			0.5		3	1
2004	36819	14.47	0.078	287	55			120	15		1	1.0		1	1
2008	36820	14.47	0.076	307	45	10	15	120	20		1	1.0		1	1
2010	29914	14.67	0.094	280	33	20	10	100	20			0.5		2	2
2009	26118	14.81	0.066	368	40	12	20	100	20		1	1.0	1	2	2
2010	29916	15.00	0.108	270	33	20	10	90	20			0.5		2	2
2003	58550	15.10	0.079	330	60			100	30		2	1.0		2	1
2009	36825	15.13	0.073	340	40	10	20	120	30		1	1.0		3	1
2002	29806	15.14	0.092	298	55			100	30			0.5		2	3
2008	54410	15.18	0.072	338	40	10	15	120	30			1.0		3	1
2009	26250	15.21	0.065	353	23	10	15	120	25		1	1.0	1	2	1
2005	63047	15.37	0.080	362	60	20	15	90	30	1		1.0		3	
2003	65782	15.43	0.103	331	60			83	25			0.5			9
2003	58545	15.55	0.074	334	60			120	30	1		1.0		2	
2002	29827	15.59	0.083	334	75			120	40			0.5			5
2005	19303	15.85	0.098	314	30	15	15	90	20		1	1.0	1	2	

The table below compares the survey code to many other RUC reviewed codes, providing further support that the current value for 36825 is not overvalued. In this table, we have utilized the RUC's current proxy of 99231 for the post-op in-hospital E/M visit.

CPT Code: 36825

RUC Year	СРТ	RVW	IWPUT	Total Time	eval	posit	s,d,w	INTRA	Immed Post- op	32	31	38	14	13	12
2007	57423	16.08	0.067	357	45	10	5	150	30	1		1.0		1	1
2007	49653	16.21	0.073	378	45	15	15	120	30	1	1	1.0		1	2
2009	28171	16.41	0.077	365	43	20	15	120	30		1	1.0	1	1	1

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) 36825

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 general surgery		How often? Rarely
Specialty vascular surgery		How often? Rarely
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 <u>percentage</u> for each specialty. Please explain the rationale for this estimate. national frequency not available

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 4,267 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate. 2009 Medicare data

 Specialty general surgery
 Frequency 2177
 Percentage 51.01 %

 Specialty vascular surgery
 Frequency 1299
 Percentage 30.44 %

 Specialty
 Frequency 0
 Percentage 0.00 %

 Do many physicians perform this service stree United States
 Vercentage 10.00 %

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix <u>will not</u> change, enter the surveyed existing CPT code number 36825

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

AMA/Specialty Society RVS Update Committee Summary of Recommendations Identified through the Site of Service Anomaly Screen and the Fourth Five-Year Review

February 2011

Excise Parotid Gland/Lesion

In September 2007, the RUC's Relativity Assessment Workgroup (formerly Five-Year Review Identification Workgroup) identified CPT codes 42415 and 42420 as potentially misvalued through the Site-of-Service Anomaly screen. In October 2008, the American Academy of Otolaryngology - Head and Neck Surgery (AAO-HNS) and the American College of Surgeons (ACS) conducted a RUC survey, but RUC action was deferred on these services until an adequate survey instrument was developed to capture information about typical site of service and post-operative visits. In February 2009, the specialties presented these services using a modified RUC survey instrument that included a question regarding site-of-service and typical visits on the day of the procedure. CMS accepted the RUC's recommendation for these services. Following the RUC's recommendation, CMS included codes 42415 and 42420 in Table 16 of the 2011 Proposed Rule and asked the RUC to re-review these services.

42415 Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve

In 2009, the RUC determined that the current work RVU of 17.99 was justified by magnitude estimation in comparison to several reference services. CMS accepted the RUC recommended value for 42415. Further, for 2010, this value was increased to 18.12 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. The RUC reviewed the previous rationale and physician work survey data for CPT code 42415. The RUC noted that the RUC recommended the 2009 work RVU of 17.99 was further validated by the 25th percentile survey data, 18.00 work RVUs. The RUC also compared 42415 to the key reference service, 60271, *Thyroidectomy, including substernal thyroid; cervical approach*, (work RVU = 17.62, intra-time = 150 minutes). The RUC noted that both procedures require the same intra-time (150 minutes), and have analogous physician work and should be valued closely. The RUC agreed that the surveyed code was accurately valued during the February 2009 meeting, with strong support from the reference service and specialty survey data, and finds no compelling evidence to change the current physician work value of this service. The RUC also reviewed a table provided by the specialties that compares the survey code to many other RUC reviewed codes as further support that the current value for 42415 is appropriate Therefore, based on this history and magnitude estimation comparisons to reference codes, the specialty societies agree and the RUC recommended that the current value of this service be maintained.

Additionally, the RUC further analyzed the site-of-service data and post-operative visit data. Code 42415 is not typically same day surgery. Patients require close monitoring for airway patency, formation of hematoma, and facial nerve function and would be kept at least one night in the hospital. This was substantiated by the survey data which shows that the typical patient receives this procedure in the hospital (97%), stays at least overnight in the hospital following surgery (91%) and receives an Evaluation and Management service on the same date (53%). Given this data, the RUC enacted its policy to allocate the appropriate proxy for the post-operative visits. Importantly, the RUC noted that whether the hospital admission criteria

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program designates this service outpatient or inpatient, the physician work at the bed of a patient in a hospital surgical ward to review the patient chart, take down dressings, examine the patient, write subsequent orders, and talk to the floor staff and the family is the same. Adjustments to the allocation of post-operative visits are used as proxies and do not constitute changes to the physician work relative value of the service which was determined by magnitude estimation and physician specialty survey data during the last RUC review. The RUC recommends a work RVU of 18.12 for CPT code 42415.

42420 Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve

In 2009, the RUC determined that the current work RVU of 20.87, was justified by magnitude estimation in comparison to several reference services. CMS accepted the RUC recommended value for 42420. Further, for 2010, this value was increased to 21.00 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. The RUC reviewed the previous rationale and physician work survey data for CPT code 42420. The RUC noted that the RUC recommended the 2009 work RVU of 20.87 which was lower than the 25th percentile survey data, 23.36 work RVUs. The RUC agreed with the specialty society survey results regarding physician time and post-operative visits. The RUC compared code 42420 to MPC code 35141, Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, common femoral artery (profunda femoris, superficial femoral), (work RVU = 20.91, intra-time = 150 minutes). The RUC noted that the two services have comparable physician work, with similar total time, 427 minutes and 432 minutes, respectively and should be valued closely. The RUC also reviewed code 34471, Thrombectomy, direct or with catheter; subclavian vein, by neck incision (work RVU = 21.11 intra-service = 180) and noted that both procedures had the same intra-service time, 180 minutes, and the reference code supports the current work RVU. The RUC agreed that the surveyed code was accurately valued during the February 2009 meeting, with strong support from reference services and specialty survey data, and finds no compelling evidence to change the current physician work value of this service. The RUC also reviewed a table provided by the specialties that compares the survey code to many other RUC reviewed codes as further support that the current value for 42420 is appropriate Therefore, based on this history and magnitude estimation comparisons to reference codes, the specialty societies agree and the RUC recommended that the current value of this service be maintained.

Additionally, the RUC further analyzed the site-of-service data and post -operative visit data. Code 42420 is not typically same day surgery. Patients require close monitoring for airway patency, hematoma formation, facial nerve function, and intervention for any noted deficits, drain function, and control of pain and nausea. This was substantiated by the survey data which shows that the typical patient receives this procedure in the hospital (100%), stays at least overnight in the hospital following surgery (97%) and receives an Evaluation and Management service on the same date (64%). Given this data, the RUC enacted its policy to allocate the appropriate proxy for the post-operative visits. Importantly, the RUC noted that patient facility status is not tied to physician work in the programs that assign patient facility status. Levels of physician work are accounted for by the level(s) of Evaluation and Management code(s) reported, not based on the facility resources utilized by a patient and facility payment system. Adjustments to the allocation of post operative visits are used as proxies and do not constitute changes to the physician work relative value of the service which was determined by magnitude estimation and physician specialty survey data during the last RUC review. **The RUC recommends a work RVU of 21.00 for CPT code 42420**.

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
42415		Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve	090	18.12 (No Change)
42420		Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve	090	21.00 (No Change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code:42415 Tracking Number

Original Specialty Recommended RVU: 18.12 Presented Recommended RVU: 18.12 RUC Recommended RVU: 18.12

Global Period: 090

CPT Descriptor: Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old woman presents with a 2-year history of a slow growing 2 centimeter mass in the right preauricular region 1.5 centimeter anterior to the tragus. There is no pain, facial weakness, history of infection. A CT scan shows a mass in the superficial lobe of the parotid gland. Fine needle biopsy is compatible with a pleomorphic adenoma. A superficial parotidectomy with dissection and preservation of the facial nerve is performed.

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 97% , In the ASC 3%, 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 9%, Kept overnight (less than 24 hours) 57%, Admitted (more than 24 hours) 34%

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 53%

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:

Select and order the appropriate antibiotic(s) and confirm timing and administration. Assure appropriate selection, timing, and administration of DVT prophylaxis. Assess need for beta-blockers, order as required. Review medical history, pathology, and radiology report. Review radiographic images. Review results of preoperative testing (labs, EKG, CXR). Review reports of consultants providing preoperative assessment and clearance as indicated. Meet with patient and family to review planned procedure and postoperative management. Reexamine patient to ensure that physical findings have not changed and dictate history and physical. Obtain informed consent. Review hospital consent, mark patient. Review airway and medical management with anesthesiologist. Review planned procedure with OR staff. Verify that all required instruments and supplies are available. Change into scrub clothes. Monitor/assist with positioning of the patient. Ensure that radiographic images are available in the OR. Mark planned incision. Inject planned incision with vasoconstrictor. Monitor/assist with prepping and draping. Scrub and gown. Perform surgical "time out" with operating surgical team.Place facial nerve monitor.

Description of Intra-Service Work:

Under anesthesia, a preauricular incision is made with curved cervical extension below the angle of the mandible. Anterior and posterior skin flaps are elevated in the subplatysmal plane, superficial to the parotid fascia, exposing the parotid gland and the sternocleidomastoid muscle. The parotid gland is dissected from the anterior border of the sternocleidomastoid muscle and the greater auricular nerve is transected. The gland is dissected from the mastoid process and the cartilage of

CPT Code: 42415

the external auditory canal. The main trunk of the facial nerve is identified and protected. Facial nerve stimulation is performed as needed at various points during the procedure. The overlying parotid tissue is elevated from the main trunk of the facial nerve to expose the bifurcation. The peripheral branches of the facial nerve are sequentially dissected, separating the overlying parotid tissue from the facial nerve and deep lobe of the gland. The lobe and associated tissue are removed and sent to pathology. All structures are inspected including the facial nerve. A deep drain is placed and the wound closed in layers.

Description of Post-Service Work:

Hospital [operative day through discharge from recovery room]:

Apply sterile dressings. Monitor patient during reversal of anesthesia. Monitor transport of patient from OR to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff. Write postoperative orders. Discuss procedure and outcome with family in waiting area. Examine the patient to ensure proper drain function and assess facial nerve function. Write postoperative note. Dictate operative note and copy to referring physician. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses.

Hospital Visit [operative day after discharge from recovery room]:

Review interval chart notes. Discuss ongoing care with floor nurses. Evaluate vital signs and intake/output. Examine patient, check wounds and drain, check flaps for viability, change dressings, and chart patient progress. Monitor closely for airway patency and for development of cervical hematoma. Assess overall medical condition of the patient including fluid balance, vital signs, and urinary function. Assess facial nerve function. Answer patient and family questions. Assure adequate level of pain control. Review orders for postoperative medications, diet, and patient activity – adjust as necessary. Chart notes. Answer nursing staff questions. Discuss patient progress with referring physician.

Hospital Discharge Management [day after surgery, IF patient is stable and can safely be discharged]:

Review interval chart notes. Evaluate vital signs and intake/output. Examine patient, check wounds and drain, check flaps for viability, and change dressings. Assess airway patency. Assess overall medical condition of the patient including fluid balance, vital signs, and urinary function. Assess facial nerve function. Answer patient and family questions. If patient is stable and the surgeon determines it is safe for patient to be discharged to home, write prescriptions for medications and supplies needed post-discharge. Review post-discharge wound care and activity limitations with patient and family. Discuss follow-up care. Dictate discharge summary. Discuss patient progress with referring physician.

Post-op Office Visits:

Obtain and review pathology report. Review interval chart notes. Examine patient, remove sutures. Monitor output and remove drain if not removed prior to discharge. Answer patient and family questions. Monitor facial nerve functional deficits, if any. Assess for adequacy of pain control. Discuss advancing daily activities with patient. Discuss long-term scar management with patient. Discuss pathology report with patient and need for any additional testing or consultation. Arrange for any indicated additional testing and review results. Arrange for any indicated consultation, prepare documents for transmission to appropriate consultants, and review reports from consultants. Discuss patient progress with referring physician. Dictate progress notes for medical chart.

SURVEY DAT	ГА						
RUC Meeting Da	ate (mm/yyyy)	02/2011					
Presenter(s):	Wayne Koch, FACS	MD, FACS; C	hristopher	Senkowski,	MD, FACS;	Charles Mab	ry, MD,
Specialty(s):	otolaryngolog	y; general sur	gery				
CPT Code:	42415						
Sample Size:	250 R	esp N:	75	Respo	onse: 30.0 %)	
Sample Type:	Random	Additional Sa	mple Info	rmation:			
			Low	25 th pctl	Median*	75th pctl	High
Service Perform	nance Rate		2.00	10.00	14.00	20.00	60.00
Survey RVW:			12.00	18.00	20.00	22.13	35.00
Pre-Service Evalu	uation Time:				40.00		
Pre-Service Posit	ioning Time:				15.00		
Pre-Service Scrul	b, Dress, Wait Ti	me:			20.00		
Intra-Service Ti	me:		90.00	120.00	150.00	150.00	250.00
Immediate Post	Service-Time:	20.00					
Post Operative	Visits	Total Min**	CPT Cod	e and Num	ber of Visit	S	
Critical Care tim	ne/visit(s):	<u>0.00</u>	99291x 0	. 00 99292	2x 0.00		
Other Hospital t	time/visit(s):	20.00	99231x 1	.00 99232	2x 0.00 9	9233x 0.00	
Discharge Day	99238x 1	. 00 99239x	0.00				
Office time/visit	:(s):	<u>62.00</u>	00 99211x 0.00 12x 1.00 13x 2.00 14x 0.00 15x 0.00				
Prolonged Serv	ices:	<u>0.00</u>	99354x 0	.00 55x C	.00 56x 0	.00 57x 0.0	00
Sub Obs Care:		0.00	99224x 0	.00 99225	5x 0.00 9	9226x 0.00	

**Physician standard total <u>minutes per E/M visit</u>: 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: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	42415		Recommended Ph	ysician Work RVU:	18.12
			Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Ti	Pre-Service Evaluation Time:			40.00	0.00
Pre-Service Positioning Time:			12.00	3.00	9.00
Pre-Service Scrub, Dress, Wait Time:			20.00	20.00	0.00
Intra-Service Time:			150.00		
Immediate Post Service	e-Time:	<u>20.00</u>			
Post Operative Visits		Total Min**	CPT Code and Nu	umber of Visits	
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 992	92x 0.00	
Other Hospital time/vis	it(s):	<u>0.00</u>	99231x 0.00 992	32x 0.00 99233x	. 0.00
Discharge Day Mgmt:		<u>38.00</u>	99238x 1.0 99239	× 0.0	
Office time/visit(s):		<u>62.00</u>	99211x 0.00 12x 1	.00 13x 2.00 14x 0	.00 15x 0.00
Prolonged Services:		<u>0.00</u>	99354x 0.00 55x	0.00 56x 0.00	57x 0.00
Sub Obs Care:		20.00	99224x 1.00 992	25x 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 SI	ERVICE:					
<u>Key CPT Code</u> 60271	<u>Global</u> 090		W	<u>fork RVU</u> 17.62	<u>Time Source</u> RUC Time	
CPT Descriptor Thyroid	ectomy, including	substernal thyroi	d; cervical approa	ich		
KEY MPC COMPARI Compare the surveyed of appropriate that have relevant	SON CODES: code to codes on the ative values higher	ne RUC's MPC and lower than t	List. Reference of the requested related the requested related	codes from the ive values for t	MPC list should the code under revi	be chosen, if ew.
MPC CPT Code 1 22554 CPT Descriptor 1 Arthu	<u>Global</u> <u>V</u> 090	<u>Vork RVU</u> 17.69 terbody, technicu	<u>Time Source</u> RUC Time	<u>Mec</u>	dicare Utilization 32,339	rspace (other
than for decompression)	; cervical below C2		ac, menualing min		Most Recent	ispace (other
<u>MPC CPT Code 2</u> 34203	<u>Global</u> 090	<u>Work RVU</u> 17.86	Time Source RUC Time	<u>Me</u>	edicare Utilization 2598	
CPT Descriptor 2 Embo	lectomy or thromb	ectomy, with or	without catheter; p	oopliteal-tibio-p	peroneal artery, by	leg incision

Other Reference CPT CodeGlobalWork RVUTime Source6026009018.26RUC Time

CPT Descriptor Thyroidectomy, removal of all remaining thyroid tissue following previous removal of a portion of thyroid

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

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

Number of respondents who choose Key Reference Code: 21 % of respondents: 28.0 %

<u>TIME ESTIMATES (Median)</u>	CPT Code: 42415	Key Reference CPT Code: <u>60271</u>	Source of Time RUC Time
Median Pre-Service Time	72.00	60.00	
Median Intra-Service Time	150.00	150.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	60.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	62.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	20.0	0.00	
Median Total Time	362.00	377.00	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

(of those that selected Key Reference code)

<u>Mental Effort and Judgment (Mean)</u>		
The number of possible diagnosis and/or the number of	3.19	3.00
management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests,	3.10	3.14
and/or other information that must be reviewed and analyzed		
Urgency of medical decision making	2.86	2.81
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.29	4.10
	0.74	0.57
Physical effort required	3.71	3.57
<u>Psychological Stress (Mean)</u>		
The risk of significant complications, morbidity and/or mortality	4.05	3.62
Outcome descriptions the shift and indemonst effortunities	4.04	4.05
Outcome depends on the skill and judgment of physician	4.24	4.05
Estimated risk of malpractice suit with poor outcome	4.67	4.24
INTENSITV/COMPLEXITV MEASURES	CPT Code	Rafaranca
INTENSITI/COMI LEATTI MEASURES		Service 1
		<u></u>
Time Segments (IVIEAN)		
Pre-Service intensity/complexity	3.00	3.05
Intro Sorrigo intensity/complexity	4.10	3.95
mua-service mensity/complexity	4.10	3.00
Post-Service intensity/complexity	2.57	2.65

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 code 42415 was a Harvard valued code that was identified by the RUC 5YR ID WG in 2007 as potentially misvalued through a site-of-service anomaly screen. The RUC recommended 42415 be surveyed. In 2008, AAO-HNS and ACS conducted a RUC survey and presented data that indicated 42415 was not same-day surgery. The specialties argued that patients require close monitoring for airway patency, bleeding, and facial nerve function and would be kept *at least* one night in a hospital. The next day, after examining the patient and reviewing the chart, the surgeon would

CPT Code: 42415 determine if it was safe to discharge the patient. Some patients would be discharged and others would remain additional days in the hospital. After hearing these arguments, the RUC deferred review of 42415 until the RUC survey instrument could be modified to capture information about typical site of service.

The AAO-HNS and ACS conducted another RUC survey in 2009 using a modified RUC survey instrument that included a question regarding site-of-service and visits on the day of the procedure. The survey data indicated the typical patient (57%) would be kept overnight. <u>Important note</u>: In our previous presentation, we incorrectly reported that the survey data did not indicate the typical patient would require an E/M visit on the same day as surgery. The correct survey information indicates that 53% of the responses with site of service "hospital" (39/74) indicated there <u>would</u> be an E/M visit on the day of surgery. Our expert panel agrees with the survey respondents. These patients are not kept in the hospital for nursing care only.

Recently, CMS requested the RUC review 42415 again as a code with a site of service anomaly.

CURRENT RECOMMENDATION

The American Academy of Otolaryngology – Head and Neck Surgery and the American College of Surgeons recommend maintaining the current RVW as published for CY 2011 (18.12). We respectfully request to defer our recommendation for the post-op evaluation and management code until the RUC approves a policy and/or rules regarding correct coding for this physician work.

CMS has suggested that the RUC use a building block methodology to adjust site-of-service anomaly codes for the RVWs associated with changes in time and visits. More specifically, CMS proposes a "reverse" BBM that subtracts E/M code work RVUs from the current work RVU and reassignment of minutes to different categories. For example, post-operative E/M minutes should be reassigned to immediate post-operative care (ie, time from skin closure through discharge from recovery).

When Harvard reviewed code 42415, estimates were provided for intra-<u>time</u>, hospital <u>time</u> and office <u>time</u> in <u>minutes</u>. Pre-time was assigned by algorithm. Because E/M codes were under revision at CPT during the Harvard study, surveyees were asked to estimate <u>minutes</u> – not E/M codes. Many years later, for purposes of practice expense RVU refinement, a CMS contractor translated the Harvard minutes to E/M codes using an algorithm.

The E/M CPT codes assigned by algorithm were NOT part of the Harvard building blocks to develop the work RVU for code 42415 for the first PFS in 1992. Therefore, CMS' proposal to use a reverse BBM that subtracts RVWs for E/M codes is flawed because Harvard did not use RVWs for E/M codes to "build" the value for 42415 – minutes were used. Additionally, the minutes assigned to the category of immediate post-operative work through discharge from recovery has a different intensity than other hospital and office work (ie, 0.0224 for immediate recovery room work versus 0.054 for 99213). Moving time from one category of work to another category of work is inconsistent with the methodology used by Harvard – the basis for the physician fee schedule.

Our consensus panel believes that <u>the procedure itself has not changed over time</u>. The Harvard geometric mean intratime of 156 minutes compared with the RUC survey median intra-time of 150 minutes, supports this belief. If only minutes were the comparable statistic to review, the table below which compares minutes from the Harvard study and minutes from the current RUC survey support maintaining the current RVW. However, the second measure of physician work - intensity – is not the same as it was 20 years ago. As with almost every other procedure and service in the PFS, physicians are now treating more complex patients who may be older and have more co-morbidities, resulting in more intense and complex work.

Source	Pre Min	Intra Min	Immed- Post-Op Min	Other Hosp Min	Office Min	Total Min
Harvard	55	156	37	39	41	328
RUC Survey	72	150	20	58	68	362

It is the clinical opinion of our expert panel that the typical patients undergoing 42415 are older and have more comorbidities compared with the typical patient of 1990 (ie, during the Harvard study) resulting in the need for more

CPT Code: 42415

complex and intense services by providers. Procedure 42415 is <u>not</u> typically same-day surgery. Patients require close monitoring for airway patency, formation of hematoma, and facial nerve function and would be kept *at least* one night in the hospital. The hospital admission criteria program may designate this outpatient instead of inpatient, but the physician work to review the patient chart, take down dressings, examine the patient, write subsequent orders, and talk to the floor staff and the family is the same. Then, the next day, <u>after</u> reviewing the patient's chart and examining the patient, the surgeon will determine if it is safe to discharge the patient. Some patients will be discharged on the second day and others will remain additional days in the hospital (either admitted to inpatient status or maintained under outpatient status). The hospital admission criteria program may designate this outpatient instead of inpatient, but the physician work at the bed of a patient in a hospital surgical ward to review the patient chart, take down dressings, examine the patient chart, take down dressings, examine the patient status.

The table below compares the survey code (utilizing 99231 as the <u>proxy</u> for the post-op in-hospital E/M visit) to many other RUC reviewed codes, providing further support that the current value for 42415 is appropriate.

RUC Year	СРТ	RVW	IWPUT	Total Time	eval	posit	s,d,w	INTRA	Immed Post-op	32	31/ <mark>24</mark>	38/ <mark>17</mark>	13	12
2005	27709	17.48	0.094	346	40	18	10	108	15		2	1.0	2	2
2005	22554	17.69	0.106	362	60	20	15	90	30	1		1.0	3	
2007	28446	17.71	0.091	339	45	10	10	120	15			1.0	3	2
1999	50945	17.97	0.089	342	60			120	18		3	1.0	2	
2000	35236	18.02	0.086	367	60			120	30	1	2	1.0	1	1
2009	42415	18.12	0.079	362	40	12	20	150	20		1	<mark>1.0</mark>	3	1
2008	27245	18.18	0.085	443	40	30	20	80	30	2	2	1.0	3	1
2000	60260	18.26	0.078	372	60			145	30	1	1	1.0	1	1
2006	58544	18.37	0.083	365	45	10	5	135	30		2	1.0	2	1
2000	35011	18.58	0.097	357	90			120	30		2	1.0	1	1
2008	27269	18.89	0.084	404	25	20	15	125	30	1	2	1.0	1	3
2000	69715	18.96	0.083	359	58			155	30			1.0	2	2

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) 42415

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 otolaryngolog	How often? Son	netimes					
Specialty general surger	У	How often? Rare	ely				
Specialty	ecialty How often?						
Estimate the number of If the recommendation i explain the rationale for	times this service m s from multiple spec this estimate. natio	ight be provided nation cialties, please provide nal frequency unavailal	ally in a the frequ ble	one-year pe ency and <u>pe</u>	riod? <u>rcentage</u> for ea	ach specialty. P	lease
Specialty	Frequency	Percenta	ıge	%			
Specialty	Frequency	Percenta	ıge	%			
Specialty	Frequency	Percenta	ıge	%			
Estimate the number of If this is a recommenda explain the rationale for	times this service m tion from multiple s this estimate. RUC	ight be provided to M o pecialties please estima database 2009 utilizatio	edicare j ate freque on	patients national particular tension of the second se	ionally in a one rcentage for eac	e-year period? 4 ch specialty. Ple	4,516 ease
Specialty otolaryngolog	y Fr	equency 4126]	Percentage	91.36 %		
Specialty general surgery Free		equency 162	Percenta	ge 3.58 %			
Specialty	Frequency	Percenta	ıge	%			
Do many physicians per	ross 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 <u>will not</u> change, enter the surveyed existing CPT code number 42415

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code:42420 Tracking Number

Original Specialty Recommended RVU: 21.00 Presented Recommended RVU: 21.00 RUC Recommended RVU: 21.00

Global Period: 090

CPT Descriptor: Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 64-year-old man presents with a 12-month history of a 1.5 centimeter left preauricular mass. Over the past 3 months, he has had increasing pain but has no evidence of facial nerve weakness. There is no palpable cervical adenopathy. An MRI shows a mass with irregular borders, in the deep lobe of the parotid gland. There is no adenopathy noted on the scan. A fine needle biopsy reveals squamous cell carcinoma. The patient undergoes a total parotidectomy with dissection and preservation of the facial nerve.

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 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 3%, Kept overnight (less than 24 hours) 36%, Admitted (more than 24 hours) 62%

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 64%

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:

Select and order the appropriate antibiotic(s) and confirm timing and administration. Assure appropriate selection, timing, and administration of DVT prophylaxis. Assess need for beta-blockers, order as required. Review medical history, pathology, and radiology report. Review radiographic images. Review results of preoperative testing (labs, EKG, CXR). Review reports of consultants providing preoperative assessment and clearance as indicated. Meet with patient and family to review planned procedure and postoperative management. Reexamine patient to ensure that physical findings have not changed and dictate history and physical. Obtain informed consent. Review hospital consent, mark patient. Review airway and medical management with anesthesiologist. Review planned procedure with OR staff. Verify that all required instruments and supplies are available. Change into scrub clothes. Monitor/assist with positioning of the patient. Ensure that radiographic images are available in the OR. Mark planned incision. Inject planned incision with vasoconstrictor. Monitor/assist with prepping and draping. Scrub and gown. Perform surgical "time out" with operating surgical team.Place facial nerve monitor.

Description of Intra-Service Work:

Under anesthesia, a preauricular incision is made with curved cervical extension below the angle of the mandible. Anterior and posterior skin flaps are elevated in the subplatysmal plane, superficial to the parotid fascia, exposing the parotid gland and the sternocleidomastoid muscle. The parotid gland is dissected from the anterior border of the sternocleidomastoid

CPT Code: 42420

muscle and the greater auricular nerve is transected. The gland is dissected from the mastoid process and the cartilage of the external auditory canal. The main trunk of the facial nerve is identified and protected. Facial nerve stimulation is performed as needed at various points during the procedure. The overlying parotid tissue is elevated from the main trunk of the facial nerve to expose the bifurcation. The peripheral branches of the facial nerve are sequentially dissected, separating the overlying parotid tissue from the facial nerve and deep lobe of the gland. The facial nerve is mobilized and gently retracted. The lobe and associated tissue are removed and sent to pathology. All structures are inspected including the facial nerve. A deep drain is placed and the wound closed in layers.

Description of Post-Service Work:

Hospital [operative day through discharge from recovery room]:

Apply sterile dressings. Monitor patient during reversal of anesthesia. Monitor transport of patient from OR to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff. Write postoperative orders. Discuss procedure and outcome with family in waiting area. Examine the patient to ensure proper drain function and assess facial nerve function. Write postoperative note. Dictate operative note and copy to referring physician. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses.

Hospital Visits [operative day and day(s) after surgery]:

Review interval chart notes. Discuss ongoing care with floor nurses. Evaluate vital signs and intake/output. Examine patient, check wounds and drain, check flaps for viability, change dressings, and chart patient progress. Monitor closely for airway patency and for development of cervical hematoma. Monitor nutritional intake until oral intake is possible. Assess overall medical condition of the patient including fluid balance, vital signs, and urinary function. Assess facial nerve function. Answer patient and family questions. Assure adequate level of pain control. Review orders for postoperative medications, diet, and patient activity – adjust as necessary. Chart notes. Answer nursing staff questions. Discuss patient progress with referring physician.

Hospital Discharge Management [when patient is stable and can safely be discharged]:

Review interval chart notes. Evaluate vital signs and intake/output. Examine patient, check wounds and drain, check flaps for viability, and change dressings. Assess airway patency. Assess overall medical condition of the patient including fluid balance, vital signs, and urinary function. Assess facial nerve function. Answer patient and family questions. If patient is stable and the surgeon determines it is safe for patient to be discharged to home, write prescriptions for medications and supplies needed post-discharge. Review post-discharge wound care and activity limitations with patient and family. Discuss follow-up care. Dictate discharge summary. Discuss patient progress with referring physician.

Post-op Office Visits:

Obtain and review pathology report. Review interval chart notes. Examine patient, remove sutures. Monitor output and remove drain if not removed prior to discharge. Answer patient and family questions. Monitor facial nerve functional deficits, if any. Assess for adequacy of pain control. Discuss advancing daily activities with patient. Discuss long-term scar management with patient. Discuss pathology report with patient and need for any additional testing or consultation. Arrange for any indicated additional testing and review results. Arrange for any indicated consultation, prepare documents for transmission to appropriate consultants, and review reports from consultants. Discuss patient progress with referring physician. Dictate progress notes for medical chart.

SURVEY DAT	ГА								
RUC Meeting Da	ate (mm/yyyy)	02/2011							
Presenter(s):	Wayne Koch, FACS	MD, FACS; C	hristopher	Senkowski,	MD, FACS;	Charles Mab	ry, MD,		
Specialty(s):	otolaryngolog	y; general sur	gery						
CPT Code:	42420	12420							
Sample Size:	250 F	lesp N:	76	S Response: 30.4 %					
Sample Type:	Random	Additional Sa	mple Info	rmation:					
			Low	25 th pctl	Median*	75th pctl	High		
Service Perform	0.00	2.00	5.00	7.00	25.00				
Survey RVW:			8.00	23.36	25.00	30.50	45.00		
Pre-Service Evalu	uation Time:				45.00				
Pre-Service Posit	ioning Time:				15.00				
Pre-Service Scrul	b, Dress, Wait Ti	me:			20.00				
Intra-Service Ti	me:		115.00	158.00	180.00	240.00	350.00		
Immediate Post	Service-Time:	<u>20.00</u>							
Post Operative	<u>Visits</u>	Total Min**	CPT Cod	e and Num	ber of Visit	S			
Critical Care tim	ne/visit(s):	<u>0.00</u>	99291x 0	. 00 99292	2x 0.00				
Other Hospital t	time/visit(s):	<u>60.00</u>	99231x 1	. 00 99232	2x 1.00 9	9233x 0.00			
Discharge Day	Mgmt:	<u>38.00</u>	99238x 1	. 00 99239x	0.00				
Office time/visit	:(s):	<u>62.00</u>	99211x 0	.00 12x 1.0	0 13x 2.00 1	4x 0.00 15x	0.00		
Prolonged Serv	ices:	<u>0.00</u>	99354x 0	.00 55x C	.00 56x 0	.00 57x 0.0)0		
Sub Obs Care:		0.00	99224x 0	.00 99225	5x 0.00 9	9226x 0.00			

**Physician standard total <u>minutes per E/M visit</u>: 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: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	42420		Recommended Physician Work RVU: 21.00				
			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:			12.00	3.00	9.00		
Pre-Service Scrub, Dress, Wait Time:			20.00	20.00	0.00		
Intra-Service Time:			180.00				
Immediate Post Servic	e-Time:	<u>20.00</u>					
Post Operative Visits		Total Min**	CPT Code and Number of Visits				
Critical Care time/visit	(s):	<u>0.00</u>	99291x 0.00 992	92x 0.00			
Other Hospital time/vis	sit(s):	<u>0.00</u>	99231x 0.00 992	32x 0.00 99233x	0.00		
Discharge Day Mgmt:		<u>38.00</u>	99238x 1.0 99239	× 0.0			
Office time/visit(s):		<u>62.00</u>	99211x 0.00 12x 1	.00 13x 2.00 14x 0	.00 15x 0.00		
Prolonged Services:		<u>0.00</u>	99354x 0.00 55x	0.00 56x 0.00	57x 0.00		
Sub Obs Care:		<u>60.00</u>	99224x 1.00 992	25x 1.00 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 S	ERVICE:		
Key CPT Code 38724	<u>Global</u> 090	Work RVU 23.95	Time Source RUC Time
<u>CPT Descriptor</u> Cervica	al lymphadenectomy (modified	d radical neck dissection)	
KEV MPC COMPAR	ISON CODES:		
KEY MPC COMPAR Compare the surveyed appropriate that have re	ISON CODES: code to codes on the RUC's lative values higher and lower	MPC List. Reference codes from than the requested relative values	the MPC list should be chosen, i for the code under review.
KEY MPC COMPAR Compare the surveyed appropriate that have re	ISON CODES: code to codes on the RUC's lative values higher and lower	MPC List. Reference codes from than the requested relative values	n the MPC list should be chosen, i for the code under review. Most Recent
KEY MPC COMPAR Compare the surveyed appropriate that have re <u>MPC CPT Code 1</u>	ISON CODES: code to codes on the RUC's lative values higher and lower <u>Global</u> Work RVU	MPC List. Reference codes from than the requested relative values	n the MPC list should be chosen, i for the code under review. Most Recent <u>Medicare Utilization</u>
KEY MPC COMPAR Compare the surveyed appropriate that have re <u>MPC CPT Code 1</u> 35656	ISON CODES: code to codes on the RUC's lative values higher and lower <u>Global</u> <u>Work RVU</u> 090 20.4	MPC List. Reference codes from than the requested relative values <u>Time Source</u> 47 RUC Time	n the MPC list should be chosen, i for the code under review. Most Recent <u>Medicare Utilization</u> 10,573
KEY MPC COMPAR Compare the surveyed appropriate that have re <u>MPC CPT Code 1</u> 35656 <u>CPT Descriptor 1</u> Bypa	ISON CODES: code to codes on the RUC's lative values higher and lower <u>Global</u> <u>Work RVU</u> 090 20.4 ss graft, with other than vein;	MPC List. Reference codes from than the requested relative values <u>Time Source</u> 47 RUC Time femoral-popliteal	n the MPC list should be chosen, i for the code under review. Most Recent <u>Medicare Utilization</u> 10,573
KEY MPC COMPAR Compare the surveyed appropriate that have re <u>MPC CPT Code 1</u> 35656 <u>CPT Descriptor 1</u> Bypa	ISON CODES: code to codes on the RUC's lative values higher and lower <u>Global</u> <u>Work RVU</u> 090 20.4 ss graft, with other than vein;	MPC List. Reference codes from than the requested relative values <u>Time Source</u> 47 RUC Time femoral-popliteal	n the MPC list should be chosen, i for the code under review. Most Recent <u>Medicare Utilization</u> 10,573 Most Recent
KEY MPC COMPAR Compare the surveyed appropriate that have re <u>MPC CPT Code 1</u> 35656 <u>CPT Descriptor 1</u> Bypa MPC CPT Code 2	ISON CODES: code to codes on the RUC's lative values higher and lower <u>Global</u> <u>Work RVU</u> 090 20.4 ss graft, with other than vein;	MPC List. Reference codes from than the requested relative values <u>Time Source</u> 47 RUC Time femoral-popliteal RVU Time Source	n the MPC list should be chosen, i for the code under review. Most Recent <u>Medicare Utilization</u> 10,573 Most Recent Medicare Utilization

<u>CPT Descriptor 2</u> Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, common femoral artery (profunda femoris, superficial femoral)

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

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 23

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

Source of Time **TIME ESTIMATES (Median) Kev Reference CPT Code: CPT Code: RUC Time** 42420 38724 Median Pre-Service Time 72.00 75.00 Median Intra-Service Time 180.00 180.00 Median Immediate Post-service Time 20.00 30.00 Median Critical Care Time 0.0 0.00 0.0 80.00 Median Other Hospital Visit Time Median Discharge Day Management Time 38.0 38.00 109.00 Median Office Visit Time 62.0 0.0 0.00 Prolonged Services Time Median Subsequent Observation Care Time 60.0 0.00 **Median Total Time** 432.00 512.00

% of respondents: 30.2 %

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 4.13 3.87 management options that must be considered The amount and/or complexity of medical records, diagnostic tests, 3.83 3.87 and/or other information that must be reviewed and analyzed Urgency of medical decision making 4.22 4.26 Technical Skill/Physical Effort (Mean) Technical skill required 4.83 4.57 4.17 Physical effort required 4.39 Psychological Stress (Mean) The risk of significant complications, morbidity and/or mortality 4.83 4.43 Outcome depends on the skill and judgment of physician 4.74 4.30 4.74 4.17 Estimated risk of malpractice suit with poor outcome **INTENSITY/COMPLEXITY MEASURES** CPT Code Reference Service 1 Time Segments (Mean) Pre-Service intensity/complexity 4.13 4.04 Intra-Service intensity/complexity 4.74 4.52 Post-Service intensity/complexity 3.39 3.57

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

CPT code 42420 was a Harvard valued code that was identified by the RUC 5YR ID WG in 2007 as potentially misvalued through a site-of-service anomaly screen. The RUC recommended 42420 be surveyed. In 2008, AAO-HNS and ACS conducted a RUC survey and presented data indicating that patients who undergo 42420 will remain for

CPT Code: 42420 several days in the hospital. The specialties argued that patients require close monitoring for airway patency, hematoma formation, and facial nerve function. Patients are maintained on IV fluids until oral intake is possible. After hearing these arguments, the RUC deferred review of 42420 until the RUC survey instrument could be modified to capture information about typical site of service.

The AAO-HNS and ACS conducted another RUC survey in 2009 using a modified RUC survey instrument that included a question regarding site-of-service and visits on the day of the procedure. The RUC accepted the survey times and visits. Because no compelling evidence for change in total work was presented, the RUC recommended maintaining the current RVW which was less than the 25th percentile RVW.

Recently, CMS requested the RUC review 42420 again as a code with a site of service anomaly.

CURRENT RECOMMENDATION

The American Academy of Otolaryngology – Head and Neck Surgery and the American College of Surgeons recommend maintaining the current RVW as published for CY 2011 (21.00). We respectfully request to defer our recommendation for coding the post-op evaluation and management visits until the RUC approves a policy and/or rules regarding correct coding for this physician work.

CMS has suggested that the RUC use a building block methodology to adjust site-of-service anomaly codes for the RVWs associated with changes in time and visits. More specifically, CMS proposes a "reverse" BBM that subtracts E/M code work RVUs from the current work RVU and reassignment of minutes to different categories. For example, post-operative E/M minutes should be reassigned to immediate post-operative care (ie, time from skin closure through discharge from recovery).

When Harvard reviewed code 42420, estimates were provided by 15 otolaryngologists for intra-time, hospital time and office time in <u>minutes</u>. Pre-time was assigned by algorithm. Because E/M codes were under revision at CPT during the Harvard study, surveyees were asked to estimate <u>minutes</u> – not E/M codes. Many years later, for purposes of practice expense RVU refinement, a CMS contractor translated the Harvard minutes to E/M codes using an algorithm.

The E/M CPT codes assigned by algorithm were NOT part of the Harvard building blocks to develop the work RVU for code 42420 for the first PFS in 1992. Therefore, CMS' proposal to use a reverse BBM that subtracts RVWs for E/M codes is flawed because Harvard did not use RVWs for E/M codes to "build" the value for 42420 – minutes were used. Additionally, the minutes assigned to the category of immediate post-operative work through discharge from recovery has a different intensity than other hospital and office work. Moving time from one category of work to another category of work is inconsistent with the methodology used by Harvard – the basis for the physician fee schedule.

Our consensus panel believes that <u>the procedure itself has not changed over time</u>. The Harvard geometric mean intratime of 182 minutes compared with the RUC survey median intra-time of 180 minutes, supports this belief. If only minutes were the comparable statistic to review, the table below which compares minutes from the Harvard study and minutes from the current RUC survey support maintaining the current RVW. However, the second measure of physician work - intensity – is not the same as it was 20 years ago. As with almost every other procedure and service in the PFS, physicians are now treating more complex patients who may be older and have more co-morbidities, resulting in more intense and complex work.

Source	Pre Min	Intra Min	Immed- Post-Op Min	Other Hosp Min	Office Min	Total Min
Harvard	57	182	22	45	39	345
RUC Survey	72	180	20	98	62	432

It is the clinical opinion of our expert panel that the typical patients undergoing 42420 are older and have more comorbidities compared with the typical patient of 1990 (ie, during the Harvard study) resulting in the need for more complex and intense services by providers. Our survey results do not suggest a decrease in operative time or total physician work. The CMS belief that a shift in reporting of hospital status (inpatient vs outpatient) would represent a decrease in physician work is faulty logic since patient facility status is not tied to physician work in the programs that assign patient status. Levels of physician work are accounted for by the levels of E/M code reported, not based on the facility resources utilized by a patient and facility payment.

Both code 42420 and key reference code 38724 include the risk of nerve dysfunction. Additionally, functional and cosmetic issues are significant. The intra-service time for 42420 and the reference code 38724 is the same (180 min), however, the intra-service intensity and complexity of 42420 is greater as seen in the survey mean intra-service intensity/complexity and all mean measures of technical skill and psychological stress statistics. The facial nerve is at risk during almost all parts of the procedure, including possible damage during flap raising, localization of main trunk, and dissection of peripheral branches, making this a high intensity procedure throughout. The nerve buried in the middle of the parotid gland, which is dense, fibrous, and vascular is difficult to find, difficult to dissect, and easy to injure; even with gentle traction or nerve stimulation. Code 42420 involves dissecting the nerve away from not only the superficial lobe, but from the underside from the deep lobe, with increased risk of injury. Deep lobe tumors are often malignant, resulting in increased technical difficulty to dissect the nerve free and more complex intraoperative decision-making regarding nerve preservation. Facial nerve injury results in significant functional issues related to speech, mastication, and eye closure as well as facial disfigurement. With 38724, nerve dissection is more limited, and nerves are less prone to injury. Similar to 38724, tumors of the parotid are prone to recurrence, requiring attention to wide margins, and meticulous handling to prevent tumor cell seeding of the operative site.

As stated above, procedure 42420 is <u>not</u> typically same-day surgery. All otolaryngologists and general surgeons on our consensus committee strongly believe that the typical patient will remain in the facility for 2 nights after the day of the procedure. We also agree with the survey respondents that the surgeon will typically perform an E/M service on the day of the procedure and the day after the procedure, followed by discharge management if the patient can safely be sent home. Patients require close monitoring for airway patency, hematoma formation, facial nerve function, and intervention for any noted deficits, drain function, and control of pain and nausea. Patients are maintained on IV fluids until oral intake is possible, which is unlikely well into the day after the procedure and possibly several days later.

RUC Year	СРТ	RVW	IWPUT	Total Time	eval	posit	s,d,w	INTRA	Immed Post-op	33	32/ <mark>25</mark>	31/ <mark>24</mark>	38/ <mark>17</mark>	14	13	12
2000	60271	17.62	0.071	377	60			150	30		1	1	1.0		1	1
2000	34203	17.86	0.075	413	75			108	30		1	3	1.0		2	1
2000	60260	18.26	0.078	372	60			145	30		1	1	1.0		1	1
2007	58572	20.09	0.082	400	45	10	5	150	30		1	1	1.0		2	1
2009	27647	20.26	0.071	469	43	20	15	144	30		2	1	1.0	1	1	1
2002	58146	20.34	0.076	429	70			150	30	1		2	1.0		2	
2003	61863	20.71	0.077	452	45	15	15	140	30		2	1	1.0		3	
1998	60650	20.73	0.081	384	70			180	30			1	1.0		2	
2002	47370	20.80	0.069	450	80			180	30		1	1	1.0		2	1
2009	42420	21.00	0.074	432	40	12	20	180	20		1	1	<mark>1.0</mark>		2	1
2002	50542	21.36	0.072	449	75			180	30		1		1.0	1	2	
2009	22905	21.58	0.078	463	40	3	20	150	30		1	2	1.0	1	2	1
2009	21558	21.58	0.068	502	40	12	20	160	30		2	1	1.0	1	2	1
2005	38720	21.95	0.075	482	45	15	15	150	30		1	2	1.0	1	3	
2007	49657	22.11	0.072	493	60	15	15	180	30		2	1	1.0		1	2

The table below compares the survey code (utilizing hospital visits as the <u>proxy</u> for the post-op in-hospital E/M visit) to many other RUC reviewed codes, providing further support that the current value for 42420 is appropriate.

	01100000.12420															
RUC Year	СРТ	RVW	IWPUT	Total Time	eval	posit	s,d,w	INTRA	Immed Post-op	33	32/ <mark>25</mark>	31/ <mark>24</mark>	38/ <mark>17</mark>	14	13	12
2009	25170	22.21	0.073	470	33	12	15	180	30		1	1	1.0	1	2	1
2000	35665	22.35	0.080	480	100			150	30		1	3	1.0		2	1
2005	24363	22.65	0.085	466	50	18	15	150	30		1	2	1.0		3	1
2005	38724	23.95	0.073	512	45	15	15	180	30		1	2	1.0	1	3	

CPT Codo: 42420

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.

Other reason (please explain)

Historical precedents.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one 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) 42420

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.

Multiple codes are used to maintain consistency with similar codes.

Specialty ototalyngology	How often? Rarely
Specialty general surgery	How often? Rarely
Specialty	How often?
Estimate the number of times the If the recommendation is from explain the rationale for this est	is service might be provided nationally in a one-year period? nultiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please mate. national frequency unavailable

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,625 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate. RUC database 2009 utilization

Specialty ototalyngology	/ Freque	ncy 1462	Percenta	age 89.96 %	CPT Code: 42420
Specialty general surgery	у	Frequency 55	Percenta	age 3.38 %	
Specialty	Frequency	Pero	centage	%	
Do many physicians per	form this service	e across the United Sta	ites? No		

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 42420

If this code is a new/revised code or an existing code in which the specialty utilization mix <u>will</u> change, please select another crosswalk based on a similar specialty mix.
AMA/Specialty Society RVS Update Committee Summary of Recommendations Identified through the Harvard Valued – Utilization over 30,000 Screen and the Fourth Five-Year Review

February 2011

Needle Biopsy of Liver – Practice Expense Only

In the 4th Five-Year Review of the RBRVS, CMS identified CPT code 47000 *Biopsy of liver, needle; percutaneous* as potentially misvalued through the Harvard Valued - Utilization over 30,000 Screen. The RUC carefully reviewed the work relative value of the service in October 2010 and recommended its value be maintained. In addition, at that time, the specialties explained that the survey data supported the fact that moderate sedation is an inherent component of this service. The RUC recommended that CPT Code 47000 be referred to the CPT Editorial Panel to be included in Appendix G. The inclusion of 47000 in CPT's Appendix G necessitates the inclusion of the direct practice expense inputs associated with moderate sedation, and therefore the RUC scheduled a review of the inputs at its February 2011 meeting.

In February 2011, the RUC carefully reviewed the specialty recommended typical clinical labor, medial supplies, and equipment for code 47000, and agreed upon the presented direct practice expense inputs to perform moderate sedation. The RUC recommends the attached direct practice expense inputs for code 47000.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
47000	Biopsy of liver, needle; percutaneous (If imaging guidance is performed, see 76942, 77002, 77012, 77021)	000	Practice Expense Recommendation

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

CPT Long Descriptor: Biopsy of liver, needle; percutaneous

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:

The SIR and ACR convened a panel that included a number of experts familiar with this service to evaluate the direct practice expense inputs for this recently surveyed biopsy code. This percutaneous biopsy code was identified by CMS as part of the Fourth Five Year Review as a Harvard valued code with utilization over 30,000 services reported in Medicare and was presented at the October 2010 RUC meeting. At that time, it was determined that conscious sedation was inherent in this procedure. As such, we are presenting standard conscious sedation inputs for this service and making minor modifications to the inputs (i.e. standards).

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

We selected the recently RUC'ed abdominal paracentesis code (4908x1) as our comparison code. The procedures are performed similarly and the resources used are comparable.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Provide pre-service education/ obtain consent
- Follow-up phone calls and prescriptions

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

• Conduct phone calls /call in prescriptions

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

CPT Long Descriptor: Biopsy of liver, needle; percutaneous

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:

The SIR and ACR convened a panel that included a number of experts familiar with this service to evaluate the direct practice expense inputs for this recently surveyed biopsy code. This percutaneous biopsy code was identified by CMS as part of the Fourth Five Year Review as a Harvard valued code with utilization over 30,000 services reported in Medicare and was presented at the October 2010 RUC meeting. At that time, it was determined that conscious sedation was inherent in this procedure. As such, we are presenting standard conscious sedation inputs for this service and making minor modifications to the inputs (i.e. standards).

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

We selected the recently RUC'ed abdominal paracentesis code (4908x1) as our comparison code. The procedures are performed similarly and the resources used are comparable.

Please describe in detail the clinical activities of your staff:

<u>Pre-Service</u> Clinical Labor Activities: Complete pre-service diagnostic and referral forms Coordinate pre-surgery services

Intra-Service Clinical Labor Activities:

The patient is greeted, gowning is provided and patient is escorted to procedure room. Registered Technologist (RT) takes the vital signs. RT interviews the patient for allergies, medications and coagulopathy. Procedure is explained and informed consent is witnessed. RT consults with the M.D regarding the type of needle to be used. RT prepares the tray including betadine, lidocaine, and biopsy needle. IV access is established with intracatheter and hep lock, flushed. RT positions the patient and may prep the skin under physician supervision. RN administers conscious sedation. RT assists the M.D. performing biopsy, including providing additional needles, lidocaine etc., collects specimen in appropriate solution. Following completion of biopsy, RT cleans betadine from the skin, applies Bandaid or dressing to the biopsy site. The patient is escorted to the observation area. RN performs sequential vital signs over 4 hour observation. RT fills out the pathology request for the lab. RT cleans up the biopsy tray with appropriate disposal of sharps. The biopsy site is checked for discharge and gives the patient complete discharge instructions.

<u>Post-Service</u> Clinical Labor Activities: Conduct phone calls /call in prescriptions

	Α	В	С	D	E	F	G
1	Meeting Date: February 2011			470	00	32	405
-				Fionsy of liv	ver needle:	Bionsy	lung or
				percuta	neous	mediastinum	nercutaneous
	AMA/Specialty Society RVS Update Committee			percute	lineous	nee	Alle
2	Recommendation	CMS	Staff				, are
3	LOCATION	Code	Туре	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD			0	0	0	0
5	TOTAL CLINICAL LABOR TIME			132.0	20.0	160.0	19.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME			4.0	17.0	3.0	16.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			125.0	0.0	154.0	0.0
8		L037D	RN/LPN/MTA				
a		L041B	RT	43.0		57.0	
10				43.0 82.0		07.0	
10	TOTAL DOST SEDVICI INICAL LADOD TIME	LUSIA	KIN	02.0	2.0	97.0	2.0
11	TOTAL FOST-SERV CLINICAL LABOR TIME			5.0	3.0	3.0	3.0
12	PRE-SERVICE Stort: Following visit when desision for surgery or presedu	ia mada					
13	Complete pro-service diagnostic & referral forms			2	3	2	2
14	Condinate pre-service diagnostic & relenarionns			3	1	3	<u> </u>
10	Schedule space and equipment in facility			1	5	0	5
17	Provide pre-service education/obtain consent	L037D			5		5
18	Follow-up phone calls & prescriptions	L037D	RN/I PN/MTA		3		3
10	Other Clinical Activity (Retrieve films/hand)	1.041R	RT		0		5
20	End: When nations enters office/facility for surgery/procedur						
20	SERVICE PERIOD	e					
22	Start: When nation enters office/facility for surgery/procedu	re: Servi	ces Prior to Procedur				
	Greet patient provide gowning ensure appropriate medical			0			
23	records are available	1041B	RT	3		3	
23	Obtain vital signs	L041B	RT	3		3	
25	Provide pre-service education/obtain consent	L041B	RT	3		3	
26	Prepare room, equipment, supplies	L041B	RT	2		2	
27	Setup scope (non facility setting only)			_			
28	Prepare and position patient/ monitor patient/ set up IV	L041B	RT	3		2	
29	Sedate/apply anesthesia	L051A	RN	2		2	
30	Intra-service			_			
31	Assist physician in performing procedure	L041B	RT	20		35	
32	Monitor drainage of fluid	L037D	RN/LPN/MTA				
33	Assist physician in performing procedure (CS)	L051A	RN	20		35	
34	Post-Service						
35	Monitor pt. following service/check tubes, monitors, drains	L051A	RN	60		60	
36	Clean room/equipment by physician staff	L041B	RT	3		3	
37	Clean Scope						
38	Clean Surgical Instrument Package						
39	Complete diagnostic forms, lab & X-ray requisitions	L041B	RT	3		3	
40	Review/read X-ray, lab, and pathology reports						
	Check dressings & wound/ home care instructions /coordinate						
41	office visits /prescriptions	L041B	RT	3		3	
42	Other Clinical Activity (process films)						
43	End: Patient leaves office						
44	POST-SERVICE Period						
45	Start: Patient leaves office/facility		5-			-	
46	Conduct phone calls/call in prescriptions	L041B	RT	3	3	3	3
47	Other Activity (please specify)					ļ	
48	End: with last office visit before end of global period		11.1				
49	MEDICAL SUPPLIES	04040	Unit	1		4	
50	pack, minimum multi-speciality	SA048	раск	1		1	
51	Conscious Sedation Pack	SA044	KIt	1		1	
52	Danualu Rotadipo	SG021	ntem	1		1	
53	Cloves storile	SJ041		30		30	
54	Gloves, sterlie	SB024	pair	<u>∠</u>		<u> </u>	
55	Lidocaine	SU012 SU047	m	10		10	
00 57	Needle Chiba	SC025		10		1U 2	
57	Needle 18G	SC020	itom	1		3 1	
50	Pre-set biopsy tray	SA061	item	1		1	
60	Saline Flush	SH065	ml	10		10	
61	Spring loaded needle, 18G (biopsy gup)	SC033	item	1		1	
62	Svringe. 5cc	SC057	item	1		. 1	
63	Equipment	20001					
64	CT room	EL007		30		31	
65	stretcher chair	EF019		262		0	
66	ECG, 3-channel (with SpO2, NIBP. temp. resp)	EQ011		252		277	
67	IV infusion pump	EQ032		252		277	

AMA Specialty Society Recommendation

	Α	В	С	D	E	F	G
	Meeting Date: February 2011			470	200		105
1				4/0		324	+05
				Biopsy of IN	ver, needle;	Biopsy,	lung or
	AMA/Specialty Society RVS Update Committee			percuta	ineous	mediastinum,	percutaneous
2	Recommendation	CMS	Staff			nee	ale
2	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility
1			. 76 -	0	0	0	0
5	TOTAL CLINICAL LABOR TIME			132.0	20.0	152.0	20.0
5	TOTAL DDE SEDV CLINICAL LABOD TIME			132.0	17.0	132.0	17.0
6	TOTAL TRE-SERV CLINICAL LADOR TIME			4.0	17.0	4.0	17.0
1	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	1.0075		125.0	0.0	145.0	0.0
8		L037D	RN/LPN/MTA				
9		L041B	RT	43.0		53.0	
10		L051A	RN	82.0		92.0	
11	TOTAL POST-SERV CLINICAL LABOR TIME			3.0	3.0	3.0	3.0
12	PRE-SERVICE						
13	Start: Following visit when decision for surgery or procedur	re made					
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3	3	3	3
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA	1	1	1	1
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA		5		5
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3		3
19	Other Clinical Activity (Retrieve films/hang)	L041B	RT				
20	End: When patient enters office/facility for surgery/procedur	e					
21	SERVICE PERIOD						
22	Start: When patient enters office/facility for surgery/procedu	re: Servi	ces Prior to Procedur	e			
	Greet patient, provide gowning, ensure appropriate medical						
23	records are available	L041B	RT	3		3	
24	Obtain vital signs	L041B	RT	3		3	
25	Provide pre-service education/obtain consent	L041B	RT	3		3	
26	Prepare room, equipment, supplies	L041B	RT	2		2	
27	Setup scope (non facility setting only)						
28	Prepare and position patient/ monitor patient/ set up IV	L041B	RT	3		3	
29	Sedate/apply anesthesia	L051A	RN	2		2	
30	Intra-service						
31	Assist physician in performing procedure	L041B	RT	20		30	
32	Monitor drainage of fluid	L037D	RN/LPN/MTA				
33	Assist physician in performing procedure (CS)	L051A	RN	20		30	
34	Post-Service						
35	Monitor pt. following service/check tubes, monitors, drains	L051A	RN	60		60	
36	Clean room/equipment by physician staff	L041B	RT	3		3	
37	Clean Scope						
38	Clean Surgical Instrument Package						
39	Complete diagnostic forms, lab & X-ray requisitions	L041B	RT	3		3	
40	Review/read X-ray, lab, and pathology reports						
	Check dressings & wound/ home care instructions /coordinate						
41	office visits /prescriptions	L041B	RT	3		3	
42	Other Clinical Activity (process films)						
43	End: Patient leaves office						
44	POST-SERVICE Period						
45	Start: Patient leaves office/facility						
46	Conduct phone calls/call in prescriptions	L041B	RT	3	3	3	3
47	Other Activity (please specify)						
48	End: with last office visit before end of global period						
49	MEDICAL SUPPLIES	0.4.0.45	Unit				
50	pack, minimum multi-specialty	SA048	pack	1		1	
51	Conscious Sedation Pack	SA044	kit	1		1	
52	Bandaid	SG021	item	1		1	
53	Beradine	SJ041	mi	30		30	
54		SB024	pair	2		2	
55	Heparin lock	SC012	Item	1		1	
56		SH047	mi	10		10	
57	INeedle, Uniba	SC035	each			3	
58	Ineedie, 186	50029	item	1		1	
59	Pre-set biopsy tray	SAU61	Item	1		1	
60 61	Saline Flush	SH065	mi ita	10		10	
61	Spring loaded needle, 18G (blopsy gun)	SC033	item			1	
62		30057	item	Ĩ		1	
63		EL 007		00		40	
64				30		40	
65	Sileicher Chair ECC. 2 channol (with SpO2, NIPD, town, room)	EF019 E0014		202		212	
00 67	$\mathbb{I}_{\mathcal{V}}$ influsion pump	EQ011		202		212	
01				202		212	

AMA Specialty Society Recommendation

AMA/Specialty Society RVS Update Committee Summary of Recommendations Identified through the Site of Service Anomaly Screen and the Fourth Five-Year Review

February 2011

Hernia Repair

In September 2007, the RUC's Relativity Assessment Workgroup (formerly Five-Year Review Identification Workgroup) identified CPT codes 49507, 49521 and 49587 as potentially misvalued through the Site-of-Service Anomaly screen. In October 2008, the American College of Surgeons (ACS) conducted a RUC survey, but RUC action was deferred on these services until an adequate survey instrument was developed to capture information about typical site of service and post-operative visits. In February 2009, the specialties presented these services using a modified RUC survey instrument that included a question regarding site-of-service and visits on the day of the procedure. CMS accepted the RUC's recommendation for these services. Following the RUC's recommendation, CMS included codes 49507, 49521 and 49587 in Table 16 of the 2011 Proposed Rule and asked the RUC to re-review these services.

49507 Repair initial inguinal hernia, age 5 years or over; incarcerated or strangulated

The RUC reviewed the previous rationale and physician work survey data for CPT code 49507. In 2009, the RUC noted that the RUC recommended the 2009 work RVU of 9.97, which was slightly higher than the 25^{th} percentile survey data. The RUC compared 49507 to the key reference service 49505, *Repair initial inguinal hernia, age 5 years or older; reducible* (work RVU = 7.96 intra-time = 70 minutes). The RUC noted that the while the two services have comparable physician work, the surveyed code should be valued higher due to greater total time, 260 minutes compared to 198 minutes. The RUC also compared 49507 to 54512, *Excision of extraparenchymal lesion of testis* (work RVU = 9.33 and intra-time = 70 minutes) and noted that the surveyed code has greater total time compared to the reference code, 260 minutes and 216 minutes, respectively and should be valued higher. In 2010, the value for 49507 was increased to 10.15 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. The RUC also reviewed a table provided by the specialties that compares the survey code to many other RUC reviewed codes as further support that the current value for 49507 is appropriate. The RUC agreed that the surveyed code was accurately valued during the February 2009 meeting, with strong support from reference services and specialty survey data, and finds no compelling evidence to change the current physician work value of this service.

Additionally, the RUC further analyzed the site-of-service data and post-operative visit data for the surveyed service. Code 49507 is not typically same day surgery. The typical patient requires close monitoring for problems such as ileus, intestinal ischemia and urinary retention. Additionally, there will be significant pain post-operatively requiring management before discharge. The specialty noted, and the RUC agreed, that the shift in patient facility status for this service has nothing to do with healthier patients that require less physician work and everything to do with the recent OPPS changes related to facility reimbursement. This was substantiated by the survey data which shows that the typical patient receives this procedure in the hospital (98%), stays at least overnight in the hospital following surgery (83%) and receives an Evaluation and Management service

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on the same date (59%). Given this data, the RUC enacted its policy to allocate the appropriate proxy for the post-operative visits. Importantly, the RUC noted that the work involved in monitoring the typical patient post-operatively on the day of surgery is the same Evaluation and Management work whether the patient's facility status ends up inpatient or outpatient. Adjustments to the allocation of post-operative visits are used as proxies and do not constitute changes to the physician work relative value of the service which was determined by magnitude estimation and physician specialty survey data during the last RUC review. **The RUC recommends a work RVU of 10.15 for CPT code 49507.**

49521 Repair recurrent inguinal hernia, any age; incarcerated or strangulated

The RUC reviewed the previous rationale and physician work survey data for CPT code 49521. In 2009, the RUC noted that the RUC recommended the 2009 work RVU for 12.36, which fell between the survey's 25th percentile and median work value estimates. The RUC compared 49521 to the key reference service, 49520, *Repair recurrent inguinal hernia, any age; reducible*, (work RVU = 9.99, intra-service time = 60 minutes). The RUC noted that the reference code contains 30 minutes less intra-service time and requires less intensity and complexity that the surveyed code. The RUC also compared 49521 to 49652, *Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible* (work RVU = 12.88, pre-time = 75, intra-time = 90, immediate post-time = 30) and noted that the two codes are similar and have identical intra- and immediate post-service time, but that the reference code has slightly more pre-service time accounting for the difference in work RVU. In 2010, the value for 49521 was increased to 12.44 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. The RUC also reviewed a table provided by the specialties that compares the survey code to many other RUC reviewed codes as further support that the current value for 49521 is appropriate. The RUC agreed that the survey doed was accurately valued during the February 2009 meeting, with strong support from reference services and specialty survey data, and finds no compelling evidence to change the current physician work value of this service.

Additionally, the RUC further analyzed the site-of-service data and post-operative visit data. Code 49521 is not typically same day surgery. The typical patient requires close monitoring for problems such as ileus, intestinal ischemia and urinary retention. Additionally, there will be significant pain post-operatively requiring management before discharge. The specialty noted, and the RUC agreed, that the shift in patient facility status for this service has nothing to do with healthier patients that require less physician work and everything to do with the recent OPPS changes related to facility reimbursement. This was substantiated by the survey data which shows that the typical patient receives this procedure in the hospital (99%), stays at least overnight in the hospital following surgery (82%) and receives an Evaluation and Management service on the same date (55%). Given this data, the RUC enacted its policy to allocate the appropriate proxy for the post-operative visits. Importantly, the RUC noted that the work involved in monitoring the typical patient post-operatively on the day of surgery is the same Evaluation and Management work whether the patient's facility status ends up inpatient or outpatient. Adjustments to the allocation of post operative visits are used as proxies and do not constitute changes to the physician work relative value of the service which was determined by magnitude estimation and physician specialty survey data during the last RUC review. **The RUC recommends a work RVU of 12.44 for CPT code 49521**.

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49587 Repair umbilical hernia, age 5 years or over; incarcerated or strangulated

The RUC reviewed the previous rationale and physician work survey data for CPT code 49587. In 2009, the RUC noted that the RUC recommended the 2009 work RVU for 7.96, which was slightly below the survey's 25th percentile physician work value estimates. The RUC compared 49587 to the key reference service, 49585, *Repair umbilical hernia, age 5 years or older; reducible*, (work RVU = 6.59, intra- time = 45 minutes). The RUC noted that the reference service requires less intra-service time compared to the surveyed codes, 45 minutes and 60 minutes, respectively. Also, the reference code requires less intensity and complexity compared to the surveyed code and should be valued less. The RUC also compared 49587 to 49572, *Repair epigastric hernia (eg, preperitoneal fat); incarcerated or strangulated* (work RVU = 7.87, total time= 312 minutes). The RUC noted that while the reference code has greater total time, the surveyed code has greater intensity and complexity in the physician work and should be valued slightly higher. In 2010, the value for 48587 was increased to 8.04 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. The RUC also reviewed a table provided by the specialties that compares the survey code to many other RUC reviewed codes as further support that the current value for 49587 is appropriate. The RUC agreed that the surveyed code was accurately valued during the February 2009 meeting, with strong support from reference services and specialty survey data, and finds no compelling evidence to change the current physician work value of this service.

Additionally, the RUC further analyzed the site-of-service data and post-operative visit data. Code 49587 is not typically same day surgery. The typical patient requires close monitoring for problems such as ileus, intestinal ischemia, and urinary retention. Additionally, there will be significant pain post-operatively requiring management before discharge. The specialty noted, and the RUC agreed, that the shift in patient facility status for this service has nothing to do with healthier patients that require less physician work, but is due to the recent OPPS changes related to facility reimbursement. This was substantiated by the survey data which shows that the typical patient receives this procedure in the hospital (100%), stays at least overnight in the hospital following surgery (71%) and receives an Evaluation and Management service on the same date (55%). Given this data, the RUC enacted its policy to allocate the appropriate proxy for the post-operative visits. Importantly, the RUC noted that the work involved in monitoring the typical patient post-operatively on the day of surgery is the same Evaluation and Management work whether the patient's facility status ends up inpatient or outpatient. Adjustments to the allocation of post operative visits are used as proxies and do not constitute changes to the physician work relative value of the service which was determined by magnitude estimation and physician specialty survey data during the last RUC review. **The RUC recommends a work RVU of 8.04 for CPT code 49587.**

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
49507		Repair initial inguinal hernia, age 5 years or over; incarcerated or strangulated	090	10.05
		(For inguinal hernia repair, with simple orchiectomy, see 49505 or 49507 and 54520)		(No Change)
		(For inguinal hernia repair, with excision of hydrocele or spermatocele, see 49505 or 49507 and 54840 or 55040)		
49521		Repair recurrent inguinal hernia, any age; incarcerated or strangulated	090	12.44
				(No Change)
49587		Repair umbilical hernia, age 5 years or over; incarcerated or strangulated	090	8.04
				(No Change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code:49507 Tracking Number

Original Specialty Recommended RVU: 10.05 Presented Recommended RVU: 10.05 RUC Recommended RVU: 10.05

Global Period: 090

CPT Descriptor: Repair initial inguinal hernia, age 5 years or over; incarcerated or strangulated

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old male presents with 2 hour history of painful swelling in the left groin. Physical exam reveals an inguinal hernia that is tender and nonreducible by manual manipulation. He undergoes operative reduction and repair.

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

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

Percent of survey respondents who stated they perform the procedure; In the hospital 98% , In the ASC 2%, 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 17%, Kept overnight (less than 24 hours) 40%, Admitted (more than 24 hours) 43%

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 73%

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: Select and order the appropriate antibiotic(s) and confirm timing and administration. Assure appropriate selection, timing, and administration of DVT prophylaxis. Assess need for beta-blockers, order as required. Review preadmission work-up, with particular attention to imaging information and reports. Reexamine patient to make sure that physical findings have not changed, that the hernia remains unreducible, and update H&P. Review results of preadmission testing (lab, EKG, chest x-ray, availability of blood products). Meet with patient and family to review planned procedure and post-operative management.. Review and obtain informed consent, including the possibility of bowel resection, with witness. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available Assist in transfer of patient from gurney to operating table. Monitor/assist with positioning of patient. Install or supervise installation of Foley catheter Assist anesthesia team with line placement and induction of anesthesia and intubation. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Incision is made through skin and subcutaneous tissue taking care not to injure the underlying bowel that is incarcerated. Dissection carried out meticulously around the hernia sac to expose the external fascial ring. Incision is then made in the external oblique fascia taking care to preserve the ilioinguinal nerve. Flaps of the external oblique fascia are made to expose underside of Poupart's ligament laterally and the internal oblique muscle medially. The defect whether direct or indirect is then determined in relation to epigastric vessels and the transversalis fascia. The neck of the hernia sac is then released to allow pressure on the hernia sac contents to be lessened. The vas deferens and spermatic vessels are carefully dissected from the hernia sac. The hernia sac is then opened to facilitate

examination of the incarcerated hernia sac contents. The viability of the bowel is assessed. If bowel resection is indicated, it is performed (reported separately). If no resection is required, the bowel is meticulously inspected, allowed to partially reduce and reinspected to ensure that it is likely viable. The operative site is then assessed to determine ability to place mesh and the potential infection risk. Once the bowel is reduced, the peritoneum of the hernia sac is circumferentially dissected (or resected if there is excess) and oversewn. The cord structures are carefully dissected and retracted to prevent injury to the Vas Deferens and vessels. The inguinal ligament, inguinal floor and conjoined tendon are defined. Mesh is placed either to plug the defect or as an onlay patch or a combination. The mesh is sutured in place to Poupart ligament and the medial conjoined tendon. A new internal ring is created as mesh encircles the spermatic vessels and vas deferens taking care to not compromise the structures to prevent injury or necrosis. Finally the mesh is placed under the internal oblique muscle to prevent recurrence. Hemostasis is obtained. The external oblique fascia is reapproximated with care to avoid ilioinguinal nerve injury, entrapment, and significant chronic pain. The wound is irrigated. The Scarpa's fascia is reapproximated and the skin is closed. Sponge, needle, and instrument counts are obtained and confirmed prior to closure.

Description of Post-Service Work:

Hospital [operative day through discharge from recovery room]: Apply sterile adhesive strips and dressings. Monitor patient during reversal of anesthesia, protecting the wound with a hand so that wound disruption does not occur with an unrestrained cough on emergence from anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia. Discontinue prophylactic antibiotic therapy, as appropriate. Review post-operative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to general surgical floor and discuss ongoing care with floor nurses.

Hospital Visit [operative day after discharge from recovery room]: Review interval chart notes. Discuss ongoing care with floor nurses. Evaluate vital signs and intake/output. Auscultate heart, lungs, and abdomen for bowel sounds. Monitor fluid and electrolyte status and renal function; monitoring for problems such as ileus, intestinal ischemia, and urinary retention. Examine patient, check wounds and drain, and change dressings. Continue prophylaxis for DVT. Assess need for beta-blockers, order as required. Assess pain scores and adequacy of analgesia. Review nursing/other staff patient chart notes. Write orders for labs, films, medications, diet, and patient activity. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions. Advance diet, as appropriate.

Hospital Discharge Management [day after surgery, IF patient is stable and can safely be discharged]: Review interval chart notes. Evaluate vital signs and intake/output. Auscultate heart, lungs, and abdomen for bowel sounds. Monitor fluid and electrolyte status and renal function; monitoring for problems such as ileus, intestinal ischemia, and urinary retention. Examine patient, check wounds and drain, and change dressings. After considering relevant data, options, and risks on the day following surgery, the surgeon will make the decision for the patient to stay in the hospital or to be discharged. The patient will not be discharged until there is return of bowel function, the patient is taking adequate nutrition, and there is adequate pain control with oral analgesics. Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy. Write prescriptions for medications needed post-discharge. Home restrictions and activity levels (ie, diet, bathing) are discussed with the patient, family members and discharging nurse. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Post-op Office Visits: Review interval chart notes. Examine and talk with patient. Assess pain scores and adequacy of analgesia. Remove staples or sutures and drain, when appropriate. Review activity and restrictions. Check for presence of post-operative hematoma/seroma and assess need for aspiration. Monitor diet caloric intake by weight. Answer patient/family questions. Write medication prescriptions. Post discharge labs/films are ordered and reviewed. Discuss progress with referring physician(s) (verbal and written). Dictate progress notes for medical chart. Review activity permission with patient and write appropriate permission.

SURVEY DAT	SURVEY DATA										
RUC Meeting Da	ate (mm/yyyy)	02/2011									
Presenter(s):	Christopher S FACS	enkowski, MD	, FACS; C	harles Mabr	y, MD, FAC	S; Michael Ed	ye, MD,				
Specialty(s):	general surge	ry									
CPT Code:	49507										
Sample Size:	300 R	esp N:	84	84 Response: 28.0 %							
Sample Type:	Random	Additional Sa	mple Info	rmation:							
			Low	25 th pctl	Median*	75th pctl	High				
Service Perform	nance Rate		0.00	2.00	5.00	10.00	50.00				
Survey RVW:			7.88	9.91	11.00	14.25	25.00				
Pre-Service Evalu	uation Time:				60.00						
Pre-Service Posit	ioning Time:				10.00						
Pre-Service Scru	b, Dress, Wait Ti	me:			15.00						
Intra-Service Ti	me:		45.00	60.00	70.00	86.00	120.00				
Immediate Post	Service-Time:	<u>30.00</u>									
Post Operative	Visits	Total Min**	CPT Cod	e and Num	nber of Visi	ts					
Critical Care tin	ne/visit(s):	<u>0.00</u>	99291x 0	.00 99292	2x 0.00						
Other Hospital	time/visit(s):	<u>20.00</u>	99231x 1	. 00 99232	2x 0.00	99233x 0.00					
Discharge Day	Mgmt:	<u>38.00</u>	99238x 1	. 00 99239x	0.00						
Office time/visit	:(s):	39.00	99211x 0	0.00 12x 1.0	0 13x 1.00	14x 0.00 15x	0.00				
Prolonged Serv	ices:	0.00	99354x 0).00 55x ().00 56x	0.00 57x 0.0	00				
Sub Obs Care:		0.00	99224x 0	0.00 99225	5x 0.00	99226x 0.00					

**Physician standard total <u>minutes per E/M visit</u>: 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: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	49507		Recommended Physician Work RVU: 10.05					
			Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time			
Pre-Service Evaluation T	ïme:		40.00	40.00	0.00			
Pre-Service Positioning	Time:		3.00	3.00	0.00			
Pre-Service Scrub, Dress	s, Wait Tim	ie:	20.00	20.00	0.00			
Intra-Service Time:			70.00					
Immediate Post Servic	e-Time:	<u>30.00</u>						
Post Operative Visits		Total Min**	CPT Code and Number of Visits					
Critical Care time/visit	(s):	<u>0.00</u>	99291x 0.00 992	92x 0.00				
Other Hospital time/vis	sit(s):	<u>0.00</u>	99231x 0.00 992	32x 0.00 99233x	0.00			
Discharge Day Mgmt:		<u>38.00</u>	99238x 1.0 99239	< 0.0				
Office time/visit(s):		<u>39.00</u>	99211x 0.00 12x 1.00 13x 1.00 14x 0.00 15x 0.00					
Prolonged Services:		<u>0.00</u>	99354x 0.00 55x	0.00 56x 0.00	57x 0.00			
Sub Obs Care:		<u>20.00</u>	99224x 1.00 992	25x 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 SERV	/ICE:								
Key CPT Code	<u>Global</u>			Work RVU	Time Source				
49505	090			7.96	RUC Time				
CPT Descriptor Repair initia	al inguinal he	rnia, age 5 years of	r older; reducibl	e					
KEY MPC COMPARISO	N CODES:								
Compare the surveyed code appropriate that have relative	e to codes on e values high	the RUC's MPC er and lower than t	List. Reference the requested rel	e codes from the ative values for	e MPC list should be chosen, i the code under review. Most Recent				
MPC CPT Code 1	<u>Global</u>	Work RVU	Time Source	<u>Me</u>	dicare Utilization				
50590	090	9.77	RUC Tim	e	53,325				
CPT Descriptor 1 Lithotrips	y, extracorpo	real shock wave							
	-				Most Recent				
MPC CPT Code 2	<u>Global</u>	Work RVU	Time Source	Me	edicare Utilization				
44950	090	10.60	RUC Time		3,857				
<u>CPT Descriptor 2</u> Appendectomy;									
Other Reference CPT Code	<u>Global</u>	<u>Work R</u> 0.00	<u>VU</u> <u>Time</u>	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: 20

% of respondents: 23.8 %

<u>TIME ESTIMATES (Median)</u>	CPT Code: 49507	Key Reference CPT Code: <u>49505</u>	Source of Time RUC Time
Median Pre-Service Time	63.00	50.00]
Median Intra-Service Time	70.00	70.00	
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	38.0	19.00	
Median Office Visit Time	39.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	20.0	0.00	
Median Total Time	260.00	198.00	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

(of those that selected Key Reference code)

<u>Mental Effort and Judgment (Mean)</u>		
The number of possible diagnosis and/or the number of	2.60	2.15
management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests,	2.40	2.10
and/or other information that must be reviewed and analyzed		
Urgency of medical decision making	3.20	2.20
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.05	2.65
Physical effort required	2.65	2.40
Psychological Stress (Mean)		II
	11	
The risk of significant complications, morbidity and/or mortality	2.90	2.20
Outcome depends on the skill and judgment of physician	3.20	2.75
	2.10	0.70
Estimated risk of malpractice suit with poor outcome	3.10	2.70
INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference
		<u>Service 1</u>
Time Segments (Mean)		
Pre-Service intensity/complexity	2.95	2.35
Intra-Service intensity/complexity	3.00	2.45
Post-Service intensity/complexity	2.40	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.*

Coding changes were made to the family of hernia codes for CPT 1994 to differentiate physician work. A request was made to separate incarcerated and strangulated hernias, but the CPT Editorial Panel chose to combine those procedures. The RUC process in **1993** utilized consistent <u>ratios</u> for valuing each type of hernia (reducible, incarcerated/strangulated, initial, and recurrent), with a goal of maintaining budget neutrality across all hernia codes. In **2000**, during the second 5-year review, the hernia codes were surveyed as mini-surveys and the work RVUs adjusted using the <u>percentage</u> change made to 49505, which underwent a full RUC survey. Many of the more difficult procedures had evidence to support higher values, but the details of the codes with mini-surveys were not reviewed on a code-by-code basis.

Code 49507 was identified by the RUC 5YR ID WG in **2007** as potentially misvalued through a site-of-service anomaly screen. The RUC recommended 49507 be surveyed. In **2008**, ACS conducted a RUC survey and presented data that indicated 49507 was not same-day surgery. We argued that that a majority of these patients require close monitoring on the day of the procedure and are kept in the hospital for continued monitoring for problems such as ileus, intestinal ischemia, and urinary retention. Additionally, there will be significant pain post-operatively requiring management before discharge. After considering relevant data, options, and risks, the surgeon will make the decision for the patient to stay in the hospital or to be discharged. The patient will not be discharged until there is return of bowel function, the patient is taking adequate nutrition, and there is adequate pain control with oral analgesics. Medicare data indicate that code 49507 has an inpatient facility status of 45%, therefore, next day discharge is not "imminent" or pre-planned when a patient is scheduled for surgery and the work in monitoring these patients post-operatively on the day of surgery is the same E/M work whether the patient's status ends up inpatient or outpatient. After hearing these arguments, the RUC deferred review of 49507 until the RUC survey instrument could be modified to capture information about typical site of service and visits.

ACS conducted another RUC survey in **2009** using a modified RUC survey instrument that included a question regarding site-of-service and visits on the day of the procedure. The RUC agreed with the survey results regarding physician time and necessary post-operative visits. The RUC compared the physician work, time, and visits of 49507 to 49505 and 54512. Without compelling evidence for a change in physician work since the prior RUC review, the RUC recommended maintaining the work RVU (below the survey median).

Why Reverse Building Block is Not Applicable to Code 49507

CMS has suggested that the RUC use a building block methodology to adjust site-of-service anomaly codes for the RVWs associated with changes in time and visits. More specifically, CMS proposes a "*reverse*" BBM that subtracts E/M code work RVUs from the current work RVU, along with reassignment of minutes to different categories of time with lower intensity. For example, "some" of the post-operative E/M minutes should be reassigned to immediate post-operative care (ie, time from skin closure through discharge from recovery) at a low intensity of 0.0224, which is inconsistent with the intensity for E/M codes (eg, 99231=0.054).

This methodology is not applicable to code 49507. When the RUC reviewed code 49507, the ACS recommendation of 12.44 work RVUs using the building block methodology was <u>not</u> accepted, and instead the RUC recommended 9.57 work RVUS (23% *less*) based on magnitude estimation. The RUC did NOT use BBM for the value of 49507, therefore, it is flawed logic to propose a reverse BBM that subtracts the RVUs for E/Ms and calculates a new value for 49507.

Discussion of Post-operative E/M Work

In the Final Rule, CMS states:

- 1. "For procedures typically performed in the inpatient setting when the codes were originally valued, the work RVUs for these codes would have been valued to include the inpatient physician work furnished, as well as to reflect the intensive care and follow-up normally associated with an inpatient procedure."
- 2. "If the typical case for the procedure has shifted from the inpatient setting to an outpatient or physician's office setting, it is reasonable to expect that there have been changes in medical practice, and that such changes would represent a decrease in physician time or intensity or both."

<u>We disagree with both of these statements.</u> First, hospital *status* (inpatient or outpatient) is an artifact of recent changes in payment policy and recent use of criteria-based programs (eg, InterQual) that <u>assign admission status for purposes of facility reimbursement</u>. The criteria for these programs are not based on physician work; they are based on facility resource utilization. Therefore, the CMS belief that a shift in reporting of hospital status (inpatient vs outpatient) would

represent a decrease in physician work is flawed logic since hospital admission status is not tied to physician work in the programs that assign patient status. Second, almost half of these patients will stay for several days in the hospital, therefore, next day discharge is not "imminent" or pre-planned as CMS suggests. The work in monitoring these patients post-operatively on the day of surgery is the same E/M work whether the patient's status ends up inpatient or outpatient. Third, the CPT descriptor includes both incarcerated and strangulated hernias. The presentation of one or the other type of hernia can vary from year to year and can vary by age group from year to year. More importantly, the Medicare data may not be representative of the national population and should not be extrapolated to represent the typical national population. Finally, the Medicare claims summary data is not without error. For example, almost 3% of the 2009 claims for 49507 are from non-surgical specialties that would not perform open hernia repair (eg, general practice, family medicine, internal medicine).

We believe that semantics about place of service and length of stay have created an undo concern with regard to screening, reviewing and accounting for physician work. Medicare representatives have stated that a claim designated as "outpatient" is a hospital stay of 23hr-59min or less. On the other hand, CPT codes describe E/M codes in a less concrete fashion. CPT indicates that codes 99234-99236 are to be used to report observation or <u>inpatient</u> hospital care services provided to patients admitted and discharged on the <u>same date of service</u>. For these codes, claims can correctly be submitted as <u>inpatient same day service</u>. In 2008, Medicare claims data show more than 55% inpatient claims for 99234 (typical patient is 19 y.o. pregnant female complaining of persistent vomiting for one day). Clearly, 55%+ of these 74,000+ Medicare patients were not admitted at 12:00am and discharged at midnight – which according to Medicare is the only way that a claim can be considered inpatient (ie, 23hr-59min+).

It is the clinical opinion of our expert panel that the typical patients undergoing 49507 require continued post-operative management by the surgeon on the day of the procedure and on subsequent days until the patient is discharged. Although the physician is responsible for writing the initial admit status order, the final decision for status is driven by criteria built into review programs, which are increasingly being used not only by hospitals but also by audit contractors for facility reimbursement purposes. Such programs focus on severity of <u>patient</u> illness and intensity of <u>facility</u> services that impact use of hospital resources, <u>not</u> physician work. Our survey results do not suggest a decrease in total physician work, compared with survey data from 2000.

We believe the shift in patient facility status for this code and many other surgical codes has nothing to do with healthier patients that require less physician work and everything to do with the recent OPPS changes related to facility reimbursement. Clinically and intellectually, there is no indication that patients undergoing surgery (designated "major surgery" with a 90-day global period) are now all of a sudden healthier and less complex to manage.

CURRENT RECOMMENDATION

The American College of Surgeons recommends maintaining the current RVW as published for CY 2011 (10.05). We believe the total physician work has not changed for 49507 and recommend maintaining a discrete evaluation and management visit on the day of surgery as indicated by our survey data and clinical rationale. We respectfully request to defer our recommendation for the designation of the post-op evaluation and management code until the RUC approves a policy and/or rules regarding correct coding for this physician work.

The table below compares the survey code to many other RUC reviewed codes, providing further support that the current value for 49507 is not overvalued. In this table, we have utilized the RUC's current proxy of 99231 for the post-op in-hospital E/M visit.

RUC				Total					Immed Post-		31 <mark>/</mark>	38/			
rear	СРТ	RVW	IWPUT	Time	eval	posit	s,d,w	INTRA	op	32	<mark>24</mark>	<mark>17</mark>	14	13	12
2005	39400	8.05	0.071	221	35	15	20	45	25		1	1.0		1	
2001	25652	8.06	0.056	225	50			60	25			0.5		1	3
2008	25310	8.08	0.056	235	40	10	15	60	20			0.5		1	3
2005	37722	8.16	0.074	198	40	10	10	60	20			0.5		1	1
2009	26262	8.29	0.061	212	14	10	10	60	20			0.5	1	1	1
2008	28296	8.35	0.052	233	30	5	10	60	15			0.5		2	3
2005	45020	8.56	0.051	255	30	15	15	45	30		1	1.0		2	1
2007	27829	8.80	0.046	271	45	10	15	45	20		1	1.0		2	2
2000	49501	9.36	0.070	232	45			60	30		1	1.0		1	1

												CPT C	ode:	49507	7
RUC Year	СРТ	RVW	IWPUT	Total Time	eval	posit	s,d,w	INTRA	Immed Post- op	32	31 <mark>/</mark> <mark>24</mark>	38/ <mark>17</mark>	14	13	12
2007	28555	9.65	0.050	281	40	10	15	60	20		1	1.0		2	2
2007	27784	9.67	0.051	281	40	10	15	60	20		1	1.0		2	2
2005	50590	9.77	0.080	234	35	15	13	60	30			0.5		2	1
2008	42145	9.78	0.061	262	40	10	15	60	30			1.0		3	
2005	15100	9.90	0.053	281	45	10	10	60	20		1	1.0		2	2
2000	49553	9.92	0.063	247	45			75	30		1	1.0		1	1
2008	21025	10.03	0.053	283	60	10	15	90	30					2	2
2009	49507	10.05	0.068	260	40	3	20	70	30		1	<mark>1.0</mark>		1	1
2009	23073	10.13	0.052	285	33	12	15	75	30		1	1.0		2	1
2009	26117	10.13	0.058	271	40	12	20	75	20			0.5		3	1
2007	27769	10.14	0.065	279	45	15	15	60	15		1	1.0		1	3
2007	27832	10.17	0.046	301	45	10	15	75	20		1	1.0		2	2
2000	54522	10.25	0.080	211	45			75	25		1			2	
2005	44186	10.38	0.059	267	60			75	15		2	1.0		1	1
2000	45190	10.42	0.076	266	80			60	45			0.5		2	1
2007	25525	10.55	0.047	303	45	10	15	70	20		1	1.0		3	1
2000	44950	10.60	0.078	252	50			60	25		2	1.0		1	1
2000	38740	10.70	0.094	231	60			60	30			0.5		2	1
2000	49557	11.62	0.072	262	45			90	30		1	1.0		1	1
2000	29883	11.77	0.058	311	75			90	30			1.0		2	2
2000	58825	11.78	0.079	282	60			65	20	1	1	1.0		1	1
2000	49560	11.92	0.091	223	45			90	30			0.5		1	1
2008	36821	12.11	0.082	256	33	10	10	90	20			1.0		1	2
2008	57288	12.13	0.091	280	35	10	15	60	20	1		1.0		2	1
2005	58720	12.16	0.062	309	37	5	10	90	30	1	1	1.0		1	1
2007	29907	12.18	0.065	293	40	15	10	90	15			1.0		3	1
2000	59150	12.29	0.110	225	60			70	30			0.5		2	
2000	49565	12.37	0.058	312	45			100	30	1	1	1.0		1	1

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.

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 49507

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 general surgery		How often? Commonly
Specialty	How often?	
Specialty	How often?	

Estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. National frequency unknown, typical patient is not Medicare aged.

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? 11,713 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate. 2009 Medicare data

Specialty general sur	rgery	Frequency 10756	Percentage 91.82 %
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

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 49507

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code:49521 Tracking Number

Original Specialty Recommended RVU: **12.44** Presented Recommended RVU: **12.44** RUC Recommended RVU: **12.44**

Global Period: 090

CPT Descriptor: Repair recurrent inguinal hernia, any age; incarcerated or strangulated

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old male with a history of right inguinal hernia repair with mesh five years ago, now presents with a progressive history of painful swelling in the right groin. Physical exam reveals an inguinal mass that is tender and nonreducible by manual manipulation. He undergoes operative reduction and repair.

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 99% , In the ASC 1%, 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 18%, Kept overnight (less than 24 hours) 37%, Admitted (more than 24 hours) 45%

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 68%

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: Select and order the appropriate antibiotic(s) and confirm timing and administration. Assure appropriate selection, timing, and administration of DVT prophylaxis. Assess need for beta-blockers, order as required. Review preadmission work-up, with particular attention to imaging information and reports. Reexamine patient to make sure that physical findings have not changed, that the hernia remains unreducible, and update H&P. Review results of preadmission testing (lab, EKG, chest x-ray, availability of blood products). Meet with patient and family to review planned procedure and post-operative management.. Review and obtain informed consent, including the possibility of bowel resection, with witness. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available Assist in transfer of patient from gurney to operating table. Monitor/assist with positioning of patient. Install or supervise installation of Foley catheter Assist anesthesia team with line placement and induction of anesthesia and intubation. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Incision is made through previous skin scar and subcutaneous tissue taking care not to injure the underlying bowel that is incarcerated. Dissection carried out meticulously around the hernia sac to expose the external fascial ring. Lateral landmarks for inguinal ligament are identified to provide orientation in the reoperative field. Incision is then made in the previously incised external oblique fascia taking care to preserve the ilioinguinal nerve. Flaps of the external oblique fascia through the scar tissue are made to expose the underside of Poupart's ligament laterally and the internal oblique muscle medially. The previous mesh and inherent adhesive reaction are assessed in order to define the hernia defect and the spermatic cord. The defect is then defined in relation to epigastric vessels and the transversalis fascia.

The scar tissue around the neck of the hernia sac is then released to allow pressure on the hernia sac contents to be lessened. The vas deferens and spermatic vessels are carefully dissected from the hernia sac. The hernia sac is then opened to facilitate examination of the incarcerated hernia sac contents. The viability of the bowel is then assessed. If bowel resection is indicated, it is performed (reported separately). If no resection is required, the bowel is reduced into the abdomen and the degree of ischemia is assessed to determine ability to place mesh and the potential infection risk. The old mesh is not removed as it is normally intensely incorporated into the tissue. Once the bowel is reduced, the peritoneum of the hernia sac is circumferentially dissected, resected if there is excess and oversewn. The cord structures are carefully dissected and retracted to prevent injury to the Vas Deferens and vessels. The inguinal ligament, inguinal floor and conjoined tendon are defined. Mesh is placed either to plug defect or as an onlay patch or a combination. The mesh is sutured in place to the defect. A new internal ring is created as mesh encircles the spermatic vessels and vas deferens taking care to not compromise the structures to prevent injury or necrosis. Finally the mesh is placed under the internal oblique muscle to prevent against recurrence. Hemostasis is obtained. The external oblique fascia is reapproximated with care to avoid ilioinguinal nerve injury, entrapment, and significant chronic pain. The wound is irrigated. The Scarpa's fascia is reapproximated and the skin is closed. Sponge, needle, and instrument counts are obtained and confirmed prior to closure.

Description of Post-Service Work:

Hospital [operative day through discharge from recovery room]: Apply sterile adhesive strips and dressings. Monitor patient during reversal of anesthesia, protecting the wound with a hand so that wound disruption does not occur with an unrestrained cough on emergence from anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia. Discontinue prophylactic antibiotic therapy, as appropriate. Review post-operative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to general surgical floor and discuss ongoing care with floor nurses.

Hospital Visit [operative day after discharge from recovery room]: Review interval chart notes. Discuss ongoing care with floor nurses. Evaluate vital signs and intake/output. Auscultate heart, lungs, and abdomen for bowel sounds. Monitor fluid and electrolyte status and renal function; monitoring for problems such as ileus, intestinal ischemia, and urinary retention. Examine patient, check wounds and drain, and change dressings. Continue prophylaxis for DVT. Assess need for beta-blockers, order as required. Assess pain scores and adequacy of analgesia. Review nursing/other staff patient chart notes. Write orders for labs, films, medications, diet, and patient activity. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions. Advance diet, as appropriate.

Hospital Discharge Management [day after surgery, IF patient is stable and can safely be discharged]: Review interval chart notes. Evaluate vital signs and intake/output. Auscultate heart, lungs, and abdomen for bowel sounds. Monitor fluid and electrolyte status and renal function; monitoring for problems such as ileus, intestinal ischemia, and urinary retention. Examine patient, check wounds and drain, and change dressings. After considering relevant data, options, and risks on the day following surgery, the surgeon will make the decision for the patient to stay in the hospital or to be discharged. The patient will not be discharged until there is return of bowel function, the patient is taking adequate nutrition, and there is adequate pain control with oral analgesics. Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy. Write prescriptions for medications needed post-discharge. Home restrictions and activity levels (ie, diet, bathing) are discussed with the patient, family members and discharging nurse. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Post-op Office Visits: Review interval chart notes. Examine and talk with patient. Assess pain scores and adequacy of analgesia. Remove staples or sutures and drain, when appropriate. Review activity and restrictions. Check for presence of post-operative hematoma/seroma and assess need for aspiration. Monitor diet caloric intake by weight. Answer patient/family questions. Write medication prescriptions. Post discharge labs/films are ordered and reviewed. Discuss progress with referring physician(s) (verbal and written). Dictate progress notes for medical chart. Review activity permission with patient and write appropriate permission.

SURVEY DAT	ГА								
RUC Meeting Da	ate (mm/yyyy)	02/2011							
Presenter(s):	Christopher S FACS	Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS; Michael Edye, MD, FACS							
Specialty(s):	general surge	general surgery							
CPT Code:	49521	49521							
Sample Size:	₃₀₀ R	esp N:	84	Respo	onse: 28.0 %	%			
Sample Type:	Random Additional Sample Information:								
			Low	25 th pctl	Median*	75th pctl	High		
Service Perform	nance Rate		0.00	2.00	4.00	5.00	50.00		
Survey RVW:			9.00	11.00	14.00	16.05	27.00		
Pre-Service Evalu	uation Time:				60.00				
Pre-Service Posit	ioning Time:				10.00				
Pre-Service Scru	b, Dress, Wait Ti	me:			15.00				
Intra-Service Ti	me:		45.00	60.00	90.00	96.00	150.00		
Immediate Post	Service-Time:	<u>30.00</u>							
Post Operative	Visits	Total Min**	CPT Cod	e and Num	nber of Visi	ts			
Critical Care tin	ne/visit(s):	0.00	99291x 0	.00 99292	2x 0.00				
Other Hospital	time/visit(s):	<u>20.00</u>	99231x 1	. 00 99232	2x 0.00	99233x 0.00			
Discharge Day	Mgmt:	<u>38.00</u>	99238x 1	. 00 99239x	0.00				
Office time/visit	:(s):	<u>39.00</u>	99211x 0	0.00 12x 1.0	0 13x 1.00	14x 0.00 15x	0.00		
Prolonged Serv	ices:	0.00	99354x 0).00 55x ().00 56x	0.00 57x 0.0)0		
Sub Obs Care:		0.00	99224x 0	0.00 99225	5x 0.00	99226x 0.00			

**Physician standard total <u>minutes per E/M visit</u>: 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: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	49521		Recommended Ph	Recommended Physician Work RVU: 12.44				
			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:			3.00	3.00	0.00			
Pre-Service Scrub, Dress	, Wait Tim	Time: 20.00 20.00			0.00			
Intra-Service Time:			90.00					
Immediate Post Service	e-Time:	<u>30.00</u>						
Post Operative Visits		Total Min**	CPT Code and Nu	umber of Visits				
Critical Care time/visit((s):	<u>0.00</u>	99291x 0.00 992	92x 0.00				
Other Hospital time/vis	sit(s):	<u>0.00</u>	99231x 0.00 992	32x 0.00 99233x	0.00			
Discharge Day Mgmt:		<u>38.00</u>	99238x 1.0 99239x 0.0					
Office time/visit(s):		<u>39.00</u>	99211x 0.00 12x 1.00 13x 1.00 14x 0.00 15x 0.00					
Prolonged Services:		<u>0.00</u>	99354x 0.00 55x	0.00 56x 0.00	57x 0.00			
Sub Obs Care:		<u>20.00</u>	99224x 1.00 992	25x 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 SERV	/ICE:							
					T ' a			
<u>Key CPT Code</u>	<u>Global</u>		<u> </u>	<u>ork RVU</u>	Time Source			
49520	090			9.99	RUC Time			
CPT Descriptor Repair recu	rrent inguinal	hernia, any age; r	educible					
KEY MPC COMPARISO	N CODES:							
Compare the surveyed code	to codes on	the RUC's MPC	List. Reference	codes from the	MPC list should be chosen, if			
appropriate that have relative	e values highe	er and lower than t	the requested rela	tive values for t	he code under review.			
					Most Recent			
MPC CPT Code 1	Global	Work RVU	Time Source	Med	licare Utilization			
60220	090	12.37	RUC Time		9,133			
CPT Descriptor 1 Total thyr	oid lobectomy	, unilateral; with	or without isthmu	isectomy				
				-	Most Recent			
MPC CPT Code 2	<u>Global</u>	Work RVU	Time Source	Me	dicare Utilization			
36819	090	14.47	RUC Time		11,884			
<u>CPT Descriptor 2</u> Arteriovenous anastomosis, open; by upper arm basilic vein transposition								
Other Reference CPT Code	<u>Global</u>	<u>Work R</u> 0.00	VU <u>Time</u> S	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: 23

% of respondents: 27.3 %

<u>TIME ESTIMATES (Median)</u>	CPT Code: 49521	Key Reference CPT Code: <u>49520</u>	Source of Time RUC Time
Median Pre-Service Time	63.00	45.00	
Median Intra-Service Time	90.00	60.00	
Median Immediate Post-service Time	30.00	23.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	38.0	19.00	
Median Office Visit Time	39.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	20.0	0.00	
Median Total Time	280.00	186.00	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

(of those that selected Key Reference code)

<u>Mental Effort and Judgment (Mean)</u>		
The number of possible diagnosis and/or the number of	2.91	2.30
management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests,	2.78	2.48
and/or other information that must be reviewed and analyzed		
I learney of modical desision making	2.40	2.52
Orgency of medical decision making	3.40	2.52
<u>Technical Skill/Physical Effort (Mean)</u>		
Technical skill required	3.57	3.04
· · · · · · · · · · · · · · · · · · ·		
Physical effort required	2.96	2.78
<u>Psychological Stress (Mean)</u>		
The risk of significant complications, morbidity and/or mortality	3.52	2.65
Outcome describes and the shift and indement of abarities	2.50	2.04
Outcome depends on the skill and judgment of physician	3.52	3.04
Estimated risk of malpractice suit with poor outcome	3.30	2.91
INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference
		Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.13	2.70
Intra-Service intensity/complexity	3.74	3.00
Post Service intensity/complexity	2.61	2 30
rost-service mensity/complexity	2.01	2.30

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.

Coding changes were made to the family of hernia codes for CPT 1994 to differentiate physician work. A request was made to separate incarcerated and strangulated hernias, but the CPT Editorial Panel chose to combine those procedures. The RUC process in **1993** utilized consistent ratios for valuing each type of hernia (reducible, incarcerated/strangulated, initial, and recurrent), with a goal of maintaining budget neutrality across all hernia codes. In **2000**, during the second 5-year review, the hernia codes were surveyed as mini-surveys and the work RVUs adjusted using the percentage change made to 49505, which underwent a full RUC survey. Many of the more difficult procedures had evidence to support higher values, but the details of the codes with mini-surveys were not reviewed on a code-by-code basis.

Code 49521 was identified by the RUC 5YR ID WG in **2007** as potentially misvalued through a site-of-service anomaly screen. The RUC recommended 49521 be surveyed. In **2008**, ACS conducted a RUC survey and presented data that indicated 49521 was not same-day surgery. We argued that that a majority of these patients require close monitoring on the day of the procedure and are kept in the hospital for continued monitoring for problems such as ileus, intestinal ischemia, and urinary retention. Additionally, there will be significant pain post-operatively requiring management before discharge. After considering relevant data, options, and risks, the surgeon will make the decision for the patient to stay in the hospital or to be discharged. The patient will not be discharged until there is return of bowel function, the patient is taking adequate nutrition, and there is adequate pain control with oral analgesics. Medicare data indicate that code 49521 has an inpatient facility status of 45%, therefore, next day discharge is not "imminent" or pre-planned when a patient is scheduled for surgery and the work in monitoring these patients post-operatively on the day of surgery is the same E/M work whether the patient's status ends up inpatient or outpatient. After hearing these arguments, the RUC deferred review of 49521 until the RUC survey instrument could be modified to capture information about typical site of service and visits.

ACS conducted another RUC survey in **2009** using a modified RUC survey instrument that included a question regarding site-of-service and visits on the day of the procedure. The RUC agreed with the survey results regarding physician time and necessary post-operative visits. The RUC compared the physician work, time, and visits of 49521 to 49505 and 54512. Without compelling evidence for a change in physician work since the prior RUC review, the RUC recommended maintaining the work RVU (below the survey median).

Why Reverse Building Block is Not Applicable to Code 49521

CMS has suggested that the RUC use a building block methodology to adjust site-of-service anomaly codes for the RVWs associated with changes in time and visits. More specifically, CMS proposes a "*reverse*" BBM that subtracts E/M code work RVUs from the current work RVU, along with reassignment of minutes to different categories of time with lower intensity. For example, "some" of the post-operative E/M minutes should be reassigned to immediate post-operative care (ie, time from skin closure through discharge from recovery) at a low intensity of 0.0224, which is inconsistent with the intensity for E/M codes (eg, 99231=0.054).

This methodology is not applicable to code 49521. When the RUC reviewed code 49521, the ACS recommendation of 14.85 work RVUs using the building block methodology was <u>not</u> accepted, and instead the RUC recommended 11.97 work RVUS (19% *less*) based on magnitude estimation. The RUC did NOT use BBM for the value of 49521, therefore, it is flawed logic to propose a reverse BBM that subtracts the RVUs for E/Ms and calculates a new value for 49521.

Discussion of Post-operative E/M Work

In the Final Rule, CMS states:

- 1. "For procedures typically performed in the inpatient setting when the codes were originally valued, the work RVUs for these codes would have been valued to include the inpatient physician work furnished, as well as to reflect the intensive care and follow-up normally associated with an inpatient procedure."
- 2. "If the typical case for the procedure has shifted from the inpatient setting to an outpatient or physician's office setting, it is reasonable to expect that there have been changes in medical practice, and that such changes would represent a decrease in physician time or intensity or both."

We disagree with both of these statements. First, hospital *status* (inpatient or outpatient) is an artifact of recent changes in payment policy and recent use of criteria-based programs (eg, InterQual) that <u>assign admission status for purposes of facility reimbursement</u>. The criteria for these programs are not based on physician work; they are based on facility

resource utilization. Therefore, the CMS belief that a shift in reporting of hospital status (inpatient vs outpatient) would represent a decrease in physician work is flawed logic since hospital admission status is not tied to physician work in the programs that assign patient status. Second, almost half of these patients will stay for several days in the hospital, therefore, next day discharge is not "imminent" or pre-planned as CMS suggests. The work in monitoring these patients post-operatively on the day of surgery is the same E/M work whether the patient's status ends up inpatient or outpatient. Third, the CPT descriptor includes both incarcerated and strangulated hernias. The presentation of one or the other type of hernia can vary from year to year and can vary by age group from year to year. More importantly, the Medicare data may not be representative of the national population and should not be extrapolated to represent the typical national population. Finally, the Medicare claims summary data is not without error. For example, almost 3% of the 2009 claims for 49521 are from non-surgical specialties that would not perform open hernia repair (eg, general practice, family medicine, internal medicine).

We believe that semantics about place of service and length of stay have created an undo concern with regard to screening, reviewing and accounting for physician work. Medicare representatives have stated that a claim designated as "outpatient" is a hospital stay of 23hr-59min or less. On the other hand, CPT codes describe E/M codes in a less concrete fashion. CPT indicates that codes 99234-99236 are to be used to report observation or <u>inpatient</u> hospital care services provided to patients admitted and discharged on the <u>same date of service</u>. For these codes, claims can correctly be submitted as <u>inpatient same day service</u>. In 2008, Medicare claims data show more than 55% inpatient claims for 99234 (typical patient is 19 y.o. pregnant female complaining of persistent vomiting for one day). Clearly, 55%+ of these 74,000+ Medicare patients were not admitted at 12:00am and discharged at midnight – which according to Medicare is the only way that a claim can be considered inpatient (ie, 23hr-59min+).

It is the clinical opinion of our expert panel that the typical patients undergoing 49521 require continued post-operative management by the surgeon on the day of the procedure and on subsequent days until the patient is discharged. Although the physician is responsible for writing the initial admit status order, the final decision for status is driven by criteria built into review programs, which are increasingly being used not only by hospitals but also by audit contractors for facility reimbursement purposes. Such programs focus on severity of <u>patient</u> illness and intensity of <u>facility</u> services that impact use of hospital resources, <u>not</u> physician work. Our survey results do not suggest a decrease in total physician work, compared with survey data from 2000.

We believe the shift in patient facility status for this code and many other surgical codes has nothing to do with healthier patients that require less physician work and everything to do with the recent OPPS changes related to facility reimbursement. Clinically and intellectually, there is no indication that patients undergoing surgery (designated "major surgery" with a 90-day global period) are now all of a sudden healthier and less complex to manage.

CURRENT RECOMMENDATION

The American College of Surgeons recommends maintaining the current RVW as published for CY 2011 (12.44). We believe the total physician work has not changed for 49521 and recommend maintaining a discrete evaluation and management visit on the day of surgery as indicated by our survey data and clinical rationale. We respectfully request to defer our recommendation for the designation of the post-op evaluation and management code until the RUC approves a policy and/or rules regarding correct coding for this physician work.

The table below compares the survey code to many other RUC reviewed codes, providing further support that the current value for 49521 is not overvalued. In this table, we have utilized the RUC's current proxy of 99231 for the post-op in-hospital E/M visit.

RUC Year	СРТ	RVW	IWPUT	Total Time	eval	posit	sdw	INTRA	Immed Post-	32	31/ <mark>24</mark>	38/ <mark>17</mark>	13	12
2007	27769	10.14	0.065	279	45	15	15	60	15		1	1.0	1	3
2000	38740	10.70	0.094	231	60			60	30			0.5	2	1
2000	49557	11.62	0.072	262	45			90	30		1	1.0	1	1
2000	29883	11.77	0.058	311	75			90	30			1.0	2	2
2000	58825	11.78	0.079	282	60			65	20	1	1	1.0	1	1
2008	36821	12.11	0.082	256	33	10	10	90	20			1.0	1	2
2008	57288	12.13	0.091	280	35	10	15	60	20	1		1.0	2	1
2005	58720	12.16	0.062	309	37	5	10	90	30	1	1	1.0	1	1

RUC Year	СРТ	RVW	IWPUT	Total Time	eval	posit	s,d,w	INTRA	Immed Post- op	32	31/ <mark>24</mark>	38/ <mark>17</mark>	13	12
2007	29907	12.18	0.065	293	40	15	10	90	15			1.0	3	1
2000	59150	12.29	0.110	225	60			70	30			0.5	2	
2000	49565	12.37	0.058	312	45			100	30	1	1	1.0	1	1
2008	60220	12.37	0.077	275	63			90	25		1	1.0	1	1
2009	49521	12.44	0.079	280	40	3	20	90	30		1	<mark>1.0</mark>	1	1
2009	14301	12.65	0.070	287	33	10	15	100	25			0.5	3	1
2002	34825	12.80	0.091	307	80			60	30	1	1	1.0	1	1
2005	38700	12.81	0.073	300	30	15	15	90	30		1	1.0	2	1
2010	66174	12.85	0.131	215	10	1	5	60	10			0.5	2	4
2001	54406	12.89	0.070	295	50			95	30		1	1.0	2	1
2000	47100	12.91	0.066	345	75			60	30	1	2	1.0	2	1
2005	32657	12.93	0.078	352	60	15	20	60	40	2		1.0	1	1
2007	27556	13.00	0.055	369	60	15	15	90	20	1	1	1.0	1	3
2002	53500	13.00	0.075	289	50			90	29		1	1.0	2	1
2006	33202	13.20	0.099	301	55	15	15	65	30	1	1	1.0	1	
2009	55873	13.60	0.083	274	33	8	15	100	30			0.5	3	
2010	66175	13.60	0.127	223	10	1	5	68	10			0.5	2	4
2000	49561	15.38	0.074	352	45			100	30	2	1	1.0	1	1

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) 49521

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 general surgery

How often? Commonly

Specialty

How often?

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. National frequency unknown, typical patient is not Medicare aged. % Specialty Frequency Percentage % Specialty Frequency Percentage Specialty Frequency Percentage %

Estimate the number of times this service might be provided to Medicare patients nationally in a one-year period? 2,785 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 data

Specialty general surger	У	Frequency 2547	Percentage 91.45 %
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

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 49521

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.

Specialty

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code:49587 Tracking Number

Original Specialty Recommended RVU: **8.04** Presented Recommended RVU: **8.04** RUC Recommended RVU: **8.04**

Global Period: 090

CPT Descriptor: Repair umbilical hernia, age 5 years or over; incarcerated or strangulated

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old obese male presents with 3 hour history of painful swelling in the umbilical region. Physical exam reveals an umbilical hernia that is tender and nonreducible by manual manipulation. He undergoes operative reduction and repair.

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 30%, Kept overnight (less than 24 hours) 42%, Admitted (more than 24 hours) 29%

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 77%

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: Select and order the appropriate antibiotic(s) and confirm timing and administration. Assure appropriate selection, timing, and administration of DVT prophylaxis. Assess need for beta-blockers, order as required. Review preadmission work-up, with particular attention to imaging information and reports. Reexamine patient to make sure that physical findings have not changed, that the hernia remains unreducible, and update H&P. Review results of preadmission testing (lab, EKG, chest x-ray, availability of blood products). Meet with patient and family to review planned procedure and post-operative management.. Review and obtain informed consent, including the possibility of bowel resection, with witness. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available Assist in transfer of patient from gurney to operating table. Monitor/assist with positioning of patient. Install or supervise installation of Foley catheter Assist anesthesia team with line placement and induction of anesthesia and intubation. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Incision is made through skin and subcutaneous tissue taking care not to injure the underlying bowel that is incarcerated. Dissection carried out meticulously around the hernia sac to expose the fascial ring. The neck of the hernia sac is then released to allow pressure on the hernia sac contents to be lessened. The hernia sac is opened to facilitate examination of the incarcerated contents. The viability of the bowel is assessed. If bowel resection is indicated, it is performed (reported separately). If no resection is required, the bowel is reduced into the abdomen and the degree of ischemia is assessed to determine ability to place mesh and the potential risk for infection. Once the bowel is reduced, the peritoneum of the hernia sac is circumferentially dissected, resected if there is excess and oversewn. The

fascial defect is closed either primarily or with added implantation of mesh (reported separately) as determined by the size of the defect and the quality of the fascia. Hemostasis is obtained. The wound is irrigated. The subcutaneous tissue is reapproximated and the skin is closed. Sponge, needle, and instrument counts are obtained and confirmed prior to closure.

Description of Post-Service Work:

Hospital [operative day through discharge from recovery room]: Apply sterile adhesive strips and dressings. Monitor patient during reversal of anesthesia, protecting the wound with a hand so that wound disruption does not occur with an unrestrained cough on emergence from anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia. Discontinue prophylactic antibiotic therapy, as appropriate. Review post-operative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to general surgical floor and discuss ongoing care with floor nurses.

Hospital Visit [operative day after discharge from recovery room]: Review interval chart notes. Discuss ongoing care with floor nurses. Evaluate vital signs and intake/output. Auscultate heart, lungs, and abdomen for bowel sounds. Monitor fluid and electrolyte status and renal function; monitoring for problems such as ileus, intestinal ischemia, and urinary retention. Examine patient, check wounds and drain, and change dressings. Continue prophylaxis for DVT. Assess need for beta-blockers, order as required. Assess pain scores and adequacy of analgesia. Review nursing/other staff patient chart notes. Write orders for labs, films, medications, diet, and patient activity. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions. Advance diet, as appropriate.

Hospital Discharge Management [day after surgery, IF patient is stable and can safely be discharged]: Review interval chart notes. Evaluate vital signs and intake/output. Auscultate heart, lungs, and abdomen for bowel sounds. Monitor fluid and electrolyte status and renal function; monitoring for problems such as ileus, intestinal ischemia, and urinary retention. Examine patient, check wounds and drain, and change dressings. After considering relevant data, options, and risks on the day following surgery, the surgeon will make the decision for the patient to stay in the hospital or to be discharged. The patient will not be discharged until there is return of bowel function, the patient is taking adequate nutrition, and there is adequate pain control with oral analgesics. Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy. Write prescriptions for medications needed post-discharge. Home restrictions and activity levels (ie, diet, bathing) are discussed with the patient, family members and discharging nurse. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Post-op Office Visits: Review interval chart notes. Examine and talk with patient. Assess pain scores and adequacy of analgesia. Remove staples or sutures and drain, when appropriate. Review activity and restrictions. Check for presence of post-operative hematoma/seroma and assess need for aspiration. Monitor diet caloric intake by weight. Answer patient/family questions. Write medication prescriptions. Post discharge labs/films are ordered and reviewed. Discuss progress with referring physician(s) (verbal and written). Dictate progress notes for medical chart. Review activity permission with patient and write appropriate permission.

SURVEY DAT	ГА								
RUC Meeting Da	ate (mm/yyyy)	02/2011							
Presenter(s):	Christopher S FACS	Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS; Michael Edye, MD, FACS							
Specialty(s):	general surge	ery							
CPT Code:	49587	49587							
Sample Size:	300 F	esp N:	84	Respo	onse: 28.0 %	6			
Sample Type:	Random	Additional Sa	mple Info	rmation:					
			Low	25 th pctl	Median*	75th pctl	High		
Service Perforn	nance Rate		0.00	3.00	5.00	8.00	60.00		
Survey RVW:			7.00	10.00	11.50	13.55	19.00		
Pre-Service Evalu	uation Time:				60.00				
Pre-Service Posit	tioning Time:				10.00				
Pre-Service Scru	b, Dress, Wait Ti	me:			15.00				
Intra-Service Ti	me:		30.00	45.00	60.00	80.00	150.00		
Immediate Post	Service-Time:	<u>30.00</u>							
Post Operative	Visits	Total Min**	CPT Cod	e and Num	nber of Visi	ts			
Critical Care tin	ne/visit(s):	0.00	99291x 0	.00 99292	2x 0.00				
Other Hospital	time/visit(s):	<u>20.00</u>	99231x 1	.00 99232	2x 0.00	99233x 0.00			
Discharge Day	Mgmt:	<u>38.00</u>	99238x 1	. 00 99239x	0.00				
Office time/visit	t(s):	<u>39.00</u>	99211x 0	.00 12x 1.0	0 13x 1.00	14x 0.00 15x	0.00		
Prolonged Serv	ices:	0.00	99354x 0	. 00 55x ().00 56x	0.00 57x 0.0	00		
Sub Obs Care:		0.00	99224x 0	.00 9922	5x 0.00	99226x 0.00			

**Physician standard total <u>minutes per E/M visit</u>: 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: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	49587		Recommended Physician Work RVU: 8.04					
			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 T	-Service Positioning Time:			3.00	0.00			
Pre-Service Scrub, Dress	, Wait Tim	ie:	20.00 20.00 0					
Intra-Service Time:			60.00					
Immediate Post Service	e-Time:	<u>30.00</u>						
Post Operative Visits		Total Min**	CPT Code and Nu	<u>Imber of Visits</u>				
Critical Care time/visit((s):	<u>0.00</u>	99291x 0.00 992	92x 0.00				
Other Hospital time/vis	sit(s):	<u>0.00</u>	99231x 0.00 992	32x 0.00 99233x	0.00			
Discharge Day Mgmt:		<u>38.00</u>	99238x 1.0 99239x 0.0					
Office time/visit(s):		<u>39.00</u>	99211x 0.00 12x 1.00 13x 1.00 14x 0.00 15x 0.00					
Prolonged Services:		<u>0.00</u>	99354x 0.00 55x	0.00 56x 0.00	57x 0.00			
Sub Obs Care:		<u>20.00</u>	99224x 1.00 992	25x 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 SER	VICE:								
<u>Key CPT Code</u> 49585	<u>Global</u> 090			<u>Work RVU</u> 6.59	Time Source RUC Time				
CPT Descriptor Repair umb	oilical hernia, ag	e 5 years or olde	er; reducible						
KEY MPC COMPARISO Compare the surveyed cod appropriate that have relative	PN CODES: e to codes on the ve values higher	ne RUC's MPC and lower than t	List. Reference the requested re	e codes from the lative values for t	MPC list should be chosen, if he code under review. Most Recent				
<u>MPC CPT Code 1</u> 49505	<u>Global</u> <u>V</u> 090	<u>Vork RVU</u> 7.96	<u>Time Source</u> RUC Tim	e <u>Med</u>	licare Utilization 82,663				
<u>CPT Descriptor 1</u> Repair in	itial inguinal he	rnia, age 5 years	or older; reduci	ble	Most Recent				
<u>MPC CPT Code 2</u> 50590	<u>Global</u> 090	<u>Work RVU</u> 9.77	Time Source RUC Time	<u>Me</u>	dicare Utilization 53,325				
<u>CPT Descriptor 2</u> Lithotripsy, extracorporeal shock wave									
Other Reference CPT Code	<u>Global</u>	<u>Work R</u> 0.00	<u>VU</u> <u>Time</u>	e 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: 20

% of respondents: 23.8 %

<u>TIME ESTIMATES (Median)</u>	CPT Code: 49587	Key Reference CPT Code: <u>49585</u>	Source of Time RUC Time
Median Pre-Service Time	63.00	45.00	
Median Intra-Service Time	60.00	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	38.0	19.00	
Median Office Visit Time	39.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	20.0	0.00	
Median Total Time	250.00	178.00	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

(of those that selected Key Reference code)

<u>Mental Effort and Judgment (Mean)</u>		
The number of possible diagnosis and/or the number of	2.65	2.30
management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests,	2.60	2.35
and/or other information that must be reviewed and analyzed		
	1	
Urgency of medical decision making	3.50	2.65
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.15	2.90
Developed offset required	2.95	2.60
	2.00	2.00
<u>Psychological Stress (Mean)</u>		
The risk of significant complications, morbidity and/or mortality	3.25	2.70
Outcome demands on the skill and indemant of neuroisian	2.25	2.00
Outcome depends on the skin and judgment of physician	3.35	5.00
Estimated risk of malpractice suit with poor outcome	3.35	3.00
INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference
		Service 1
Time Seminarte (Moon)		
Pre-Service intensity/complexity	3.25	2.70
Intra-Service intensity/complexity	3,25	2.70
and set net menory, comprendy	0.20	2.70
	·	·
Post-Service intensity/complexity	2.60	2.40

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.*

Coding changes were made to the family of hernia codes for CPT 1994 to differentiate physician work. A request was made to separate incarcerated and strangulated hernias, but the CPT Editorial Panel chose to combine those procedures. The RUC process in **1993** utilized consistent ratios for valuing each type of hernia (reducible, incarcerated/strangulated, initial, and recurrent), with a goal of maintaining budget neutrality across all hernia codes. In **2000**, during the second 5-year review, the hernia codes were surveyed as mini-surveys and the work RVUs adjusted using the percentage change made to 49505, which underwent a full RUC survey. Many of the more difficult procedures had evidence to support higher values, but the details of the codes with mini-surveys were not reviewed on a code-by-code basis.

Code 49587 was identified by the RUC 5YR ID WG in **2007** as potentially misvalued through a site-of-service anomaly screen. The RUC recommended 49587 be surveyed. In **2008**, ACS conducted a RUC survey and presented data that indicated 49587 was not same-day surgery. We argued that that a majority of these patients require close monitoring on the day of the procedure and are kept in the hospital for continued monitoring for problems such as ileus, intestinal ischemia, and urinary retention. Additionally, there will be significant pain post-operatively requiring management before discharge. After considering relevant data, options, and risks, the surgeon will make the decision for the patient to stay in the hospital or to be discharged. The patient will not be discharged until there is return of bowel function, the patient is taking adequate nutrition, and there is adequate pain control with oral analgesics. Medicare data indicate that code 49587 has an inpatient facility status of 35%, therefore, next day discharge is not "imminent" or pre-planned when a patient is scheduled for surgery and the work in monitoring these patients post-operatively on the day of surgery is the same E/M work whether the patient's status ends up inpatient or outpatient. After hearing these arguments, the RUC deferred review of 49587 until the RUC survey instrument could be modified to capture information about typical site of service and visits.

ACS conducted another RUC survey in **2009** using a modified RUC survey instrument that included a question regarding site-of-service and visits on the day of the procedure. The RUC agreed with the survey results regarding physician time and necessary post-operative visits. The RUC compared the physician work, time, and visits of 49587 to 49505 and 54512. Without compelling evidence for a change in physician work since the prior RUC review, the RUC recommended maintaining the work RVU (below the survey median).

Why Reverse Building Block is Not Applicable to Code 49587

CMS has suggested that the RUC use a building block methodology to adjust site-of-service anomaly codes for the RVWs associated with changes in time and visits. More specifically, CMS proposes a "*reverse*" BBM that subtracts E/M code work RVUs from the current work RVU, along with reassignment of minutes to different categories of time with lower intensity. For example, "some" of the post-operative E/M minutes should be reassigned to immediate post-operative care (ie, time from skin closure through discharge from recovery) at a low intensity of 0.0224, which is inconsistent with the intensity for E/M codes (eg, 99231=0.054).

When the RUC reviewed code 49587, the ACS recommendation of 10.48 work RVUs using the building block methodology was <u>not</u> accepted, and instead the RUC recommended 7.56 work RVUS (28% *less*) based on magnitude estimation. The RUC did NOT use BBM for the value of 49587, therefore, it is flawed logic to propose a reverse BBM that subtracts the RVUs for E/Ms and calculates a new value for 49587.

Discussion of Post-operative E/M Work

In the Final Rule, CMS states:

- 1. "For procedures typically performed in the inpatient setting when the codes were originally valued, the work RVUs for these codes would have been valued to include the inpatient physician work furnished, as well as to reflect the intensive care and follow-up normally associated with an inpatient procedure."
- 2. "If the typical case for the procedure has shifted from the inpatient setting to an outpatient or physician's office setting, it is reasonable to expect that there have been changes in medical practice, and that such changes would represent a decrease in physician time or intensity or both."

<u>We disagree with both of these statements.</u> First, hospital *status* (inpatient or outpatient) is an artifact of recent changes in payment policy and recent use of criteria-based programs (eg, InterQual) that <u>assign admission status for purposes of facility reimbursement</u>. The criteria for these programs are not based on physician work; they are based on facility

resource utilization. Therefore, the CMS belief that a shift in reporting of hospital status (inpatient vs outpatient) would represent a decrease in physician work is flawed logic since hospital admission status is not tied to physician work in the programs that assign patient status. Second, more than one-third of these patients will stay for several days in the hospital, therefore, next day discharge is not "imminent" or pre-planned as CMS suggests. The work in monitoring these patients post-operatively on the day of surgery is the same E/M work whether the patient's status ends up inpatient or outpatient. Third, the CPT descriptor includes both incarcerated and strangulated hernias. The presentation of one or the other type of hernia can vary from year to year and can vary by age group from year to year. More importantly, the Medicare data may not be representative of the national population and should not be extrapolated to represent the typical national population. Finally, the Medicare claims summary data is not without error. For example, almost 3% of the 2009 claims for 49587 are from non-surgical specialties that would not perform open hernia repair (eg, general practice, family medicine, internal medicine).

We believe that semantics about place of service and length of stay have created an undo concern with regard to screening, reviewing and accounting for physician work. Medicare representatives have stated that a claim designated as "outpatient" is a hospital stay of 23hr-59min or less. On the other hand, CPT codes describe E/M codes in a less concrete fashion. CPT indicates that codes 99234-99236 are to be used to report observation or <u>inpatient</u> hospital care services provided to patients admitted and discharged on the <u>same date of service</u>. For these codes, claims can correctly be submitted as <u>inpatient same day service</u>. In 2008, Medicare claims data show more than 55% inpatient claims for 99234 (typical patient is 19 y.o. pregnant female complaining of persistent vomiting for one day). Clearly, 55%+ of these 74,000+ Medicare patients were not admitted at 12:00am and discharged at midnight – which according to Medicare is the only way that a claim can be considered inpatient (ie, 23hr-59min+).

It is the clinical opinion of our expert panel that the typical patients undergoing 49587 require continued post-operative management by the surgeon on the day of the procedure and on subsequent days until the patient is discharged. Although the physician is responsible for writing the initial admit status order, the final decision for status is driven by criteria built into review programs, which are increasingly being used not only by hospitals but also by audit contractors for facility reimbursement purposes. Such programs focus on severity of <u>patient</u> illness and intensity of <u>facility</u> services that impact use of hospital resources, <u>not</u> physician work. Our survey results do not suggest a decrease in total physician work, compared with survey data from 2000.

We believe the shift in patient facility status for this code and many other surgical codes has nothing to do with healthier patients that require less physician work and everything to do with the recent OPPS changes related to facility reimbursement. Clinically and intellectually, there is no indication that patients undergoing surgery (designated "major surgery" with a 90-day global period) are now all of a sudden healthier and less complex to manage.

CURRENT RECOMMENDATION

The American College of Surgeons recommends maintaining the current RVW as published for CY 2011 (8.04). We believe the total physician work has not changed for 49587 and recommend maintaining a discrete evaluation and management visit on the day of surgery as indicated by our survey data and clinical rationale. We respectfully request to defer our recommendation for the designation of the post-op evaluation and management code until the RUC approves a policy and/or rules regarding correct coding for this physician work.

The table below compares the survey code to many other RUC reviewed codes, providing further support that the current value for 49587 is not overvalued. In this table, we have utilized the RUC's current proxy of 99231 for the post-op in-hospital E/M visit.

RUC Year	СРТ	RVW	IWPUT	Total Time	eval	posit	s,d,w	INTRA	Immed Post- op	31/ <mark>24</mark>	38/ <mark>17</mark>	14	13	12
2008	17108	7.49	0.078	148	7			60	10				1	3
2005	67911	7.50	0.081	183	10	10	15	50	15		0.5			4
2005	67901	7.59	0.069	188	10	10	10	60	15		0.5			4
2003	37765	7.71	0.066	201	33	10	15	60	25		0.5		1	1
2005	57295	7.82	0.064	202	15	15	15	60	20		1.0		1	1
2001	24332	7.91	0.051	230	50			60	30		0.5		1	3
2000	46262	7.91	0.089	179	40			45	20		0.5		1	2
2004	66711	7.93	0.076	192	10	5	10	30	10		0.5		4	1

RUC Year	СРТ	RVW	IWPUT	Total Time	eval	posit	s,d,w	INTRA	Immed Post- op	31/ <mark>24</mark>	38/ <mark>17</mark>	14	13	12
2007	26665	7.94	0.047	237	35	10	15	60	20		0.5		2	2
2008	38542	7.95	0.066	198	33	10	15	60	15		0.5		2	
2005	49505	7.96	0.065	198	20	15	15	70	20		0.5		1	1
2005	67904	7.97	0.089	185	10	10	15	45	15		0.5		1	3
2009	49587	8.04	0.046	250	40	3	20	60	30	1	<mark>1.0</mark>		1	1
2005	39400	8.05	0.071	221	35	15	20	45	25	1	1.0		1	
2001	25652	8.06	0.056	225	50			60	25		0.5		1	3
2008	25310	8.08	0.056	235	40	10	15	60	20		0.5		1	3
2005	37722	8.16	0.074	198	40	10	10	60	20		0.5		1	1
2009	26262	8.29	0.061	212	14	10	10	60	20		0.5	1	1	1
2008	28296	8.35	0.052	233	30	5	10	60	15		0.5		2	3
2005	45020	8.56	0.051	255	30	15	15	45	30	1	1.0		2	1
2007	27829	8.80	0.046	271	45	10	15	45	20	1	1.0		2	2
2000	49501	9.36	0.070	232	45			60	30	1	1.0		1	1
2007	28555	9.65	0.050	281	40	10	15	60	20	1	1.0		2	2
2007	27784	9.67	0.051	281	40	10	15	60	20	1	1.0		2	2
2005	50590	9.77	0.080	234	35	15	13	60	30		0.5		2	1
2008	42145	9.78	0.061	262	40	10	15	60	30		1.0		3	
2005	15100	9.90	0.053	281	45	10	10	60	20	1	1.0		2	2
2000	49553	9.92	0.063	247	45			75	30	1	1.0		1	1

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) 49587

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	How often?		CPT Code: 49587
Specialty	How often?		
Estimate the number of a If the recommendation i explain the rationale for	times this service might s from multiple specialti this estimate. National t	be provided nationally in a c es, please provide the freque frequency unknown, typical	one-year period? 0 ency and <u>percentage</u> for each specialty. Please patient is not Medicare aged.
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
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? 9,345 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate. 2009 Medicare data

Specialty general surge	ery	Frequency 8469	Percentage 90.	62 %
Specialty	Frequency	Percentage	%	
Specialty	Frequency	Percentage	%	
Do many physicians pe	erform this servic	e 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 <u>will not</u> change, enter the surveyed existing CPT code number 49587

If this code is a new/revised code or an existing code in which the specialty utilization mix <u>will</u> change, please select another crosswalk based on a similar specialty mix.
AMA/Specialty Society RVS Update Committee Summary of Recommendations Identified through the Site of Service Anomaly Screen and the Fourth Five-Year Review

February 2011

Laparoscopic Hernia Repair

In June 2007, the CPT Editorial Panel created six new CPT codes to describe the specific levels of work associated with abdominal hernia repairs that are being performed frequently with laparoscopic techniques. This new type of surgery is different from the open repair of abdominal wall hernia that involves placement of mesh prosthesis on the surface of the muscle layers through the incision, whereas these new procedure codes describe the laparoscopic placement of the mesh behind the fascia and muscle layers, where it is affixed to the abdominal wall muscles. CMS accepted the RUC's recommendation for these services. In 2010, CMS submitted to the RUC four of the laparoscopic hernia repair codes, 49652, 49653, 49654 and 49655, as part of their request for services to be reviewed under the Fourth Five-Review that met the criteria for the Site-of-Service Anomaly screen.

49652 *Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible* The RUC reviewed the previous rationale and physician work survey data for CPT code 49652. The RUC noted that in 2007, the RUC recommended the survey's 25th percentile, 12.80 work RVUs which was a 12% reduction from the 2007 work value. The RUC compared 49652 to its key reference code 49560 *Repair initial incisional or ventral hernia; reducible* (work RVU = 11.92, intra-time= 90 minutes) and noted the surveyed code has more intra-service time, 100 minutes compared to 90 minutes. The RUC also understood that the mesh implantation requires additional work (valued at 4.88 RVUs), however in relation to code 49654 the value would have to be lower than the sum of its parts (11.92 RVUs from code 49560 plus 4.88 equals 16.80). The RUC therefore believed that the specialty society's 25th percentile survey results of 12.80 work RVUs reflected the true value for code 49652. In 2010, this value was increased to 12.88 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. The RUC also reviewed a table provided by the specialties that compares the survey code to many other RUC reviewed codes as further support that the current value for 49652 is appropriate. The RUC agreed that the survey code was accurately valued during the September 2007 meeting, with appropriate relativity across the family and strong support from reference services and specialty survey data, and finds no compelling evidence to change the current physician work value of this service.

Code 49652 is not typically same day surgery. Although, these laparoscopic procedures result in significantly lower incidence of incisional pain and morbidity related to the incision (compared with an open repair), these patients do have considerable postoperative pain from the fixation of the sensitive peritoneal surface and are typically provided postoperative narcotics. Patients are also susceptible to post-operative ileus, and patients typically require hospital care. The RUC also noted that this procedure is considered a site-of-service anomaly based on one year of Medicare claims data (2009), indicating 35% inpatient. Given that this service was published in CPT just two years ago, Medicare claims data is still new and may not reflect accurate Medicare utilization for this procedure. Some providers may still be using the unlisted procedure code or an open procedure code with a modifier and report.

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The specialties noted, and the RUC agreed, that the typical patients undergoing code 49652 require continued post-operative management by the surgeon on the day of the procedure and on subsequent days until the patient is discharged. This was substantiated by the survey data which shows that the typical patient receives this procedure in the hospital (100%), stays at least overnight in the hospital following surgery (84%) and receives an Evaluation and Management service on the same date (84%). Given this data, the RUC enacted its policy to allocate the appropriate proxy for the post-operative visits. Importantly, the RUC noted that the work involved in monitoring the typical patient post-operatively on the day of surgery is the same Evaluation and Management work whether the patient's facility status ends up inpatient or outpatient. Adjustments to the allocation of post-operative visits are used as proxies and do not constitute changes to the physician work relative value of the service which was determined by magnitude estimation and physician specialty survey data during the last RUC review. **The RUC recommends a work RVU of 12.88 for CPT code 49652**.

49653 Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated

The RUC reviewed the previous rationale and physician work survey data for CPT code 49653. The RUC noted that in 2007, the RUC recommended the survey's 25th percentile, 16.10 work RVUs which was a 11% reduction from the 2007 work value. The RUC compared 49653 to key reference service 49566 *Repair recurrent incisional or ventral hernia; incarcerated or strangulated* (work RVU = 15.53) and determined that both require the same physician intra-service time of 120 minutes. However, the surveyed code is more intense and complex, therefore the 25th percentile survey work of 16.10 appropriately places this service in the proper rank order. In 2010, the value for 49653 was increased to 16.21 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. The RUC also reviewed a table provided by the specialties that compares the survey code to many other RUC reviewed codes as further support that the current value for 49653 is appropriate. The RUC agreed that the surveyed code was accurately valued during the September 2007 meeting, with appropriate relativity across the family and strong support from reference services and specialty survey data, and finds no compelling evidence to change the current physician work value of this service.

Code 49653 is not typically same day surgery. Although, these laparoscopic procedures result in significantly lower incidence of incisional pain and morbidity related to the incision (compared with an open repair), these patients do have considerable postoperative pain from the fixation of the sensitive peritoneal surface and are typically provided postoperative narcotics. Patients are also susceptible to post-operative ileus, and patients typically require hospital care. The RUC also noted that this procedure is considered a site-of-service anomaly based on one year of Medicare claims data (2009), indicating 39% inpatient. Given that this service was published in CPT just two years ago, Medicare claims data is still new and may not reflect accurate Medicare utilization for this procedure. Some providers may still be using the unlisted procedure code or an open procedure code with a modifier and report.

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The specialties noted, and the RUC agreed, that the typical patients undergoing code 49653 require continued post-operative management by the surgeon on the day of the procedure and on subsequent days until the patient is discharged. The typical patient will stay in the hospital for three calendar days and two nights. This was substantiated by the survey data which shows that the typical patient receives this procedure in the hospital (100%), stays at least overnight in the hospital following surgery (91%) and receives an Evaluation and Management service on the same date (91%). Given this data, the RUC enacted its policy to allocate the appropriate proxy for the post-operative visits. Importantly, the RUC noted that the work involved in monitoring the typical patient post-operatively on the day of surgery is the same Evaluation and Management work whether the patient's facility status ends up inpatient or outpatient. Adjustments to the allocation of post operative visits are used as proxies and do not constitute changes to the physician work relative value of the service which was determined by magnitude estimation and physician specialty survey data during the last RUC review. **The RUC recommends a work RVU of 16.21 for CPT code 49653**.

49654 Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible

The RUC reviewed the previous rationale and physician work survey data for CPT code 49654. The RUC noted that in 2007, the RUC recommended the survey's 25th percentile, 14.95 work RVUs which was a 7% reduction from the current work value. The RUC compared 49654 to key reference service *44180 Laparoscopy, surgical, enterolysis (freeing of intestinal adhesion) (separate procedure)* (work RVU = 15.27) and determined that both services require similar physician time, intra-service of 120 minutes, and physician work to complete. Therefore, the RUC recommended the survey 25th percentile work RVU, 14.95 work RVUs. In 2010, this value was increased to 15.03 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. The RUC also reviewed a table provided by the specialties that compares the survey code to many other RUC reviewed codes as further support that the current value for 49654 is appropriate. The RUC agreed that the surveyed code was accurately valued during the September 2007 meeting, with appropriate relativity across the family and strong support from reference services and specialty survey data, and finds no compelling evidence to change the current physician work value of this service.

Code 49654 is not typically same day surgery. Although, these laparoscopic procedures result in significantly lower incidence of incisional pain and morbidity related to the incision (compared with an open repair), these patients do have considerable postoperative pain from the fixation of the sensitive peritoneal surface and are typically provided postoperative narcotics. Patients are also susceptible to postoperative ileus, and patients typically require hospital care. The RUC also noted that this procedure is considered a site-of-service anomaly based on one year of Medicare claims data (2009), indicating 37% inpatient. Given that this service was published in CPT just two years ago, Medicare claims data is still new and may not reflect accurate Medicare utilization for this procedure. Some providers may still be using the unlisted procedure code or an open procedure code with a modifier and report.

The specialties noted, and the RUC agreed, that the typical patients undergoing code 49654 require continued post-operative management by the surgeon on the day of the procedure and on subsequent days until the patient is discharged. The typical patient will stay in the hospital for three calendar days and two nights. This was substantiated by the survey data which shows that the typical patient receives this procedure in the hospital (100%), stays at least overnight in the hospital following surgery (90%) and receives an Evaluation and Management service on the same date (90%). Given this data, the RUC enacted its policy to allocate the appropriate proxy for the post-operative visits. Importantly, the RUC noted that the work involved in monitoring the typical patient post-operatively on the day of surgery is the same Evaluation and Management work whether the patient's facility status ends up inpatient or outpatient. Adjustments to the allocation of post operative visits are used as proxies and do not constitute changes to the physician work relative value of the service which was determined by magnitude estimation and physician specialty survey data during the last RUC review. **The RUC recommends a work RVU of 15.03 for CPT code 49654**.

49655 Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated

The RUC reviewed the previous rationale and physician work survey data for CPT code 49655. The RUC noted that in 2007, the RUC recommended a direct crosswalk to CPT code 43280 *Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)* (work RVU=18.10), which fell between the survey's 25th percentile and median estimated physician work values. This represented a 10% reduction from the 2007 work value. In 2010, the value for 49655 was increased to 18.11 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. The RUC also reviewed a table provided by the specialties that compares the survey code to many other RUC reviewed codes as further support that the current value for 49655 is appropriate. The RUC agreed that the surveyed code was accurately valued during the September 2007 meeting, with appropriate relativity across the family and strong support from reference services and specialty survey data, and finds no compelling evidence to change the current physician work value of this service.

Code 49655 is not typically same day surgery. Although, these laparoscopic procedures result in significantly lower incidence of incisional pain and morbidity related to the incision (compared with an open repair), these patients do have considerable post-operative pain from the fixation of the sensitive peritoneal surface and are typically provided postoperative narcotics. Patients are also susceptible to post-operative ileus, and patients typically require hospital care. The RUC also noted that this procedure is considered a site-of-service anomaly based on one year of Medicare claims data (2009), indicating 45% inpatient. Given that this service was published in CPT just two years ago, Medicare claims data is still new and may not reflect accurate Medicare utilization for this procedure. Some providers may still be using the unlisted procedure code or an open procedure code with a modifier and report. Additionally, the RUC agreed with the specialty that almost 3% of the Medicare claims were from non-surgical specialties that could not perform the procedure.

The specialties noted, and the RUC agreed, that the typical patients undergoing code 49655 require continued post-operative management by the surgeon on the day of the procedure and on subsequent days until the patient is discharged. The typical patient will stay in the hospital for three calendar days and two nights. This was substantiated by the survey data which shows that the typical patient receives this procedure in the hospital (100%), stays at least overnight in the hospital following surgery (95%), requires multiple days in the hospital (87%), and receives an Evaluation and Management service on the same day of the procedure (95%). Given this data, the RUC enacted its policy to allocate the appropriate proxy for the post-operative visits. Importantly, the RUC noted that the work involved in monitoring the typical patient post-operatively on the day of surgery is the same Evaluation and Management work whether the patient's facility status ends up inpatient or outpatient. Adjustments to the allocation of post-operative visits are used as proxies and do not constitute changes to the physician work relative value of the service which was determined by magnitude estimation and physician specialty survey data during the last RUC review. **The RUC recommends a work RVU of 18.11 for CPT code 49655.**

New Technology:

These services were placed on the Relativity Assessment Workgroup's New Technology List and will be re-reviewed by the RUC after Medicare utilization is more robust.

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
49652		Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible (Do not report 49652 in conjunction with 44180, 49568)	090	12.88 (No Change)
49653		incarcerated or strangulated (Do not report 49653 in conjunction with 44180, 49568)	090	16.21 (No Change)
49654		Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible	090	15.03 (No Change)

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
49655		incarcerated or strangulated	090	18.11
		(Do not report 49655 in conjunction with 44180, 49568)		(No Change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code:49652 Tracking Number

Original Specialty Recommended RVU: **12.88** Presented Recommended RVU: **12.88** RUC Recommended RVU: **12.88**

Global Period: 090

CPT Descriptor: Laparoscopy, surgical repair ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35-year-old obese man presents with a new abdominal wall bulge first noted after exercise, which has been increasing in size over the last few months. It is occasionally painful, with tender edges. The hernia is reducible on exam. He is referred for a laparoscopic repair.

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

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

Percent of survey respondents who stated they perform the procedure; In the hospital 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 16%, Kept overnight (less than 24 hours) 60%, Admitted (more than 24 hours) 24%

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: Select and order the appropriate antibiotic(s) and confirm timing and administration. Assure appropriate selection, timing, and administration of DVT prophylaxis. Assess need for beta-blockers, order as required. Review results of preadmission work-up and testing (lab, EKG, chest x-ray, availability of blood products), with particular attention to imaging information and reports. Reexamine patient to make sure that physical findings have not changed, that the hernia remains unreducible, and update H&P. Meet with patient and family to review planned procedure. Mark the palpable edge of the hernia defect(s) and sites of the proposed skin incisions with cooperation of patient. Review and obtain informed consent, including witness. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available, including reusable and disposable laparoscopic equipment and mesh, if needed. Assist in transfer of patient from gurney to operating table. Monitor/assist with positioning of patient. Assist anesthesia team with line placement and induction of anesthesia and intubation, relative to all laparoscopic equipment. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: If hernia contents are present, they are manually reduced. Pneumoperitoneum is induced by insertion of a Veress needle, bladeless optical trocar, open insertion of the first port (described below) or other appropriate technique. Starting at a distance from the hernia location, for open insertion the first skin incision is made and carried through the subcutaneous tissues. Hemostasis is obtained. The fascia is exposed, incised and the peritoneum opened carefully under direct vision avoiding underlying bowel, omentum or adhesions. The first trocar is inserted and

secured with stay sutures as needed. The abdomen is then insufflated while physiologic changes are monitored. The appropriate camera is inserted, and a preliminary visual exploration of the abdominal cavity is made prior to placing subsequent cannulae. With the camera viewing placement of each port, typically two more are positioned to allow two handed surgical technique, while remaining at a distance from the hernia. A thorough visual examination of the abdominal cavity is then undertaken with the aid of instruments inserted through the other ports, viewing where possible the liver, small bowel, colon, stomach, spleen, and pelvic organs. At any stage in this initial process adhesions may require sharp and/or blunt lysis to allow adequate exposure. The hernia defect is identified and if necessary its contents reduced. An appropriate margin around the defect to accommodate overlapping mesh is cleared by lysing adhesions or mobilizing structures such as the falciform ligament. Hemostasis is secured before continuing and a careful check of intestine that has been handled or freed by adhesiolysis is made to confirm that it is intact. Sites on the abdominal wall are selected for the transfascial fixation sutures if used. The size of the defect is measured and an appropriate sized mesh patch is selected. The mesh is rolled and introduced though the largest available cannula or abdominal puncture and once inside is unfurled and positioned with the correct surface facing the abdominal wall. The entire periphery of the mesh is secured at appropriate intervals to the abdominal wall with a combination of any or all of the following: tacks, staples, transfascial or intracorporeal stitches, or other permanent fixation devices. A fourth or subsequent port may be necessary to permit access of instrumentation for fixation of an inaccessible corner of the mesh. The number and position of these fixation points is intended to achieve adequate overlap of flat lying mesh beyond the edge of the defect, and prevent both movement of the mesh and protrusion of intestine, omentum or other abdominal structures between the mesh and the abdominal wall. A second or subsequent concentric inner ring of fixation points between the outer ring and the edge of the defect may be inserted according to surgeon preference. The mesh is inspected for gaps, large ripples and other defects, with and without insufflation, and corrected as needed. The secondary cannulae are removed, carbon dioxide is allowed to escape from the abdomen, and the fascial defect of all port punctures are repaired as appropriate. Local anesthetic is injected once again to all trocar sites and transfascial fixation points. If needed the subcutaneous tissues of the larger punctures are approximated with interrupted sutures to eliminate a dead space. The skin incisions are closed according to surgeon preference. Sponge, needle, and instrument counts are obtained and confirmed prior to closure.

Description of Post-Service Work:

Hospital [operative day through discharge from recovery room]: Apply sterile adhesive strips and dressings. Monitor patient during reversal of anesthesia, protecting the wound with a hand so that wound disruption does not occur with an unrestrained cough on emergence from anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia. Discontinue prophylactic antibiotic therapy, as appropriate. Review post-operative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to general surgical floor and discuss ongoing care with floor nurses.

Hospital Visit [operative day after discharge from recovery room]: Review interval chart notes. Discuss ongoing care with floor nurses. Evaluate vital signs and intake/output. Auscultate heart, lungs, and abdomen for bowel sounds. Monitor fluid and electrolyte status and renal function; monitoring for problems such as ileus, intestinal ischemia, and urinary retention. Examine patient, check wounds and drain, and change dressings. Continue prophylaxis for DVT. Assess need for beta-blockers, order as required. Assess pain scores and adequacy of analgesia. Review nursing/other staff patient chart notes. Write orders for labs, films, medications, diet, and patient activity. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions. Advance diet, as appropriate.

Hospital Discharge Management [day after surgery, IF patient is stable and can safely be discharged]: Review interval chart notes. Evaluate vital signs and intake/output. Auscultate heart, lungs, and abdomen for bowel sounds. Monitor fluid and electrolyte status and renal function; monitoring for problems such as ileus, intestinal ischemia, and urinary retention. Examine patient, check wounds and drain, and change dressings. After considering relevant data, options, and risks on the day following surgery, the surgeon will make the decision for the patient to stay in the hospital or to be discharged. The patient will not be discharged until there is return of bowel function, the patient is taking adequate nutrition, and there is adequate pain control with oral analgesics. Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy. Write prescriptions for medications needed post-discharge. Home restrictions and activity levels (ie, diet, bathing) are discussed with the patient, family members and discharging nurse. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Post-op Office Visits: Review interval chart notes. Examine and talk with patient. Assess pain scores and adequacy of analgesia. Remove staples or sutures and drain, when appropriate. Review activity and restrictions. Check for presence of

post-operative hematoma/seroma and assess need for aspiration. Monitor diet caloric intake by weight. Answer patient/family questions. Write medication prescriptions. Post discharge labs/films are ordered and reviewed. Discuss progress with referring physician(s) (verbal and written). Dictate progress notes for medical chart. Review activity permission with patient and write appropriate permission.

SURVEY DAT	ГА										
RUC Meeting Da	ate (mm/yyyy)	02/2011									
Presenter(s):	Michael Edye FACS	Michael Edye, MD, FACS; Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS									
Specialty(s):	general surge	general surgery, GI endoscopic surgery									
CPT Code:	49652	49652									
Sample Size:	300 F	lesp N:	45	Respo	onse: 15.0 %	, D					
Sample Type:	e: Random Additional Sample Information:										
			Low	25 th pctl	Median*	75th pctl	<u>High</u>				
Service Perform	nance Rate		0.00	5.00	8.00	15.00	150.00				
Survey RVW:			7.00	12.80	14.50	16.00	30.00				
Pre-Service Evalu	uation Time:				45.00						
Pre-Service Posit	tioning Time:				15.00						
Pre-Service Scru	b, Dress, Wait Ti	me:			15.00						
Intra-Service Ti	me:		60.00	75.00	90.00	90.00	150.00				
Immediate Post	Service-Time:	<u>30.00</u>									
Post Operative	<u>Visits</u>	Total Min**	CPT Cod	e and Num	ber of Visit	S					
Critical Care tin	ne/visit(s):	<u>0.00</u>	99291x 0	.00 99292	2x 0.00						
Other Hospital t	time/visit(s):	<u>20.00</u>	99231x 1	. 00 99232	2x 0.00 9	9233x 0.00					
Discharge Day	Mgmt:	<u>38.00</u>	99238x 1	. 00 99239x	0.00						
Office time/visit	t(s):	<u>39.00</u>	99211x 0	0.00 12x 1.0	0 13x 1.00 1	4x 0.00 15x	0.00				
Prolonged Serv	ices:	<u>0.00</u>	99354x 0	.00 55x C	.00 56x 0	.00 57x 0.0	00				
Sub Obs Care:		0.00	99224x 0	.00 99225	5x 0.00 9	9226x 0.00					

**Physician standard total <u>minutes per E/M visit</u>: 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: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code: 49652			Recommended Physician Work RVU: 12.88					
			Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time			
Pre-Service Evaluation T	ïme:		40.00	40.00	0.00			
Pre-Service Positioning	Time:		15.00	3.00	12.00			
Pre-Service Scrub, Dress	s, Wait Tim	ie:	15.00	20.00	-5.00			
Intra-Service Time:			90.00					
Immediate Post Servic	e-Time:	<u>30.00</u>						
Post Operative Visits		Total Min**	CPT Code and Number of Visits					
Critical Care time/visit	(s):	<u>0.00</u>	99291x 0.00 992	92x 0.00				
Other Hospital time/vis	sit(s):	<u>0.00</u>	99231x 0.00 992	32x 0.00 99233x	0.00			
Discharge Day Mgmt:		<u>38.00</u>	99238x 1.0 99239x 0.0					
Office time/visit(s):		<u>39.00</u>	99211x 0.00 12x 1	.00 13x 1.00 14x 0	.00 15x 0.00			
Prolonged Services:		<u>0.00</u>	99354x 0.00 55x	0.00 56x 0.00	57x 0.00			
Sub Obs Care:		<u>20.00</u>	99224x 1.00 992	25x 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 SERV	/ICE:				
<u>Key CPT Code</u> 49560	<u>Global</u> 090		<u>v</u>	<u>Vork RVU</u> 11.92	Time Source RUC Time
CPT Descriptor Repair initia	al incisional o	or ventral hernia; re	educible		
KEY MPC COMPARISO Compare the surveyed code appropriate that have relativ MPC CPT Code 1	N CODES: to codes on e values high Global	the RUC's MPC ner and lower than t Work RVU	List. Reference the requested rela Time Source	codes from th tive values for Me	e MPC list should be chosen, the code under review. Most Recent edicare Utilization
60220	090	12.37	RUC Time	<u></u>	9,133
CPT Descriptor 1 Total thyr	oid lobectom	ny, unilateral; with	or without isthm	usectomy	,
<u>MPC CPT Code 2</u> 36819	<u>Global</u> 090	<u>Work RVU</u> 14.47	Time Source RUC Time	M	Most Recent Iedicare Utilization 11,884
CPT Descriptor 2 Arteriover	nous anaston	nosis, open; by upp	er arm basilic ve	in transposition	ı
Other Reference CPT Code	<u>Global</u>	<u>Work R</u> 0.00	<u>VU</u> <u>Time</u>	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: 15

% of respondents: 33.3 %

<u>TIME ESTIMATES (Median)</u>	CPT Code: 49652	Key Reference CPT Code: <u>49560</u>	Source of Time RUC Time
Median Pre-Service Time	70.00	45.00	
Median Intra-Service Time	90.00	90.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	38.0	19.00	
Median Office Visit Time	39.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	20.0	0.00	
Median Total Time	287.00	223.00	
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	2.53	2.62
management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests,	2.67	2.69
and/or other information that must be reviewed and analyzed		
Urgency of medical decision making	2.33	2.23
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.47	2.77
	2.20	0.77
Physical effort required	3.20	2.11
<u>Psychological Stress (Mean)</u>		
The risk of significant complications, morbidity and/or mortality	2.93	2.63
	2.22	2.02
Outcome depends on the skill and judgment of physician	3.33	2.92
Estimated risk of malpractice suit with poor outcome	3.27	3.00
INTENSITY/COMPLEXITY MEASURES	<u>CPT Code</u>	<u>Reference</u> Service 1
Time Segments (Mean)		
Dra Samiaa intensity/aamulavity	2.67	2.46
rie-Service intensity/complexity	2.07	2.40
Intra-Service intensity/complexity	3.07	2.46
	0.01	
	0.01	
Post Service intensity/complexity	2 40	2.22

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.*

In 2007, CPT approved new - but well-established - laparoscopic procedures for repair of abdominal wall hernias for CPT 2009. These laparoscopic repairs represented a significant technical departure from the open repairs for several reasons including the technical mechanics of performing the repair and the near universal placement of mesh prosthesis. All laparoscopic hernia repairs are performed within the peritoneal cavity. Adhesiolysis is major part of each procedure and is typically extensive.

In the open procedures, only enough abdominal wall for suture or mesh positioning would typically be exposed and in many circumstances entry into the peritoneal cavity would be avoided or limited. In the laparoscopic operation, since the laparoscope must be free to see the edges of the hernia defect, as well as have free areas for trocar / instrument placement, complete liberation of the intra-abdominal portion of the abdominal wall from adherent bowel and omentum is necessary for safe mesh placement. Mesh is usually placed behind the fascial and muscle layers of the abdominal wall, rather than on the surface of the muscle, as in the open setting. The mesh must be fixed securely in a circumferential pattern, to prevent displacement or herniation of viscera between mesh and muscle. Although the net result is in a markedly decreased incidence of incisional pain and morbidity related to the incision, these patients do have considerable postoperative pain from the fixation to the sensitive peritoneal surface and they are prone to postoperative narcotics and postoperative ileus.

The ACS and SAGES conducted a RUC survey for new code 49652. The RUC reviewed the survey data and determined that the specialty survey median work RVU for 49652 was greater than the typical patient scenario should warrant. The RUC instead recommended the survey 25th percentile work RVU as a better relative value, which was 12% less than the survey median and the specialty recommendation.

Why Reverse Building Block is Not Applicable to Code 49652

CMS has suggested that the RUC use a building block methodology to adjust site-of-service anomaly codes for the RVWs associated with changes in time and visits. More specifically, CMS proposes a "*reverse*" BBM that subtracts E/M code work RVUs from the current work RVU, along with reassignment of minutes to different categories of time with lower intensity. For example, "some" of the post-operative E/M minutes should be reassigned to immediate post-operative care (ie, time from skin closure through discharge from recovery) at a low intensity of 0.0224, which is inconsistent with the intensity for E/M codes (eg, 99231=0.054).

This methodology is not applicable to code 49652. When the RUC reviewed code 49652, the specialty recommendation of 14.50 work RVUs using the survey median and relative comparison to references was <u>not</u> accepted, and instead the RUC recommended a work RVU that was 12% *less*. The RUC did NOT use BBM to value 49652, therefore, it is flawed logic to propose a reverse BBM that subtracts the RVUs for E/Ms and calculates a new value for 49652.

Discussion of Post-operative E/M Work

In the Final Rule, CMS states:

- 1. "For procedures typically performed in the inpatient setting when the codes were originally valued, the work RVUs for these codes would have been valued to include the inpatient physician work furnished, as well as to reflect the intensive care and follow-up normally associated with an inpatient procedure."
- 2. "If the typical case for the procedure has shifted from the inpatient setting to an outpatient or physician's office setting, it is reasonable to expect that there have been changes in medical practice, and that such changes would represent a decrease in physician time or intensity or both."

<u>We disagree with both of these statements.</u> First, hospital *status* (inpatient or outpatient) is an artifact of recent changes in payment policy and recent use of criteria-based programs (eg, InterQual) that <u>assign admission status for purposes of facility reimbursement</u>. The criteria for these programs are not based on physician work; they are based on facility resource utilization. Therefore, the CMS belief that a shift in reporting of hospital status (inpatient vs outpatient) would represent a decrease in physician work is flawed logic since hospital admission status is not tied to physician work in the programs that assign patient status. Second, more than one-third of these patients have a hospital inpatient status, therefore, next day discharge is not "imminent" or pre-planned as CMS suggests. The work in monitoring these patients post-operatively on the day of surgery is the same E/M work whether the patient's status ends up inpatient or outpatient. Finally, the determination to review code 49652 is based on one year of Medicare data (2009) that indicates 35 %

CPT Code: 49652 inpatient. The Medicare claims summary data is not without error. For example, over <u>6%</u> of the 2009 claims for 46952 are from non-surgical specialties that could not perform laparoscopic hernia repair.

It is the clinical opinion of our expert panel that the typical patients undergoing 49652 require continued post-operative management by the surgeon on the day of the procedure and on subsequent days until the patient is discharged. Although the physician is responsible for writing the initial admit status order, the final decision for status is driven by criteria built into review programs, which are increasingly being used not only by hospitals but also by audit contractors for facility reimbursement purposes. Such programs focus on severity of <u>patient</u> illness and intensity of <u>facility</u> services (at admission) that impact use of hospital resources, <u>not</u> physician work. The physician work captured in the RUC survey was reduced by 12% two years ago. There is no reason to believe that there is a change in physician work since that time.

CURRENT RECOMMENDATION

The ACS and SAGES recommend maintaining the current RVW as published for CY 2011 (12.88). We believe the total physician work has not changed for 49652 and recommend maintaining a discrete evaluation and management visit on the day of surgery as indicated by our survey data and, more importantly by the clinical rationale. We respectfully request to defer our recommendation for the designation of the post-op evaluation and management code until the RUC approves a policy and/or rules regarding correct coding for this physician work.

The table below compares the survey code to many other RUC reviewed codes, providing further support that the current value for 49652 is not overvalued. In this table, we have utilized the RUC's current proxy of 99231 for the post-op in-hospital E/M visit.

vear	СРТ	SHORT DESC	RVW	IWPUT	Time	eval	posit	s,d,w	INTRA	sd- im	32	31/ <mark>24</mark>	38/ <mark>17</mark>	14	13	12
2000	49557	Rerepair fem hernia blocked	11.62	0.072	262	45	•		90	30		1	1.0	1	1	1
2000	29883	Knee arthroscopy/surgery	11.77	0.058	311	75			90	30			1.0	2	2	1
2000	58825	Transposition ovary(s)	11.78	0.079	282	60			65	20	1	1	1.0	1	1	1
2008	36821	Av fusion direct any site	12.11	0.082	256	33	10	10	90	20			1.0	1	2	1
2008	57288	Repair bladder defect	12.13	0.091	280	35	10	15	60	20	1		1.0	2	1	1
2005	58720	Removal of ovary/tube(s)	12.16	0.062	309	37	5	10	90	30	1	1	1.0	1	1	
2007	29907	Subtalar arthro w/fusion	12.18	0.065	293	40	15	10	90	15			1.0	3	1	1
2000	49565	Rerepair ventrl hern reduce	12.37	0.058	312	45			100	30	1	1	1.0	1	1	1
2008	60220	Partial removal of thyroid	12.37	0.077	275	63			90	25		1	1.0	1	1	
2009	49521	Rerepair ing hernia blocked	12.44	0.079	280	40	3	20	90	30		1	1.0	1	1	
2009	14301	Skin tissue rearrangement	12.65	0.070	287	33	10	15	100	25			0.5	3	1	
2002	34825	Endovasc extend prosth init	12.80	0.091	307	80			60	30	1	1	1.0	1	1	
2005	38700	Removal of lymph nodes neck	12.81	0.073	300	30	15	15	90	30		1	1.0	2	1	
2007	49652	Lap vent/abd hernia repair	12.88	0.081	292	45	15	15	90	30		1	<mark>1.0</mark>	1	1	
2001	54406	Remove muti-comp penis pros	12.89	0.070	295	50			95	30		1	1.0	2	1	
2000	47100	Wedge biopsy of liver	12.91	0.066	345	75			60	30	1	2	1.0	2	1	
2005	32657	Thoracoscopy surgical	12.93	0.078	352	60	15	20	60	40	2		1.0	1	1	
2007	27556	Treat knee dislocation	13.00	0.055	369	60	15	15	90	20	1	1	1.0	1	3	
2002	53500	Urethrlys transvag w/ scope	13.00	0.075	289	50			90	29		1	1.0	2	1	
2006	33202	Insert epicard eltrd open	13.20	0.099	301	55	15	15	65	30	1	1	1.0	1		
2009	55873	Cryoablate prostate	13.60	0.083	274	33	8	15	100	30			0.5	3		
2010	66175	Trnslum dil eye canal w/stnt	13.60	0.127	223	10	1	5	68	10			0.5	2	4	
2004	36819	Av fuse uppr arm basilic	14.47	0.078	287	55			120	15		1	1.0		1	1

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) 49652

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 general surgery		How often? Commonly
Specialty	How often?	
Specialty	How often?	

Estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. national frequeny not available

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 6,190 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate. 2009 Medicare data

Specialty general sur	rgery	Frequency 5681	Percentage 91.77 %
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

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 49652

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code:49653 Tracking Number

Original Specialty Recommended RVU: 16.21 Presented Recommended RVU: 16.21 RUC Recommended RVU: 16.21

Global Period: 090

CPT Descriptor: Laparoscopy, surgical repair ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old woman with no past surgical history presents with a large abdominal wall mass. She reports that it has been slowly increasing in size over the last 3-4 years. It would initially go away when she lay down, but has been non-reducible for the last year. It is increasingly tender and often painful. She has occasional nausea but no vomiting associated with it. On exam she is afebrile with normal vital signs. She has a chronically incarcerated ventral hernia and is referred for a laparoscopic repair.

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 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 9%, Kept overnight (less than 24 hours) 16%, Admitted (more than 24 hours) 76%

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: Select and order the appropriate antibiotic(s) and confirm timing and administration. Assure appropriate selection, timing, and administration of DVT prophylaxis. Assess need for beta-blockers, order as required. Review results of preadmission work-up and testing (lab, EKG, chest x-ray, availability of blood products), with particular attention to imaging information and reports. Reexamine patient to make sure that physical findings have not changed, that the hernia remains unreducible, and update H&P. Meet with patient and family to review planned procedure. Mark the palpable edge of the hernia defect(s) and sites of the proposed skin incisions with cooperation of patient. Review and obtain informed consent, including witness. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available, including reusable and disposable laparoscopic equipment and mesh, if needed. Assist in transfer of patient from gurney to operating table. Monitor/assist with positioning of patient. Assist anesthesia team with line placement and induction of anesthesia and intubation, relative to all laparoscopic equipment. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: An attempt is made to reduce the hernia contents manually. Pneumoperitoneum is induced by insertion of a Veress needle, bladeless optical trocar, open insertion of the first port (described below) or other appropriate technique. Starting at a distance from the hernia location, for open insertion the first skin incision is made and

carried through the subcutaneous tissues. Hemostasis is obtained. The fascia is exposed, incised and the peritoneum opened carefully under direct vision avoiding underlying bowel, omentum or adhesions. The first trocar is inserted and secured with the stay sutures as needed. The abdomen is then insufflated while physiologic changes are monitored. The appropriate camera is inserted, and a preliminary visual exploration of the abdominal cavity is made prior to placing subsequent cannulae. With the camera viewing placement of each port, typically two more are positioned to allow two handed surgical technique, while remaining at a distance from the hernia. A thorough visual examination of the abdominal cavity is then undertaken with the aid of instruments inserted through the other ports, viewing where possible the liver, small bowel, colon, stomach, spleen, and pelvic organs. At any stage in this initial process adhesions may require sharp and/or blunt lysis to allow adequate exposure. The hernia defect is identified and if necessary its contents is reduced using a combination of external pressure, careful traction with the laparoscopic instruments and judicious adhesiolysis as necessary. An appropriate margin around the defect to accommodate overlapping mesh is cleared by lysing adhesions or mobilizing structures such as the falciform ligament. Hemostasis is secured before continuing and a careful check of intestine that has been reduced, handled or freed by adhesiolysis is made to confirm that it is intact. Devitalized tissue such as fat or omentum is excised and removed. Sites on the abdominal wall are selected for the transfascial fixation sutures if used. The size of the defect is measured and an appropriate sized mesh patch is selected. The mesh is rolled and introduced though the largest available cannula or abdominal puncture and once inside is unfurled and positioned with the correct surface facing the abdominal wall. The entire periphery of the mesh is secured at appropriate intervals to the abdominal wall with a combination of any or all of the following: tacks, staples, transfascial or intracorporeal stitches, or other permanent fixation devices. A fourth or subsequent port may be necessary to permit access of instrumentation for fixation of an inaccessible corner of the mesh. The number and position of these fixation points is intended to achieve adequate overlap of flat lying mesh beyond the edge of the defect, and prevent both movement of the mesh and protrusion of intestine, omentum or other abdominal structures between the mesh and the abdominal wall. A second or subsequent concentric inner ring of fixation points between the outer ring and the edge of the defect may be inserted according to surgeon preference. The mesh is inspected for gaps, large ripples and other defects, with and without insufflation, and corrected as needed. The secondary cannulae are removed, carbon dioxide is allowed to escape from the abdomen, and the fascial defect of all port punctures are repaired as appropriate. Local anesthetic is injected once again to all trocar sites and transfascial fixation points. If needed the subcutaneous tissues of the larger punctures are approximated with interrupted sutures to eliminate a dead space. The skin incisions are closed according to surgeon preference. Sponge, needle, and instrument counts are obtained and confirmed prior to closure.

Description of Post-Service Work:

Hospital [operative day through discharge from recovery room]: Apply sterile adhesive strips and dressings. Monitor patient during reversal of anesthesia, protecting the wound with a hand so that wound disruption does not occur with an unrestrained cough on emergence from anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia. Discontinue prophylactic antibiotic therapy, as appropriate. Review post-operative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to general surgical floor and discuss ongoing care with floor nurses.

Hospital Visits [operative day and subsequent days after discharge from recovery room]: Review interval chart notes. Discuss ongoing care with floor nurses. Evaluate vital signs and intake/output. Auscultate heart, lungs, and abdomen for bowel sounds. Monitor fluid and electrolyte status and renal function; monitoring for problems such as ileus, intestinal ischemia, and urinary retention. Examine patient, check wounds and drain, and change dressings. Continue prophylaxis for DVT. Assess need for beta-blockers, order as required. Assess pain scores and adequacy of analgesia. Review nursing/other staff patient chart notes. Write orders for labs, films, medications, diet, and patient activity. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions. Advance diet, as appropriate.

Hospital Discharge Management [when patient is stable and can safely be discharged]: Review interval chart notes. Evaluate vital signs and intake/output. Auscultate heart, lungs, and abdomen for bowel sounds. Monitor fluid and electrolyte status and renal function; monitoring for problems such as ileus, intestinal ischemia, and urinary retention. Examine patient, check wounds and drain, and change dressings. After considering relevant data, options, and risks on the day following surgery, the surgeon will make the decision for the patient to stay in the hospital or to be discharged. The patient will not be discharged until there is return of bowel function, the patient is taking adequate nutrition, and there is adequate pain control with oral analgesics. Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy. Write prescriptions for medications needed post-discharge. Home restrictions and activity levels (ie, diet,

bathing) are discussed with the patient, family members and discharging nurse. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Post-op Office Visits: Review interval chart notes. Examine and talk with patient. Assess pain scores and adequacy of analgesia. Remove staples or sutures and drain, when appropriate. Review activity and restrictions. Check for presence of post-operative hematoma/seroma and assess need for aspiration. Monitor diet caloric intake by weight. Answer patient/family questions. Write medication prescriptions. Post discharge labs/films are ordered and reviewed. Discuss progress with referring physician(s) (verbal and written). Dictate progress notes for medical chart. Review activity permission with patient and write appropriate permission.

						-				
SURVEY DAT	ГА									
RUC Meeting Da	ate (mm/yyyy)	02/2011								
Presenter(s):	Christopher S	hristopher Senkowski, MD, FACS; Charles Mabry, MD, FACS								
Specialty(s):	general surge	eneral surgery, GI endoscopic surgery								
CPT Code:	49653									
Sample Size:	300 R	esp N:	45	45 Response: 15.0 %						
Sample Type:	Random	Random Additional Sample Information:								
			Low	25 th pctl	Median*	75th pctl	<u>High</u>			
Service Perform	nance Rate		0.00	1.00	5.00	10.00	60.00			
Survey RVW:			12.00	16.10	18.00	20.00	32.00			
Pre-Service Evalu	uation Time:				45.00					
Pre-Service Posit	tioning Time:				15.00					
Pre-Service Scru	b, Dress, Wait Tii	ne:			15.00					
Intra-Service Ti	me:		75.00	90.00	120.00	150.00	270.00			
Immediate Post	Service-Time:	30.00								
Post Operative	<u>Visits</u>	Total Min**	CPT Cod	e and Num	ber of Visit	<u>S</u>				
Critical Care tin	ne/visit(s):	<u>0.00</u>	99291x 0	. 00 99292	2x 0.00					
Other Hospital 1	<u>60.00</u>	99231x 1	.00 99232	2x 1.00 9	9233x 0.00					
Discharge Day	Mgmt:	<u>38.00</u>	99238x 1	. 00 99239x	0.00					
Office time/visit	t(s):	<u>55.00</u>	99211x 0	.00 12x 2.0	0 13x 1.00 1	4x 0.00 15x	0.00			
Prolonged Serv	ices:	<u>0.00</u>	99354x 0	. 00 55x 0).00 56x 0	.00 57x 0.0	00			
Sub Obs Care:		0.00	99224x 0	.00 99225	5x 0.00 9	9226x 0.00				

**Physician standard total <u>minutes per E/M visit</u>: 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: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	19653		Recommended Physician Work RVU: 16.21						
			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:			15.00	20.00	-5.00				
Intra-Service Time:			120.00						
Immediate Post Service	e-Time:	<u>30.00</u>							
Post Operative Visits		Total Min**	CPT Code and Number of Visits						
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 992	92x 0.00					
Other Hospital time/vis	it(s):	<u>0.00</u>	99231x 0.00 992	32x 0.00 99233x	0.00				
Discharge Day Mgmt:		<u>38.00</u>	99238x 1.0 99239	× 0.0					
Office time/visit(s):		<u>55.00</u>	99211x 0.00 12x 2	.00 13x 1.00 14x 0	.00 15x 0.00				
Prolonged Services:		<u>0.00</u>	99354x 0.00 55x	0.00 56x 0.00	57x 0.00				
Sub Obs Care:		<u>40.00</u>	99224x 2.00 992	25x 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:										
<u>Key CPT Code</u> 49566	<u>Global</u> 090	<u>Work RVU</u> 15.53	<u>Time Source</u> RUC Time							
CPT Descriptor Repair	recurrent incisional or ventral	hernia; incarcerated or strangulated								
KEY MPC COMPAR	ISON CODES:	MDC Lite D. Grand and La Grand de								

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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	Medicare Utilization
19318	090	16.03	RUC Time	6,342
CPT Descriptor 1 Reduc	ction mammaplast	у		
				Most Recent
MPC CPT Code 2	<u>Global</u>	Work RVU	Time Source	Medicare Utilization
58150	090	17.31	RUC Time	15,005

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

Other Reference CPT Code	<u>Global</u>	<u>Work RVU</u> 0.00	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: 17 % of respondents: 37.7 %

<u>TIME ESTIMATES (Median)</u>	CPT Code: 49653	Key Reference CPT Code: <u>49566</u>	Source of Time RUC Time
Median Pre-Service Time	70.00	45.00	
Median Intra-Service Time	120.00	120.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	100.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	55.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	40.0	0.00	
Median Total Time	353.00	372.00	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

(of those that selected Key Reference code)

<u>Mental Effort and Judgment (Mean)</u>		
The number of possible diagnosis and/or the number of	2.94	2.73
management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests,	3.18	3.20
and/or other information that must be reviewed and analyzed		
<u> </u>		
Urgency of medical decision making	3.76	3.60
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.24	3.53
Physical effort required	3.82	3.27
Psychological Stress (Mean)		
	0.00	2.00
The risk of significant complications, morbidity and/or mortality	3.82	3.60
Outcome depends on the skill and judgment of physician	3.94	3.60
Estimated risk of malpractice suit with poor outcome	3.94	3.67
	L	II
INTENSITY/COMPLEXITY MEASURES	CPT Code	<u>Reference</u> Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.59	3.27
Intra-Service intensity/complexity	3.94	3.60
Post-Service intensity/complexity	2.76	2.41
	L	L

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.*

In 2007, CPT approved new - but well-established - laparoscopic procedures for repair of abdominal wall hernias for CPT 2009. These laparoscopic repairs represented a significant technical departure from the open repairs for several reasons including the technical mechanics of performing the repair and the near universal placement of mesh prosthesis. All laparoscopic hernia repairs are performed within the peritoneal cavity. Adhesiolysis is major part of each procedure and is typically extensive.

In the open procedures, only enough abdominal wall for suture or mesh positioning would typically be exposed and in many circumstances entry into the peritoneal cavity would be avoided or limited. In the laparoscopic operation, since the laparoscope must be free to see the edges of the hernia defect, as well as have free areas for trocar / instrument placement, complete liberation of the intra-abdominal portion of the abdominal wall from adherent bowel and omentum is necessary for safe mesh placement. Mesh is usually placed behind the fascial and muscle layers of the abdominal wall, rather than on the surface of the muscle, as in the open setting. The mesh must be fixed securely in a circumferential pattern, to prevent displacement or herniation of viscera between mesh and muscle. Although the net result is in a markedly decreased incidence of incisional pain and morbidity related to the incision, these patients do have considerable postoperative pain from the fixation to the sensitive peritoneal surface and they are prone to postoperative narcotics and postoperative ileus.

The ACS and SAGES conducted a RUC survey for new code 49653. The RUC reviewed the relativity amongst the family of laparoscopic hernia codes and relative to the open hernia codes and believed in maintaining survey rank order at the 25th percentile survey results, which was 11% less than the survey median and the specialty recommendation.

Why Reverse Building Block is Not Applicable to Code 49653

CMS has suggested that the RUC use a building block methodology to adjust site-of-service anomaly codes for the RVWs associated with changes in time and visits. More specifically, CMS proposes a "*reverse*" BBM that subtracts E/M code work RVUs from the current work RVU, along with reassignment of minutes to different categories of time with lower intensity. For example, "some" of the post-operative E/M minutes should be reassigned to immediate post-operative care (ie, time from skin closure through discharge from recovery) at a low intensity of 0.0224, which is inconsistent with the intensity for E/M codes (eg, 99231=0.054).

This methodology is not applicable to code 49653. When the RUC reviewed code 49653, the specialty recommendation of 18.00 work RVUs using the survey median and relative comparison to references was <u>not</u> accepted, and instead the RUC recommended a work RVU that was 11% *less*. The RUC did NOT use BBM to value 49653, therefore, it is flawed logic to propose a reverse BBM that subtracts the RVUs for E/Ms and calculates a new value for 49653.

Discussion of Post-operative E/M Work

In the Final Rule, CMS states:

- 1. "For procedures typically performed in the inpatient setting when the codes were originally valued, the work RVUs for these codes would have been valued to include the inpatient physician work furnished, as well as to reflect the intensive care and follow-up normally associated with an inpatient procedure."
- 2. "If the typical case for the procedure has shifted from the inpatient setting to an outpatient or physician's office setting, it is reasonable to expect that there have been changes in medical practice, and that such changes would represent a decrease in physician time or intensity or both."

<u>We disagree with both of these statements.</u> First, hospital *status* (inpatient or outpatient) is an artifact of recent changes in payment policy and recent use of criteria-based programs (eg, InterQual) that <u>assign admission status for purposes of facility reimbursement</u>. The criteria for these programs are not based on physician work; they are based on facility resource utilization. Therefore, the CMS belief that a shift in reporting of hospital status (inpatient vs outpatient) would represent a decrease in physician work is flawed logic since hospital admission status is not tied to physician work in the programs that assign patient status. Second, more than one-third of these patients have a hospital inpatient status, therefore, next day discharge is not "imminent" or pre-planned as CMS suggests. The work in monitoring these patients post-operatively on the day of surgery and subsequent days is the same E/M work whether the patient's status ends up inpatient or outpatient. Finally, the determination to review code 49653 is based on one year of Medicare data (2009) that indicates 39 % inpatient. The Medicare claims summary data is not without error. For example, almost <u>4%</u> of the 2009 claims for 49653 are from non-surgical specialties that could not perform laparoscopic hernia repair.

It is the clinical opinion of our expert panel that the typical patients undergoing 49653 require continued post-operative management by the surgeon on the day of the procedure and on subsequent days until the patient is discharged. Monitoring for problems such as ileus, intestinal ischemia, urinary retention, and pain management is necessary for the typical patient. The typical national population will be in the hospital for three calendar days after undergoing 49653. The Medicare data, for one year or even multiple years, does not reflect the national population for this procedure.

<u>The nature of the disease impacts the LOS, not the approach.</u> We believe the multiple year data indicating over 50% inpatient for the comparable open code 49565 is more accurate and reflective of these patients than one year of data for a new code. Additionally, code 49653 includes both incarcerated and strangulated hernia repair which can be variable year to year. Further 2009, was the first year of reporting 49653. Some surgeons may still have been reporting the laparoscopic unlisted code.

Although the physician is responsible for writing the initial admit status order, the final decision for status is driven by criteria built into review programs, which are increasingly being used not only by hospitals but also by audit contractors for facility reimbursement purposes. Such programs focus on severity of <u>patient</u> illness and intensity of <u>facility</u> services (at admission) that impact use of hospital resources, <u>not</u> physician work. The physician work captured in the RUC survey was reduced by 11% two years ago. There is no reason to believe that there is a change in physician work since that time.

Even if one were to believe that the facility designation assigned to these hernia repair patients was typically outpatient, it is still our consensus that the typical patient will remain in the hospital for 3 calendar days and 2 nights. CMS representatives have stated that a patient would rarely stay more than 24 hours in a facility under outpatient or observation status; this is flawed logic in that the requirements for assignment of status in programs such as InterQual are not based on time, but on criteria of facility resource utilization. Further, in the Medicare Benefit Policy Manual, Chapter 6, it is noted that "in the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours." Forty-eight hours translates to a stay that spans three days and two nights. This is consistent with the RUC survey results and the consensus of our expert panel that the typical national patient will remain in the hospital and require care for three days and two nights.

Although some CMS representatives may contend patients would rarely stay more than 24 hours in outpatient or observation status, this is not a rule, this is not applicable to all procedures, and this is contrary to what is stated in the Medicare Benefit Policy Manual. We note that Jonathan Blum, deputy administrator at CMS has indicated that the most recent data show claims for observation care rose from 828,000 in 2006 to more than 1.1 million in 2009. At the same time, claims for observation care lasting more than 48 hours tripled to 83,183. We believe these statistics are a direct result of changes in OPPS regulations in the recent years – and NOT a change in patients undergoing surgery or the physician work post-operatively. It is illogical to believe patients undergoing surgery are getting healthier every year; suggesting physician work is decreasing because facility status assignment is shifting from inpatient to outpatient.

CURRENT RECOMMENDATION

The ACS and SAGES recommend maintaining the current RVW as published for CY 2011 (16.21). We believe the total physician work has not changed for 49653 and recommend maintaining two discrete evaluation and management visits on the day of surgery and post-op day 1, followed by full discharge work on post-op day 2 as indicated by our survey data and, more importantly by the clinical rationale. We respectfully request to defer our recommendation for the designation of the post-op evaluation and management code until the RUC approves a policy and/or rules regarding correct coding for this physician work.

The table below compares the survey code to many other RUC reviewed codes, providing further support that the current value for 49653 is not overvalued. In this table, we have utilized the RUC's current proxy of inpatient visits for the post-op in-hospital E/M visits.

year	СРТ	SHORT DESC	RVW	IWPUT	Time	eval	posit	s,d,w	INTRA	sd- im	33	32	31/ <mark>24</mark>	38/ <mark>17</mark>	14	13	12
2007	49656	Lap inc hernia repair recur	15.08	0.067	362	45	15	15	120	30		1	1	1.0		1	1
2003	58550	Laparo-asst vag hysterectomy	15.10	0.079	330	60			100	30			2	1.0		2	1

	CPT Code: 49653																
2009	36825	Artery-vein autograft	15.13	0.073	340	40	10	20	120	30			1	1.0		2	1
2005	24430	Repair of humerus	15.25	0.074	343	30	18	15	102	15			2	1.0		3	1
2005	52601	Prostatectomy (turp)	15.26	0.088	355	35	10	15	75	40		1	2	1.0		2	1
2000	35226	Repair blood vessel lesion	15.30	0.084	327	60			100	30		1	1	1.0		1	1
2000	35371	Rechanneling of artery	15.31	0.085	325	75			103	30			2	1.0		1	1
2005	63047	Removal of spinal lamina	15.37	0.080	362	60	20	15	90	30		1		1.0		3	
2000	49561	Rpr ventral hern init block	15.38	0.074	352	45			100	30		2	1	1.0		1	1
2003	58545	Laparoscopic myomectomy	15.55	0.074	334	60			120	30		1		1.0		2	
2005	43772	Lap rmvl gastr adj device	15.70	0.103	317	45	25	10	90	30		1		1.0		1	1
2005	43774	Lap rmvl gastr adj all parts	15.76	0.106	304	45	25	15	90	25			1	1.0		2	
2000	35266	Repair blood vessel lesion	15.83	0.091	337	60			90	30		1	2	1.0		1	1
2005	19303	Mast simple complete	15.85	0.098	314	30	15	15	90	20			1	1.0	1	2	
2005	57265	Extensive repair of vagina	15.94	0.070	367	45	5	10	120	30		1	2	1.0		1	1
2000	47605	Removal of gallbladder	15.98	0.075	387	75			90	30	1	1	1	1.0		1	1
2002	62201	Brain cavity shunt w/scope	16.04	0.077	425	143			75	60			2	1.0		3	
2005	49010	Exploration behind abdomen	16.06	0.087	357	30	15	15	90	30		1	3	1.0		1	1
2007	57423	Repair paravag defect lap	16.08	0.067	357	45	10	5	150	30		1		1.0		1	1
2005	32655	Thoracoscopy surgical	16.17	0.079	425	60	15	20	73	40		3	1	1.0		1	1
2007	49653	Lap vent/abd hern proc comp	16.21	0.079	353	45	15	15	120	30			2	<mark>1.0</mark>		1	2
2007	67229	Tr retinal les preterm inf	16.30	0.088	354	15	15	15	75	18		1		1.0		6	
2009	28171	Resect tarsal tumor	16.41	0.077	365	43	20	15	120	30			1	1.0	1	1	1
2002	62163	Neuroendoscopy w/fb removal	16.53	0.090	358	78			90	30			3	1.0		2	1
2006	58542	Lsh w/t/o ut 250 g or less	16.56	0.085	340	45	10	5	110	30			2	1.0		2	1
2000	35321	Rechanneling of artery	16.59	0.097	337	90			100	30			2	1.0		1	1
2000	34501	Repair valve femoral vein	16.85	0.073	393	90			120	30		1	1	1.0		1	2
2002	34900	Endovasc iliac repr w/graft	16.85	0.086	352	105			120	30			1	1.0		1	1
2006	58543	Lsh uterus above 250 g	16.87	0.081	350	45	10	5	120	30			2	1.0		2	1
2003	58552	Laparo-vag hyst incl t/o	16.91	0.081	350	60			120	30			2	1.0		2	1
2003	57425	Laparoscopy surg colpopexy	17.03	0.072	404	60	10	20	120	30		2		1.0		2	
2005	27470	Repair of thigh	17.14	0.072	400	30	10	15	120	20		1	2	1.0		1	4
2005	46710	Repr per/vag pouch sngl proc	17.14	0.097	370	60	20	10	90	30		1	1	1.0		2	1
2000	35286	Repair blood vessel lesion	17.19	0.092	350	60			100	30			3	1.0		2	1
2005	58150	Total hysterectomy	17.31	0.071	394	45	5	10	120	30		1	3	1.0		2	
2005	44187	Lap ileo/jejuno-stomy	17.40	0.105	385	45	25	10	75	30		2	1	1.0		2	1
2005	47600	Removal of gallbladder	17.48	0.068	420	30	15	15	115	30	1	1	1	1.0		2	1
2000	44700	Suspend bowel w/prosthesis	17.48	0.081	402	60			95	30		2	3	1.0		1	1
2005	27709	Incision of tibia & fibula	17.48	0.094	346	40	18	10	108	15			2	1.0		2	2
2005	27236	Treat thigh fracture	17.61	0.077	433	60	15	15	90	30		2	1	1.0		3	1
2000	60271	Removal of thyroid	17.62	0.071	377	60			150	30		1	1	1.0		1	1
2007	58571	Tlh w/t/o 250 g or less	17.69	0.073	385	45	10	5	135	30		1	1	1.0		2	1
2005	22554	Neck spine fusion	17.69	0.106	362	60	20	15	90	30		1		1.0		3	
2000	34203	Removal of leg artery clot	17.86	0.075	413	75			108	30		1	3	1.0		2	1
2005	34001	Removal of artery clot	17.88	0.097	384	30	15	15	90	30		3		1.0		2	
2000	34530	Leg vein fusion	17.93	0.068	436	90			120	30		1	2	1.0		2	2
1999	50945	Laparoscopy ureterolithotomy	17.97	0.089	342	60			120	18			3	1.0		2	

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) 49653

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 general surgerey	How often? Sometimes
Specialty	How often?
Specialty	How often?
Estimate the number of times	this service might be provided nationally in a one-year pe

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 <u>percentage</u> for each specialty. Please explain the rationale for this estimate. national frequency not available

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,376 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate. 2009 Medicare data

Specialty general surg	ery	Frequency 2228	Percentage 93.77 %
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

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 <u>will not</u> change, enter the surveyed existing CPT code number 49653

CPT Code: 49653 If this code is a new/revised code or an existing code in which the specialty utilization mix <u>will</u> change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code:49654 Tracking Number

Original Specialty Recommended RVU: **15.03** Presented Recommended RVU: **15.03** RUC Recommended RVU: **15.03**

Global Period: 090

CPT Descriptor: Laparoscopy, surgical repair incisional hernia (includes mesh insertion, when performed); reducible

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old man with a prior laparotomy for a colectomy has developed a bulge in the midline incision. The defect has been increasing in size during follow-up. He has symptoms of pain and local tenderness. He has had no history of incarceration or bowel obstruction. On examination he is found to have a reducible incisional hernia. He is referred for laparoscopic repair.

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 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 10%, Kept overnight (less than 24 hours) 33%, Admitted (more than 24 hours) 56%

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: Select and order the appropriate antibiotic(s) and confirm timing and administration. Assure appropriate selection, timing, and administration of DVT prophylaxis. Assess need for beta-blockers, order as required. Review results of preadmission work-up and testing (lab, EKG, chest x-ray, availability of blood products), with particular attention to imaging information and reports. Reexamine patient to make sure that physical findings have not changed, that the hernia remains unreducible, and update H&P. Meet with patient and family to review planned procedure. Mark the palpable edge of the hernia defect(s) and sites of the proposed skin incisions with cooperation of patient. Review and obtain informed consent, including witness. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available, including reusable and disposable laparoscopic equipment and mesh, if needed. Assist in transfer of patient from gurney to operating table. Monitor/assist with positioning of patient. Assist anesthesia team with line placement and induction of anesthesia and intubation, relative to all laparoscopic equipment. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: If hernia contents are present they are gently reduced. Pneumoperitoneum is induced by open insertion of the first port (described below) or other appropriate technique. Starting at a distance from the hernia location, for open insertion the first skin incision is made and carried through the subcutaneous tissues. Hemostasis is obtained. The fascia is exposed, incised and the peritoneum opened carefully under direct vision avoiding underlying bowel, omentum or adhesions. The first trocar is inserted and secured with the stay sutures as needed. The abdomen is

then insufflated while physiologic changes are monitored. The appropriate camera is inserted, and a preliminary visual exploration of the abdominal cavity to identify the pattern of adhesions is made prior to placing subsequent cannulae. With the camera viewing placement of each port, typically two more are positioned to allow two handed surgical technique, while remaining at a distance from the hernia. A thorough visual examination of the abdominal cavity is then undertaken with the aid of instruments inserted through the other ports, viewing where possible the liver, small bowel, colon, stomach, spleen, and pelvic organs. At any stage in this initial process adhesions may require sharp and/or blunt lysis to allow adequate exposure. There are several defects adjacent to each other containing suture loops from the first wound closure. Adhesions to the abdominal wall, between loops of bowel, and between bowel and other structures are meticulously lysed to free the entire anterior abdominal fascia. The hernia defects are identified and if necessary their contents reduced. An appropriate margin around the ensemble of defects to accommodate overlapping mesh is cleared by lysing adhesions or mobilizing structures such as the falciform ligament. Hemostasis is secured before continuing and a careful check of intestine that has been handled or freed by adhesiolysis is made to confirm that it is intact. Sites on the abdominal wall are selected for the transfascial fixation sutures if used. The distribution of the defects is measured and an appropriate sized mesh patch is selected. The mesh is rolled and introduced though the largest available cannula or abdominal puncture and once inside is unfurled and positioned with the correct surface facing the abdominal wall. The entire periphery of the mesh is secured at appropriate intervals to the abdominal wall with a combination of any or all of the following: tacks, staples, transfascial or intracorporeal stitches, or other permanent fixation devices. A fourth or subsequent port may be necessary to permit access of instrumentation for fixation of an inaccessible corner of the mesh. The number and position of these fixation points is intended to achieve adequate overlap of flat lying mesh beyond the edge of the defect, and prevent both movement of the mesh and protrusion of intestine, omentum or other abdominal structures between the mesh and the abdominal wall. A second or subsequent concentric inner ring of fixation points between the outer ring and the edge of the defect may be inserted according to surgeon preference. The mesh is inspected for gaps, large ripples and other defects, with and without insufflation, and corrected as needed. The secondary cannulae are removed, carbon dioxide is allowed to escape from the abdomen, and the fascial defect of all port punctures are repaired as appropriate. Local anesthetic is injected once again to all trocar sites and transfascial fixation points. If needed the subcutaneous tissues of the larger punctures are approximated with interrupted sutures to eliminate a dead space. The skin incisions are closed according to surgeon preference. Sponge, needle, and instrument counts are obtained and confirmed prior to closure.

Description of Post-Service Work:

Hospital [operative day through discharge from recovery room]: Apply sterile adhesive strips and dressings. Monitor patient during reversal of anesthesia, protecting the wound with a hand so that wound disruption does not occur with an unrestrained cough on emergence from anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia. Discontinue prophylactic antibiotic therapy, as appropriate. Review post-operative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to general surgical floor and discuss ongoing care with floor nurses.

Hospital Visits [operative day and subsequent days after discharge from recovery room]: Review interval chart notes. Discuss ongoing care with floor nurses. Evaluate vital signs and intake/output. Auscultate heart, lungs, and abdomen for bowel sounds. Monitor fluid and electrolyte status and renal function; monitoring for problems such as ileus, intestinal ischemia, and urinary retention. Examine patient, check wounds and drain, and change dressings. Continue prophylaxis for DVT. Assess need for beta-blockers, order as required. Assess pain scores and adequacy of analgesia. Review nursing/other staff patient chart notes. Write orders for labs, films, medications, diet, and patient activity. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions. Advance diet, as appropriate.

Hospital Discharge Management [when patient is stable and can safely be discharged]: Review interval chart notes. Evaluate vital signs and intake/output. Auscultate heart, lungs, and abdomen for bowel sounds. Monitor fluid and electrolyte status and renal function; monitoring for problems such as ileus, intestinal ischemia, and urinary retention. Examine patient, check wounds and drain, and change dressings. After considering relevant data, options, and risks on the day following surgery, the surgeon will make the decision for the patient to stay in the hospital or to be discharged. The patient will not be discharged until there is return of bowel function, the patient is taking adequate nutrition, and there is adequate pain control with oral analgesics. Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy. Write prescriptions for medications needed post-discharge. Home restrictions and activity levels (ie, diet, bathing) are discussed with the patient, family members and discharging nurse. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Post-op Office Visits: Review interval chart notes. Examine and talk with patient. Assess pain scores and adequacy of analgesia. Remove staples or sutures and drain, when appropriate. Review activity and restrictions. Check for presence of post-operative hematoma/seroma and assess need for aspiration. Monitor diet caloric intake by weight. Answer patient/family questions. Write medication prescriptions. Post discharge labs/films are ordered and reviewed. Discuss progress with referring physician(s) (verbal and written). Dictate progress notes for medical chart. Review activity permission with patient and write appropriate permission.

SURVEY DAT	ГА										
RUC Meeting Da	ate (mm/yyyy)	02/2011									
Presenter(s):	Michael Edye FACS	Michael Edye, MD, FACS; Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS									
Specialty(s):	general surge	general surgery, GI endoscopic surgery									
CPT Code:	49654	49654									
Sample Size:	300 F	300 Resp N:		Respo	onse: 13.3 %	, D					
Sample Type:	Random	Additional Sa	mple Info	rmation:							
			Low	25 th pctl	Median*	75th pctl	High				
Service Perform	nance Rate		0.00	5.00	12.00	15.00	70.00				
Survey RVW:			11.84	14.95	16.00	17.00	25.00				
Pre-Service Evalu	ation Time:				45.00						
Pre-Service Posit	ioning Time:				15.00						
Pre-Service Scrul	b, Dress, Wait Ti	me:			15.00						
Intra-Service Ti	me:		60.00	90.00	120.00	120.00	240.00				
Immediate Post	Service-Time:	<u>30.00</u>									
Post Operative	<u>Visits</u>	Total Min**	CPT Cod	e and Num	ber of Visit	S					
Critical Care tim	ne/visit(s):	<u>0.00</u>	99291x 0	. 00 99292	2x 0.00						
Other Hospital t	time/visit(s):	<u>60.00</u>	99231x 1	.00 99232	2x 1.00 9	9233x 0.00					
Discharge Day	Mgmt:	<u>38.00</u>	99238x 1	. 00 99239x	0.00						
Office time/visit	(s):	<u>39.00</u>	99211x 0	.00 12x 1.0	0 13x 1.00 1	4x 0.00 15x	0.00				
Prolonged Serv	ices:	<u>0.00</u>	99354x 0	.00 55x C	.00 56x 0	.00 57x 0.0	00				
Sub Obs Care:		0.00	99224x 0	.00 99225	5x 0.00 9	9226x 0.00					

**Physician standard total <u>minutes per E/M visit</u>: 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: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	49654	Recommended Physician Work RVU: 15.03						
			Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time			
Pre-Service Evaluation Ti	ime:		40.00	40.00	0.00			
Pre-Service Positioning Time:			15.00	3.00	12.00			
Pre-Service Scrub, Dress	, Wait Tim	ie:	15.00	20.00	-5.00			
Intra-Service Time:			120.00					
Immediate Post Servic	e-Time:	<u>30.00</u>						
Post Operative Visits Total Min**			CPT Code and Number of Visits					
Critical Care time/visit	(s):	<u>0.00</u>	99291x 0.00 992	92x 0.00				
Other Hospital time/vis	sit(s):	<u>0.00</u>	99231x 0.00 992	32x 0.00 99233x	0.00			
Discharge Day Mgmt:		<u>38.00</u>	99238x 1.0 99239x 0.0					
Office time/visit(s):		<u>39.00</u>	99211x 0.00 12x 1.00 13x 1.00 14x 0.00 15x 0.00					
Prolonged Services:		<u>0.00</u>	99354x 0.00 55x	0.00 56x 0.00	57x 0.00			
Sub Obs Care:		<u>40.00</u>	99224x 2.00 992	25x 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 S	ERVICE:		
<u>Key CPT Code</u> 44180	<u>Global</u> 090	<u>Work RVI</u> 15.27	J Time Source RUC Time
<u>CPT Descriptor</u> Laparo	scopy, surgical, enterolysis (fr	reeing of intestinal adhesion) (sep	parate procedure)
KEY MPC COMPAR Compare the surveyed appropriate that have re	ISON CODES: code to codes on the RUC's lative values higher and lower	MPC List. Reference codes from the requested relative value	om the MPC list should be chosen, es for the code under review. Most Recent
KEY MPC COMPAR Compare the surveyed appropriate that have re <u>MPC CPT Code 1</u>	ISON CODES: code to codes on the RUC's lative values higher and lower <u>Global</u> Work RVU	MPC List. Reference codes from the requested relative value <u>Time Source</u>	om the MPC list should be chosen, es for the code under review. Most Recent <u>Medicare Utilization</u>
KEY MPC COMPAR Compare the surveyed appropriate that have re <u>MPC CPT Code 1</u> 36819	ISON CODES: code to codes on the RUC's lative values higher and lower <u>Global</u> <u>Work RVU</u> 090 14.	MPC List. Reference codes from than the requested relative value <u>Time Source</u> 47 RUC Time	om the MPC list should be chosen, es for the code under review. Most Recent <u>Medicare Utilization</u> 11,884
KEY MPC COMPAR Compare the surveyed appropriate that have re <u>MPC CPT Code 1</u> 36819 <u>CPT Descriptor 1</u> Arter	ISON CODES: code to codes on the RUC's lative values higher and lower <u>Global</u> <u>Work RVU</u> 090 14. iovenous anastomosis, open; b	MPC List. Reference codes from than the requested relative value <u>Time Source</u> 47 RUC Time by upper arm basilic vein transpo	om the MPC list should be chosen, es for the code under review. Most Recent <u>Medicare Utilization</u> 11,884 osition
KEY MPC COMPAR Compare the surveyed appropriate that have re <u>MPC CPT Code 1</u> 36819 <u>CPT Descriptor 1</u> Arter	ISON CODES: code to codes on the RUC's lative values higher and lower <u>Global</u> <u>Work RVU</u> 090 14. iovenous anastomosis, open; b	MPC List. Reference codes from the requested relative value than the requested relative value <u>Time Source</u> 47 RUC Time by upper arm basilic vein transponder	om the MPC list should be chosen, es for the code under review. Most Recent <u>Medicare Utilization</u> 11,884 osition Most Recent
KEY MPC COMPAR Compare the surveyed appropriate that have re <u>MPC CPT Code 1</u> 36819 <u>CPT Descriptor 1</u> Arter <u>MPC CPT Code 2</u>	ISON CODES: code to codes on the RUC's lative values higher and lower <u>Global</u> <u>Work RVU</u> 090 14. iovenous anastomosis, open; b <u>Global</u> <u>Work</u>	MPC List. Reference codes from the requested relative value than the requested relative value <u>Time Source</u> 47 RUC Time by upper arm basilic vein transpondent RVU Time Source	om the MPC list should be chosen, es for the code under review. Most Recent <u>Medicare Utilization</u> 11,884 osition Most Recent <u>Medicare Utilization</u>

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

Other Reference CPT Code	<u>Global</u>	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: 16

% of respondents: 40.0 %

<u>TIME ESTIMATES (Median)</u>	CPT Code: 49654	Key Reference CPT Code: <u>44180</u>	Source of Time RUC Time
Median Pre-Service Time	70.00	100.00	
Median Intra-Service Time	120.00	120.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	80.00	
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	40.0	0.00	
Median Total Time	337.00	407.00	
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	3.00	3.00
management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests,	3.06	3.00
and/or other information that must be reviewed and analyzed		
Urgency of medical decision making	2.69	2.86
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.25	3.64
Physical effort required	4.13	3.93
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.00	3.57
Outcome depends on the skill and judgment of physician	4.59	4.21
Estimated risk of malpractice suit with poor outcome	4.44	4.21
INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference
		Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.31	3.31
	0.01	0.01
		·
Intra-Service intensity/complexity	3.94	3.69
Post-Service intensity/complexity	3.00	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.*

In 2007, CPT approved new - but well-established - laparoscopic procedures for repair of abdominal wall hernias for CPT 2009. These laparoscopic repairs represented a significant technical departure from the open repairs for several reasons including the technical mechanics of performing the repair and the near universal placement of mesh prosthesis. All laparoscopic hernia repairs are performed within the peritoneal cavity. Adhesiolysis is major part of each procedure and is typically extensive.

In the open procedures, only enough abdominal wall for suture or mesh positioning would typically be exposed and in many circumstances entry into the peritoneal cavity would be avoided or limited. In the laparoscopic operation, since the laparoscope must be free to see the edges of the hernia defect, as well as have free areas for trocar / instrument placement, complete liberation of the intra-abdominal portion of the abdominal wall from adherent bowel and omentum is necessary for safe mesh placement. Mesh is usually placed behind the fascial and muscle layers of the abdominal wall, rather than on the surface of the muscle, as in the open setting. The mesh must be fixed securely in a circumferential pattern, to prevent displacement or herniation of viscera between mesh and muscle. Although the net result is in a markedly decreased incidence of incisional pain and morbidity related to the incision, these patients do have considerable postoperative pain from the fixation to the sensitive peritoneal surface and they are prone to postoperative narcotics and postoperative ileus.

The ACS and SAGES conducted a RUC survey for new code 49654. The RUC reviewed the relativity amongst the family of laparoscopic hernia codes and relative to the open hernia codes and believed in maintaining survey rank order at the 25th percentile survey results, which was 7% less than the survey median and the specialty recommendation.

Why Reverse Building Block is Not Applicable to Code 49654

CMS has suggested that the RUC use a building block methodology to adjust site-of-service anomaly codes for the RVWs associated with changes in time and visits. More specifically, CMS proposes a "*reverse*" BBM that subtracts E/M code work RVUs from the current work RVU, along with reassignment of minutes to different categories of time with lower intensity. For example, "some" of the post-operative E/M minutes should be reassigned to immediate post-operative care (ie, time from skin closure through discharge from recovery) at a low intensity of 0.0224, which is inconsistent with the intensity for E/M codes (eg, 99231=0.054).

This methodology is not applicable to code 49654. When the RUC reviewed code 49654, the specialty recommendation of 16.10 work RVUs using the survey median and relative comparison to references was <u>not</u> accepted, and instead the RUC recommended a work RVU that was 7% *less*. The RUC did NOT use BBM to value 49654, therefore, it is flawed logic to propose a reverse BBM that subtracts the RVUs for E/Ms and calculates a new value for 49654.

Discussion of Post-operative E/M Work

In the Final Rule, CMS states:

- 1. "For procedures typically performed in the inpatient setting when the codes were originally valued, the work RVUs for these codes would have been valued to include the inpatient physician work furnished, as well as to reflect the intensive care and follow-up normally associated with an inpatient procedure."
- 2. "If the typical case for the procedure has shifted from the inpatient setting to an outpatient or physician's office setting, it is reasonable to expect that there have been changes in medical practice, and that such changes would represent a decrease in physician time or intensity or both."

<u>We disagree with both of these statements.</u> First, hospital *status* (inpatient or outpatient) is an artifact of recent changes in payment policy and recent use of criteria-based programs (eg, InterQual) that <u>assign admission status for purposes of facility reimbursement</u>. The criteria for these programs are not based on physician work; they are based on facility resource utilization. Therefore, the CMS belief that a shift in reporting of hospital status (inpatient vs outpatient) would represent a decrease in physician work is flawed logic since hospital admission status is not tied to physician work in the programs that assign patient status. Second, more than one-third of these patients have a hospital inpatient status, therefore, next day discharge is not "imminent" or pre-planned as CMS suggests. The work in monitoring these patients post-operatively on the day of surgery and subsequent days is the same E/M work whether the patient's status ends up inpatient or outpatient. Finally, the determination to review code 49654 is based on one year of Medicare data (2009) that indicates 39% inpatient. The Medicare claims summary data is not without error. For example, almost <u>3%</u> of the 2009 claims for 49654 are from non-surgical specialties that could not perform laparoscopic hernia repair.

It is the clinical opinion of our expert panel that the typical patients undergoing 49654 require continued post-operative management by the surgeon on the day of the procedure and on subsequent days until the patient is discharged. Monitoring for problems such as ileus, intestinal ischemia, urinary retention, and pain management is necessary for the typical patient. The typical national population will be in the hospital for three calendar days after undergoing 49654. The Medicare data, for one year or even multiple years, does not reflect the national population for this procedure. Additionally, code 49654 includes both incarcerated and strangulated hernia repair which can be variable year to year. Further 2009, was the first year of reporting 49654. Some surgeons may still have been reporting the laparoscopic unlisted code.

Although the physician is responsible for writing the initial admit status order, the final decision for status is driven by criteria built into review programs, which are increasingly being used not only by hospitals but also by audit contractors for facility reimbursement purposes. Such programs focus on severity of <u>patient</u> illness and intensity of <u>facility</u> services (at admission) that impact use of hospital resources, <u>not</u> physician work. The physician work captured in the RUC survey was reduced by 7% two years ago. There is no reason to believe that there is a change in physician work since that time.

Even if one were to believe that the facility designation assigned to these hernia repair patients was typically outpatient, it is still our consensus that the typical patient will remain in the hospital for 3 calendar days and 2 nights. CMS representatives have stated that a patient would rarely stay more than 24 hours in a facility under outpatient or observation status; this is flawed logic in that the requirements for assignment of status in programs such as InterQual are not based on time, but on criteria of facility resource utilization. Further, in the Medicare Benefit Policy Manual, Chapter 6, it is noted that "in the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours." Forty-eight hours translates to a stay that spans three days and two nights. This is consistent with the RUC survey results and the consensus of our expert panel that the typical national patient will remain in the hospital and require care for three days and two nights.

Although some CMS representatives may contend patients would rarely stay more than 24 hours in outpatient or observation status, this is not a rule, this is not applicable to all procedures, and this is contrary to what is stated in the Medicare Benefit Policy Manual. We note that Jonathan Blum, deputy administrator at CMS has indicated that the most recent data show claims for observation care rose from 828,000 in 2006 to more than 1.1 million in 2009. At the same time, claims for observation care lasting more than 48 hours tripled to 83,183. We believe these statistics are a direct result of changes in OPPS regulations in the recent years – and NOT a change in patients undergoing surgery or the physician work post-operatively. It is illogical to believe patients undergoing surgery are getting healthier every year; suggesting physician work is decreasing because facility status assignment is shifting from inpatient to outpatient.

CURRENT RECOMMENDATION

The ACS and SAGES recommend maintaining the current RVW as published for CY 2011 (15.03). We believe the total physician work has not changed for 49654 and recommend maintaining two discrete evaluation and management visits on the day of surgery and post-op day 1, followed by full discharge work on post-op day 2 as indicated by our survey data and, more importantly by the clinical rationale. We respectfully request to defer our recommendation for the designation of the post-op evaluation and management codes until the RUC approves a policy and/or rules regarding correct coding for this physician work.

The table below compares the survey code to many other RUC reviewed codes, providing further support that the current value for 49654 is not overvalued. In this table, we have utilized the RUC's current proxy of inpatient visits for the post-op in-hospital E/M visits.

	ODT				T :					sd-	~~	~~	31/	38/		40	40
year	CPI	Repair blood vessel	RVW		Time	eval	posit	s,a,w		im of	33	32	24	17 1 0	14	13	12
2000	35206	lesion	13.84	0.088	282	50			90	25			2	1.0		1	1
2001	54408	Repair multi-comp penis pros	13.91	0.060	334	50			110	30			1	1.0	1	2	
2006	33203	Insert epicard eltrd endo	13.97	0.080	326	55	15	15	90	30		1	1	1.0		1	
2002	58260	Vaginal hysterectomy	14.15	0.104	311	60			60	30		1	1	1.0	1	1	
2009	28173	Resect metatarsal tumor	14.16	0.072	304	19	3	5	110	30			1	1.0	1	1	1
2001	53444	Insert tandem cuff	14.19	0.066	320	50			120	30			1	1.0		2	1
2000	37605	Ligation of neck artery	14.28	0.071	342	55			90	25	1	1		1.0		1	1
2009	57426	Revise prosth vag graft lap	14.30	0.061	360	40	3	20	110	40		1		1.0		3	
2007	57284	Repair paravag defect open	14.33	0.075	327	45	10	5	100	30		1	1	1.0		1	1
2007	27726	Repair fibula nonunion	14.34	0.081	319	40	15	15	100	20			1	1.0		1	3
2006	64911	Neurorraphy w/vein autograft	14.39	0.075	294	25	10	15	120	20				0.5		3	1
2005	57260	Repair of vagina	14.44	0.077	337	45	5	10	90	30		1	2	1.0		1	1
2000	69714	Implant temple bone w/stimul	14.45	0.098	284	55			90	30				1.0		1	3
2008	36820	Av fusion/forearm vein	14.47	0.076	307	45	10	15	120	20			1	1.0		1	1
2004	36819	Av fuse uppr arm basilic	14.47	0.078	287	55			120	15			1	1.0		1	1
2001	29807	Shoulder arthroscopy/surgery	14.67	0.097	288	55			90	30				0.5		2	3
2005	21395	Treat eye socket fracture	14.70	0.067	347	30	15	15	120	30		1	1	1.0		1	1
2006	58541	Lsh uterus 250 g or less	14.70	0.079	325	45	10	5	95	30			2	1.0		2	1
2009	26118	Exc hand tum ra > 3 cm	14.81	0.066	368	40	12	20	100	20			1	1.0	1	2	2
2000	58740	Adhesiolysis tube ovary	14.90	0.060	374	68			120	33		1	1	1.0	1		1
2008	27057	w/dbrdmt	14.91	0.062	389	43	12	5	90	30		1	3	1.0		1	3
2005	32662	Thoracoscopy surgical	14.99	0.083	350	60	15	20	98	40		1		1.0		1	1
2000	66982	Cataract surgery complex	15.02	0.163	228	40			60	15				0.5		2	3
2007	49654	Lap inc hernia repair	15.03	0.073	337	45	15	15	120	30			2	<mark>1.0</mark>		1	1
2007	49656	Lap inc hernia repair recur	15.08	0.067	362	45	15	15	120	30		1	1	1.0		1	1
2003	58550	Laparo-asst vag hysterectomy	15.10	0.079	330	60			100	30			2	1.0		2	1
2009	36825	Artery-vein autograft	15.13	0.073	340	40	10	20	120	30			1	1.0		2	1
2009	26250	Extensive hand surgery	15.21	0.065	353	23	10	15	120	25			1	1.0	1	2	1
2005	24430	Repair of humerus	15.25	0.074	343	30	18	15	102	15			2	1.0		3	1
2009	21016	Resect face tum + cm	15.26	0.060	398	40	8	20	100	30		1	1	1.0	1	2	1
2005	52601	Prostatectomy (turp)	15.26	0.088	355	35	10	15	75	40		1	2	1.0		2	1
2000	35226	lesion	15.30	0.084	327	60			100	30		1	1	1.0		1	1
2000	35371	Rechanneling of artery	15.31	0.085	325	75			103	30			2	1.0		1	1
2005	63047	lamina	15.37	0.080	362	60	20	15	90	30		1		1.0		3	
2000	49561	block	15.38	0.074	352	45			100	30		2	1	1.0		1	1
2000	69717	revision	15.43	0.105	282	50			95	28				1.0		1	3
2000	49566	Rerepair ventri hern block	15.53	0.063	372	45			120	30		2	1	1.0		1	1
2003	58545	Laparoscopic myomectomy	15.55	0.074	334	60			120	30		1		1.0		2	
2005	43772	Lap rmvl gastr adj device	15.70	0.103	317	45	25	10	90	30		1		1.0		1	1
2000	35266	Repair blood vessel lesion	15.83	0.091	337	60			90	30		1	2	1.0		1	1
2005	19303	Mast simple complete	15.85	0.098	314	30	15	15	90	20			1	1.0	1	2	
2007	58570	Tlh uterus 250 g or less	15.88	0.067	370	45	10	5	120	30		1	1	1.0		2	1
2007	27557	Treat knee dislocation	15.90	0.065	399	60	15	15	120	20		1	1	1.0		1	3
2005	57265	Extensive repair of vagina	15.94	0.070	367	45	5	10	120	30		1	2	1.0		1	1
											UPI	Cod	e: 49	654			
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year	СРТ	SHORT DESC	RVW	IWPUT	Time	eval	posit	s,d,w	INTRA	sd- im	33	32	31/ <mark>24</mark>	38/ <mark>17</mark>	14	13	12
2000	47605	Removal of gallbladder	15.98	0.075	387	75			90	30	1	1	1	1.0		1	1
2002	62163	Neuroendoscopy w/fb removal	16.53	0.090	358	78			90	30			3	1.0		2	1
2006	58542	Lsh w/t/o ut 250 g or less	16.56	0.085	340	45	10	5	110	30			2	1.0		2	1
2006	58543	Lsh uterus above 250 g	16.87	0.081	350	45	10	5	120	30			2	1.0		2	1
2003	58552	Laparo-vag hyst incl t/o	16.91	0.081	350	60			120	30			2	1.0		2	1

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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) 49654

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 general surgery		How often?	Sometimes
Specialty	How often?		
Specialty	How often?		

Estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. national frequency not available

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

CPT Code: 49654

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,389 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate. 2009 Medicare data

Specialty general surger	У	Frequency 5099	Percentage 94.61 %						
Specialty	Frequency	Percentage	%						
Specialty	Frequency	Percentage	%						
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 <u>will not</u> change, enter the surveyed existing CPT code number 49654

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code:49655 Tracking Number

Original Specialty Recommended RVU: **18.11** Presented Recommended RVU: **18.11** RUC Recommended RVU: **18.11**

Global Period: 090

CPT Descriptor: Laparoscopy, surgical repair incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 54-year-old man has a surgical history of a partial gastrectomy for ulcer disease. He has developed an incisional hernia in the midline incision. Over the past few months, it has become chronically protuberant. He reports increasing pain and discomfort associated with it. He has had episodes of worsening distention and occasionally vomiting with the episodes of pain. He is not able to reduce the hernia even when lying down. He is referred for laparoscopic repair.

Percentage of Survey Respondents who found Vignette to be Typical: 73%

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 5%, Kept overnight (less than 24 hours) 8%, Admitted (more than 24 hours) 87%

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: Select and order the appropriate antibiotic(s) and confirm timing and administration. Assure appropriate selection, timing, and administration of DVT prophylaxis. Assess need for beta-blockers, order as required. Review results of preadmission work-up and testing (lab, EKG, chest x-ray, availability of blood products), with particular attention to imaging information and reports. Reexamine patient to make sure that physical findings have not changed, that the hernia remains unreducible, and update H&P. Meet with patient and family to review planned procedure. Mark the palpable edge of the hernia defect(s) and sites of the proposed skin incisions with cooperation of patient. Review and obtain informed consent, including witness. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available, including reusable and disposable laparoscopic equipment and mesh, if needed. Assist in transfer of patient from gurney to operating table. Monitor/assist with positioning of patient. Assist anesthesia team with line placement and induction of anesthesia and intubation, relative to all laparoscopic equipment. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: If hernia contents are present they are gently reduced if possible. Pneumoperitoneum is induced by open insertion of the first port (described below) or other appropriate technique. Starting at a distance from the hernia location, for open insertion the first skin incision is made and carried through the subcutaneous tissues. Hemostasis

CPT Code: 49655

is obtained. The fascia is exposed, incised and the peritoneum opened carefully under direct vision avoiding underlying bowel, omentum or adhesions. The first trocar is inserted and secured with the stay sutures as needed. The abdomen is then insufflated while physiologic changes are monitored. The appropriate camera is inserted, and a preliminary visual exploration of the abdominal cavity to identify the pattern of adhesions is made prior to placing subsequent cannulae. There are many adhesions to the anterior abdominal wall involving the small and large intestine. The hernia contains both omentum and multiple loops of small bowel. The small bowel entering the hernia appears chronically dilated; the loops leaving are flat and decompressed. With the camera viewing placement of each port, typically two more are positioned to allow two handed surgical technique, while remaining at a distance from the hernia. A thorough visual examination of the abdominal cavity is then undertaken with the aid of instruments inserted through the other ports, viewing where possible the liver, small bowel, colon, stomach, spleen, and pelvic organs. At any stage in this initial process adhesions may require sharp and/or blunt lysis to allow adequate exposure. The hernia defect or defects are identified and if necessary the contents are reduced. Adhesions to the hernia(s), abdominal wall, between loops of bowel, and between bowel and other structures are slowly and meticulously lysed to free the entire anterior abdominal fascia. An appropriate margin around the defect(s) to accommodate overlapping mesh is cleared by lysing adhesions or mobilizing structures such as the falciform ligament or adjacent colon. Hemostasis is secured before continuing and a careful check of intestine that has been handled or freed by adhesiolysis is made to confirm that it is intact. Sites on the abdominal wall are selected for the transfascial fixation sutures if used. The size/distribution of the defects is measured and an appropriate sized mesh patch is selected. The mesh is rolled and introduced though the largest available cannula or abdominal puncture and once inside is unfurled and positioned with the correct surface facing the abdominal wall. The entire periphery of the mesh is secured at appropriate intervals to the abdominal wall with a combination of any or all of the following: tacks, staples, transfascial or intracorporeal stitches, or other permanent fixation devices. A fourth or subsequent port may be necessary to permit access of instrumentation for fixation of an inaccessible corner of the mesh. The number and position of these fixation points is intended to achieve adequate overlap of flat lying mesh beyond the edge of the defect, and prevent both movement of the mesh and protrusion of intestine, omentum or other abdominal structures between the mesh and the abdominal wall. A second or subsequent concentric inner ring of fixation points between the outer ring and the edge of the defect(s) may be inserted according to surgeon preference. The mesh is inspected for gaps, large ripples and other defects, with and without insufflation, and corrected as needed. The secondary cannulae are removed, carbon dioxide is allowed to escape from the abdomen, and the fascial defect of all port punctures are repaired as appropriate. Local anesthetic is injected once again to all trocar sites and transfascial fixation points. If needed the subcutaneous tissues of the larger punctures are approximated with interrupted sutures to eliminate a dead space. The skin incisions are closed according to surgeon preference. Sponge, needle, and instrument counts are obtained and confirmed prior to closure.

Description of Post-Service Work:

Hospital [operative day through discharge from recovery room]: Apply sterile adhesive strips and dressings. Monitor patient during reversal of anesthesia, protecting the wound with a hand so that wound disruption does not occur with an unrestrained cough on emergence from anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia. Discontinue prophylactic antibiotic therapy, as appropriate. Review post-operative labs. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to general surgical floor and discuss ongoing care with floor nurses.

Hospital Visits [operative day and subsequent days after discharge from recovery room]: Review interval chart notes. Discuss ongoing care with floor nurses. Evaluate vital signs and intake/output. Auscultate heart, lungs, and abdomen for bowel sounds. Monitor fluid and electrolyte status and renal function; monitoring for problems such as ileus, intestinal ischemia, and urinary retention. Examine patient, check wounds and drain, and change dressings. Continue prophylaxis for DVT. Assess need for beta-blockers, order as required. Assess pain scores and adequacy of analgesia. Review nursing/other staff patient chart notes. Write orders for labs, films, medications, diet, and patient activity. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions. Advance diet, as appropriate.

Hospital Discharge Management [when patient is stable and can safely be discharged]: Review interval chart notes. Evaluate vital signs and intake/output. Auscultate heart, lungs, and abdomen for bowel sounds. Monitor fluid and electrolyte status and renal function; monitoring for problems such as ileus, intestinal ischemia, and urinary retention. Examine patient, check wounds and drain, and change dressings. After considering relevant data, options, and risks on the day following surgery, the surgeon will make the decision for the patient to stay in the hospital or to be discharged. The patient will not be discharged until there is return of bowel function, the patient is taking adequate nutrition, and there is

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adequate pain control with oral analgesics. Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy. Write prescriptions for medications needed post-discharge. Home restrictions and activity levels (ie, diet, bathing) are discussed with the patient, family members and discharging nurse. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Post-op Office Visits: Review interval chart notes. Examine and talk with patient. Assess pain scores and adequacy of analgesia. Remove staples or sutures and drain, when appropriate. Review activity and restrictions. Check for presence of post-operative hematoma/seroma and assess need for aspiration. Monitor diet caloric intake by weight. Answer patient/family questions. Write medication prescriptions. Post discharge labs/films are ordered and reviewed. Discuss progress with referring physician(s) (verbal and written). Dictate progress notes for medical chart. Review activity permission with patient and write appropriate permission.

SURVEY DA	ГА									
RUC Meeting Da	ate (mm/yyyy)	02/2011								
Presenter(s):	Christopher Se	enkowski, MD	, FACS; C	harles Mabr	y, MD, FACS	6				
Specialty(s):	general surge	ry, GI endosco	opic surgei	гу						
CPT Code:	49655									
Sample Size:	nple Size: 300 Resp N:			40 Response: 13.3 %						
Sample Type: Random Additional Sample Information:										
			Low	25 th pctl	Median*	75th pctl	High			
Service Perforn	nance Rate		0.00	3.00	8.00	12.00	25.00			
Survey RVW:			16.00	17.40	20.00	22.00	30.00			
Pre-Service Eval	uation Time:				50.00					
Pre-Service Posit	tioning Time:				15.00					
Pre-Service Scru	b, Dress, Wait Tir	ne:			15.00					
Intra-Service Ti	me:		90.00	120.00	150.00	180.00	250.00			
Immediate Post	Service-Time:	<u>30.00</u>								
Post Operative	<u>Visits</u>	Total Min**	CPT Cod	e and Num	ber of Visit	S				
Critical Care tin	ne/visit(s):	<u>0.00</u>	99291x 0	. 00 99292	2x 0.00					
Other Hospital	time/visit(s):	<u>60.00</u>	99231x 1	.00 99232	2x 1.00 9	9233x 0.00				
Discharge Day	Mgmt:	<u>38.00</u>	99238x 1	.00 99239x	0.00					
Office time/visit	t(s):	55.00	99211x 0	.00 12x 2.0	0 13x 1.00 1	4x 0.00 15x	0.00			
Prolonged Serv	vices:	0.00	99354x 0	.00 55x C	.00 56x 0	.00 57x 0.0	00			
Sub Obs Care:		0.00	99224x 0	.00 99225	5x 0.00 9	9226x 0.00				

**Physician standard total <u>minutes per E/M visit</u>: 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: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	49655		Recommended Physician Work RVU: 18.11							
			Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time					
Pre-Service Evaluation Ti	me:		40.00	40.00	0.00					
Pre-Service Positioning T	ime:		15.00	3.00	12.00					
Pre-Service Scrub, Dress	, Wait Tim	ie:	15.00	20.00	-5.00					
Intra-Service Time:			150.00							
Immediate Post Service	e-Time:	<u>30.00</u>								
Post Operative Visits		<u>Total Min**</u>	CPT Code and Nu	<u>Imber of Visits</u>						
Critical Care time/visit((s):	<u>0.00</u>	99291x 0.00 992	92x 0.00						
Other Hospital time/vis	sit(s):	<u>0.00</u>	99231x 0.00 992	32x 0.00 99233x	0.00					
Discharge Day Mgmt:		<u>38.00</u>	99238x 1.0 99239	< 0.0						
Office time/visit(s):		<u>55.00</u>	99211x 0.00 12x 2	.00 13x 1.00 14x 0	.00 15x 0.00					
Prolonged Services:		<u>0.00</u>	99354x 0.00 55x	0.00 56x 0.00	57x 0.00					
Sub Obs Care:		<u>40.00</u>	99224x 2.00 992	25x 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 SERV	ICE:					
<u>Key CPT Code</u> 49566	<u>Global</u> 090		2	<u>Work RVU</u> 15.53	Time Source RUC Time	
CPT Descriptor Repair recur	rent incisional	l or ventral hernia	a; incarcerated of	r strangulated		
KEY MPC COMPARISO Compare the surveyed code appropriate that have relative	N CODES: to codes on t e values higher	he RUC's MPC r and lower than	List. Reference the requested rel	e codes from th ative values for	e MPC list should be cho the code under review. Most Recent	sen, if
MPC CPT Code 1	Global	Work RVU	Time Source	Me	edicare Utilization	
34203	090	17.86	RUC Time	e	2,598	
<u>CPT Descriptor 1</u> Embolecto	omy or thromb	bectomy, with or	without catheter	; popliteal-tibio	-peroneal artery, by leg inc Most Recent	vision
MPC CPT Code 2	<u>Global</u>	Work RVU	Time Source	M	ledicare Utilization	
45400	090	19.44	RUC Time		213	
CPT Descriptor 2 Laparosco	py, surgical; p	proctopexy (for pr	rolapse)			
Other Reference CPT Code	<u>Global</u>	<u>Work R</u> 0.00	<u>VU</u> <u>Time</u>	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: 16

% of respondents: 40.0 %

<u>TIME ESTIMATES (Median)</u>	CPT Code: 49655	Key Reference CPT Code: <u>49566</u>	Source of Time RUC Time
Median Pre-Service Time	70.00	45.00	
Median Intra-Service Time	150.00	120.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	100.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	55.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	40.0	0.00	
Median Total Time	383.00	372.00	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

(of those that selected Key Reference code)

<u>Mental Effort and Judgment (Mean)</u>		
The number of possible diagnosis and/or the number of	3.50	3.54
management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests,	3.69	3.85
and/or other information that must be reviewed and analyzed		
Urgency of medical decision making	3.81	3.77
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.56	4.08
Physical effort required	4.06	3.85
	4.00	0.00
<u>Psychological Stress (Ivicali)</u>		
The risk of significant complications, morbidity and/or mortality	4.38	4.23
Outcome depends on the skill and judgment of physician	4.44	4.08
o we only appendo on the only and judginent of physicial		
Г]		
Estimated risk of malpractice suit with poor outcome	4.31	4.00
INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference
		Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3 56	3 85
	0.00	0.00
Intra-Service intensity/complexity	4.31	3.92
Post-Service intensity/complexity	3.06	3.23

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.*

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In 2007, CPT approved new - but well-established - laparoscopic procedures for repair of abdominal wall hernias for CPT 2009. These laparoscopic repairs represented a significant technical departure from the open repairs for several reasons including the technical mechanics of performing the repair and the near universal placement of mesh prosthesis. All laparoscopic hernia repairs are performed within the peritoneal cavity. Adhesiolysis is major part of each procedure and is typically extensive.

In the open procedures, only enough abdominal wall for suture or mesh positioning would typically be exposed and in many circumstances entry into the peritoneal cavity would be avoided or limited. In the laparoscopic operation, since the laparoscope must be free to see the edges of the hernia defect, as well as have free areas for trocar / instrument placement, complete liberation of the intra-abdominal portion of the abdominal wall from adherent bowel and omentum is necessary for safe mesh placement. Mesh is usually placed behind the fascial and muscle layers of the abdominal wall, rather than on the surface of the muscle, as in the open setting. The mesh must be fixed securely in a circumferential pattern, to prevent displacement or herniation of viscera between mesh and muscle. Although the net result is in a markedly decreased incidence of incisional pain and morbidity related to the incision, these patients do have considerable postoperative pain from the fixation to the sensitive peritoneal surface and they are prone to postoperative narcotics and postoperative ileus.

The ACS and SAGES conducted a RUC survey for new code 49655. The RUC believed the relative work value was between the 25th percentile survey results and the median. The RUC agreed that code 43280 had similar overall physician work and required the same intra-service time. The RUC recommended a work <u>relative</u> value equal to code 43280, which was 10% less than the survey median and the specialty recommendation.

Why Reverse Building Block is Not Applicable to Code 49655

CMS has suggested that the RUC use a building block methodology to adjust site-of-service anomaly codes for the RVWs associated with changes in time and visits. More specifically, CMS proposes a "*reverse*" BBM that subtracts E/M code work RVUs from the current work RVU, along with reassignment of minutes to different categories of time with lower intensity. For example, "some" of the post-operative E/M minutes should be reassigned to immediate post-operative care (ie, time from skin closure through discharge from recovery) at a low intensity of 0.0224, which is inconsistent with the intensity for E/M codes (eg, 99231=0.054).

This methodology is not applicable to code 49655. When the RUC reviewed code 49655, the specialty recommendation of 20.00 work RVUs using the survey median and relative comparison to references was <u>not</u> accepted, and instead the RUC recommended a work RVU that was 10% *less*. The RUC did NOT use BBM to value 49655, therefore, it is flawed logic to propose a reverse BBM that subtracts the RVUs for E/Ms and calculates a new value for 49655.

Discussion of Post-operative E/M Work

In the Final Rule, CMS states:

- 1. "For procedures typically performed in the inpatient setting when the codes were originally valued, the work RVUs for these codes would have been valued to include the inpatient physician work furnished, as well as to reflect the intensive care and follow-up normally associated with an inpatient procedure."
- 2. "If the typical case for the procedure has shifted from the inpatient setting to an outpatient or physician's office setting, it is reasonable to expect that there have been changes in medical practice, and that such changes would represent a decrease in physician time or intensity or both."

<u>We disagree with both of these statements.</u> First, hospital *status* (inpatient or outpatient) is an artifact of recent changes in payment policy and recent use of criteria-based programs (eg, InterQual) that <u>assign admission status for purposes of facility reimbursement</u>. The criteria for these programs are not based on physician work; they are based on facility resource utilization. Therefore, the CMS belief that a shift in reporting of hospital status (inpatient vs outpatient) would represent a decrease in physician work is flawed logic since hospital admission status is not tied to physician work in the programs that assign patient status. Second, more than one-third of these patients have a hospital inpatient status, therefore, next day discharge is not "imminent" or pre-planned as CMS suggests. The work in monitoring these patients post-operatively on the day of surgery and subsequent days is the same E/M work whether the patient's status ends up inpatient. Finally, the determination to review code 49655 is based on one year of Medicare data (2009)

CPT Code: 49655 that indicates 45 % inpatient. The Medicare claims summary data is not without error. For example, almost <u>3%</u> of the 2009 claims for 49655 are from non-surgical specialties that could not perform laparoscopic hernia repair.

It is the clinical opinion of our expert panel that the typical patients undergoing 49655 require continued post-operative management by the surgeon on the day of the procedure and on subsequent days until the patient is discharged. Monitoring for problems such as ileus, intestinal ischemia, urinary retention, and pain management is necessary for the typical patient. The typical national population will be in the hospital for three calendar days after undergoing 49655. The Medicare data, for one year or even multiple years, does not reflect the national population for this procedure.

<u>The nature of the disease impacts the LOS, not the approach.</u> We believe the multiple year data indicating over 50% inpatient for the comparable open code 49561 (comparable open procedure) is more accurate and reflective of these patients than one year of data for a new code. Additionally, code 49655 includes both incarcerated and strangulated hernia repair which can be variable year to year. Further 2009, was the first year of reporting 49655. Some surgeons may still have been reporting the laparoscopic unlisted code.

Although the physician is responsible for writing the initial admit status order, the final decision for status is driven by criteria built into review programs, which are increasingly being used not only by hospitals but also by audit contractors for facility reimbursement purposes. Such programs focus on severity of <u>patient</u> illness and intensity of <u>facility</u> services (at admission) that impact use of hospital resources, <u>not</u> physician work. The physician work captured in the RUC survey was reduced by 10% two years ago. There is no reason to believe that there is a change in physician work since that time.

Even if one were to believe that the facility designation assigned to these hernia repair patients was typically outpatient, it is still our consensus that the typical patient will remain in the hospital for 3 calendar days and 2 nights. CMS representatives have stated that a patient would rarely stay more than 24 hours in a facility under outpatient or observation status; this is flawed logic in that the requirements for assignment of status in programs such as InterQual are not based on time, but on criteria of facility resource utilization. Further, in the Medicare Benefit Policy Manual, Chapter 6, it is noted that "in the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours." Forty-eight hours translates to a stay that spans three days and two nights. This is consistent with the RUC survey results and the consensus of our expert panel that the typical national patient will remain in the hospital and require care for three days and two nights.

Although some CMS representatives may contend patients would rarely stay more than 24 hours in outpatient or observation status, this is not a rule, this is not applicable to all procedures, and this is contrary to what is stated in the Medicare Benefit Policy Manual. We note that Jonathan Blum, deputy administrator at CMS has indicated that the most recent data show claims for observation care rose from 828,000 in 2006 to more than 1.1 million in 2009. At the same time, claims for observation care lasting more than 48 hours tripled to 83,183. We believe these statistics are a direct result of changes in OPPS regulations in the recent years – and NOT a change in patients undergoing surgery or the physician work post-operatively. It is illogical to believe patients undergoing surgery are getting healthier every year; suggesting physician work is decreasing because facility status assignment is shifting from inpatient to outpatient.

CURRENT RECOMMENDATION

The ACS and SAGES recommend maintaining the current RVW as published for CY 2011 (18.11). We believe the total physician work has not changed for 49655 and recommend maintaining two discrete evaluation and management visits on the day of surgery and post-op day 1, followed by full discharge work on post-op day 2 as indicated by our survey data and, more importantly by the clinical rationale. We respectfully request to defer our recommendation for the designation of the post-op evaluation and management code until the RUC approves a policy and/or rules regarding correct coding for this physician work.

The table below compares the survey code to many other RUC reviewed codes, providing further support that the current value for 49655 is not overvalued. In this table, we have utilized the RUC's current proxy of inpatient visits for the post-op in-hospital E/M visits.

year	СРТ	SHORT DESC	RVW	IWPUT	Time	eval	posit	s,d,w	INTRA	sd- im	33	32	31/ <mark>24</mark>	38/ <mark>17</mark>	14	13	12
2000	34501	Repair valve femoral	16.85	0.073	393	90			120	30		1	1	1.0		1	2

											СРТ	Cod	e: 49	655			
year	СРТ	SHORT DESC	RVW	IWPUT	Time	eval	posit	s,d,w	INTRA	sd- im	33	32	31/ <mark>24</mark>	38/ <mark>17</mark>	14	13	12
		vein											-				
2006	58543	Lsh uterus above 250 g	16.87	0.081	350	45	10	5	120	30			2	1.0		2	1
2003	58552	Laparo-vag hyst incl t/o	16.91	0.081	350	60			120	30			2	1.0		2	1
2003	57425	colpopexy	17.03	0.072	404	60	10	20	120	30		2		1.0		2	
2005	27470	Repair of thigh	17.14	0.072	400	30	10	15	120	20		1	2	1.0		1	4
2005	46710	Repr per/vag pouch sngl proc	17.14	0.097	370	60	20	10	90	30		1	1	1.0		2	1
2000	35286	Repair blood vessel lesion	17.19	0.092	350	60			100	30			3	1.0		2	1
2005	44187	Lap ileo/jejuno-stomy	17.40	0.105	385	45	25	10	75	30		2	1	1.0		2	1
2009	28047	Resect foot/toe tumor > 3 cm	17.45	0.069	413	40	8	20	120	25		1	1	1.0	1	2	1
2005	47600	Removal of gallbladder	17.48	0.068	420	30	15	15	115	30	1	1	1	1.0		2	1
2005	27709	Incision of tibia & fibula	17.48	0.094	346	40	18	10	108	15			2	1.0		2	2
2005	27236	Treat thigh fracture	17.61	0.077	433	60	15	15	90	30		2	1	1.0		3	1
2000	60271	Removal of thyroid	17.62	0.071	377	60			150	30		1	1	1.0		1	1
2009	25078	Resect forearm/wrist tum3+cm	17.69	0.070	422	40	12	20	120	30		1	1	1.0	1	2	1
2007	58571	Tlh w/t/o 250 g or less	17.69	0.073	385	45	10	5	135	30		1	1	1.0		2	1
2005	22554	Neck spine fusion	17.69	0.106	362	60	20	15	90	30		1		1.0		3	
2005	34001	Removal of artery clot	17.88	0.097	384	30	15	15	90	30		3		1.0		2	
2000	34530	Leg vein fusion	17.93	0.068	436	90			120	30		1	2	1.0		2	2
2005	43770	Lap place gastr adj device	18.00	0.108	367	60	25	15	90	30		1		1.0		3	
2000	35236	Repair blood vessel	18.02	0.086	367	60			120	30		1	2	1.0		1	1
2005	33886	Endovasc prosth delayed	18.09	0.100	379	65	20	20	100	30		1	1	1.0		2	
2007	49655	Lap inc hern repair comp	18.11	0.076	383	50	15	15	150	30			2	<mark>1.0</mark>		1	2
2008	27244	Treat thigh fracture	18.18	0.091	438	40	30	20	75	30		2	2	1.0		3	1
2000	60260	Repeat thyroid surgery	18.26	0.078	372	60			145	30		1	1	1.0		1	1
2007	23616	Treat humerus fracture	18.37	0.078	413	50	15	15	120	30		1	1	1.0		3	1
2006	58544	Lsh w/t/o uterus above 250 g	18.37	0.083	365	45	10	5	135	30			2	1.0		2	1
2007	27558	Treat knee dislocation	18.39	0.069	429	60	15	15	150	20		1	1	1.0		1	3
2004	29867	Allgrft implnt knee w/scope	18.39	0.081	404	45	15	15	120	30		1		1.0		3	2
2000	35011	Repair defect of artery	18.58	0.097	357	90			120	30			2	1.0		1	1
2000	35372	Rechanneling of artery	18.58	0.099	347	80			120	30			2	1.0		1	1
2005	27465	Shortening of thigh bone	18.60	0.086	384	33	20	13	120	23			3	1.0		2	2
2000	35184	Repair blood vessel lesion	18.82	0.074	413	88			150	30		1	1	1.0		1	1.5
2008	27269	Optx thigh fx	18.89	0.084	404	25	20	15	125	30		1	2	1.0		1	3
2004	37216	Transcath stent cca w/o eps	18.95	0.122	341	60	15	15	97	30		1		1.0		2	
2000	35261	Repair blood vessel lesion	18.96	0.090	382	60			120	30	1	1		1.0		1	1
2000	35256	Repair blood vessel lesion	19.06	0.100	347	60			120	30			3	1.0		1	1
2000	34520	Cross-over vein graft	19.18	0.069	443	90			143	30		1	2	1.0		2	1
2007	27513	Treatment of thigh fracture	19.25	0.067	464	60	15	15	145	20		2	1	1.0		1	3
2005	44188	Lap colostomy	19.35	0.103	407	45	25	10	90	30		2	1	1.0		3	
2005	45400	Laparoscopic proc	19.44	0.097	410	45	25	10	100	30		1	3	1.0		2	1
2005	39220	Removal chest lesion	19.55	0.085	436	60	15	20	124	40		2	1	1.0		1	1

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

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

The surveyed code is an add-on code or a base code expected to be reported with an add-on code. Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.

Multiple codes allow flexibility to describe exactly what components the procedure included.

Multiple codes are 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) 49655

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 general surgery		How often? Commonly
Specialty	How often?	
Specialty	How often?	

Estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. national frequency is not available

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,219 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate. 2009 Medicare data

Specialty general surger	У	Frequency 2077	Percentage 93.60 %
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

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

CPT Code: 49655

If the surveyed code is an existing code and the specialty believes the specialty utilization mix <u>will not</u> change, enter the surveyed existing CPT code number 49655

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

AMA/Specialty Society RVS Update Committee Summary of Recommendations Identified through the Site of Service Anomaly Screen

February 2011

Urological Procedures

In September 2007, the RUC's Relativity Assessment Workgroup (formerly Five-Year Review Identification Workgroup) identified CPT codes 53445 and 54410 as potentially misvalued through the Site-of-Service Anomaly screen. In February 2008, the American Urological Association (AUA) conducted a RUC survey and presented data that showed that the typical setting for this procedure was an inpatient hospital. CMS accepted the RUC's recommendation for these services. Following the RUC's recommendation, CMS included codes 53445 and 54410 in Table 15 of the 2011 Proposed Rule and asked the RUC to re-review these services. Prior to this meeting, the RUC approved a mini-survey instrument to be utilized by the specialty society that included questions regarding site-of-service and whether or not an Evaluation and Management service is performed on the same date of service as these questions were not on the original survey conducted by the specialty society in 2008.

53445 Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff

The RUC reviewed the previous rationale and physician work survey data for CPT code 53445. The RUC noted that during the last review in 2008, the RUC removed the code from the Site-of-Service Anomaly Screen and recommended to maintain the 2008 physician work RVU of 15.21 for this service. As part of its re-review of code 53445, the RUC reviewed the specialty's mini-survey data to get an accurate portrayal of the typical site-of-service for this code. The specialty society indicated that the typical patient has had a radical prostatectomy and are kept in the hospital overnight in order to administer intravenous antibiotics and manage urethral catheters post-operatively. This was substantiated by the mini-survey data which shows that the typical patient receives the procedure in the hospital (98%), stays at least overnight in the hospital following surgery (82%) and receives an Evaluation and Management service on the same date (64%).

The RUC, and the specialty agreed, that the typical patient stays in the hospital one night and agreed that the post-operative hospital visits should be reduced to one. Given this data, the RUC enacted its policy to allocate the appropriate proxy for the post-operative visits. To arrive at a physician work value, the RUC reviewed the previous survey data and agreed that the survey's 25th percentile of 13.00 work RVUs is the appropriate value for this service. To validate this recommended work RVU, the RUC reviewed CPT code 63030 *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 (work RVU= 13.18 and intra time= 90 minutes). The RUC agreed that since this service has similar total time to code 53445, 342 minutes and 343 minutes respectively, the services should be valued similarly. Additionally, the RUC reviewed CPT code 27556 <i>Open treatment of knee dislocation, includes internal fixation, when performed; without primary ligamentous repair or augmentation/reconstruction* (work RVU= 13.00 and intra time= 90 minutes) and agreed that the surveyed code should be valued similarly to this service given the analogous total time 369 minutes and 343 minutes respectively.

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

The RUC noted that all post-operative visits for services reviewed by the RUC are used as proxies to account for the appropriate physician work involved in the global service of the code. The RUC work RVU was originally valued based off the specialty's 25th percentile survey data. The physician work, whether the typical patient is considered inpatient or outpatient, for this service is the same. **The RUC recommends a work RVU of** 13.00 for CPT code 53445

54410 Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session

The RUC reviewed the previous rationale and physician work survey data for CPT code 54410. The RUC noted that the RUC recommended the 25th percentile specialty survey data of 15.00 work RVU during the last review. The RUC compared 54410 to reference service 54411 *Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue* (work RVU = 18.35 and intra-time= 180 minutes) and determined that 54411 is a more intense procedure and has greater intra-service time compared to the surveyed code, 180 minutes and 120 minutes, respectively. Therefore, the 25th percentile work RVU appropriately places this service in the proper rank order. In 2010, the value for code 54410 was increased to 15.18 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. The RUC agreed that the surveyed code was accurately valued, with strong support from reference services and specialty survey data, during the February 2008 meeting and finds no compelling evidence to change the current physician work value of this service.

As part of its re-review of code 54410, the RUC reviewed the specialty's mini-survey data to get an accurate portrayal of the typical site-of-service for this code. The specialty society indicated that the typical patient undergoes 30 minutes of immediate post-service care, at which point the physician rounds on them late in the day and the decision is made that the patient needs to stay in a monitored hospital setting overnight. This was substantiated by the mini-survey data which shows that the typical patient receives the procedure in the hospital (96%), stays at least overnight in the hospital following surgery (80%) and receives an Evaluation and Management service on the same date (64%). Given this data, the RUC enacted its policy to allocate the appropriate proxy for the post-operative visits.

The RUC noted that all post-operative visits for services reviewed by the RUC are used as proxies to account for the appropriate physician work involved in the global service of the code. The RUC work RVU was originally valued based off the specialty's 25th percentile survey data. The physician work, whether the typical patient is considered inpatient or outpatient, for this service is the same. **The RUC recommends a work RVU of 15.18 for CPT code 54410.**

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
53445		Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff	090	13.00
54410		Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session	090	15.18 (No Change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code:53445 Tracking Number

Original Specialty Recommended RVU: **13.00** Presented Recommended RVU: **13.00** RUC Recommended RVU: **13.00**

Global Period: 090

CPT Descriptor: Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Eighteen months following a radical retropubic prostatectomy, a 62-year-old man has an undetectable PSA but intractable stress urinary incontinence requiring 7 pads a day. After appropriate counseling regarding all therapeutic options, the patient elects to have an artificial urinary sphincter inserted.

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

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

Percent of survey respondents who stated they perform the procedure; In the hospital 98% , In the ASC 2%, 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 16%, Kept overnight (less than 24 hours) 50%, Admitted (more than 24 hours) 32%

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 64%

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? 11%

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? 11%

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

Description of Pre-Service Work:

Pre-service Work- Day before surgery:

- Review pre-op lab results
- Review medical record
- Write pre-op orders (to be faxed to hospital)
- Check to be sure necessary prosthesis components are at hospital

Pre-service work- Day of surgery:

- Change into scrub cloths
- Review surgical procedure, post-op recovery in and out of hospital with patient and family
- Answer patient and family questions, be sure informed consent is in record

- Speak to anesthesiologist about expected length of procedure and any special concerns about this particular patient (teeth, positioning, unusual medical problems)

- Position patient on operating table
- Verify that all necessary instruments and prosthetic components are available

Description of Intra-Service Work:

- A Foley catheter is placed
- With patient in lithotomy position, a perineal incision is made and the urethra is delicately mobilized

- A sizer is used to measure the circumference of the urethra
- A urethral cuff is very carefully placed around the urethra
- The cuff tubing is placed through the inguinal ring The perineum is closed in a layered fashion with subcuticular skin closure
- Patient is repositioned supine and re-prepped and draped
- Infra pubic incision is made
- Electrocautery dissection is done
- Rectus muscles are opened and reservoir space created and dilated
- Scrotal pouch is dissected and the pump/activation-deactivation system is placed
- The wound and prosthetic components are irrigated throughout the procedure with antibiotic solution spray
- The reservoir is placed beneath rectus muscles, space is closed
- The pump/activation-deactivation system is placed in the scrotum
- System is filled with fluid and connections are made
- System is tested
- Wound is irrigated
- Closure of abdomen and perineum, is done in usual fashion

Description of Post-Service Work:

Post-op Same day work through discharge from recovery

- Apply dressings
- Assist in transfer of patient from operating table to post-op stretcher
- Accompany anesthesiologist with patient to recovery area
- Assist in transfer of patient to recovery area bed
- Write post-op orders
- Review recovery area care and medications with staff
- Meet with family and discuss the procedure, expected outcome, planned post operative care in hospital and out of hospital
- Discuss procedure with patient as necessary in recovery area when awake
- Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)
- Dictate detailed operative narrative

Post-op Same day work after discharge from recovery

- Examine patient, check wound and patient progress
- Review patient hospital medical record notes (nursing, pharmacy, dietary, discharge planner)
- Answer patient and family questions
- Answer nursing and other staff questions
- Write any further necessary orders
- Write note in progress note section of medical record

Post-op Other Hospital Work - Beginning on post op-day 1, until discharge day (if applicable)

- Examine and talk to patient
- Check wounds and dressings
- Discuss patient progress with patient and family
- Review all patient hospital medical record notes
- Discuss post operative care of wound and prosthesis at home
- Answer nursing and other staff questions
- Answer patient and family questions
- Write orders in medical record
- Write progress notes

Discharge day work:

- Examine and talk with patient and family
- Check wounds and patient progress
- Review all patient hospital medical records
- Answer patient and family questions
- Write orders for post-discharge care
- Write prescriptions for post-op medications
- Discuss post-op care of prosthesis with patient and family

- Dictate detailed hospital discharge summary
- Arrange post-operative follow-up

SURVEY DAT	TA						
RUC Meeting Da	RUC Meeting Date (mm/yyyy) 02/2011						
Presenter(s):	Richard Gilbe	rt, MD					
Specialty(s):	Urology						
CPT Code:	53445						
Sample Size:	1279 R	esp N:	26	Respo	onse: 2.0 %		
Sample Type:	Random	Additional Sa	mple Info	rmation:			
			Low	25 th pctl	Median*	75th pctl	<u>High</u>
Service Perform	ance Rate		1.00	3.00	5.50	14.00	40.00
Survey RVW:			10.26	13.00	14.00	14.14	23.50
Pre-Service Evalu	ation Time:				50.00		
Pre-Service Posit	ioning Time:				15.00		
Pre-Service Scrul	o, Dress, Wait Ti	me:			20.00		
Intra-Service Ti	ne:		45.00	78.75	90.00	120.00	180.00
Immediate Post	Service-Time:	<u>25.00</u>					
Post Operative	<u>Visits</u>	Total Min**	CPT Cod	e and Num	ber of Visit	<u>s</u>	
Critical Care tim	ie/visit(s):	<u>0.00</u>	99291x 0	. 00 99292	2x 0.00		
Other Hospital t	ime/visit(s):	<u>95.00</u>	99231x 0.00 99232x 1.00 99233x 1.00				
Discharge Day I	Ngmt:	<u>38.00</u>	99238x 1.00 99239x 0.00				
Office time/visit	(s):	<u>85.00</u>	99211x 0.00 12x 1.00 13x 3.00 14x 0.00 15x 0.00				
Prolonged Serv	ices:	<u>0.00</u>	99354x 0	.00 55x C).00 56x 0	.00 57x 0.0)0
Sub Obs Care:		<u>0.00</u>	99224x 0	.00 99225	5x 0.00 9	9226x 0.00	

**Physician standard total <u>minutes per E/M visit</u>: 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: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	53445		Recommended Physician Work RVU: 13.00			
			Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time	
Pre-Service Evaluation T	ime:		40.00	40.00	0.00	
Pre-Service Positioning	lime:		3.00	3.00	0.00	
Pre-Service Scrub, Dress	, Wait Tim	ie:	20.00	20.00	0.00	
Intra-Service Time:			90.00			
Immediate Post Servic	e-Time:	<u>25.00</u>				
Post Operative Visits		<u>Total Min**</u>	CPT Code and Nu	<u>Imber of Visits</u>		
Critical Care time/visit	(s):	<u>0.00</u>	99291x 0.00 992	92x 0.00		
Other Hospital time/vis	sit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:		<u>38.00</u>	99238x 1.0 99239x 0.0			
Office time/visit(s):		<u>85.00</u>	99211x 0.00 12x 1	.00 13x 3.00 14x 0	.00 15x 0.00	
Prolonged Services:		<u>0.00</u>	99354x 0.00 55x	0.00 56x 0.00	57x 0.00	
Sub Obs Care:		<u>20.00</u>	99224x 1.00 992	25x 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 CodeGlobal53447090	Work RVUTime Source14.15RUC Time
<u>CPT Descriptor</u> Removal and replacement of inflatable at the same operative session	e urethral/bladder neck sphincter including pump, reservoir, and cuff
KEY MPC COMPARISON CODES:Compare the surveyed code to codes on the RUC's Mappropriate that have relative values higher and lower toMPC CPT Code 1Global5872009012.08CPT Descriptor 1Salpingo-oophorectomy, complete ofMPC CPT Code 2GlobalWork RY	APC List. Reference codes from the MPC list should be chosen, if han the requested relative values for the code under review. Most Recent <u>Time Source</u> <u>Medicare Utilization</u> 8 RUC Time 7,760 r partial, unilateral or bilateral (separate procedure) Most Recent VU Time Source Medicare Utilization
<u>CPT Descriptor 2</u> <u>CPT Descriptor 2</u>	
Other Reference CPT Code Global Wo 0.0	rk RVU <u>Time Source</u> 0
<u>CPT Descriptor</u>	
RELATIONSHIP OF CODE BEING REVIEWED Compare the pre-, intra-, and post-service time (by the are rating to the key reference services listed above. I available, Harvard if no RUC time available) for the	TO KEY REFERENCE SERVICE(S): e median) and the intensity factors (by the mean) of the service you Make certain that you are including existing time data (RUC if e reference code listed below.
Number of respondents who choose Key Reference	Code:9% of respondents:0.0%
<u>TIME ESTIMATES (Median)</u>	Key ReferenceSource of TimeCPT Code:CPT Code:5344553447
Median Pre-Service Time	63.00 50.00
Median Intra-Service Time	90.00 140.00

	20100	
Median Immediate Post-service Time	25.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	20.00
Median Discharge Day Management Time	38.0	38.00
Median Office Visit Time	85.0	62.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	20.0	0.00
Median Total Time	321.00	340.00
ther time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

(of those that selected Key Reference code)

<u>Mental Effort and Judgment (Mean)</u>		
The number of possible diagnosis and/or the number of	4.22	3.44
management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests,	3.78	3.67
and/or other information that must be reviewed and analyzed		
Urgency of medical decision making	3.22	3.33
<u>Technical Skill/Physical Effort (Mean)</u>		
Technical skill required	4.33	4.33
		,
Devoiced offert required	2.67	2.90
Physical effort required	3.07	3.69
<u>Psychological Stress (Mean)</u>		
The risk of significant complications, morbidity and/or mortality	4.11	4.22
Outcome depends on the skill and judgment of physician	1 33	1 33
Outcome depends on the skin and judgment of physician	4.00	4.55
Estimated risk of malpractice suit with poor outcome	3.78	3.78
INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference
		Service 1
Time Segments (Mean)		
	· · · · · · · · · · · · · · · · · · ·	
Pre-Service intensity/complexity	4.11	4.22
Intra-Service intensity/complexity	4.00	4.22
De et Comine intervier/community	2 70	4.00
rost-service intensity/complexity	ა./ბ	4.00

Additional Rationale and Comments

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

From RUC Draft Recommendations for February 2011 RUC Meeting

In September 2007, the RUC's Relativity Assessment Workgroup (formerly Five-Year Review Identification Workgroup) identified CPT codes 53445 and 54410 as potentially misvalued through the Site-of-Service Anomaly screen. In February 2008, the American Urological Association (AUA) conducted a RUC survey and presented data that showed that the typical setting for this procedure was an inpatient hospital. CMS accepted the RUC's recommendation for these services.

CPT Code: 53445 Following the RUC's recommendation, CMS included codes 53445 and 54410 in Table 15 of the 2011 Proposed Rule and asked the RUC to re-review these services. Prior to this meeting, the RUC approved a mini-survey instrument to be utilized by the specialty society that included questions regarding site-of-service and whether or not an Evaluation and Management service is performed on the same date of service as these questions were not on the original survey conducted by the specialty society in 2008.

53445 Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff

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The RUC, and the specialty agreed, that the typical patient stays in the hospital one night and agreed that the post-operative hospital visits should be reduced to one. Given this data, the RUC enacted its policy to allocate the appropriate proxy for the post-operative visits. To arrive at a physician work value, the RUC reviewed the previous survey data and agreed that the survey's 25th percentile of 13.00 work RVUs is the appropriate value for this service. To validate this recommended work RVU, the RUC reviewed CPT code 63030 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 (work RVU= 13.18 and intra time= 90 minutes). The RUC agreed that since this service has similar total time to code 53445, 342 minutes and 343 minutes respectively, the services should be valued similarly. Additionally, the RUC reviewed CPT code 27556 Open treatment of knee dislocation, includes internal fixation, when performed; without primary ligamentous repair or augmentation/reconstruction (work RVU= 13.00 and intra time= 90 minutes) and agreed that the surveyed code should be valued similarly to this service given the analogous total time 369 minutes and 343 minutes respectively.

The RUC noted that all post-operative visits for services reviewed by the RUC are used as proxies to account for the appropriate physician work involved in the global service of the code. The RUC work RVU was originally valued based off the specialty's 25th percentile survey data. The physician work, whether the typical patient is considered inpatient or outpatient, for this service is the same. The RUC recommends a work RVU of 13.00 for CPT code 53445

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 53445

How often do physicians <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 Urology	How often? Commonly
Specialty	How often?
Specialty	How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2500 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. expert panel estimate

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,897 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate. 2009 Medicare utilization data for code 53445

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

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

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix <u>will not</u> change, enter the surveyed existing CPT code number 53445

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code:54410 Tracking Number

Original Specialty Recommended RVU: 15.18 Presented Recommended RVU: 15.18 RUC Recommended RVU: 15.18

Global Period: 090

CPT Descriptor: Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 77-year-old man had a multi-component, inflatable penile prosthesis placed 11 years ago. When having vigorous intercourse 2 days ago, he heard a "pop" and suddenly lost his erection. On exam the prosthesis will not inflate when compressing the scrotal pump. An x-ray confirms loss of fluid from the system. The patient is anxious to correct the problem as soon as possible. Removal of all old components and replacement with all new components of a multi-component, inflatable penile prosthesis is planned.

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

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

Percent of survey respondents who stated they perform the procedure; In the hospital 97% , In the ASC 3%, 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 16%, Kept overnight (less than 24 hours) 49%, Admitted (more than 24 hours) 32%

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 64%

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? 25%

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 Work- Day before surgery

- Review pre-op lab results
- Review medical record
- Write pre-op orders (to be faxed to hospital)
- Check to be sure necessary prosthesis components are at hospital
- Pre-service Work- Day before surgery
- Review pre-op lab results
- Review medical record
- Write pre-op orders (to be faxed to hospital)
- Check to be sure necessary prosthesis components are at hospital

Description of Intra-Service Work:

- A Foley catheter is placed
- A transverse infrapubic incision is made
- Dissection is done entirely with the electrocautery so as not to cut the prosthesis and tubing

- Fluid from the prosthesis is noted tracking along the tubing
- The tubing is traced to the cylinders in the corpora cavernosa
- Longitudinal corporotomies are made
- Both cylinders are delivered into the wound
- The right cylinder is noted to have a crack at the level of the tubing exit
- A leak in the system is identified at the tubing exit from the cylinder
- Tubing is divided from both cylinders
- New measurements of the corporal length are made
- Appropriate new penile prosthesis cylinders are selected and opened

• New connections to the old tubing are made and the system is carefully refilled with fluid to the exact amount necessary. The prostheses are pumped and deflated to make sure they work properly.

- The prostheses are then replaced in the corpora
- Rear Tip Extenders are added as necessary
- The wound is irrigated throughout the procedure with antibiotic spray
- The corporotomies are closed.
- The wound is irrigated and closed in usual fashion

Description of Post-Service Work:

Post-op Same day work through discharge from recovery

- Apply dressings
- Assist in transfer of patient from operating table to post-op stretcher
- Accompany anesthesiologist with patient to recovery area
- Assist in transfer of patient to recovery area bed
- Write post-op orders
- Review recovery area care and medications with staff
- Meet with family and discuss the procedure, expected outcome, planned post operative care in hospital and out of hospital
- Discuss procedure with patient as necessary in recovery area when awake

• Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)

• Dictate detailed operative narrative

Post-op Same day work after discharge from recovery

- Examine patient, check wound and patient progress
- Review patient hospital medical record notes (nursing, pharmacy, dietary, discharge planner)
- Answer patient and family questions
- Answer nursing and other staff questions
- Write any further necessary orders
- Write note in progress note section of medical record
- Arrange appropriate postoperative follow up

SURVEY DAT	ГА							
RUC Meeting Da	ate (mm/yyyy)	02/2011						
Presenter(s):	Richard Gilbe	Richard Gilbert, MD						
Specialty(s):	Urology							
CPT Code:	54410							
Sample Size:	831 R	esp N:	17	Respo	onse: 2.0 %			
Sample Type:	Random	Additional Sa	mple Info	rmation:				
			Low	25 th pctl	Median*	75th pctl	<u>High</u>	
Service Perform	nance Rate		1.00	2.00	3.00	11.25	65.00	
Survey RVW:			10.85	15.00	16.95	18.05	54.55	
Pre-Service Evalu	uation Time:				55.00			
Pre-Service Posit	ioning Time:				10.00			
Pre-Service Scrul	b, Dress, Wait Ti	me:			15.00			
Intra-Service Ti	me:		60.00	90.00	120.00	121.00	180.00	
Immediate Post	Service-Time:	<u>30.00</u>						
Post Operative	<u>Visits</u>	Total Min**	CPT Cod	e and Num	ber of Visit	<u>s</u>		
Critical Care tim	ne/visit(s):	<u>0.00</u>	99291x 0	. 00 99292	2x 0.00			
Other Hospital t	time/visit(s):	<u>95.00</u>	99231x 0.00 99232x 1.00 99233x 1.00					
Discharge Day	Mgmt:	<u>38.00</u>	99238x 1.00 99239x 0.00					
Office time/visit	:(s):	<u>69.00</u>	99211x 0.00 12x 0.00 13x 3.00 14x 0.00 15x 0.00					
Prolonged Serv	ices:	0.00	99354x 0	.00 55x C).00 56x 0	.00 57x 0.0)0	
Sub Obs Care:		<u>0.00</u>	99224x 0	. 00 99225	5x 0.00 9	9226x 0.00		

**Physician standard total <u>minutes per E/M visit</u>: 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: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	54410		Recommended Physician Work RVU: 15.18			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time		
Pre-Service Evaluation T	ime:		40.00	40.00	0.00	
Pre-Service Positioning	lime:		3.00	3.00	0.00	
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00		
Intra-Service Time:		120.00				
Immediate Post Servic	e-Time:	<u>30.00</u>				
Post Operative Visits		<u>Total Min**</u>	CPT Code and Nu	<u>Imber of Visits</u>		
Critical Care time/visit	(s):	<u>0.00</u>	99291x 0.00 992	92x 0.00		
Other Hospital time/vis	sit(s):	<u>0.00</u>	99231x 0.00 992	32x 0.00 99233x	0.00	
Discharge Day Mgmt: <u>38.00</u>			99238x 1.0 99239	< 0.0		
Office time/visit(s):		<u>85.00</u>	99211x 0.00 12x 1.00 13x 3.00 14x 0.00 15x 0.00			
Prolonged Services:		<u>0.00</u>	99354x 0.00 55x	0.00 56x 0.00	57x 0.00	
Sub Obs Care:		<u>20.00</u>	99224x 1.00 992	25x 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 SERV	ICE:			
<u>Key CPT Code</u> 54411	<u>Global</u> 090		<u>Work RVU</u> 18.14	Time Source RUC Time
<u>CPT Descriptor</u> Removal and infected field at the same ope	d replacement of all corrative session, includi	omponents of a mu ng irrigation and de	lti-component infla bridement of infect	table penile prosthesis through an ed tissue
KEY MPC COMPARISON Compare the surveyed code appropriate that have relative	N CODES: to codes on the RUC values higher and low	's MPC List. Refe ver than the requested	erence codes from the relative values for	the MPC list should be chosen, if or the code under review. Most Recent
<u>MPC CPT Code 1</u> 58720 <u>CPT Descriptor 1</u> Salpingo-o	Global Work RV 090 1 ophorectomy, comple	<u>Time Second</u> 2.08 RUG te or partial, unilate	ource <u>M</u> C Time ral or bilateral (sep	<u>1edicare Utilization</u> 7,760 arate procedure) Most Recent
MPC CPT Code 2	Global 0.00	<u>k RVU Time Sou</u>	lirce]	Medicare Utilization
CPT Descriptor 2				
Other Reference CPT Code	<u>Global</u>	Work RVU 0.00	Time Source	
CPT Descriptor				
RELATIONSHIP OF COE Compare the pre-, intra-, and are rating to the key reference available, Harvard if no RU	DE BEING REVIEW 1 post-service time (by ce services listed abov JC time available) for	ED TO KEY REF y the median) and t ye. Make certain t r the reference cod	ERENCE SERVI he intensity factors that you are inclu le listed below.	CE(S): (by the mean) of the service you ding existing time data (RUC if
Number of respondents wh	o choose Key Refere	nce Code: 8	% of respondents	: 47.0 %
TIME ESTIMATES (Median)	CPT Code:	Key Reference CPT Code:	Source of Time RUC Time

<u>TIME ESTIMATES (Median)</u>	CPT Code: 54410	CPT Code: <u>54411</u>	RUC T
Median Pre-Service Time	63.00	50.00	
Median Intra-Service Time	120.00	180.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	180.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	85.0	102.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	20.0	0.00	
Median Total Time	356.00	580.00	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

(of those that selected Key Reference code)

<u>Mental Effort and Judgment (Mean)</u>		
The number of possible diagnosis and/or the number of	3.88	4.00
management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests,	3.75	3.88
and/or other information that must be reviewed and analyzed		
Urgency of medical decision making	3.75	4.13
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.88	4.88
	4.42	4.05
Physical effort required	4.13	4.25
<u>Psychological Stress (Mean)</u>		
The risk of significant complications, morbidity and/or mortality	4.63	4.75
Outcome demands on the skill and indemant of neuroisian	4.75	4 75
Outcome depends on the skin and judgment of physician	4.75	4.75
Estimated risk of malpractice suit with poor outcome	4.75	4.75
INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference
	0110000	Service 1
Time Segments (Mean)		
Time Segments (Ivicali)		
Pre-Service intensity/complexity	4.50	4.38
Intra-Service intensity/complexity	4.63	4.63
y		
· · · · · · · · · · · · · · · · · · ·	·	ı
Post-Service intensity/complexity	4.25	4.38

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.*

From RUC Draft Recommendation for February 2011 RUC Meeting

In September 2007, the RUC's Relativity Assessment Workgroup (formerly Five-Year Review Identification Workgroup) identified CPT codes 53445 and 54410 as potentially misvalued through the Site-of-Service Anomaly screen. In February 2008, the American Urological Association (AUA) conducted a RUC survey and presented data that showed that the typical setting for this procedure was an inpatient hospital. CMS accepted the RUC's recommendation for these services.

CPT Code: 54410 Following the RUC's recommendation, CMS included codes 53445 and 54410 in Table 15 of the 2011 Proposed Rule and asked the RUC to re-review these services. Prior to this meeting, the RUC approved a mini-survey instrument to be utilized by the specialty society that included questions regarding site-of-service and whether or not an Evaluation and Management service is performed on the same date of service as these questions were not on the original survey conducted by the specialty society in 2008.

54410 *Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session*

The RUC reviewed the previous rationale and physician work survey data for CPT code 54410. The RUC noted that the RUC recommended the 25th percentile specialty survey data of 15.00 work RVU during the last review. The RUC compared 54410 to reference service 54411 *Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue* (work RVU = 18.35 and intra-time= 180 minutes) and determined that 54411 is a more intense procedure and has greater intra-service time compared to the surveyed code, 180 minutes and 120 minutes, respectively. Therefore, the 25th percentile work RVU appropriately places this service in the proper rank order. In 2010, the value for code 54410 was increased to 15.18 work RVUs based on the redistribution of RVUs from the CMS coverage determination to no longer recognize the consultation services. The RUC agreed that the surveyed code was accurately valued, with strong support from reference services and specialty survey data, during the February 2008 meeting and finds no compelling evidence to change the current physician work value of this service.

As part of its re-review of code 54410, the RUC reviewed the specialty's mini-survey data to get an accurate portrayal of the typical site-of-service for this code. The specialty society indicated that the typical patient undergoes 30 minutes of immediate post-service care, at which point the physician rounds on them late in the day and the decision is made that the patient needs to stay in a monitored hospital setting overnight. This was substantiated by the mini-survey data which shows that the typical patient receives the procedure in the hospital (96%), stays at least overnight in the hospital following surgery (80%) and receives an Evaluation and Management service on the same date (64%). Given this data, the RUC enacted its policy to allocate the appropriate proxy for the post-operative visits.

The RUC noted that all post-operative visits for services reviewed by the RUC are used as proxies to account for the appropriate physician work involved in the global service of the code. The RUC work RVU was originally valued based off the specialty's 25th percentile survey data. The physician work, whether the typical patient is considered inpatient or outpatient, for this service is the same. **The RUC recommends a work RVU of 15.18 for CPT code 54410**.

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.)

		l	

The surveyed code is an add-on code or a base code expected to be reported with an add-on code. Different specialties work together to accomplish the procedure; each specialty codes its part of the

physician work using different codes.

Multiple codes allow flexibility to describe exactly what components the procedure included.

Multiple codes are 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.

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 54410

How often do physicians <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 Urology	How often? Sometimes
Specialty	How often?
Specialty	How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1500 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. expert panel estimate

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1349 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate. 2009 Medicare utilization data for 54410

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

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

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix <u>will not</u> change, enter the surveyed existing CPT code number 54410

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



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January 11, 2011

Barbara Levy, MD Chair, AMA/Specialty Society RVS Update (RUC) Committee American Medical Association 515 North State Street Chicago, IL 60604

Dear Dr. Levy,

SUBJECT: Results of Site of Service Mini-Survey for:

53445 Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff

54410 Removal and replacement of all component(s) of a multicomponent, inflatable penile prosthesis at the same operative session

The above codes were identified in the Site of Service Anomaly Screen and were surveyed and presented by the American Urological Association (AUA) at the February/April 2008 RUC Meeting. However, the Centers for Medicare and Medicaid Services (CMS) requested a re-review of these codes at the October 2010 RUC Meeting.

Because of a question of an overnight stay for these outpatient procedures, the RUC made the following request:

"The specialty argues that the typical patient spends at least one night in the hospital. The RUC has requested that the specialty survey to address whether an overnight stay is typical."

Since the original survey conducted in 2008 did not contain specific questions on the site of service, the AUA was directed to conduct a special mini-survey to determine the place of service for the above CPT codes. These codes are not to be revalued but to determine whether the patient typically requires an overnight stay.

The AUA sent the mini-survey instrument developed by the RUC Research Subcommittee to 2000 random urologists for each CPT code to determine where the procedures were performed.





The AUA submits the following findings as a result of the Physician Work RVS Update Mini-Survey:

53445 Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff

250 urologists completed the survey for a response rate of 12.5%

For the typical patient, the procedure was performed: 0% in office 2% in ASC 32% Inpatient 16.4% Outpatient released same day 49.6% Outpatient with overnight stay of <24 hours

Of the 250 respondents, 62% stated if patient stayed overnight, there was a hospital visit performed the same date.

	Physician total	Typical	History	Complexity of
Respondents stated they spent the	time (Min per	physician	examination	medical decision
following time and/or performed the	CMS)	face-to-face		making
appropriate component of history and		time (Min		
medical decision making		per CPT)		
	20	15	Problem	Low or
83.64%			focused	straightforward
12.73%	40	25	Expanded	Moderate
3.64%	55	35	Detailed	High

54410 Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session

258 urologists completed the survey for a response rate of 12.9%

For the typical patient, the procedure was performed:

0% in office 3.49% in ASC 31.78% Inpatient 16.28% Outpatient released same day 48.45% Outpatient with overnight stay of <24 hours Of the 258 respondents, 62.5 % stated if patient stayed overnight, there was a hospital visit performed the same date.

	Physician total	Typical	History	Complexity of
Respondents stated they spent the	time (Min per	physician	examination	medical decision
following time and/or performed the	CMS)	face-to-face		making
appropriate component of history and		time (Min		_
medical decision making		per CPT)		
	20	15	Problem	Low or
83.64%			focused	straightforward
12.73%	40	25	Expanded	Moderate
3.64%	55	35	Detailed	High

This survey data supports the specialty society's claim that an overnight stay is required for patients who undergo procedures described in CPT codes 53445 and 54410.

Sincerely,

James J. 2. 200

James G. Giblin, M.D. AUA RUC Advisor

AMA/Specialty Society RVS Update Committee Summary of Recommendations February 2011 **Identified through the Site of Service Anomaly Screen

Repair of Eye Wound

In September 2007, the RUC's Relativity Assessment Workgroup (formerly Five-Year Review Identification Workgroup) identified CPT code 65285 *Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue* and 68810 *Probing of nasolacrimal duct, with or without irrigation* as potentially misvalued through the Site-of-Service Anomaly screen. The service for eye wound repair was initially priced in the facility setting, i.e. have hospital visits and full discharge management services associated with them, and are now being performed in the outpatient setting more than 50% of the time, according to the Medicare Claims data. CMS had requested the RUC review these identified site of service anomaly services. In February 2008, the RUC reviewed the service and accepted the evidence presented by the specialty society that the procedure required inpatient services and an overnight inpatient stay. The RUC agreed that the procedure is typically provided within the facility inpatient setting, and CMS agreed with the RUC's recommendation for CY 2009. It was also suggested by the specialty that this service not be included on the ASC list and a CPT Assistant article should be written to describe appropriate use of this code. Following the RUC's recommendation, CMS included code 65285 in Table 15 of the 2011 Proposed Rule and asked the RUC to re-review the service.

The RUC discussed the specialty society's survey results and heard from the specialty regarding its compelling evidence that the physician work value should be changed. This service had never been RUC surveyed in the past and the RUC agreed with the specialty that this service is the most serious eye trauma service there is, where there is typically a corneal scar or cut and the internal contents of the eye have been extruded. In the past, techniques and procedures limited the success and recovery from such an injury, and the eye was more often enucleated. Today, the microsurgery surgery techniques have improved and there is an enhanced knowledge base for caring for these patients. In addition, new high sheer visco-elastics allow the surgeon to re-inflate the eye with a substance similar to jelly that allows the eye to retain its shape and form without leaking while the surgeon attempts to suture the eye. Although the typical patient has not changed (non-Medicare young patient) the intensity of and complexity of the procedure has increased due to enhanced microsurgical technology, improvements in suture and graft materials, and new pharmaceuticals that control post operative complications. In addition, the injuries repaired are more severe and extensive than 20 years ago, as documented in several peer-reviewed articles. The RUC agreed with the compelling evidence presented and the specialty's 25th percentile work relative value survey results, indicating 16.00 RVUs of physician work for code 65285.

The RUC also concluded that, based on discussions with the specialty, the pre-service time package should be changed to package 3 from package 4 as these patients were considered by the RUC to have less co-morbidities and therefore less difficult to treat. In addition, the RUC agreed that the patient today is seen in an outpatient facility which would include a subsequent observation visit (99217) rather than the current discharge day management service (99238).

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

The RUC unanimously agreed that the typical service is emergent, difficult, and highly intense. In addition, these patients typically have extensive post-operative followed up involving a subsequent observation and six office visits. The RUC also used magnitude estimation by referencing the following four services in comparison to the work of 65285 to value the work of this service at 16.00 RVUs.

65710 - Keratoplasty (corneal transplant); anterior lamellar (work RVU = 14.45, 90 minutes intra-service time). The RUC considered the service of code 65285 clearly more physician work and emergent than code 65710. However, both services have similar extensive post operative follow up care.

35266 - *Repair blood vessel with graft other than vein; upper extremity* (work RVU = 15.83, 90 minutes intra-service time). RUC members compared the service of 35266 and agreed that 65285 is more overall work than 35266 and is highly intense and emergent.

65750 - *Keratoplasty (corneal transplant); penetrating (in aphakia)* (work RVU = 16.90, 90 minutes intra-service time) RUC members compared the service of 65750 to 65285 and agreed that 65285 is less overall work with similar post operative follow up care.

43420 - *Closure of esophagostomy or fistula; cervical approach* (work RVU = 16.78, 90 minutes intra-service time). RUC members compared the service of 43420 to 65285 and agreed that 65285 is less overall work than 43420.

The RUC recommends a relative work value of 16.00 for CPT code 65285.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲65285	P1	Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue (65280 and 65285 are not used for repair of a surgical wound.)	090	16.00
AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code:65285 Tracking Number

Original Specialty Recommended RVU: 17.00 Presented Recommended RVU: 17.00 RUC Recommended RVU: 16.00

Global Period: 090

CPT Descriptor: Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue (65280 and 65285 are not used for repair of surgical wound)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25 year old male is struck in the face with a blunt object causing a corneoscleral laceration with iris prolapse. Surgical repair is performed

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 13%, Kept overnight (less than 24 hours) 47%, Admitted (more than 24 hours) 40%

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 21%

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? 30%

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: The medical history is reviewed. Any orbital images are reviewed for the presence of orbital fractures or foreign bodies. A handlight exam is performed and the injured eye identified. The risks and benefits of the procedure are reviewed with the family.

Description of Intra-Service Work: The patient is positioned in the operating room and prepped for surgery. An eyelid speculum is placed. A conjunctival peritomy is performed over the laceration and extend posteriorly so that the entire extent of the scleral laceration can be identified. Where this extends beneath an extraocular muscle, the muscle is secured on a suture and disinserted from the globe. The scleral wound is closed with interrupted sutures after repositioning any visibly prolapsed choroid. The corneal wound is examined. Iris is gently repositioned into the anterior chamber with irrigation and/or blunt instruments. The anterior chamber is reformed with balanced salt solution. The corneal wound is closed with 10-0 interrupted nylon sutures. The extraocular muscle is reattached to the original insertion site. Antibiotics are injected subconjunctivally. Topical antibiotics and steroids are administered.

Description of Post-Service Work: The outcome of the procedure is reviewed with the patient and family. The operative note is dictated. The next day after examination is concluded the patient is discharged and instructions are provided. Follow-up visits are scheduled for days 3 and 4 immediately after surgery. Additional postoperative visits are scheduled after 1 week, 2 weeks, 1 month, 2 months and 3 months after the repair.

SURVEY DATA							
RUC Meeting Da	ate (mm/yyyy)	02/2011					
Presenter(s):	Stephen A Ka	menetzky, M.I	D.				
Specialty(s):	Ophthalmolog	Ophthalmology					
CPT Code:	65285	65285					
Sample Size:	200 R e	Resp N: 30 Response: 15.0 %					
Sample Type:	Random Additional Sample Information: This code was surveyed previously in 2007 but the 5Yr Identification Workgroup (now RAW workgroup) deemed that a survey was not necessary. We reached out to the previous respondants as well as a random list of members who indicated an interest in trauma surgery.						
			Low	25 th pctl	Median*	75th pctl	<u>High</u>
Service Perform	ance Rate		0.00	1.00	4.00	7.00	121.00
Survey RVW:			14.00	16.00	17.00	21.50	25.00
Pre-Service Evalu	ation Time:				30.00		
Pre-Service Posit	ioning Time:				10.00		
Pre-Service Scrul	o, Dress, Wait Tir	ne:			20.00		
Intra-Service Ti	me:		45.00	90.00	90.00	120.00	150.00
Immediate Post	Service-Time:	<u>30.00</u>					
Post Operative	Visits	Total Min**	CPT Cod	e and Num	ber of Visit	S	
Critical Care tim	ne/visit(s):	0.00	99291x 0	. 00 99292	2x 0.00		
Other Hospital t	Il time/visit(s): 40.00 99231x 0.00 99232x 1.00 99233x 0.00						
Discharge Day I	Ngmt:	<u>38.00</u>	0 99238x 1.00 99239x 0.00				
Office time/visit	(s):	<u>171.00</u>	99211x 0.00 12x 1.00 13x 5.00 14x 1.00 15x 0.00				
Prolonged Serv	ices:	0.00	99354x 0	. 00 55x ().00 56x 0	.00 57x 0.0	00
Sub Obs Care:		0.00 99224x 0.00 99225x 0.00 99226x 0.00					

**Physician standard total <u>minutes per E/M visit</u>: 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: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	65285		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:			30.00	40.00	-10.00	
Pre-Service Positioning Time:			10.00	3.00	7.00	
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00		
Intra-Service Time:	ntra-Service Time:					
Immediate Post Servic	e-Time:	<u>30.00</u>				
Post Operative Visits		<u>Total Min**</u>	CPT Code and Nu	umber of Visits		
Critical Care time/visit	(s):	<u>0.00</u>	99291x 0.00 992	92x 0.00		
Other Hospital time/vis	sit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:		<u>38.00</u>	99238x 1.0 99239x 0.0			
Office time/visit(s):		<u>154.00</u>	99211x 0.00 12x 1	.00 13x 6.00 14x 0	.00 15x 0.00	
Prolonged Services:		<u>0.00</u>	99354x 0.00 55x	0.00 56x 0.00	57x 0.00	

					(CPT Code: 65285
Sub Obs Care:	<u>0.00</u>	99224x	0.00 99	9225x 0.00	99226x	0.00
Modifier -51 Exempt Status Is the recommended value for	the new/revised pr	ocedure ba	ised on it	s modifier -51	exempt s	status? No
New Technology/Service: Is this new/revised procedure of	considered to be a	new techno	ology or s	service? No		
KEY REFERENCE SERVIC	E:					
<u>Key CPT Code</u> 65750	<u>Global</u> 090			<u>Work RV</u> 16.90	<u>U</u>	Time Source RUC Time
<u>CPT Descriptor</u> Keratoplasty (o	corneal transplant);	penetrating	(in apha	kia)		
KEY MPC COMPARISON Compare the surveyed code to appropriate that have relative very <u>MPC CPT Code 1</u>	CODES: codes on the RUC alues higher and lo <u>Global</u> Work R	C's MPC Li wer than the <u>VU</u>	ist. Refe e requeste <u>Time So</u>	rence codes fr ed relative valu <u>ource</u>	om the N ues for the <u>Medic</u>	IPC list should be chosen, i code under review. Most Recent are Utilization
65750 <u>CPT Descriptor 1</u> Keratoplasty	010 (corneal transplant	16.90 t); penetratir	RUC ng (in apł	C Time nakia)	6	510
<u>MPC CPT Code 2</u> <u>C</u> 49002	<u>ilobal Wo</u> 090	o <u>rk RVU</u> 17.63	<u>Time Sou</u> RUC	<u>irce</u> Time	Medi	Most Recent care Utilization 5,836
<u>CPT Descriptor 2</u> Reopening o	f recent laparotomy	7				
Other Reference CPT Code 43420	<u>Global</u> 090	<u>Work RV</u> 16.78	<u>U ′</u>	<u>Time Source</u> RUC Time		
<u>CPT Descriptor</u> Closure of esop	phagostomy or fist	ula; cervical	approacl	h		
RELATIONSHIP OF CODE Compare the pre-, intra-, and p are rating to the key reference available, Harvard if no RUC	BEING REVIEV post-service time (b services listed abo t time available) f	VED TO K by the media ove. Make or the refer	EY REF an) and th certain the cod	ERENCE SE he intensity fa hat you are i e listed below	RVICE(S ctors (by ncluding	5): the mean) of the service you existing time data (RUC i

Number of respondents who choose Key Reference Code:7% of respondents:23.3%TIME ESTIMATES (Median)Key ReferenceSource of Time

<u>11ME ESTIMATES (Median)</u>	CPT Code: 65285	CPT Code: <u>65750</u>	RUC Time
Median Pre-Service Time	60.00	40.00	
Median Intra-Service Time	90.00	90.00	
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	38.0	0.00	
Median Office Visit Time	154.0	138.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	372.00	288.00	

Other time if appropriate	

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)			
<u>Mental Effort and Judgment (Mean)</u>				
The number of possible diagnosis and/or the number of management options that must be considered	4.29	3.57		
management options and must be considered				
The amount and/or complexity of medical records, diagnostic tests,	4.14	3.14		
and/or other information that must be reviewed and analyzed				
Urgency of medical decision making	4.71	2.86		
	<u> </u>			
Technical Skill/Physical Effort (Mean)				
Technical skill required	4.43	4.43		
Physical effort required	4.14	3.86		
Psychological Stress (Mean)				
The risk of significant complications, morbidity and/or mortality	4.57	4.00		
Outcome depends on the skill and judgment of physician	4.57	4.43		
Estimated risk of malpractice suit with poor outcome	4.00	3.71		
INTENSITY/COMPLEXITY MEASURES	<u>CPT Code</u>	<u>Reference</u> Service 1		
		<u></u>		
Time Segments (Mean)				
Pre-Service intensity/complexity	4.57	3.57		
Intra-Service intensity/complexity	4.43	3.71		
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.*

This code is being reviewed because of a continuing concern from CMS regarding site of service issues. The RUC considered the code in 2008 and accepted the evidence submitted by the society that the procedure required inpatient services and an overnight inpatient stay. CMS database indicated that it was an outpatient procedure. The Academy believes that the reason for the discrepancy was a combination of miscoding and/or hospital observation policies and

CPT Code: 65285

proposed educational efforts and coding language to mitigate the problem. However CMS again raised the site of service issue in the 2011 proposed rule and indicated that the work for visits for hospital care and discharge management would be removed unless the code was resurveyed. CPT modified the descriptor to make clear that the code was not to be used for surgical wound repair and the Academy resurveyed.

The survey was sent to the original respondents as well as a new random list of members who indicated an interest in trauma services in our membership data base. We struggled to meet the required numbers of responses and went back to RUC staff to inquire if we could reach out to the previous respondents who did not complete a second survey to ask the missing site of service questions that have been added since the previous survey and add that info to their previous responses. Permission was granted to proceed with a mini-survey for 15 individuals (10 responded) and then their old data along with their responses on site of service were tabulated.

The Academy's consensus panel recommends the median WRVU 17.0 for code 65285. The reference code 65750 is RUC reviewed with the same IST, is less complex in all parameters of intensity and complexity and has a WRVU of 16.9. For comparison, 35266 *Repair of vessel with graft other than vein, upper extremity* is RUC reviewed with WRVU of 15.83 with similar pre, intra and post service times. 43420 *Closure of esophagostomy or fistula, cervical approach* is also RUC reviewed and has a WRVU of 16.78 and comparable pre, intra and post service times. Our recommendation is consistent within the family of complex anterior segment codes and previous decisions of the RUC for other complicated surgical procedures.

Compelling Evidence

We believe there is compelling evidence that this code is undervalued. The code has never been RUC reviewed so the current values and times represent the original Harvard data. In addition the patient population treated has changed so that many eyes that were previously enucleated primarily because of severe trauma are now repaired. We are able to do this because of advances in microsurgical techniques, improvements in suture and graft materials, and advent of new pharmaceuticals (primarily antibiotics and anti-inflammatory medications) that better control post-operative complications. Thus the injuries repaired are more severe and extensive than 20 years ago. This information is documented in several peer-reviewed articles that are attached.

Further Survey Info

This is an infrequently performed procedure in the Medicare age group which we believe accounts for the anomaly for site of service in the data base. The severe injury associated with use of the code usually occurs in a younger patient who has had trauma. The service represents one of the more complex procedures performed by ophthalmologists, typically requiring an overnight hospital admission postoperatively for IV antibiotics and close observation because of the significant anatomical disruption associated with this type of injury.

The AAO surveyed 200 ophthalmologists and received 30 responses for a completion rate of 15%. All felt that the vignette was typical. All performed the service in the hospital. Twenty six of 30 either kept the patient overnight or admitted the patient to the facility. The 25th percentile WRVU was 16.0 and the median WRVU 17.0 with a median intra-service time of 90 minutes. Both the 25th percentile and the median intraservice times were 90 minutes. Preservice package 4 (difficult patient/difficult procedure) was used. The total time for this package was less than the times in the survey. The primary reference code chosen, CPT 65750 *(keratoplasty (corneal transplant); penetrating (in aphakia))* is RUC-reviewed code with a WRVU of 16.9 and an intra-service time of 90 minutes.

The Academy's consensus panel reviewed the survey results. For all of the intensity- complexity measures considered, 65285 had a higher value than the reference code, with urgency of medical decision making, complexity of medical information and risk of complications showing particularly large positive variances. The pre-service time is long, but that is because there is significant clinical material to be collected and reviewed. Consultation with multiple medical specialties is usually required to plan the surgical procedure in these patients who frequently have other serious injuries. Pre-service scrub, dress and wait is time is also longer than that for a typical ophthalmology procedures, because of the required special precautions for protection of the eye and induction of general anesthesia in a patient with an open eye wound.

Post-operative care is also intense with multiple visits in the 7-10 days after surgery to gauge healing, adjust medications and watch for signs of endophthalmitis, a common and devastating complication related to this type of injury. Six 99213 and one 99212 visits occur in the global period along with a hospital visit and discharge day. The surveys indicated there is one visit with an extended problem-focused exam and moderate decision making (mid-level) visit on the day of the procedure. We are defining the visit in this fashion because of the issues raised about the

CPT Code: 65285 appropriate coding series that should be used to designate this EM service and would propose that we be allowed to adjust the code after that issue is clarified by the RUC.

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) N/A

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 OphthalmologyHow often? SometimesSpecialtyHow often?SpecialtyHow 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 <u>percentage</u> 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? 1,069 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate. RUC Database

Specialty Ophthan	nology	Frequency 1063	Percen	tage 99.43 %
Specialty	Free	luency	Percentage	%

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 65285

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

AMA/Specialty Society RVS Update Committee Summary of Recommendations Identified through the New Technology List

February 2011

Stereotactic Body Radiation Delivery

In September 2010, CPT codes 77373 Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions and 77435 Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions were identified by the RUC's Relativity Assessment Workgroup as services listed on the RUC's New Technology list in need of RUC review. Therefore, in February 2011 the RUC reviewed CPT code 77435 for physician work and its direct practice expense inputs, and 77373 only for its direct practice expense inputs, as it does not involve the work of a physician.

CPT codes 77373 and 77435 were initially reviewed by the RUC in April 2006 as new services. At that time, the RUC valued the physician work for CPT code 77435 at the specialty's survey median of 13.00 RVUs, which was accepted by CMS for CY 2007. In February 2011, the RUC agreed that the specialty survey results from 65 radiation oncologists was slightly overstated in the pre-service and post-service time periods by 10 minutes each. The RUC agreed then that the typical patient service involves 20 minutes pre-service evaluation and 20 minutes immediate post-service, rather than 30 minutes each, and 210 minutes of intra-service time. The RUC reviewed the physician work of the specialty's key reference service CPT code 77432 *Stereotactic radiation treatment management of cranial lesion(s) (complete course of treatment consisting of 1 session)* (work RVU = 7.92) in relation to code 77435, and agreed that 77435 involves more time as the physician is directing a large quantity of radiation at a respiratory continuously moving 3-4 centimeter tumor(s) and delivering an average of 4 high dose treatments with very high precision, which is understood to be a higher intensity service than directing radiation to a stationary cranial lesion. The dose per fraction (generated by the radiation delivery machine) is higher than the traditional dose per fraction that is typical for a 6 to 7 week conventional course of treatment. Therefore, the risk of toxicity is severe. In addition, the physician confirms the patient is placed into a body mold, to prevent movement, and the radiation delivery apparatus is moved around the patient prior to the radiation delivery in order to assure that there is no patient or other device interference (this activity is quite different than the separately billable service of 77290 *Therapeutic radiology simulation-aided field setting; complex* (work RVU = 1.56) and 77435 is not typically billed with 77290).

The RUC also reviewed the physician work of CPT code 77301 *Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications* (work RVU = 7.99, XXX, total time = 196 minutes), and understood that the work of 77435 in comparison to 77301 required more time to perform, 250 minutes and 196 minutes, respectively and required more overall physician work.

The RUC discussed the specialty society's survey results for CPT code 77435 and did not agree with the median survey results. The RUC agreed with the survey time results which suggested that the typical service time had decreased since the RUC's last evaluation due to efficiencies in this now mature technology. Using magnitude estimation, the committee agreed that the percentage change in the intra-service time from the first specialty survey to the current survey (230 minutes to 210 minutes, a 8.7% decrease) should be applied to the current physician work value of 13.00, resulting in a work value of 11.87. The RUC recommends a work relative value of 11.87 for CPT code 77435. The RUC also recommends that CPT codes 77373 and 77435 be removed from the new technology list as the service is now mature.

Practice Expense: The RUC carefully reviewed the practice expense recommendations for CPT code 77373 and 77435 and agreed the practice expense inputs for CPT codes 77373 and 77435 had not changed since the codes were created. However, the RUC agreed the specialty will provide current invoices from 5-6 different vendors for the equipment used in this procedure.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation			
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions (Do not report 77373 in conjunction with 77401-77416, 77418)	XXX	0.00 (Practice Expense Inputs Only)			
	(For single fraction cranial lesion[s], see 77371, 77372)					
(For single fraction cranial lesion[s], see 77371, 77372)Radiation treatment management is reported in units of five fractions or treatment sessions, regardless of the actual time period in which the services are furnished. The services need not be furnished on consecutive days. Multiple fractions representing two or more treatment sessions furnished on the same day may be counted separately as long as there has been a distinct break in therapy sessions, and the fractions are of the character usually furnished on different days. Code 77427 is also reported if there are three or four fractions beyond a multiple of five at the end of a course of treatment; one or two fractions beyond a multiple of five at the end of a course of treatment requires and includes a minimum of one examination of the patient by the physician for medical evaluation and management (eg, assessment of the patient's response to treatment, coordination of care and treatment, review of imaging and/or lab test results with documentation) for each reporting of the radiation treatment management service. The professional services furnished during treatment management typically <u>include-consist of</u> : • <i>Review of port films;</i> • <i>Review of patient treatment set-up;</i>						

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
77435	Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	XXX	11.87
	(Do not report 77435 in conjunction with 77427-77432)		
	(The same physician should not report both stereotactic radiosurgery services 63620, 63621 and radiation treatment management 77435 for extracranial lesions)		

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

<u>**CPT Long Descriptor:**</u> Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions

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:

CPT codes 77435 and 77373 were included on the new technology review list for the October 2010 RUC meeting. The coding for these services has evolved over time described by various G codes, Cat III codes and Cat I codes. These codes were preceded by Category III code 0082T (Stereotactic body radiation therapy, treatment delivery, one or more treatment areas, per day) and 0083T (Stereotactic body radiation therapy, treatment management, per day).

ASTRO recommended that CPT codes 77435 and 77373 be removed from the Emerging Technology Services List. Our rationale for the recommendation of removing these services from the New Technology Services List was based on multiple factors: the growth of the services since it was established in 2007, the vignette and typical case at the time the code was approved and a review of the current process of care. However, the RUC requested that we review practice expense inputs for the February RUC meeting.

ASTRO convened a panel that included a number of experts familiar with this service to evaluate the direct practice expense inputs and prepare practice expense recommendations. The panel reviewed the current direct practice expense inputs for CPT code 77373 and recommends no changes to the inputs.

There are currently 213 minutes of clinical time for CPT code 77373. The standards have changed since April 2006. So, the total clinical time in our recommendation is 210 minutes. The change relates to "reviewing charts". That activity has been combined with "*Greet patient, provide gowning, ensure appropriate medical records are available*".

In addition, CMS has allocated 111 minutes of equipment time for CPT code 77373. According to CMS methodology ASTRO believes there are 8 minutes missing from that equipment time allocation. Those activities would include:

- Prepare room, equipment and supplies (2)
- Prepare and position patient (2)
- Sedate/apply anesthesia (1)
- Clean room/equipment (3)

Those activities are performed in the procedure room, not during a separate patient encounter in another location before the procedure. Those minutes should be added into the equipment times.

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

ASTRO is recommending maintaining the current direct practice expense inputs. We did not include a comparison code in our recommendations.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

N/A

Intra-Service Clinical Labor Activities:

The nurse evaluates the patient in an exam room, takes vitals and administers any pre-SBRT medications (antiemetic anti-anxiety or analgesic medications or steroid anti-inflammatory agents in some lung SBRT cases). Prior to the first treatment, the therapist and the medical physicist confirm the chart prescription dose, the patient treatment set-up instructions, and respiratory motion control parameters. The medical physicist confirms treatment isocenter verification in accordance with the departmental practice (typically performed daily using the Winston-Lutz test or equivalent method). Results of the isocenter precision measurements are reviewed with the physician and compared to the planning margins on the patient's treatment volume. The medical physicist also analyzes the set up for potential collisions of the apparatus with the patient, treatment couch, or other devices and discusses with the physician if appropriate modifications are required. This process may involve doing a test run of the treatment delivery machinery to reproduce in the treatment room the intended gantry or robotic arm motion path according to the computer-designed plan of treatment.

Prior to each individual SBRT treatment, the therapist identifies the correct patient chart and loads into the treatment control software the patient-specific treatment plan file on their work station outside the treatment room. The therapist gives specific instructions to the patient prior to positioning. The patient is positioned by the therapist with the assistance of either another therapist or the medical physicist in the previously constructed immobilization device (e.g. alphacradle or body frame) with the help of in-room lasers aligned to external reference fiducial marks. After positioning the patient on the table, the therapist positions the abdominal compression device, breath coordination equipment, or optical tracking devices. The medical physicist, with the physician, will confirm the positioning of these devices. The medical physicist and physician confirm effective dampening of abdominal respiration or readiness of the gating or motion tracking system. The therapist confirms patient comfort in the treatment position and confirms that the patient can receive and understand audio or visual instructions.

With the patient secured in the treatment position and respiratory control devices deployed, the therapist and the medical physicist go outside the room to the treatment console. The therapist then activates the image guidance device (kV or MV radiographs or CT scan), and the medical physicist and radiation oncologist review the acquired images for quality and interpretability. If technically unsuitable for interpretation, the images are acquired again. Once suitable images are obtained, the medical physicist and physician compare them with digitally reconstructed radiographs (DRR's) or a CT data set to determine whether the images obtained match the expected appearance; bony landmarks/soft tissue features and/or internal fiducial markers are visualized for this purpose. The patient position is then adjusted either automatically or manually to allow for precise match of the obtained guidance images and expected appearance. If the required patient position shift is larger than a pre-determined acceptable limit, the patient is typically assisted up from the treatment table and repositioned, and the process of setting up the respiratory control system and acquisition of guidance images is repeated. For systems using orthogonal kV images, prior to the first SBRT treatment it is routine to confirm internal target location with additional CT images which the radiation oncologist reviews images with the medical physicist to verify that the internal isocenter in the reconstructed 3D volume is positioned appropriately in reference to the observed tumor location in accordance with the previously

designed treatment plan. If necessary, linac clearance around the patient is verified once more with the patient in the final treatment position.

Only when the medical physicist and radiation oncologist are certain that the correct target position has been acquired, can the Radiation Therapist energize the radiation delivery system and commence treatment. The respiration signal, patient position, and target location are continuously monitored during the delivery of image guided SBRT. Multiple images are taken throughout the course of the treatment by the therapist to verify target localization. If the patient is observed to move or requires a break in the treatment for any reason (e.g. discomfort or fatigue from the respiratory control system), the entire patient positioning and image-guided verification process is repeated. The respiratory control system is monitored continuously by the therapist, and the therapist discontinues treatment if there are observed or suspected deviations in its performance; these concerns are brought to the attention of the medical physicist and radiation oncologist, who order patient repositioning or resynchronization of the gating or tracking system if needed prior to resuming treatment. Repeat image guidance might also be required in this circumstance. The medical physicist and physician again must both review and approve acquired guidance images before the beam can be turned on again.

It is necessary for a medical physicist to have direct involvement in the treatment delivery process because of the complexity of combining image guided radiotherapy therapy and respiratory motion control and also the need for a second expert confirmation (in addition to the radiation oncologist) of the setup accuracy. There is a greater need for very high accuracy in view of the very high doses per treatment, the complex arrangement of beams and arcs, and very high dose rate of machine output used given the desire to complete the entire individual SBRT treatment as efficiently as possible. These conditions of operation generates frequent automatic stop and warning responses within the linear accelerator; it is the medical physicist's responsibility to respond appropriately and over-ride warnings when appropriate or correct and re-calibrate alignment or monitor machine cooling and re-institute treatment when appropriate and safe.

Once the dose has been delivered the therapists go into the room, disconnect all respiratory control devices, and assist the patient in the process of rising up from the immobilization device. To ensure patient safety and avoid damage to the respiratory control device and immobilization equipment, it is necessary for two therapists or a therapist and medical physicist to aid the patient in dismounting from the treatment couch. The therapist then makes sure that the patient has no immediate concerns and is escorted out of the room to the nurse, who then takes the patient to an exam room. The medical physicist tabulates the daily dose and confirms that there has been no shift from the planned dose or if there is an interrupted treatment makes appropriate calculations on dose to report to the physician. Both the therapist and medical physicist complete their paperwork and sign the prescription sheet. After the fraction of SBRT a nurse will check the patient's vitals signs and evaluate the patient in an exam room separate from the treatment room. While the patient is resting, the nurse monitors vital signs, and provides post treatment education (review of potential side effects) and schedules the follow up appointments.

Post-Service Clinical Labor Activities:

N/A

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

<u>CPT Long Descriptor</u>: Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions

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:

CPT codes 77435 and 77373 were included on the new technology review list for the October 2010 RUC meeting. The coding for these services has evolved over time described by various G codes, Cat III codes and Cat I codes. These codes were preceded by Category III code 0082T (Stereotactic body radiation therapy, treatment delivery, one or more treatment areas, per day) and 0083T (Stereotactic body radiation therapy, treatment management, per day).

ASTRO recommended that CPT codes 77435 and 77373 be removed from the Emerging Technology Services List. Our rationale for the recommendation of removing these services from the New Technology Services List was based on multiple factors: the growth of the services since it was established in 2007, the vignette and typical case at the time the code was approved and a review of the current process of care. However, the RUC requested that we review practice expense inputs for the February RUC meeting.

CPT Code 77435 was included on the new technology review list for the October 2010 RUC meeting. CPT 77435 is a code for physician work only. ASTRO recommended that CPT code 77435 be removed from the Emerging Technology Services List. However, the RUC requested that we conduct a work survey for the code and review practice expense inputs for the February RUC meeting.

CPT code 77435 is an SBRT management code billed once per course of treatment for an SBRT case. It describes the physician work associated with the treatment management of SBRT. There are companion CPT codes that are coded separately to describe the delivery of radiation and the delivery codes do NOT include physician work.

ASTRO convened a panel that included a number of experts familiar with this service to evaluate the RUC physician work survey data and prepare practice expense recommendations. The panel reviewed the current direct practice expense inputs for CPT code 77435 and recommends no changes to the inputs.

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

ASTRO is recommending maintaining the current direct practice expense inputs. We did not include a comparison code in our recommendations.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Prior to SBRT the nurse (RN, LPN, MTA) completes the necessary referral forms, coordinates the planned participation of the personnel involved in treatment delivery, and schedules usage of required treatment machines

and accessory equipment. The nurse conducts with the patient an educational session concerning SBRT, reviewing information already given to the patient by the radiation oncologist and confirming the patient's informed consent to proceed.

 $\frac{Intra-Service}{N/A}$ Clinical Labor Activities:

Post-Service Clinical Labor Activities:

The nurse makes phone calls to follow up on side effects within 2-3 weeks after SBRT and phones in prescriptions.

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

<u>CPT Long Descriptor</u>: Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions

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:

CPT codes 77435 and 77373 were included on the new technology review list for the October 2010 RUC meeting. The coding for these services has evolved over time described by various G codes, Cat III codes and Cat I codes. These codes were preceded by Category III code 0082T (Stereotactic body radiation therapy, treatment delivery, one or more treatment areas, per day) and 0083T (Stereotactic body radiation therapy, treatment management, per day).

ASTRO recommended that CPT codes 77435 and 77373 be removed from the Emerging Technology Services List. Our rationale for the recommendation of removing these services from the New Technology Services List was based on multiple factors: the growth of the services since it was established in 2007, the vignette and typical case at the time the code was approved and a review of the current process of care. However, the RUC requested that we review practice expense inputs for the February RUC meeting.

ASTRO convened a panel that included a number of experts familiar with this service to evaluate the RUC physician work survey data and prepare practice expense recommendations. The panel reviewed the current direct practice expense inputs for CPT code 77435 and recommends no changes to the inputs.

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

ASTRO is recommending maintaining the current direct practice expense inputs. We did not include a comparison code in our recommendations.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Prior to SBRT the nurse (RN, LPN, MTA) completes the necessary referral forms and coordinates the planned participation of the personnel involved in treatment delivery. The nurse conducts with the patient an educational session concerning SBRT, reviewing information already given to the patient by the radiation oncologist and confirming the patient's informed consent to proceed.

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

The nurse makes phone calls to follow up on side effects within 2-3 weeks after SBRT and phones in prescriptions.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code:77435 Tracking Number

Original Specialty Recommended RVU: **13.00** Presented Recommended RVU: **13.00** RUC Recommended RVU: **11.87**

Global Period: XXX

CPT Descriptor: Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old male is diagnosed with a 3.0 cm non-small cell lung cancer in the periphery of the left lower lobe of the lung and his metastatic work is negative. He is medically inoperable secondary to poor pulmonary reserve. Stereotactic body radiation therapy (SBRT) is selected to enhance local control and cure and decrease treatment related morbidity. The prescription is to deliver 20 Gy per fraction X 3 fractions. After simulation and appropriate conformal treatment planning he presents to the department for SBRT.

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

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? 15%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated moderate sedation is typical in the office setting? 9%

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 radiation oncologist performs a clinical evaluation of the patient to ascertain that the patient is medically stable to undergo the procedure and obtains the patient consent. He/She then ensures that any ordered pre-SBRT medications have been administered (anti-emetic anti-anxiety or analgesic medications as needed to ensure patient comfort, steroid anti-inflammatory agents in some lung SBRT cases). The radiation oncologist reviews the chart prescription, patient treatment set-up instructions and motion control parameters and confirms with the medical physicist that there will be no collisions of the apparatus with the patient, treatment couch, or other devices and makes appropriate modifications. This may involve supervising a dry run of the treatment delivery. The physician selects and validates the method used to account for respiratory motion or other types of patient motion and correlate these findings with the parameters of the accepted treatment plan.

Description of Intra-Service Work: Under the direct supervision of the radiation oncologist, the patient is set up on the treatment table and all the treatment parameters are verified. Image guidance with respiratory correlation may be achieved through a variety of methods all of which are supervised, corrected and approved in real time by the physician. The radiation oncologist remains available throughout SBRT treatment to manage the execution of the treatment and make real-time adjustments in response to patient motion, target movement, or equipment issues to ensure accuracy and safety. After positioning, breath coordination equipment or optical tracking (for monitoring the respiration signals) are turned on and

CPT Code: 77435

time is allowed for the patient to acquaint with the audio or visual instructions. Gated (manually or automatic) setup radiographs (kV or MV) are taken and compared by the physician with digitally reconstructed radiographs (DRR's) to detect patient shifts. The patient position is adjusted if the films show a misalignment greater than a predetermined threshold. An on board image series (orthogonal kv or CT scan) is acquired and the radiation oncologist reviews images with the medical physicist to verify that the internal isocenter in the reconstructed 3D volume is positioned appropriately in reference to the observed tumor location in accordance with the previously designed treatment plan. Once the beam is turned on the respiration signal, patient position and target location are continuously monitored during the delivery of image guided SBRT. Multiple images are taken throughout the course of the treatment to verify target localization and these are contemporaneously approved by the physician before the beam can be turned on again. Each time the patient coughs or shifts the treatment has to be interrupted and re-initiated after re-localization and repeat image guidance and correlation. The beam is turned on when the image guidance confirms that the target lesion is in the treatment zone. The physician assesses and approves all of the ongoing images used for localization, tumor tracking, any gating application, as well any complementary single (beam's eye) view localization images for any of the fields or arcs that are arranged to deliver a dose. At all points of decision-making with regard to patient setup, the radiation oncologist will confer with the medical physicist and approve the final setup.

Description of Post-Service Work: After the radiation is given, the patient is taken off the couch taken to an exam room and vital signs are taken and the patient is examined and provided post treatment education. The radiation oncologist will enter a note into the medical record documenting the symptoms and physical findings as well as the successful completion of SBRT at the end of each fraction and a note on the completion of the entire course summarizing the course of treatment, including the dose given, the site(s) treated, and the patient's clinical experience during SBRT. The radiation oncologist communicates this information to the patient's other medical caregivers and ensures that any other planned anti-cancer therapy is arranged to commence as appropriate. The entire treatment process and treatment management is repeated for each subsequent treatment fraction.

SURVEY DAT	ГА						
RUC Meeting Da	ate (mm/yyyy)	02/2011					
Presenter(s):	David Beyer, MD; and Ger	David Beyer, MD, Brian Kavanagh, MD; Michael Kuettel, MD, PhD; Najeeb Mohideen, MD; and Gerald White, MS					
Specialty(s):	American So	ciety for Radiat	tion Oncole	ogy (ASTRO)		
CPT Code:	77435						
Sample Size:	284 F	Resp N:	65	Respo	onse: 22.8 %	, D	
Sample Type:	Random	Additional Sa	mple Info	rmation:			
			Low	25 th pctl	Median*	75th pctl	High
Service Perforn	nance Rate		1.00	11.00	25.00	45.00	300.00
Survey RVW:			7.00	8.51	13.00	14.72	19.00
Pre-Service Evalu	uation Time:				30.00		
Pre-Service Posit	tioning Time:				0.00		
Pre-Service Scru	b, Dress, Wait T	ime:			0.00		
Intra-Service Ti	me:		45.00	120.00	210.00	240.00	450.00
Immediate Post	Service-Time	<u>30.00</u>					
Post Operative	<u>Visits</u>	Total Min**	CPT Cod	e and Num	ber of Visit	S	
Critical Care tin	ne/visit(s):	<u>0.00</u>	99291x 0	. 00 99292	2x 0.00		
Other Hospital	time/visit(s):	<u>0.00</u>	0 99231x 0.00 99232x 0.00 99233x 0.00				
Discharge Day	Mgmt:	<u>0.00</u>	99238x 0.00 99239x 0.00				
Office time/visit	t(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00				
Prolonged Serv	vices:	<u>0.00</u>	99354x 0	.00 55x C).00 56x 0	.00 57x 0.0	00
Sub Obs Care:		0.00	99224x 0	.00 99225	5x 0.00 9	9226x 0.00	

**Physician standard total <u>minutes per E/M visit</u>: 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: 2a-FAC Diff Pat/Straightfor Proc(no sedation/anes)

CPT Code:	77435		Recommended Physician Work RVU: 11.87			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time		
Pre-Service Evaluation Time:			20.00	18.00	2.00	
Pre-Service Positioning Time:		0.00	1.00	-1.00		
Pre-Service Scrub, Dress, Wait Time:		0.00	6.00	-6.00		
Intra-Service Time:			210.00			
Immediate Post Servic	e-Time:	<u>20.00</u>				
Post Operative Visits		Total Min**	CPT Code and Nu	<u>Imber of Visits</u>		
Critical Care time/visit	(s):	<u>0.00</u>	99291x 0.00 992	92x 0.00		
Other Hospital time/vis	sit(s):	<u>0.00</u>	99231x 0.00 992	32x 0.00 99233x	0.00	
Discharge Day Mgmt:		<u>0.00</u>	99238x 0.0 99239x 0.0			
Office time/visit(s):		<u>0.00</u>	99211x 0.00 12x 0	.00 13x 0.00 14x 0	.00 15x 0.00	
Prolonged Services:		<u>0.00</u>	99354x 0.00 55x	0.00 56x 0.00	57x 0.00	
Sub Obs Care:		<u>0.00</u>	99224x 0.00 992	25x 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

			0.			
KEY REFERENCE SERV	ICE:					
<u>Key CPT Code</u> 77432	<u>Global</u> XXX		<u>Work F</u> 7.92	<u>RVU</u>	<u>Time Source</u> CMS Time File	
<u>CPT Descriptor</u> Stereotactic of 1 session)	radiation tre	eatment manageme	nt of cranial lesion(s)	(complete c	course of treatment consist	ing
KEY MPC COMPARISON Compare the surveyed code appropriate that have relative	N CODES: to codes on e values high	the RUC's MPC er and lower than t	List. Reference codes he requested relative v	from the N alues for the	MPC list should be chosen e code under review. Most Recent	, if
<u>MPC CPT Code 1</u> CPT Descriptor 1	<u>Global</u>	Work RVU 0.00	<u>Time Source</u>	Medic	care Utilization	
<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u> 0.00	Time Source	Medi	Most Recent icare Utilization	
<u>CPT Descriptor 2</u>						
Other Reference CPT Code 77301	<u>Global</u> XXX	<u>Work R</u> 7.99	VU <u>Time Source</u> RUC Time	2		

<u>CPT Descriptor</u> Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications

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

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

Number of respondents who choose Key Reference Code: 51 % of respondents: 78.4 %

<u>TIME ESTIMATES (Median)</u>	CPT Code: 77435	Key Reference CPT Code: <u>77432</u>	Source of Time CMS Time File
Median Pre-Service Time	20.00	0.00	
Median Intra-Service Time	210.00	156.00]
Median Immediate Post-service Time	20.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	250.00	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 4.47 3.94 management options that must be considered The amount and/or complexity of medical records, diagnostic tests, 4.59 4.20 and/or other information that must be reviewed and analyzed Urgency of medical decision making 4.24 4.06 Technical Skill/Physical Effort (Mean) Technical skill required 4.80 4.39 Physical effort required 4.16 3.75 Psychological Stress (Mean) The risk of significant complications, morbidity and/or mortality 4.78 4.43 Outcome depends on the skill and judgment of physician 4.78 4.45 4.33 Estimated risk of malpractice suit with poor outcome 4.67 **INTENSITY/COMPLEXITY MEASURES** CPT Code Reference Service 1 Time Segments (Mean) 4.33 Pre-Service intensity/complexity 3.86 Intra-Service intensity/complexity 4.67 4.12 Post-Service intensity/complexity 3.86 3.51

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 Code 77435 was included on the new technology review list for the October 2010 RUC meeting. CPT 77435 is a code for physician work only. ASTRO recommended that CPT code 77435 be removed from the Emerging Technology Services List. However, the RUC requested that we survey the code and present recommendations at the February RUC meeting.

SBRT has been performed since the early 1990s and is distinct from conventional radiation therapy. It describes the delivery of potent doses of radiation using numerous carefully directed fields to extracranial sites. The coding for these services has evolved over time described by various G codes, Cat III codes and Cat I codes. What has been consistent and remains consistent is the process of care for these services. CPT code 77435 was established in 2007. It was previously reported by Category III code 0083T (Stereotactic body radiation therapy, treatment management, per day).

CPT code 77435 is an SBRT management code billed once per course of treatment for an SBRT case. It describes the physician work associated with the treatment management of SBRT. There are companion CPT codes that are coded separately to describe the delivery of radiation and the delivery codes do NOT include physician work.

ASTRO conducted a survey and collected 65 surveys. ASTRO convened a panel that included a number of experts familiar with this service to evaluate the RUC survey data. ASTRO recommends maintaining the current RVU for CPT code 77435. Our rationale for that recommendation is based on multiple factors and is described below.

Vignette

The Medicare data indicates that our original vignette describing an early stage lung cancer patient in *April 2006* is in fact the most reported diagnosis (ICD 162) for this CPT code. Therefore, we used the original vignette in this survey and 92% of our survey respondents felt the vignette was typical.

Number of Fractions

We included a question on the survey asking respondents to indicate the typical number of fractions used to treat the patient described in the vignette. The median (and average) survey response was 4 fractions.

At the time this code was presented, we said that this code would be billed once per course of SBRT treatment and that the average number of fractions per course would be at least 3. We carefully examined the Medicare claims data to determine the typical number of SBRT fractions. We estimated the number of fractions per course of SBRT for which the physician would provide the management of treatment delivery and patient management by summing the number of times SBRT treatment delivery codes (77371, G0251, G0340, and G0339) were reported and divided by the number of times the SBRT management code (77435) was reported. Our analysis yields 4 fractions per course of SBRT treatment, which consistent with our current survey data.

Codes Reported on the Same Day

The Medicare claims data supports the "codes reported together" data on the original SOR in *April 06*. In the SOR, we indicated that a simulation code (CPT Codes 77280- 290) may be billed with CPT code 77435. The data in the "Same Day Billings from CMS" File shows that 29% of the time CPT code 77435 is billed alone; 26% of the time CPT code 77435 is billed with CPT code 77290 a complex simulation code; 18% of the time CPT code 77435 is billed with CPT code 77280 a simple simulation code. No other codes are reported frequently with CPT code 77435.

Recommendations:

We are recommending the current RVUw of 13.00, pre-service package 2a (with adjustments) and the median intra and post service times of 210 and 30 minutes, respectively, total time 270 minutes.

Changes to Pre-Service Time:

Our panel recommends pre-service package 2a (*Difficult Patient/Straightforward Procedure (No sedation/anesthesia care)* which has a total preservice time of 25 minutes. We recommend deleting the positioning and scrub/dress/wait times. We recommend increasing the evaluation time to account for the additional fractions.

CPT Code: 77435 Our current surveyed total time was 270 minutes (30, 210, 30), which is the same as current total time (20, 230, 20). The total time is broken out slightly different in the current survey, than in the RUC database. It is important to note that in the *April* 2006 recommendations the Society recommended, and the RUC agreed, that **total surveyed time** should be used to develop the time distribution.

"We received over 50 completed surveys from our membership and it is clear from our survey responses that many people in our sample continue to interpret pre/intra/post differently for XXX codes. Therefore, we are recommending to use the total time as our basis for time recommendations. (We often use this approach, as recently as with the 5 year review recommendations.) The consensus panel has reviewed the data and feels that the surveyed median total time is appropriate for this new management code, which is for a complete course of SBRT. (Note: the vignette was for 3 fractions). Recognizing that there is some pre and post time, we recommend backing out (from total median time) 20 minutes for PreTime and 20 minutes for Post Time (Specific activities are described in the Description of Work section)."

Comparison to the Key Reference Services:

The key reference service code is 77432 *Stereotactic radiation treatment management of cranial lesion(s) (complete course of treatment consisting of 1 session)*, the same reference service code selected in the April 2006 survey. At that time the RUC compared 77435 to reference service code 77432 Stereotactic radiation treatment management of cerebral lesion(s) (complete course of treatment consisting of one session) (Work RVU=7.92) which is for one session of SBRT management. The RUC agreed that the mental effort and judgment, technical skill/physical effort and psychological stress were higher for 77435 than the reference code 77432.

IWPUT

The current IWPUT for CPT code 77435 is 0.0526. The surveyed IWPUT is 0.0555. CPT code 77432, the reference service code, has an IWPUT of 0.0507. We believe our current recommendations supports this slight change in IWPUT, maintains the relationship between the surveyed code and the reference service code and stays in line with other radiation oncology IWPUTs.

Building Block

The consensus panel also used a building block to validate our recommendations. Again, this management code reflects a "complete course" of therapy. The following codes were used as a "cross check" of our recommendation: one 77432 (7.92) + one 77427 (3.37) + four 77421s (0.39 *4=1.56) = 12.85, which is right in line with our median of 13.00. *These codes would not be billed along with this new code*.

Volume Growth:

SBRT has proven to be a tremendous advance in the management of certain previously difficult to treat malignancies. Lung cancer has the 2nd highest incidence and the highest mortality rate among both men and women in the United States. A significant proportion of early stage lung cancer patients are deemed medically inoperable due to co-morbid conditions. These patients have historically been offered external beam radiotherapy alone using conventional techniques as primary management, with results consistently inferior to the results of surgery alone. An increasing number of studies on SBRT for lung cancer, including prospective clinical trials (JAMA. 2010 Mar 17;303(11):1070-6.) have established the feasibility, safety, and efficacy of this treatment modality in this patient population. These studies demonstrate high rates of local control and improved outcomes with remarkably few high grade toxicities in this patient population. SBRT has also been proven to be highly effective in the local control of solitary and oligo spine, liver and lung metastases. We consider the increased acceptance of SBRT for the management of early stage medically inoperable non small cell lung cancers (NSCLC) and non surgical management of other oligo metastatic sites as an important clinical reason for the growth reflected in the Medicare database. The typical diagnosis (ICD 162) and the vignette (early stage lung cancer) would be unchanged today compared to when the code was approved.

In the original RUC recommendations, ASTRO estimated that this service would be provided approximately 3,000 times annually to the Medicare population. The current Medicare frequency data indicates this service was performed approximately 10,000 times in 2009. Clearly the number 3000 was too low. This code is

CPT Code: 77435 reported both in the facility and non facility. This service was already being provided in the hospital outpatient facility prior to 2007 and that number was unknown at the time due to the lag in CMS utilization data. The volume of these procedures being reported prior to 2007 should serve as the baseline. The frequency data for 2007 was 4672. We believe that number (4672) really should be considered the baseline or the number of procedures that were already being performed at the time of the recommendations. If you add the 3,000 to the baseline it is much closer to the current number of 10,000.

The volume has essentially doubled over 3 years for the clinical reasons mentioned above. SBRT has become the standard of care for medically inoperable early stage lung cancer and non surgical management of oligometastases. In addition, the growing acceptance of this procedure and ongoing protocols has resulted in the volume growth seen in recent Medicare claims data. We believe it provides evidence for the appropriateness of the volume growth for this code.

u		ms Duiu 2007-				
	CPT Code 77435					
	Year	MFS Total				
	2007	4,672				
	2008	7,334				
	2009	10,067				

Medicare Claims Data 2007-2009

Conclusion

When the RUC examined the survey median RVU of 13.00 in *April 2006* they agreed that it appropriately reflected the physician work involved to perform this procedure. The higher pre-service, intra-service, and immediate post-service times compared to the reference code 77432, brought the work RVU to approximately 13.00. We believe our 65 person survey supports our recommendation of maintaining the current RVUw of 13.00 and with a total time of 270 (30/210/30).

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. The Medicare claims data supports the original SOR [April 06]. In the SOR, we indicated that a simulation code (CPT Codes 77280- 290) may be billed with CPT code 77435. The data in the "Same Day Billings from CMS" File shows that 29% of the time CPT code 77435 is billed alone; 26% of the time CPT code 77435 is billed with CPT code 77280 a simple simulation code. No other codes are reported frequently with CPT code 77435. 77280: XXX global period. 0.70 work RVUs. 0/23/0 time. 77290: XXX global period. 1.56 work RVUs. 0/70/0 time.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 77435

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 Radiation Oncology	How often?	Commonly
Specialty Diagnostic Radiology	How often?	Rarely
Specialty Hematology/Oncology	How often?	Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 16778 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.

Specialty Radiation Oncology	Frequency 15604	Percentage 93.00 %
Specialty Diagnostic Radiology	Frequency 672	Percentage 4.00 %
Specialty Hematology/Oncology	Frequency 336	Percentage 2.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 10,277 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate. 2009 Medicare claims data for 77435

Specialty Radiation Oncology	Frequency 9760	Percentage 94.96 %
Specialty Diagnostic Radiology	Frequency 339	Percentage 3.29 %
Specialty Hematology/Oncology	Frequency 212	Percentage 2.10 %

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 <u>will not</u> change, enter the surveyed existing CPT code number 77435

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

	Α	В	С	D	E	F	G
1	AMA/Specialty Society RVS Update Committee Recommend	ation		 CPT	77373	77	435
<u> </u>	Meeting Date: February 2011			Stereotactic body radiation		Stereotactic k	ody radiation
				therapy treatment delivery per		ner therapy treatment managemen	
				fraction to 1 o	r moro lociono	nor trootmont	acurso to 1 or
					or more lesions,	per treatment	course, to 1 or
				including image	e guidance, entire	ce, entire more lesions, including im	
				course not to e	xceed 5 fractions	guidance, entir	e course not to
						exceed 5	fractions
2		CMS	Staff				
2		Code	Туре	Non Facility	Facility	Non Facility	Facility
3		Code	туре				
4				***	***	***	***
5	TOTAL CLINICAL LABOR TIME			210.0	0.0	12.0	15.0
	TOTAL DDE SEDV CLINICAL LADOD TIME	1.027D		0.0	0.0	0.0	12.0
6	TOTAL TRE-SERV CLINICAL LADOR TIME	L037D	KIN/LPIN/MITA	0.0	0.0	9.0	12.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			210.0	0.0	0.0	0.0
8	Medical Physicist	L152A	MedPhy	75.0			
	Padiation Thoranist	10500	DT	111.0			
9		LUJUC	KI	111.0			
10	RN/LPN/MTA	L037D	RN/LPN/MTA	24.0			
11	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	0.0	3.0	3.0
12	PRE-SERVICE						
13	Start: Following visit when decision for surgery or procedu	ire made					
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA			3	3
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA			3	3
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA				3
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA			3	3
18	Follow-up phone calls & prescriptions						
19	Other Clinical Activity (please specify)						
20	End: When patient enters office/facility for surgery/procedu	re					
21	SERVICE PERIOD						
22	Start: When patient enters office/facility for surgery/procedu	ure: Serv	vices Prior to Pr	ocedure			
	Greet patient, provide gowning, ensure appropriate medical						
23	records are available	L037D	RN/LPN/MTA	3			
24	Obtain vital signs	L037D	RN/LPN/MTA	3			
25	Provide pre-service education/obtain consent			-			
26	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2			
27	Setup scope (non facility setting only)						
28	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	2			
29	Sedate/apply anesthesia	L037D	RN/LPN/MTA	1			
30	Intra-service						
31	Enter Treatment Plan	L050C	RT	4			
32	Review and check plan coordinates	L050C	RT	4			
33	Assist in patient positioning	1050C	RT	8			
34	Monitor treatment delivery and patient	1 050C	RT	90			
35	Complete treatment and documentation	L050C	RT	5			
36				U			
37	Setup DRR reference positions	L152A	MedPhv	20			
38	Establish Respiratory Cycle (RC) for patient	L152A	MedPhy	5			
39	Correlate RC with Target (fiducial) position	L152A	MedPhv	5			
40	Compare with reference DRR's and consult with MD	L152A	MedPhv	5			
41	Treatment	L152A	MedPhy	30			
42	Re-establish RC/Target position if correlation is lost	L152A	MedPhy	5			
43	Compare DRR's, consult with MD	L152A	MedPhy	5			
44			· · ·	75			
45	Post-Service			-			
46	Monitor pt. following service/check tubes monitors drains	L037D	RN/I PH/MTA	10			
47	Clean room/equipment by physician staff	L037D	RN/I PH/MTA	3			
48	Clean Scope			V			
40	Clean Surgical Instrument Package						
50	Complete diagnostic forms Jab & X-ray requisitions						
50	Review/read X-ray lab and nathology reports						
	Check dressings & wound/ home care instructions /coordinate						
50	office visits /prescriptions						
52	Discharge day management						
55	Other Clinical Activity (nlesse specify)						
54	Fnd: Patient leaves office						
55	POST-SERVICE Period						
00	Start: Patient leaves office/facility						
51	Conduct phone calls/call in prescriptions					3	2
50	Other Activity (nlease specify)	20070				5	5
60	End: with last office visit before and of global period				<u>۸</u>		
1 00					. 🗸		

AMA Specialty Society Recommendation

	A	В	С	D	E	F	G	
1	AMA/Specialty Society RVS Update Committee Recommend	lation		CPT 77373		77435		
	Meeting Date: February 2011			Stereotactic	body radiation	Stereotactic body radiation		
				therapy, treatm	nent delivery, per	therapy, treatme	ent management,	
				fraction to 1 o	or more lesions,	per treatment	course, to 1 or	
				including image	e guidance, entire	more lesions,	including image	
				course not to e	xceed 5 fractions	guidance, enti	re course not to	
						exceed 5	fractions	
2		CMS	Staff					
3	LOCATION	Code	Туре	Non Facility	Facility	Non Facility	Facility	
61	MEDICAL SUPPLIES		Unit					
62	pack, minimum multi-sof-setspecialty visit	SA048		1				
63	drape, non-sterile, sheet 40in x 60in	SB006		1				
64	gloves, non-sterile	SB022		2				
65	underpad 2ft x 3ft (Chux)	SB044		3				
66	gas, oxygen	SD084		10				
67	tape, surgical paper 1in (Micropore)	SG079		10				
68	EQUIPMENT							
69	pulse oximeter w-printer	EQ211		111				
70	SRS system, SBRT, six systems, average			111				

AMA Specialty Society Recommendation

AMA/Specialty Society RVS Update Committee Summary of Recommendations Identified through the Top 9 Harvard Screen

February 2011

Special Stains

The special stains services were identified by the RUC's Relativity Assessment Workgroup through its CMS screen for Harvard-valued codes with utilization greater than 1 million. At the October 2009 RUC Meeting, the RUC recommended that all of the identified codes in this family be surveyed using the standard RUC survey instrument, present an alternative methodology to the Research Subcommittee for review, or present a code change proposal to the CPT Editorial Panel for their review. The College of American Pathologists (CAP) submitted a CPT coding proposal to revise the current descriptors of the special stains services to clarify the appropriate use of these codes. CAP conducted a standard RUC survey for each of the special stains services. The survey data demonstrates that the current work associated with these services is accurate and furthermore supports the specialty society's recommendation that there is no compelling evidence to change the current work of these services. However, as 88318 is being deleted and the utilization is shifting to another code, 88313, which has a lower work RVU, and the RUC understands that these recommendations will represent a work savings.

88312 Special stain including interpretation and report; Group I for microorganisms (eg, acid fast, methenamine silver)

The RUC reviewed the survey data for 88312. The specialty society recommended and the RUC agreed that the surveyed time accurately reflects the service being performed. The RUC reviewed the surveyed code in comparison to 88334 *Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site* (Work RVU=0.73). The RUC noted that although the surveyed code has slightly more intra-service time as compared to the reference code, 24 minutes and 20 minutes, respectively, the reference code is a more intense service to perform as the survey respondents indicated in all of the intensity/complexity measures. Although the survey median for this service was 0.73 work RVUs, the specialty society recommended and the RUC agreed that there was no compelling evidence to change the current value for this service, 0.54 work RVUs. **Therefore, the RUC recommends a work RVU of 0.54 for CPT code 88312.**

88313 Special stain including interpretation and report; Group II, all other, (eg, iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry

The RUC reviewed the survey data for 88313. The specialty society recommended and the RUC agreed that the surveyed time accurately reflects the service being performed. The RUC reviewed the surveyed code in comparison to 89060 *Crystal identification by light microscopy with or without polarizing lens analysis, tissue or any body fluid (except urine)* (Work RVU=0.37). The RUC noted that the surveyed code has slightly more intra-service time as compared to the reference code, 13 minutes and 10 minutes, respectively. Further, the surveyed code is a more intense service to perform as the survey respondents indicated in all of the intensity/complexity measures. The RUC also compared the surveyed code to another reference code 77083 *Radiographic absorptiometry (eg, photodensitometry, radiogrammetry), 1 or more sites* (Work RVU=0.20). The RUC noted that the surveyed code has more intra-service time in comparison to this reference code, 13 minutes and 10 minutes, respectively. Although the survey median for this service was 0.56 work RVUs, the specialty society recommended and the RUC agreed that there was no

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compelling evidence to change the current value for this service, 0.24 work RVUs. Therefore, the RUC recommends a work RVU of 0.24 for CPT code 88313.

88314 Special stain including interpretation and report; histochemical stain on frozen tissue block

The RUC reviewed the survey data for 88314. The specialty society recommended and the RUC agreed that the surveyed time accurately reflects the service being performed. The RUC reviewed the surveyed code in comparison to 88334 *Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site* (Work RVU=0.73). The RUC noted that the surveyed code has less intra-service time as compared to the reference code, 13 minutes and 20 minutes, respectively. Further, the reference code requires more mental effort and judgment, technical skill and overall is a more intense service to perform in comparison to the surveyed code as indicated by the survey respondents. The surveyed 25th percentile for this service was 0.45 Work RVUs, which is the current work RVU. Based on these magnitude estimation comparisons and the specialty society recommendation that there was no compelling evidence to change the current value for this service, the RUC recommends maintaining the current value of this service. **The RUC recommends a work RVU of 0.45 for CPT code 88314**.

88319 Special stain including interpretation and report; Group III, for enzyme constituents

The RUC reviewed the survey data for 88319. The specialty society recommended and the RUC agreed that the surveyed time accurately reflects the service being performed. The RUC reviewed the surveyed code in comparison to 88334 *Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site* (Work RVU=0.73). The RUC noted that the surveyed code has slightly less intraservice time as compared to the reference code, 18 minutes and 20 minutes, respectively. Further, the reference code requires more mental effort and judgment, psychological stress and overall is a more intense service to perform in comparison to the surveyed code as indicated by the survey respondents. Although the survey median for this service was 0.75 work RVUs, the specialty society recommended and the RUC agreed that there was no compelling evidence to change the current value for this service, 0.53 work RVUs. **Therefore, the RUC recommends a work RVU of 0.53 for CPT code 88319**.

Practice Expense Inputs:

After the specialty society made several modifications, the RUC approved the clinical labor, supplies and equipment associated with special stains services.

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommenda- tion
▲88312	C1	Special stains <u>including interpretation and report</u> ; Group I for microorganisms (eg, Gridley, acid fast, methenamine silver), including interpretation and report, each (Report one unit of 88312 for each special stain, on each surgical pathology	XXX	0.54 (No Change)

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CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommenda- tion
		block, cytologic specimen, or hematologic smear)		
▲88313	C2	Group II, all other, (eg, iron, trichrome), except <u>stain for</u> <u>microorganisms</u> , <u>stains for enzyme constituents</u> , <u>or</u> immunocytochemistry and <u>immunohistochemistry</u> immunoperoxidasestains, including interpretation and report, each (<u>Report one unit of 88313 for each special stain</u> , <u>on each surgical pathology</u> <u>block</u> , <u>cytologic specimen</u> , <u>or hematologic smear</u>) (For immunocytochemistry and <u>immunohistochemistry</u> immunoperoxidase <u>tissue studies</u> , use 88342)	XXX	0.24 (No Change)
+▲88314	C3	 histochemical staining on with frozen tissue block, section(s), including interpretation and report (List separately in addition to code for primary procedure) (Use 88314 in conjunction with 17311-17315, 88302-88309, 88331-88332) (Do not report 88314 in conjunction with 17311-17315 for routine frozen section stain [eg, hematoxylin and eosin, toluidine blue], performed during Mohs surgery. When a non-routine histochemical stain on frozen tissue during Mohs surgery is utilized, report 88314 with modifier 59) (Report one unit of 88314 for each stain on each frozen surgical pathology block) (For a special stain performed on frozen tissue section material to identify enzyme constituents, use 88319) 	ZZZ	0.45 (No Change)
D 88318		Determinative histochemistry to identify chemical components (eg, copper, zinc)	XXX	N/A

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CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommenda- tion
		(88318 has been deleted) (For determinative histochemistry to identify chemical components, use 88313)		
▲88319	C4	Group III, for Determinative histochemistry or cytochemistry to identify enzyme constituents, each (For each stain on each surgical pathology block, cytologic specimen, or hematologic smear, use one unit of 88319) (For detection of enzyme constituents by immunohistochemical or immunocytochemical technique, use 88342)	XXX	0.53 (No Change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code:88312 Tracking Number Global Period: XXX Specialty Society Recommended RVU: 0.54 RUC Recommended RVU: 0.54

CPT Descriptor: Special stain including interpretation and report; Group I for microorganisms (eg, acid fast, methenamine silver)

(Report one unit of 88312 for each special stain, on each surgical pathology block, cytologic specimen, or hematologic smear)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Microscopic examination of a Warthin Starry stain performed on stomach biopsy with gastritis obtained from a 70-year-old male.

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

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: N/A

Description of Intra-Service Work: The pathologist performs microscopic examination of the positive control for appropriately stained microorganisms to verify that the appropriate structures are stained. The patient sample is then microscopically examined. The pathologist examines for the presence of any microscopic organisms and interprets them morphologically. The findings are correlated with clinical history, previous tissue samples and laboratory tests. The pathologist composes and dictates the report. The report is edited and signed with the results communicated to appropriate caregivers.

Description of Post-Service Work: N/A

SURVEY DAT	A						
RUC Meeting Date (mm/yyyy) 10/2010							
Presenter(s):	Jonathan L. N	/lyles, MD, FC/	AP				
Specialty(s):	College of An	nerican Patholo	ogists				
CPT Code:	F Code: 88312						
Sample Size:	2500 F	esp N:	108	Respo	onse: 4.3 %		
Sample Type:	Random	Additional Sa	mple Info	rmation:			
			Low	25 th pctl	Median*	75th pctl	<u>High</u>
Service Perform	ance Rate		10.00	58.00	178.00	400.00	1100.00
Survey RVW:			0.30	0.52	0.73	0.86	1.25
Pre-Service Evaluation Time:					0.00		
Pre-Service Positioning Time:					0.00		
Pre-Service Scrub, Dress, Wait Time:					0.00		
Intra-Service Time:			5.00	20.00	24.00	25.00	35.00
Immediate Post	Service-Time:	<u>0.00</u>					
Post Operative	<u>Visits</u>	Total Min**	CPT Cod	e and Num	ber of Visit	S	
Critical Care tim	e/visit(s):	<u>0.00</u>	99291x 0	. 00 99292	2x 0.00		
Other Hospital time/visit(s): <u>0.00</u>		99231x 0	. 00 99232	2x 0.00 9	9233x 0.00		
Discharge Day Mgmt: <u>0.00</u>		99238x 0	.00 99239x	0.00			
Office time/visit	(s):	0.00	99211x 0	.00 12x 0.0	0 13x 0.00 1	4x 0.00 15x	0.00
Prolonged Servi	ces:	0.00	99354x 0	.00 55x 0.	00 56x 0.0	5 7x 0.00	

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

PT Code: 88312		Recommended Physician Work RVU: 0.54			
			Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation T	ïme:		0.00	0.00	0.00
Pre-Service Positioning	Time:		0.00	0.00	0.00
Pre-Service Scrub, Dress	s, Wait Tim	ie:	0.00	0.00	0.00
Intra-Service Time:		24.00			
Immediate Post Servic	e-Time:	<u>0.00</u>			
Post Operative Visits Total Min**		CPT Code and Nu	<u>umber of Visits</u>		
Critical Care time/visit	(s):	<u>0.00</u>	99291x 0.00 992	92x 0.00	
Other Hospital time/vis	sit(s):	<u>0.00</u>	99231x 0.00 992	32x 0.00 99233x	0.00
Discharge Day Mgmt:		<u>0.00</u>	99238x 0.0 99239	< 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

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
88334	XXX	0.73	RUC Time

<u>CPT Descriptor</u> Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site

KEY MPC COMPARISON CODES:

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

				wost Recent		
MPC CPT Code 1	<u>Global</u> Wo	ork RVU	Time Source	Medicare Utilization		
99212	XXX	0.48	RUC Time	19,660,131		
<u>CPT Descriptor 1</u> Office or	other outpatier	t visit for the	e evaluation and man	agement of an established patient, which		
requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward						
medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent						
with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited						
or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.						

				Most Recent
MPC CPT Code 2	<u>Global</u>	Work RVU	Time Source	Medicare Utilization
11056	000	0.61	Other	1,687,654

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

Other Reference CPT Code	<u>Global</u>	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: 44 % of respondents: 40.7 % **TIME ESTIMATES (Median) Kev Reference** Source of Time **CPT Code:** CPT Code: **RUC Time** 88312 88334 Median Pre-Service Time 0.00 0.00 Median Intra-Service Time 24.00 20.00 Median Immediate Post-service Time 0.00 0.00 Median Critical Care Time 0.0 0.00 0.0 0.00 Median Other Hospital Visit Time Median Discharge Day Management Time 0.0 0.00 0.00 Median Office Visit Time 0.0 Prolonged Services Time 0.00 0.0 **Median Total Time** 24.00 20.00

Other time if appropriate	

INTENSITY/COMPLEXITY MEASURES (Mean) (of those that selected Key **Reference code**) Mental Effort and Judgment (Mean) The number of possible diagnosis and/or the number of 3.34 4.16 management options that must be considered The amount and/or complexity of medical records, diagnostic tests, 3.27 3.64 and/or other information that must be reviewed and analyzed 4.25 Urgency of medical decision making 3.34 Technical Skill/Physical Effort (Mean) Technical skill required 3.73 4.23 Physical effort required 3.07 3.16 Psychological Stress (Mean) The risk of significant complications, morbidity and/or mortality 3.52 4.18 Outcome depends on the skill and judgment of physician 3.95 4.23 3.98 Estimated risk of malpractice suit with poor outcome 3.39 **INTENSITY/COMPLEXITY MEASURES** CPT Code Reference Service 1 Time Segments (Mean) Pre-Service intensity/complexity 0.00 0.00 Intra-Service intensity/complexity 3.36 3.73 Post-Service intensity/complexity 0.00 0.00

Additional Rationale and Comments

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

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor and representatives from the general and academic pathology practice settings.

The expert panel recommends the current RVW value of 0.54

The panel took these steps in reaching their conclusion:

- 1) Reviewed the survey results
- 2) Compared the recommended RVW, time and intensity/complexity of 88312 to the reference service 88334 *Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site*
- 3) Compared other services/procedures on the MPC list to the recommended RVW and time of 88312

Review of Survey Results

The survey had a response rate of 108 and a survey median time of 24 minutes. The expert panel felt the survey respondents fairly estimated the physician work time. The 24 minutes compares favorably with the data from the Hsiao studies at 22 minutes.

Panel members reviewed the recommended RVW from the survey data and noted that while the data indicates an increase in RVW may be warranted, the panel was unable to identify compelling evidence to support it. The panel recommends the current value of 0.54.

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.)

1	

The surveyed code is an add-on code or a base code expected to be reported with an add-on code. Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.

Multiple codes allow flexibility to describe exactly what components the procedure included.

Multiple codes are 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) 88312

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 Pathology	How often? Commonly
Specialty	How often?
Specialty	How often?

Estimate the number of times this service might be provided nationally in a one-year period?
CPT Code: 88312

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.

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,326,652 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate. RUC Database 2009 Utilization

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

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

Professional Liability Insurance Information (PLI)

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

If no, please select another crosswalk and provide a brief rationale. 88312

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code:88313 Tracking Number Global Period: XXX Specialty Society Recommended RVU: 0.24 RUC Recommended RVU: 0.24

CPT Descriptor: Special stain including interpretation and report; Group II, all other, (eg, iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry

(Report one unit of 88313 for each special stain, on each surgical pathology block, cytologic specimen, or hematologic smear)

(For immunocytochemistry and immunohistochemistry, use 88342)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Microscopic examination of a Congo red stain performed on a bone marrow biopsy from a 75year-old male with monoclonal gammopathy

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

Is moderate sedation inherent to this procedure in the office setting? Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: N/A

Description of Intra-Service Work: The pathologist examines control tissue known to contain amyloid deposits using both nonpolarized and polarized light microscopy to determine the presence of congophilic apple green birefringent material and that the appropriate structures are stained. The pathologist then examines the patient's sample using both nonpolarized and polarized light microscopy. The pathologist interprets the staining pattern and determines its significance in its histologic location. The findings are correlated with clinical history, previous tissue samples and laboratory tests. The pathologist composes and dictates the report. The report is edited and signed with the results communicated to appropriate caregivers.

Description of Post-Service Work: N/A

SURVEY DAT	ΓΑ						
RUC Meeting Da	ate (mm/yyyy)	10/2010					
Presenter(s):	Jonathan L. N	lyles, MD, FC	٩P				
Specialty(s):	College of An	nerican Patholo	ogists				
CPT Code:	88313						
Sample Size:	2500 R	esp N:	70	Respo	onse: 2.8 %		
Sample Type:	Random	Additional Sa	mple Info	rmation:			
			Low	25 th pctl	Median*	75th pctl	High
Service Perform	ance Rate		10.00	20.00	150.00	300.00	1500.00
Survey RVW:			0.30	0.34	0.56	0.73	1.18
Pre-Service Evaluation Time:					0.00		
Pre-Service Positioning Time:					0.00		
Pre-Service Scrub, Dress, Wait Time:					0.00		
Intra-Service Time:			5.00	10.00	13.00	15.00	25.00
Immediate Post	Service-Time:	<u>0.00</u>					
Post Operative	Visits	Total Min**	n** CPT Code and Number of Visits				
Critical Care tim	ne/visit(s):	<u>0.00</u>	99291x 0	. 00 99292	2x 0.00		
Other Hospital t	ime/visit(s):	0.00	99231x 0	. 00 99232	2x 0.00 9	9233x 0.00	
Discharge Day I	Ngmt:	0.00	99238x 0	. 00 99239x	0.00		
Office time/visit	(s):	0.00	99211x 0	.00 12x 0.0	0 13x 0.00 1	4x 0.00 15x	0.00
Prolonged Serv	ices:	0.00	99354x 0	.00 55x 0.	00 56x 0.0	0 57x 0.00	

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	88313		Recommended Physician Work RVU: 0.24			
			Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time	
Pre-Service Evaluation T	ime:		0.00	0.00	0.00	
Pre-Service Positioning	Time:		0.00	0.00	0.00	
Pre-Service Scrub, Dress	s, Wait Tim	e:	0.00	0.00	0.00	
Intra-Service Time:			13.00			
Immediate Post Servic	e-Time:	<u>0.00</u>				
Post Operative Visits		<u>Total Min**</u>	CPT Code and Nu	umber of Visits		
Critical Care time/visit	(s):	<u>0.00</u>	99291x 0.00 992	92x 0.00		
Other Hospital time/vis	sit(s):	<u>0.00</u>	99231x 0.00 992	32x 0.00 99233x	0.00	
Discharge Day Mgmt:		0.00	99238x 0.0 99239	× 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	

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
89060	XXX	0.37	RUC Time

<u>CPT Descriptor</u> Crystal identification by light microscopy with or without polarizing lens analysis, tissue or any body fluid (except urine)

KEY MPC COMPARISON CODES:

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

				Most Recent	
MPC CPT Code 1	<u>Global</u> W	ork RVU	Time Source	Medicare Utilization	
99211	XXX	0.18	RUC Time	8,696,065	
CPT Descriptor 1 Office of	or other outpatient	visit for the ev	valuation and mana	agement of an established patient, that may	y not
require the presence of a	a physician. Usua	lly, the prese	enting problem(s)	are minimal. Typically, 5 minutes are s	spent
performing or supervising	these services.				_
				Most Decent	

				WIOSt Recent
MPC CPT Code 2	<u>Global</u>	Work RVU	Time Source	Medicare Utilization
95900	XXX	0.42	RUC Time	1,371,085

<u>CPT Descriptor 2</u> Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

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: 25 % of respondents: 35.7 %

<u>TIME ESTIMATES (Median)</u>	CPT Code: 88313	Key Reference CPT Code: <u>89060</u>	Source of Time RUC Time
Median Pre-Service Time	0.00	3.00	
Median Intra-Service Time	13.00	10.00	
Median Immediate Post-service Time	0.00	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 Total Time	13.00	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	3.04	2.36
management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests,	3.04	2.40
and/or other information that must be reviewed and analyzed		
Urgency of medical decision making	2.68	2.32
$T = 1 + 1 \leq 1 \leq 1 \leq 1 \leq 1 \leq n \leq (M_{00})$		
<u>Technical Skill/Physical Effort (Wieali)</u>		
Technical skill required	3.24	2.64
	0.50	0.00
Physical effort required	2.52	2.28
<u>Psychological Stress (Mean)</u>		
The risk of significant complications, morbidity and/or mortality	3.00	2.24
) (- 1	ı
Outcome depends on the skill and judgment of physician	3.44	2.80
Estimated risk of malpractice suit with poor outcome	2 84	2 12
Estimated risk of malphetice suit with poor outcome	2.01	2.12
INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference
		<u>Service 1</u>
Time Segments (Mean)		
Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	3.04	2.72
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

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

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor and representatives from the general and academic pathology practice settings.

The expert panel recommends the current RVW value of 0.24

The panel took these steps in reaching their conclusion:

- 1) Reviewed the survey results
- 2) Compared the recommended RVW, time and intensity/complexity of 88313 to the reference service 89060 *Crystal identification by light microscopy with or without polarizing lens analysis, tissue or any body fluid (except urine)*
- 3) Compared other services/procedures on the MPC list to the recommended RVW and time of 88313

Review of Survey Results

The survey had a response rate of 70 and a survey median time of 13 minutes. The expert panel felt the survey respondents fairly estimated the physician work time. The 13 minutes compares favorably with the data from the Hsiao studies at 11 minutes.

Panel members reviewed the recommended RVW from the survey data and noted that while the data indicates an increase in RVW may be warranted, the panel was unable to identify compelling evidence to support it. The panel recommends the current value of 0.24.

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) 88313

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 Pathology	How often? Commonly
Specialty	How often?
Specialty	How often?

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

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,273,054 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate. RUC Database 2009 Utilization

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

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

Professional Liability Insurance Information (PLI)

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

If no, please select another crosswalk and provide a brief rationale. 88313

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code:88314 Tracking Number

Specialty Society Recommended RVU: 0.45

Global Period: XXX

RUC Recommended RVU: 0.45

CPT Descriptor: Special stain including interpretation and report; histochemical stain on frozen tissue block (List separately in addition to code for primary procedure)

(Use 88314 in conjunction with 17311-17315, 88302-88309, 88331-88332)

(Do not report 88314 in conjunction with 17311-17315 for routine frozen section stain [eg, hematoxylin and eosin, toluidine blue], performed during Mohs surgery. When a non-routine histochemical stain on frozen tissue during Mohs surgery is utilized, report 88314 with modifier 59)

(Report one unit of 88314 for each stain on each frozen surgical pathology block)

(For a special stain performed on frozen tissue section material to identify enzyme constituents, use 88319)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Microscopic examination of an Oil Red O stain performed on a frozen skeletal muscle biopsy in a 30-year-old male with muscular dystrophy

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

Is moderate sedation inherent to this procedure in the office setting? Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: N/A

Description of Intra-Service Work: An oil red O stain is performed on frozen tissue sections from the control and patient sample. The pathologist examines control tissue known to contain oil red O positive lipids to verify that the appropriate structures are stained. The pathologist then examines the patient's sample to determine the presence and pattern of Oil red O staining. The pathologist interprets the staining pattern and determines its significance in its histologic location. The findings are correlated with clinical history, previous tissue samples and laboratory tests. The pathologist composes and dictates the report. The report is edited and signed with the results communicated to appropriate caregivers.

SURVEY DAT	Ά						
RUC Meeting Da	ite (mm/yyyy)	10/2010					
Presenter(s):	Jonathan L. N	onathan L. Myles, MD, FCAP					
Specialty(s):	College of An	nerican Patholo	ogists				
CPT Code:	88314						
Sample Size:	2500 R	esp N:	37	Respo	onse: 1.4 %		
Sample Type:	Random Additional Sample Information:						
			Low	25 th pctl	Median*	75th pctl	<u>High</u>
Service Perform	ance Rate		5.00	15.00	20.00	50.00	162.00
Survey RVW:			0.20	0.45	0.71	0.75	1.00
Pre-Service Evalu	ation Time:				0.00		
Pre-Service Posit	ioning Time:				0.00		
Pre-Service Scrut	o, Dress, Wait Ti	me:			0.00		
Intra-Service Tir	ne:		5.00	12.00	13.00	15.00	25.00
Immediate Post	Service-Time:	<u>0.00</u>					
Post Operative	<u>Visits</u>	Total Min**	CPT Cod	e and Num	ber of Visit	<u>S</u>	
Critical Care time/visit(s): <u>0.00</u>			99291x 0	. 00 99292	2x 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 0.0	0 13x 0.00 1	4x 0.00 15x	0.00
Prolonged Serv	ices:	<u>0.00</u>	99354x 0	.00 55x 0.	00 56x 0.0	0 57x 0.00	

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	88314	Recommended Physician Work RVU: 0.45			
i			Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation T	ime:		0.00	0.00	0.00
Pre-Service Positioning	Fime:		0.00	0.00	0.00
Pre-Service Scrub, Dress	s, Wait Tim	e:	0.00	0.00	0.00
Intra-Service Time:			13.00		
Immediate Post Servic	e-Time:	<u>0.00</u>			
Post Operative Visits		<u>Total Min**</u>	CPT Code and Nu	<u>Imber of Visits</u>	
Critical Care time/visit	(s):	<u>0.00</u>	99291x 0.00 992	92x 0.00	
Other Hospital time/vis	sit(s):	<u>0.00</u>	99231x 0.00 992	32x 0.00 99233x	0.00
Discharge Day Mgmt:		<u>0.00</u>	99238x 0.0 99239	< 0.0	
Office time/visit(s):		<u>0.00</u>	99211x 0.00 12x 0	.00 13x 0.00 14x 0	.00 15x 0.00
Prolonged Services:		<u>0.00</u>	99354x 0.00 55x	0.00 56x 0.00 57x	0.00

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
88334	XXX	0.73	RUC Time

<u>CPT Descriptor</u> Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site

KEY MPC COMPARISON CODES:

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

				Most Recent
MPC CPT Code 1	<u>Global</u> W	ork RVU	Time Source	Medicare Utilization
94060	XXX	0.31	RUC Time	1,231,072
CPT Descriptor 1 Bronch	odilation responsiv	veness, spiromet	ry as in 94010, pre-	and post-bronchodilator administration
				Most Recent
MPC CPT Code 2	<u>Global</u>	Work RVU	Time Source	Medicare Utilization
95900	XXX	0.42	RUC Time	1,371,085

<u>CPT Descriptor 2</u> Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

Other Reference CPT Code

 $\frac{W \text{ ork}}{0.00}$

Global

<u>Work RVU</u> <u>Time Source</u>

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 17 % of respondents: 45.9 %

<u>TIME ESTIMATES (Median)</u>	CPT Code: 88314	Key Reference CPT Code: <u>88334</u>	Source of Time RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	13.00	20.00]
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	13.00	20.00	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

(of those that selected Key Reference code)

<u>Mental Effort and Judgment (Mean)</u>		
The number of possible diagnosis and/or the number of	3.41	3.53
management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests,	3.35	3.24
and/or other information that must be reviewed and analyzed		
TT 0 1' 1 1 '' 1'	0.47	0.70
Urgency of medical decision making	3.47	3.76
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.82	3.94
Physical effort required	3.12	3.06
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.24	3.35
Outcome depends on the skill and judgment of physician	3.94	3.88
Estimated rick of malaractice suit with poor outcome	3 18	3.65
Estimated fisk of mapfactice suit with pool outcome	5.10	5.05
INTENSITY/COMPLEXITY MEASURES	<u>CPT Code</u>	Reference
		<u>Service 1</u>
<u>Time Segments (Mean)</u>		
Pre-Service intensity/complexity	0.00	0.00
		·
Later Commission interview/commission	2.47	2.65
Intra-Service Intensity/complexity	3.47	3.03
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

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

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor and representatives from the general and academic pathology practice settings.

The expert panel recommends the current RVW value of 0.45

The panel took these steps in reaching their conclusion:

- 1) Reviewed the survey results
- 2) Compared the recommended RVW, time and intensity/complexity of 88314 to the reference service 88334 *Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site*
- 3) Compared other services/procedures on the MPC list to the recommended RVW and time of 88314

Review of Survey Results

The survey had a response rate of 37 and a survey median time of 13 minutes. The expert panel felt the survey respondents fairly estimated the physician work time. The 13 minutes compares favorably with the time data from the RUC database. The panel noted that the time in the RUC database is not surveyed-based but is the result of a crosswalk, while the current survey data and RVW are a more robust evaluation of the actual work for this service.

Panel members reviewed the recommended RVW from the survey data and indicated that the survey median of 0.71 is high for this service, whereas the 25% of the survey at 0.45RVW and current RVW of 88314, is appropriate. There is no compelling evidence to increase the current value of 88314. Therefore, no change in value is recommended.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: 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 are 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) 88314

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 Pathology	How often? Sometimes
Specialty	How often?
Specialty	How often?

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

CPT Code: 88314

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.

Specialty	Frequency 0	Percentage 0.00 %	
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? 22,138 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate. RUC Database 2009 Utilization

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

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

Professional Liability Insurance Information (PLI)

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

If no, please select another crosswalk and provide a brief rationale. 88314

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code:88319 Tracking Number

Specialty Society Recommended RVU: 0.53

Global Period: XXX

RUC Recommended RVU: 0.53

CPT Descriptor: Special stain including interpretation and report; Group III, for enzyme constituents

(For each stain on each surgical pathology block, cytologic specimen, or hematologic smear, use one unit of 88319)

(For detection of enzyme constituents by immunohistochemical or immunocytochemical technique, use 88342)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Microscopic examination of a Nicotinamide adenosine dinucleotide-tetrazolium reductase (NADH-TR) stained slide performed on a skeletal muscle biopsy in a 30-year old-male with muscular dystrophy.

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

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: N/A

Description of Intra-Service Work: The pathologist examines control tissue known to contain NADH-TR positive muscle fibers to verify that the appropriate structures are stained. The pathologist then examines the patient's sample to determine the presence and pattern of NADH-TR staining. The pathologist interprets the staining pattern and determines its significance in its histologic location. The findings are correlated with clinical history, previous tissue samples and laboratory tests. The pathologist composes and dictates the report. The report is edited and signed with the results communicated to appropriate caregivers.

Description of Post-Service Work: N/A

SURVEY DAT	ΓΑ						
RUC Meeting Da	ite (mm/yyyy)	10/2010					
Presenter(s):	Jonathan L. N	onathan L. Myles, MD, FCAP					
Specialty(s):	College of An	College of American Pathologists					
CPT Code:	88319	88319					
Sample Size:	2500 R	2500 Resp N: 31 Response: 1.2 %					
Sample Type:	Random Additional Sample Information:						
			Low	25 th pctl	Median*	75th pctl	<u>High</u>
Service Perform	ance Rate		10.00	38.00	75.00	150.00	300.00
Survey RVW:			0.30	0.73	0.75	1.00	1.20
Pre-Service Evalu	ation Time:				0.00		
Pre-Service Posit	ioning Time:				0.00		
Pre-Service Scrut	o, Dress, Wait Ti	me:			0.00		
Intra-Service Tir	ne:		5.00	15.00	18.00	20.00	30.00
Immediate Post	Service-Time:	<u>0.00</u>					
Post Operative	<u>Visits</u>	Total Min**	CPT Cod	e and Num	ber of Visit	<u>S</u>	
Critical Care time/visit(s): 0.00 99291x 0.00 99292x 0.00							
Other Hospital t	ime/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00				
Discharge Day I	Ngmt:	0.00	<u>0.00</u> 99238x 0.00 99239x 0.00				
Office time/visit	(s):	0.00	99211x 0	.00 12x 0.0	0 13x 0.00 1	4x 0.00 15x	0.00
Prolonged Servi	ices:	0.00	99354x 0	.00 55x 0.	00 56x 0.0	0 57x 0.00	

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	88319		Recommended Physician Work RVU: 0.53			
			Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time	
Pre-Service Evaluation T	ime:		0.00	0.00	0.00	
Pre-Service Positioning	Time:		0.00	0.00	0.00	
Pre-Service Scrub, Dress	s, Wait Tim	e:	0.00	0.00	0.00	
Intra-Service Time:			18.00			
Immediate Post Servic	e-Time:	<u>0.00</u>				
Post Operative Visits		<u>Total Min**</u>	CPT Code and Nu	umber of Visits		
Critical Care time/visit	(s):	<u>0.00</u>	99291x 0.00 992	92x 0.00		
Other Hospital time/vis	sit(s):	<u>0.00</u>	99231x 0.00 992	32x 0.00 99233x	0.00	
Discharge Day Mgmt:		0.00	99238x 0.0 99239	× 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	

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	<u>Global</u>	Work RVU	Time Source
88334	XXX	0.73	RUC Time

<u>CPT Descriptor</u> Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site

KEY MPC COMPARISON CODES:

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

	-		-	Most Recent						
MPC CPT Code 1	<u>Global</u> Worl	<u>k RVU</u>	Time Source	Medicare Utilization						
99212	XXX	0.48	RUC Time	19,660,131						
CPT Descriptor 1 Office or othe	er outpatient	visit for the eva	luation and man	nagement of an established patient, which						
requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward										
medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent										
with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited										
or minor. Physicians typically spen	or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.									

				Most Recent
MPC CPT Code 2	<u>Global</u>	Work RVU	Time Source	Medicare Utilization
11056	000	0.61	Other	1,687,654

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

Other Reference CPT Code	<u>Global</u>	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: 41.9 %

Median Pre-Service Time 0.00 0.00	
Median Intra-Service Time 18.00 20.00	
Median Immediate Post-service Time 0.00 0.00	
Median Critical Care Time 0.0 0.00	
Median Other Hospital Visit Time 0.0 0.00	
Median Discharge Day Management Time 0.0 0.00	
Median Office Visit Time 0.0 0.00	
Prolonged Services Time 0.0 0.00	
Median Total Time 18.00 20.00	

Other time if appropriate	

INTENSITY/COMPLEXITY MEASURES (Mean) (of those that selected Key **Reference code**) Mental Effort and Judgment (Mean) 3.77 The number of possible diagnosis and/or the number of 3.85 management options that must be considered The amount and/or complexity of medical records, diagnostic tests, 3.85 3.69 and/or other information that must be reviewed and analyzed Urgency of medical decision making 3.31 3.92 Technical Skill/Physical Effort (Mean) Technical skill required 4.00 3.77 Physical effort required 3.31 3.31 Psychological Stress (Mean) The risk of significant complications, morbidity and/or mortality 3.31 3.77 Outcome depends on the skill and judgment of physician 3.85 3.92 3.77 Estimated risk of malpractice suit with poor outcome 3.15 **INTENSITY/COMPLEXITY MEASURES** CPT Code Reference Service 1 Time Segments (Mean) Pre-Service intensity/complexity 0.00 0.00 Intra-Service intensity/complexity 3.77 3.77 Post-Service intensity/complexity 0.00 0.00

Additional Rationale and Comments

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

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor and representatives from the general and academic pathology practice settings.

The expert panel recommends the current RVW value of 0.53

The Panel took these steps in reaching their conclusion:

- 1) Reviewed the survey results
- 2) Compared the recommended RVW, time and intensity/complexity of 88319 to the reference service 88334 *Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site*
- 3) Compared other services/procedures on the MPC list to the recommended RVW and time of 88319

Review of Survey Results

The survey had a response rate of 31 and a survey median time of 18 minutes. The expert panel felt the survey respondents fairly estimated the physician work time. The 18 minutes compares favorably with the data from the Hsiao studies at 17 minutes.

Panel members reviewed the recommended RVW from the survey data and noted that while the data indicates an increase in RVW may be warranted, the panel was unable to identify compelling evidence to support it. The panel recommends the current value of 0.53.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

1	

The surveyed code is an add-on code or a base code expected to be reported with an add-on code. Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.

Multiple codes allow flexibility to describe exactly what components the procedure included.

Multiple codes are 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) 88319

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 Pathology	How often? Sometimes
Specialty	How often?
Specialty	How often?

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

CPT Code: 88319

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.

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? 17,584 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate. RUC Database 2009 Utilization

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

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

Professional Liability Insurance Information (PLI)

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

If no, please select another crosswalk and provide a brief rationale. 88319

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

<u>CPT Long Descriptor</u>: Special stain including interpretation and report; Group I for microorganisms (eg, acid fast, methenamine silver)

(Report one unit of 88312 for each special stain, on each surgical pathology block, cytologic specimen, or hematologic smear)

Global Period: XXX

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: The practice expense inputs were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor and representatives from the general and academic pathology practice settings.

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

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: Accession special stain order in laboratory information system Pull and verify tissue block and control block Cut block on microtome and place tissue on microscopic slide Cut control tissue on microtome and place tissue on microscopic slide De-paraffinize in xylene and rehydrate slides in progressive alcohols to water - place in distilled water Prepare uranyl nitrate and sensitize slides in uranyl nitrate solution. Microwave 1 min Rinse slides in distilled water Prepare 1% silver nitrate. Place slides in 1% silver nitrate and heat in microwave 1 min. Stand in hot sliver nitrate for 3 min Rinse in 3 changes distilled water Rinse in 2 changes 95% alcohol Rinse in 2 changes 100% alcohol Prepare gum mastic and hydroquinone and filter. Place slide in solution for 5 min Rinse in 3 changes distilled water Prepare reducing solution and place slides in solution in microwave 20 sec Place warm reducing solution in warm waterbath. Place slide in solution. Set timer for 4 min Rinse in distilled water. Check slides every min for correct staining. Return to solution if not correct Rinse in 100% alcohol Dehydrate to xylene through progressive alcohols Load slides on automatic coverslipper Review positive control slide Label slides, collate paperwork and deliver to physician

Intra-Service Clinical Labor Activities: None

<u>Post-Service</u> Clinical Labor Activities: Re-file block Clean equipment and workstation in accession area Clean equipment and workstation in histology lab Load solvent in recycle system File slides

<u>CPT Long Descriptor</u>: Special stain including interpretation and report; Group II, all other, (eg, iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry

(Report one unit of 88313 for each special stain, on each surgical pathology block, cytologic specimen, or hematologic smear)

(For immunocytochemistry and immunohistochemistry, use 88342)

Global Period: XXX

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: The practice expense inputs were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor and representatives from the general and academic pathology practice settings.

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

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: Accession special stain order in laboratory information system Pull and verify tissue block and control block Cut block on microtome and place tissue on microscopic slide Identify purchased positive control slide De-paraffinize in xylene and rehydrate slides in progressive alcohols to water - place in distilled water Stain in Congo Red 1 hour Rinse in 3 changes distilled water Prepare alkaline alcohol and differentiate 3 sec Wash in running water 5 min Counterstain 3 min Rinse in 3 changes distilled water Prepare acid alcohol and decolorize 15 sec Rinse in 3 changes distilled water Prepare ammonia water and blue for 15 sec Rinse in 2 changes distilled water Dehydrate to xylene through progressive alcohols Load slides on automatic coverslipper Review positive control slide Label slides, collate paperwork and deliver to physician

Intra-Service Clinical Labor Activities: None

<u>Post-Service</u> Clinical Labor Activities: Re-file block Clean equipment and workstation in accession area Clean equipment and workstation in histology lab Load solvent in recycle system File slides

<u>CPT Long Descriptor</u>: Special stain including interpretation and report; histochemical stain on frozen tissue block (List separately in addition to code for primary procedure)

(Use 88314 in conjunction with 17311-17315, 88302-88309, 88331-88332)

(Do not report 88314 in conjunction with 17311-17315 for routine frozen section stain [eg, hematoxylin and eosin, toluidine blue], performed during Mohs surgery. When a non-routine histochemical stain on frozen tissue during Mohs surgery is utilized, report 88314 with modifier 59)

(Report one unit of 88314 for each stain on each frozen surgical pathology block)

(For a special stain performed on frozen tissue section material to identify enzyme constituents, use 88319)

Global Period: XXX

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: The practice expense inputs were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor and representatives from the general and academic pathology practice settings.

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

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Accession special stain order in laboratory information system Mount fresh tissue on chuck and freeze in isopentane and liquid nitrogen Cut frozen block on cryostat and place tissue on microscopic slides for sectioning Prepare solutions: 60% isopropyl alcohol, 0.5% ORO solution (in isopropyl alcohol) Prepare working solution, let stand, and filter twice Incubate in working solution Counterstain in hematoxylin and "blue" in ammonia water Coverslip by hand Review positive control slide Label slides, collate paperwork and deliver to physician

Intra-Service Clinical Labor Activities: None

<u>Post-Service</u> Clinical Labor Activities: Prepare frozen block for storage in freezer Clean equipment and workstation in accession area Clean equipment and workstation in histology lab File slides

<u>CPT Long Descriptor</u>: Special stain including interpretation and report; Group III, for enzyme constituents

(For each stain on each surgical pathology block, cytologic specimen, or hematologic smear, use one unit of 88319)

(For detection of enzyme constituents by immunohistochemical or immunocytochemical technique, use 88342)

Global Period: XXX

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: The practice expense inputs were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor and representatives from the general and academic pathology practice settings.

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

Please describe in detail the clinical activities of your staff:

<u>Pre-Service</u> Clinical Labor Activities: Accession special stain order in laboratory information system Mount fresh tissue on chuck and freeze in isopentane and liquid nitrogen Cut frozen block on cryostat and place tissue on microscopic slides for sectioning Prepare and dispense monobasic and dibasic phosphate buffers Prepare and dispense 30%, 60%, 90% and 100% acetone solutions Preparation of incubation media Incubate slides with NADH solution, rinse with 30/60/90% Dehydrate to xylene through progressive alcohols Coverslip by hand Review positive control slide Label slides, collate paperwork and deliver to physician

Intra-Service Clinical Labor Activities: None None

<u>Post-Service</u> Clinical Labor Activities: Prepare frozen block for storage in freezer Clean equipment and workstation in accession area Clean equipment and workstation in histology lab Load solvent in recycle system File slides

	А	В	С	D	E	F	G	Н	I	J	K
1	AMA/Specialty Society RVS Update Committee Recommend	dation		88312	Manual	88313	Manual	88	314	88	319
	Meeting Date: February 2011			Special sta	in including	Special sta	ain including	Special sta	in including	Specia	al stain
				interpretation	n and report;	interpretation a	ind report; Group	interpret	ation and tochemical	inclu	iding ation and
				Grou	o I for sms (eq. acid	except stain for	microorganisms,	stain on fre	ozen tissue	report; Gr	oup III, for
				fast, methen	amine silver)	stains for enzy	me constituents,	blo	ock	enzyme co	onstituents
						or immunocyt	ochemistry and				
		CMS	Staff			Initiations	stochemistry				
2			Stan	Nam		Nen		Nan		Nan	
		Codo	Туро	NON Eacility	Facility	NON Eacility	Facility	NON Eacility	Facility	NON Eacility	Escility
3		Code	туре	гасти	гасшту	Гасти	Facility	Facility	гасти	гасти	гасшту
4											
5	TOTAL CLINICAL LABOR TIME			50.0		46.0		53.0		70.0	
6	TOTAL PRE-SERV CLINICAL LABOR TIME			43.0		39.0		42.0		58.0	
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0		0.0		0.0		0.0	
8	TOTAL POST-SERV CLINICAL LABOR TIME			7.0		7.0		11.0		12.0	
9	PRE-SERVICE			7.0		7.0		11.0		12.0	
10	Start: When preparing containers/requisitions for physicia	n begins	2								
11	Accession special stain order in laboratory information system	1.033A	l ah Tech	1		1		1		1	
12	Pull and verify tissue block and control block	L037B	Histotech	1		1		•		•	
12		2007.0	1 1101010011	•		•					
13	Cut block on microtome and place tissue on microscopic slide	L037B	Histotech	10		10					
	Cut control tissue on microtome and place tissue on										
14	microscopic slide	L037B	Histotech	2							
15	Identify purchased positive control slide	L037B	Histotech			1		1			
	De-paraffinize in xylene and rehydrate slides in progressive										
16	alcohols to water - place in distilled water	L037B	Histotech	2		2					
	Prepare uranyl nitrate and sensitize slides in uranyl nitrate										
17	solution. Microwave 1 min	L037B	Histotech	5							
18	Rinse slides in distilled water	L037B	Histotech	1							
10	Prepare 1% silver nitrate. Place slides in 1% silver nitrate and		Llistatash	•							
19	heat in microwave 1 min. Stand in not sliver nitrate for 3 min	L037B	Histotech	2							
20	Stain in Congo Red 1 nour	L037B	Histotech			1					
21	Rinse in 3 changes distilled water	L037B	Histotech	1		1					
22	Rinse in 2 changes 95% alcohol	L037B	Histotech	0							
23	Rinse in 2 changes 100% alcohol	L037B	Histotech	0							
	Prepare gum mastic and hydroquinone and filter. Place slide		Llistatash	_							
24	In solution for 5 min	L037B	Histotech	5		_					
25	Prepare alkaline alcohol and differentiate 3 sec	L037B	Histotech			5					
26	Wash in running water 5 min	L037B	Histotech			1					
27		L037B	Histotech			1					
28	Rinse in 3 changes distilled water	L037B	Histotech			1					
29	Prepare acid alcohol and decolorize 15 sec	L037B	Histotech			5					
30	Rinse in 3 changes distilled water	L037B	Histotech			1					
31	Prepare ammonia water and blue for 15 sec	L037B	Histotech			3					
32	Rinse in 2 changes distilled water	L037B	Histotech	1		1					
	Prepare reducing solution and place slides in solution in		L Batata ak								
33	microwave 20 sec	L037B	Histotech	2							
34	in solution. Set timer for 4 min	10370	Histotoch	•							
34	Piece in dictilled water. Check clides every min for correct	L037B	HISIOLECH	0							
35	staining Return to solution if not correct	1 037B	Histotech	6							
30	Rinse in 100% alcohol	1 037B	Histotech	0							
30	Mount fresh tissue on chuck and freeze in isopentane and	20070	1 IISTOLEUN	U							
37	liquid nitrogen	L037B	Histotech					3		3	
	Cut frozen block on cryostat and place tissue on microscopic							-		-	
38	slides for sectioning	L037B	Histotech					10		10	
	Prepare solutions: 60% isopropyl alcohol, 0.5% ORO solution							-			
39	(in isopropyl alcohol)	L037B	Histotech					10			
	Prepare and dispense monobasic and dibasic phosphate										
40	buffers	L037B	Histotech							6	
	Prepare and dispense 30%, 60%, 90% and 100% acetone	1.00	1.8-1.7								
41	solutions	L037B	Histotech							10	
42	Prepare working solution, let stand, and filter twice	L037B	Histotech					10			
43	Preparation of incubation media	L037B	Histotech							5	
44	Incubate in working solution	L037B	Histotech					1			
45	Incubate slides with NADH solution, rinse with 30/60/90%	L037B	Histotech							18	
46	Counterstain in hematoxylin and "blue" in ammonia water	L037B	Histotech					2			
47	Dehydrate to xylene through progressive alcohols	L037B	Histotech	1		1				1	
48	Coverslip by hand	L037B	Histotech					2		2	
49	Load slides on automatic coverslipper	L037B	Histotech	1		1					
50	Review positive control slide	L037B	Histotech	1		1		1		1	
51	Label slides, collate paperwork and deliver to physician	L037B	Histotech	1		1		1		1	
52	End: When specimen is ready for examination by physiciar										
53	Service Period										
54				None							
55	Post-Service Period										

AMA Specialty Society

Recommendation

	A	В	С	D	Е	F	G	Н	I	J	K
1	AMA/Specialty Society RVS Update Committee Recommend	dation		88312	Manual	8831	3 Manual	88	314	88	319
	Meeting Date: February 2011			Special stat	in including	g Special stain including		Special stain including		Special stain	
				interpretation Grou	n and report;	II, all other, (e	g, iron, trichrome),	report; his	tochemical	interpret	ation and
				microorganis	sms (eg, acid	except stain fo	or microorganisms,	stain on fro	ozen tissue	report; Gr	oup III, for
				fast, methen	amine silver)	stains for enz	yme constituents,	blo	ock	enzyme co	onstituents
						immunoc	istochemistry and				
2		смѕ	Staff				,				
~				Non		Non		Non		Non	
3	LOCATION	Code	Type	Facility	Facility	Facility	Facility	Facility	Facility	Facility	Facility
56	Start: When specimen examination by physician is comple	te	71							,	,
57	Refile block	L 033A	Lah Tech	1		1					
58	Prepare frozen block for storage in freezer	L033A	Lab Tech	•		•		1		1	
50	Clean equipment and workstation in accession area		Lab Tech	0		0		5		5	
60	Clean equipment and workstation in histology lab	L033A	Lab Tech	4		4		 Д		4	
61	Load solvent in recycle system	L033A	Lab Tech	- - 1		1		-		1	
62	File slides	L033A	Lab Tech	1		1		1		1	
63	End: When specimen, chemical waste and record handling	is com	plete	•		•		•		•	
64	SUPPLIES	,	Unit								
65	positive control block/slide	SL112	item	1		1		1			
66	slide, microscope	SL122	item	2		1					
67	label for slides	SL085	item	2		2		2		1	
68	eye shield,non-fog	SG049	item	1		1		1		1	
69	gloves,nonsterile,nitrile	SB023	pair	3		3		3		3	
70	gown, impervious, staff	SB027	item	1		1		1		1	
71	blade, microtome	SF004	item	1		1		1		1	
72	mask, surgical	SB033	item	1		1		1		1	
73	gauze, 4x4	SG051	item	5		4		2		1	
74	kimwipe	SM037	item	2		1					
75	disposable spatula	SL130	item	4		1					
76	coverslip, glass	SL030	item	2		2		2		1	
77	filter paper, qualitative, 18.5cm	SL065	item	1		1		1			
78	distilled water	SK087	oz	205ml		70ml					
79	uranyl nitrate		gm	0.5 gms							
80	hydroquinone		gm	0.5 gms							
81	gum mastic		gm	1.25 gms							
82	silver nitrate		gm	0.52 gms							
83	xylene solution	SL151	ml	50 ml		50 ml				30ml	
84	ethanol 100%	SL189	ml	255ml		235ml		125ml		160ml	
85	counterstain (neutral red soln)	SL029	ml			0					
86	Congo Red					25ml					
87	sodium hydroxide	SL128	gm			1 gm					
88	Harris hematoxilin reagent, filtered	SL077	ml			25 ml		25ml			
89	ammonium hydroxide					.5ml		.5ml			
90	HCl, 1% hydrochloric acid	SL229	ml			0.25 ml					
91	bleach	SL020	ml	30ml		30ml		30ml		30 ml	
92	Insulated gloves for handling liquid nitrogen		pair					0		0	
93	satety glasses for liquid nitrogen	SB038	item					0		0	
94		SI 004	mi							3mg	
95	acelone transfer pipettes 22 ml	SL001	:t a					4		112mi	
96	Nitro blue tetrazolium	SE109	m			1		1		3 2ml	
97	nhao bide tetrazolium phosphate huffer monohasio	SI 105	ml							.2101 15ml	
90	phosphate buffer, dibasic	SI 104	ml							85ml	
100	.9% sodium chloride	02104	ml							1.1ml	
101	liquid nitrogen.	SD082	ml					500ml		400ml	
102	10% Gum Tragacanth/OCT	22002	ml					2ml		2ml	
103	aqueous mounting media (Histomount)	SL095	ml					.5ml		.5ml	
104	isopentane	SL091	ml					5ml		5ml	
105	cork disc (5 mm thick 15 mm diameter)		item					1			
106	Oil Red O		mg					.25mg			
107	syringe filter		item					1			
108	weighing boat		item	1		1		1		1	
109	slide, microscope, coated	SL183	item					2		1	
110	Equipment										
111	waterbath	EP043		7		5					
112	microtome	ER041		12		10					
113	hood, fume	EP017		6		11		5		20	
114	solvent recycler system	EP038		12		12				7	
115	robotic coverslipper	EP033		2		2				0	
116	compound microscope	EP024		15		8		8		11	
117	slide etcher/labeler	EP025		1		1		1		1	
118	slide dryer	EP034		12		12		-		12	
119	palance, analytic			5				2		5	
120		EP030								2	

AMA Specialty Society

Recommendation

	A	В	С	D	E	F	G	Н		J	K
1	AMA/Specialty Society RVS Update Committee Recommen	dation		88312	Manual	88313 Manual		88314		88319	
	Meeting Date: February 2011			Special sta interpretatio Grou microorgani fast, mether	nin including n and report; p I for sms (eg, acid amine silver)	Special s interpretation II, all other, (e except stain fo stains for enz or immunoc immunoh	tain including and report; Group g, iron, trichrome), or microorganisms, syme constituents, ytochemistry and uistochemistry	Special sta interpret report; his stain on fr	in including ation and tochemical ozen tissue ock	Special stain including interpretation and report; Group III, for enzyme constituents	
2		CMS	Staff								
3		Code	Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
3		oouc	Type	raomy	raomty	raomey	raomy	Taomty	Taomty	raomity	raomty
121	1 cryostat	EQ092						15		15	
122	2 isotemp, oven	EP049						60			

AMA Specialty Society Recommendation

Fisher Scientific			Nelcome Punc Fisher PunchO	hout User ut Partner	- Place Rapid Orde - My Hotlists - My Templates	er - Vie - Vie - Re
Scientific Home Browse by: Produ	HCARE SCIENCE	EDUCATION Application	1	Help	8	MSDS
Search 🔞 🔹 🚽	Back to Searc	h Results				
uranyl nitrate Submit MSDS Search Substructure Search Certificate Of Analysis Shopping Cart View Cart	POLY SCIE 32OZ <i>Fisher Scientific</i> <i>may be one of a</i> <i>available. Howe</i> <i>cart.</i>	NTIFICURA c offers many pr those products, ever, you may b	NYL NIT oducts that o so pictures a e able to ord	RATE 19 do not app and detaile ler it by ad	% AQUEOUS ear in our catalogs. The d descriptions are not lding it to your shoppir	is ng
No items in cart	ltem		<u> </u>			
For security reasons you will be automatically logged out	Description	Catalog Numb	er Qı	antity	Price	
	URANYL NITRATE 1%	NC9040426 No.:S288B-32O	z		Each for \$265.88	
	AQUEOUS 32OZ	Ada	litio flotlis			

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Line 79

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DRICH 梁雪田M					S650G-250	G0878-100G	<u>.</u>	H3660-5G		MATERIAL NUMBER	NCT AVAILABLE	TI: LEE YORK	ETCHUM WOOD & BUR 899 EIDER COURT ALLAHASSEE FL 32308	ETCHUM WOOD & BUR ATHOLOGY ASSOCIATE ALLAHASSEE FL 32317	ORMA INVOID
A BHUMA GATOBRICH			- - - -	HAZ Line 82 UN	AN VED NITRATE READENTRINS THA 49 392	NON-HAZ	Line 80	Hydroquinone, meete USP testing specificatio		DESCRIPTION	Dr. Neal		ROERT R		SE/QUOTATION
rvygh Szience, Technolag				1493				55 56 		OUANT	Phone: 800-325 Fax: 800-325	SIGMA-ALDRICH 3050 SPRUCE S SAINT LOUIS MU	INQUIRIES TO:	NA-A	R
SSUPEL y and Servi			999-000-00-00-00-00-00-00-00-00-00-00-00		1.00 EA	1.90 EA		1.00 EA		אסע איח	-3010 5052	INC T 7 63103			Jo
÷ 6					72,00	102,50		36,40		A UNIT PRICE		SN			
					72.00	102.50	- - 	36.40		EXTENDED PRICE			×	i ozdani	
			items Total 210.90 Trans / Handling 24.39 Total Tax 15.82	Shipped From MILWAUKEE	FEDEX GROUND	Shipped From SAINT LOUIS	Shipped From SAINT LOUIS	FEDEX GROUND		PROPOSED ROUT	Page 1 of 2	FCA/SHIPPING PO	49493820 CUSTOMER REFERENCE N FORMAL	DATE 04/01/2011 VALID UNTIL 05/01/2011 SOLD TO CUSTOMER NU	PROFOSIMA INVIQUOTAT 21382837
;	0F 2	T	S S S		•				1			NA 7.	CWSER D: 87.: TO	TIOZ/TO/	TON #

Requisition: VENTANA

Business

Unit: 0100

Requester: BURTON,MARK

Requisition ID: 0001970315 Date: 11/30/2009

Comments:

	Line 1	Descripti LIQUID C TEMPER	on OVERSLIP LOW ATURE	Qt 1	y Price 46.340	Curr USD	UOM BO	Total 46.34	
		<u>Sched Line</u> 1	<u>Ship To</u> MGH - BLOSSOM STREET RECEIVING		Attention BURTON,MARK	Due 11/3	<u>Date</u> 0/2009	<u>Qty</u> 1	<u>Total</u> 46.34
	Line 10	Descripti REAGEN KT/75 TE	on T STAIN SPECIAL PAS STS	Qt 3	y Price 167.100	Curr USD	UOM KT	Total 501.3	0
The		<u>Sched Line</u> 1	Ship To MGH - BLOSSOM STREET RECEIVING		<u>Attention</u> BURTON,MARK	Due I 11/30	Date /2009	Qty 3	<u>Total</u> 501.30
86)	Line 11	Descripti REAGEN CONGO	ion IT STAIN SPECIAL RED KT/40 TESTS	Qt 3	y Price 167.100	Curr USD	UOM KT	Total 501.3	30
		<u>Sched Line</u> 1	<u>Ship To</u> MGH - BLOSSOM STREET RECEIVING		<u>Attention</u> BURTON,MARK	<u>Due I</u> 11/30	<u>Date</u> /2009	<u>Qty</u> 3	<u>Total</u> 501.30
	1 ine 12	Descript REAGEN IRON KT	ion IT STAIN SPECIAL 775 TESTS	Q1 1	ty Price 167.100	Curr USD	UOM KT	Tota 167.1	10
		<u>Sched Line</u> 1	Ship To MGH - BLOSSOM STREET RECEIVING		<u>Attention</u> BURTON,MARK	Due 11/30	<u>Date</u>)/2009	<u>Qty</u> 1	<u>Tota</u> l 167.10
	Line 13	Descript REAGEN CLEANIN	ion IT STAIN SPECIAL NG KT/50B TESTS	Q 3	ty Price 83.540	Curr USD	UOM KT	Tota 250.6	1 52
		<u>Sched Line</u> 1	<u>Ship To</u> MGH - BLOSSOM STREET RECEIVING	1	<u>Attention</u> BURTON,MARK	<u>Due</u> 11/30	Date)/2009	<u>Qty</u> 3	<u>Total</u> 250.62
	Line 14	Descript REAGEN WASH 1	tion NT STAIN SPECIAL 0X BO/2 LT	Q 6	ty Price 100.260	Curr USD	UOM BO	Tota 601.:	56
		<u>Sched Line</u> 1	<u>Ship To</u> MGH - BLOSSOM STREET RECEIVING		Attention BURTON,MARK	<u>Due</u> 11/30	<u>Date</u>)/2009	<u>Qty</u> 6	<u>Total</u> 601.56
	Line 15	Descript LABEL E	tion BLANK FLAP 540 ROLL	Q 4	ty Price 207.640	Curr USD	UOM RL	Tota 830.	il 56
		<u>Sched Line</u> 1	Ship To MGH - BLOSSOM STREET RECEIVING		Attention BURTON,MARK	Due 11/3	Date 0/2009	Qty 4	<u>Total</u> 830.56
	Line 16	Descrip REAGEI MUCICA	tion NT STAIN SPECIAL ARMINE KT/75 TESTS	G 2	ty Price 167.100	Curr USD	UOM KT	Tota 334.	ni 20
		Sched Line	<u>Ship To</u>		<u>Attention</u>	Due	Date	<u>Qty</u>	<u>Total</u>

Requisition: AMMONIUM HYDROXIDE

Requester: BURTON,MARK Business Unit: 0100 Requisition ID: 0001972179 Date: 12/1/2009

Comments:

Lice 1	Descrip Fisher S HYDRO	tion científic: AMMON X ACS SAFCOT 500ML	Qty 4	y Price 40.980	Curr USD	UOM EA	Tot 163	ai .02
	<u>Sched Line</u> 1	<u>Ship To</u> MGH - BLOSSOM STREET RECEIVING		<u>Attention</u> BURTON,MARK	Due 12/1/2	Date 2009	<u>Qty</u> 4	Total 163.92



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GLOVES HVY WEIGHT XL PK12				

Supp

Thermal Gloves^ Dura-Therm* 10-gauge cotton/poly gloves for extra thermal protection. Latex dipped palm/fingers. Size: X-Large.

ORDER	ADD TO BASKE	VIEW SHOPPING BASKET			
Description GLOVES HVY WEIGHT XL PK12	Supplier No. 9690XL	Cat. No. 80081-718	Unit Pack of 12	Price \$87.79	Quantity
				ADD TO SASK	T

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line 92



NADH Line 94

Purchase Order Inquiry

Business Unit: 0100

Requisition i	nforma	ation						Find View	All	First 🧃 1 of 1 🕑 Last
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Return to Requisition Cycle

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Line 97

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Line 100

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Requisition: OCT

Requester: BURTON, MARK Business Unit: 0100 Requisition ID: 0002015428 Date: 1/8/2010

Comments:

Line 1	Descript MEDIUM C T COM	tion 1 FROZEN SECTION O APOUND 40Z CS/12EA	Qty 3	Price 95.753	Curr USD	UOM CS	Tot 287	al .26
	<u>Sched Line</u> 1	<u>Ship To</u> MGH - BLOSSOM STREET RECEIVING	<u>At</u> BL	<u>tention</u> JRTON,MARK	Due I 1/8/20	<u>Date</u> 010	<u>Qty</u> 3	<u>Total</u> 287.26

Line 102

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Line 105

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Line 106

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Line 107

Purchase Order Inquiry

Business Unit: 0100

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1		Fisher Scientific: WEIGHINU ALUMINU 144/PK	DISH G M	2	28.57 USD	РК	1.0000	D Active 📑

Return to Requisition Cycle

Line 108

	Α	В	С	D	E	F	G	Н	I	J	К
1	Tab 33 Revised 2-4-2011			88312	Manual	8831	3 Manual	88	314	883	319
	Meeting Date: February 2011			Special stain	including	Special stain in	ncluding	Special stain	n including	Special stai	in
	College of American Pathologists			interpretation	n and report;	interpretation a	and report; Group	interpretatio	n and	including	on and
				Group I for	me (eg. acid	except stain fo	r microorganisms,	stain on froz	en tissue	report; Gro	up III, for
				fast, methena	amine silver)	stains for enzy	me constituents,	block		enzyme cor	nstituents
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		0.40	01-11			immunonistoc	nemistry				
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3		Code	гуре	Facility	Facility	Facility	Facility	Facility	Facility	Facility	Facility
4	GLOBAL PERIOD XXX										
5	TOTAL CLINICAL LABOR TIME			50.0		46.0		53.0		70.0	
6	TOTAL PRE-SERV CLINICAL LABOR TIME			43.0		39.0		42.0		58.0	
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0		0.0		0.0		0.0	
Q	TOTAL POST-SERV CLINICAL LABOR TIME			7.0		7.0		11.0		12.0	
0	PRE-SERVICE			7.0		7.0		11.0		12.0	
10	Start: When preparing containers/requisitions for physicia	n begins									
11	Accession special stain order in laboratory information system		Lah Tech	1		1		1		1	
12	Pull and verify tissue block and control block	L037B	Histotech	1		1		•		•	
12		2007.0	110000011	•		•					
13	Cut block on microtome and place tissue on microscopic slide	L037B	Histotech	10		10					
	Cut control tissue on microtome and place tissue on										
14	microscopic slide	L037B	Histotech	2							
15	Identify purchased positive control slide	L037B	Histotech			1		1			
	De-paraffinize in xylene and rehydrate slides in progressive										
16	alcohols to water - place in distilled water	L037B	Histotech	2		2					
	Prepare uranyl nitrate and sensitize slides in uranyl nitrate	1.00-5		_							
17	solution. Microwave 1 min	L037B	Histotech	5							
18	Rinse slides in distilled water	L037B	Histotech	1							
	Drepare 1% eiker nitrate . Diago clides in 1% eiker nitrate and										
10	Prepare 1% sliver nitrate. Place slides in 1% sliver nitrate and	1.027B	Histotoch	2							
19	Stoin in Congo Red 1 hour	L037B	Histotech	2		4					
20	Stain in Congo Reu Thour	L037B	Histotech	4		1					
21	Rinse in 3 changes distilled water	L037B	Histotech	1		1					
22	Rinse in 2 changes 95% alcohol		Histotech	0							
23	Rinse in 2 changes 100% alcohol	L037B	HIStotech	0							
24	in solution for 5 min	1.037B	Histotech	5							
25	Prepare alkaline alcohol and differentiate 3 sec	L037B	Histotech	5		5					
20	Wash in running water 5 min	L037B	Histotech			1					
20	Counterstain 3 min	L037B	Histotech			1					
28	Rinse in 3, changes distilled water	L037B	Histotech			1					
20	Prepare acid alcohol and decolorize 15 sec	L037B	Histotech			5					
30	Rinse in 3 changes distilled water	L037B	Histotech			1					
21	Prepare ammonia water and blue for 15 sec	L037B	Histotech			3					
32	Rinse in 2 changes distilled water	L037B	Histotech	1		1					
52	Prepare reducing solution and place slides in solution in	LUUID	11101010011			•					
33	microwave 20 sec	L037B	Histotech	2							
	Place warm reducing solution in warm waterbath. Place slide										
34	in solution. Set timer for 4 min	L037B	Histotech	0							
	Rinse in distilled water. Check slides every min for correct										
35	staining. Return to solution if not correct	L037B	Histotech	6							
36	Rinse in 100% alcohol	L037B	Histotech	0							
	Mount fresh tissue on chuck and freeze in isopentane and										
37	liquid nitrogen	L037B	Histotech					3		3	
_	Cut frozen block on cryostat and place tissue on microscopic	1.00									
38	Slides for sectioning	L037B	Histotech					10		10	
20	repare solutions: 00% isopropyl alconol, 0.5% ORO solution	1 037P	Histotech					10			
39	Prepare and dispense monobasic and dibasic phosphate	20070	THEOLECH					10			
40	buffers	L037B	Histotech							6	
	Prepare and dispense 30%, 60%, 90% and 100% acetone									~	
41	solutions	L037B	Histotech							10	
42	Prepare working solution, let stand, and filter twice	L037B	Histotech					10			
43	Preparation of incubation media	L037B	Histotech							5	
44	Incubate in working solution	L037B	Histotech					1			
45	Incubate slides with NADH solution, rinse with 30/60/90%	L037B	Histotech							18	
46	Counterstain in hematoxylin and "blue" in ammonia water	L037B	Histotech					2		-	
47	Dehydrate to xylene through progressive alcohols	L037B	Histotech	1		1		_		1	
48	Coverslip by hand	L037B	Histotech					2		2	
49	Load slides on automatic coverslipper	L037B	Histotech	1		1		_			
50	Review positive control slide	L037B	Histotech	1		1		1		1	
51	Label slides, collate paperwork and deliver to physician	L037B	Histotech	1		1		1		1	
52	End: When specimen is ready for examination by physiciar	 1						n			
53	Service Period					· 					
54				None							
55	Post-Service Period										

AMA Specialty Society

Recommendation

	Α	В	С	D	E	F	G	Н	I	J	K
1	Tab 33 Revised 2-4-2011			88312	Manual	88313	3 Manual	883	314	883	319
	Meeting Date: February 2011			Special stain	including	Special stain in	cluding	Special stair	n including	Special sta	in
	College of American Pathologists			interpretation	and report;	interpretation a	and report; Group	interpretatio	on and	including	on and
				Group I for	ms (eg. acid	except stain fo	r microorganisms,	stain on froz	zen tissue	report; Gro	up III, for
				fast, methena	amine silver)	stains for enzy	me constituents,	block		enzyme co	nstituents
						or immunocyto	ochemistry and				
		CMS	Staff			mmunonistoci	lemistry				
2			Stan	Nen				Nam		Ner	
_		Code	Type	NON Eacility	Facility	NON Eacility	Facility	NON Eacility	Facility	NON Eacility	Eacility
3		Coue	туре	Tacinty	Tacinty	гастиу	raciiity	Гастиу	гастту	raciiity	raciiity
56	Start: When specimen examination by physician is comple	ete	1 - L T L								
57		L033A		1		1					
58	Prepare frozen block for storage in freezer	L033A	Lab Tech					1		1	
59	Clean equipment and workstation in accession area	L033A		0		0		5		5	
60	Clean equipment and workstation in histology lab	L033A	Lab Tech	4		4		4		4	
61	Load solvent in recycle system	L033A		1		1				1	
62		L033A	Lab Tech	1		1		1		1	
63	End: When specimen, chemical waste and record handling	j is comp	ete								
64	SUPPLIES		Unit								
65	positive control block/slide	SL112	item	1		1		1			
66	slide, microscope	SL122	item	2		1				-	
67	nabel for sindes	SLU85	item	2		2		2		1	
68		36049	item	1				1		1	
69	gioves,nonsterile,nitrile	SB023	pair	3		3		3		3	
70	gown, impervious, statt	SB027	item	1		1		1		1	
71	blade, microtome	SF004	item	1		1				1	
72	mask, surgical	SB033	Item	1		1				1	
73	gauze, 4x4	SG051	item	5		4		2		1	
74	kimwipe	SM037	item	2		1					
75	disposable spatula	SL130	item	4		1					
76	coverslip, glass	SL030	item	2		2		2		1	
77	filter paper, qualitative, 18.5cm	SL065	item	1		1		1			
78	distilled water	SK087	OZ	205ml		70ml					
79	uranyi nitrate		gm	0.5 gms							
80	nyaroquinone		gm	0.5 gms							
81	gum mastic		gm	1.25 gms							
82	silver hitrate	01454	gm	0.52 gms		50 1					
83	xyiene solution	SL151	ml	50 ml		50 ml		405		30ml	
84	ethanol 100%	SL189	mi	255mi		235mi		125mi		160mi	
85	Counterstain (neutral red soln)	SL029	mi			0					
86	colligo Red	CI 120				25mi					
87	Harria hamatavilin raagant filtarad	SL120	gm			1 gm		0Emal			
00	ammonium hydroxide	SLUTT	mi			25 mi		Zomi			
09	HCL 1% bydrochloric acid	SI 220	ml			.5mi		.əm			
90	hleach	SL229	m	20ml		0.25 ml		20ml		20 ml	
91	insulated gloves for handling liquid hitrogen	SL020	noir	30111		30111		30111		30 mi	
92	safety glasses for liquid nitrogen	SB038	itom					0		0	
93 Q/	NADH	0000	ml					J		3mg	
04 05	acetone	SL001								112ml	
90	transfer pipettes 23 ml	SL109	item			1		1		3	
97	Nitro blue tetrazolium		ml			•				.2ml	
98	phosphate buffer, monobasic	SL105	ml							15ml	
99	phosphate buffer, dibasic	SL104	ml							85ml	
100	.9% sodium chloride		ml							1.1ml	
101	liquid nitrogen,	SD082	ml					500ml		400ml	
102	10% Gum Tragacanth/OCT		ml					2ml		2ml	
103	aqueous mounting media (Histomount)	SL095	ml					.5ml		.5ml	
104	isopentane	SL091	ml					5ml		5ml	
105	cork disc (5 mm thick 15 mm diameter)		item					1			
106	Oil Red O		mg					.25mg			
107	syringe filter		item					1			
108	weighing boat		item	1		1		1		1	
109	slide, microscope, coated	SL183	item					2		1	
110	Equipment										
111	waterbath	EP043		7		5					
112	microtome	ER041		12		10					
113	hood, fume	EP017		6		11		5		20	
114	solvent recycler system	EP038		12		12				7	
115	robotic coverslipper	EP033		2		2				0	
116	compound microscope	PE024		15		15		15		18	
117	slide etcher/labeler	EP025		1		1		1		1	
118	slide dryer	EP034		12		12				12	
119	balance, analytic	EP004		5				2		5	
120	pH conductivity meter	EP030		0		0				2	

AMA Specialty Society

Recommendation

	А	В	С	D	E	F	G	Н		J	K
1	Tab 33 Revised 2-4-2011			88312	Manual	nual 88313 Manual		88314		88319	
2	Meeting Date: February 2011 College of American Pathologists	CMS	Staff	Special stain including interpretation and report; Group I for microorganisms (eg, acid fast, methenamine silver)		Special stain including interpretation and report; Group II, all other, (eg, iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry		Special stain including interpretation and report; histochemical , stain on frozen tissue block		ncluding Special sta and including hemical interpretati n tissue enzyme co	
				Non		Non		Non		Non	
3	LOCATION	Code	Туре	Facility	Facility	Facility	Facility	Facility	Facility	Facility	Facility
121	cryostat	EQ092						15		15	
122	isotemp, oven	EP049						60			

AMA Specialty Society Recommendation

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

February 2011 Osteopathic Manipulative Treatment

In the 4th Five-Year Review of the RBRVS, CMS identified codes 98925, 98928 and 98929 through the Harvard-Valued – Utilization over 30,000 screen. Additionally, the American Osteopathic Association (AOA) identified codes 98926 and 98927 to be reviewed as part of this family since these were also identified to be reviewed by the Relativity Assessment Workgroup through the Harvard-Valued – Utilization over 100,000. The AOA originally planned on requesting as global period change for these codes, however determined that it was unnecessary.

The RUC accepted the compelling evidence that these services were based on flawed methodology when established by Harvard. The original Hsiao study only provided one reference service, the original code values were derived form a combination of Harvard surveyed codes with crosswalks performed by Contractor Medical Directors (CMDs) and errors were made when the work values were crosswalked from the Harvard surveyed codes to the CMD valued codes.

The RUC had a robust discussion regarding Evaluation and Management codes being reported separately on the same day. The specialty society clearly indicated that the Evaluation and Management and the OMT procedure performed are separately identifiable procedures. The separate pre-service time for the OMT procedures include the physician explaining the regions to address and positioning. The separate post-service time for these procedures includes discussion of potential adverse effects, post procedure instructions and separate documentation. The specialty society reiterated that the descriptions of service for the OMT services do not describe work associated with an Evaluation and Management service.

98925 Osteopathic manipulative treatment (OMT); 1-2 body regions involved

The RUC reviewed the survey results of 295 osteopathic physicians and compared the survey 25^{th} percentile, 0.50 work RVU, to key reference service 99212 *Office visit, established patient* (work RVU = 0.48, 2 minutes pre, 10 minutes intra, and 4 minutes post-service time). The RUC agreed with the survey respondents that this service requires greater intensity and complexity for all the surveyed measures: mental effort and judgment, technical and physical effort, and psychological stress than 99212. The RUC noted that the intra-service time of 10 minutes and the total physician time of 16 minutes is identical to key reference service 99212. Therefore based on these comparisons, the survey 25^{th} percentile work RVU of 0.50 reflects the accurate amount of physician work required to perform this service based on magnitude estimation.

The RUC specifically discussed the pre and post physician work associated with 98925 and determined that 3 minutes pre- and 3 minutes posttime were separate from the separately reportable Evaluation and Management service reported on the same day as the surveyed code. The pre-service and post-service time for the surveyed service requires explaining the regions to address, positioning, discussion of potential adverse effects, post procedure instructions and separate documentation. To further support 3 minutes of immediate post-service time, the RUC referenced code 20552 *Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)* (work RVU = 0.66 and 3.5 minutes of post-CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

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service time) which is also typically performed with an Evaluation and Management visit on the same date of service. The RUC recommends the survey 25th percentile work RVU of 0.50 for code 98925.

98926 Osteopathic manipulative treatment (OMT); 3-4 body regions involved

The RUC reviewed the survey results of 253 osteopathic physicians and determined that the survey 25th percentile work RVU of 0.75 provides the appropriate increment (0.25 work RVUs) and magnitude estimation between this family of services to account for the 5 additional minutes of intra-service time required for the additional body regions involved.

To further support the survey 25^{th} percentile work RVU of 0.75 the RUC compared 98926 to similar services 43756 *Injection(s); single tendon origin/insertion* (work RVU = 0.77 and 15 minutes intra-service time) and 49424 *Contrast injection for assessment of abscess or cyst via previously placed drainage catheter or tube* (work RVU = 0.76 and 15 minutes intra-service time) and determined that these service require similar physician work and time.

The RUC agreed that the intra-service time of 15 minutes appropriately accounts for the time required to perform this service and places this service in the proper rank order among this family and similar services. The RUC specifically discussed the pre and post physician work and determined that 3 minutes pre-service and 3 minutes post-service time were separate from the Evaluation and Management service reported on the same day as the surveyed code. The pre-service and post-service time for the surveyed code requires explaining the regions to address, positioning, discussion of potential adverse effects, post procedure instructions and separate documentation. To further support 3 minutes of immediate post-service time, the RUC referenced code 20552 *Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)* (work RVU = 0.66 and 3.5 minutes of post-service time) which is also typically performed with an Evaluation and Management visit on the same date of service. **The RUC recommends the survey 25th percentile work RVU of 0.75 for code 98926.**

98927 Osteopathic manipulative treatment (OMT); 5-6 body regions involved

The RUC reviewed the survey results of 233 osteopathic physicians and determined that a work RVU of 1.00 provides the appropriate increment (0.25 work RVUs) and magnitude estimation between this family of services to account for the 5 additional minutes of intra-service time required for the additional body regions involved. Additionally, the recommended work RVU of 1.00 is supported by the survey 25th percentile work RVU of 0.97.

To further support a work RVU of 1.00 the RUC compared 98927 to key reference service 99213 *Office visit, established patient* (work RVU = 0.97 and 15 minutes intra-service time) and MPC code 45330 *Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (work RVU = 0.96 and 17 minutes intra-service time). The RUC agreed with the survey respondents that 98927 requires greater intensity and complexity for all the surveyed measures: mental effort and judgment, technical and physical effort, and psychological stress than 99213. Therefore, the slightly higher 25^{th} percentile work RVU of 1.00 provides the appropriate magnitude estimation.

The RUC agreed that the intra-service time of 20 minutes appropriately accounts for the time required to perform this service and places this service in the proper rank order among this family and similar services. The RUC specifically discussed the pre-service and post-service physician work and determined that 3 minutes pre-service time and 3 minutes post-service time were separate from the Evaluation and

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Management service reported on the same day as the surveyed code and requires explaining the regions to address and positioning, discussion of potential adverse effects, post procedure instructions and separate documentation. To further support 3 minutes of immediate post-service time, the RUC referenced code 20552 *Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)* (work RVU = 0.66 and 3.5 minutes of post-service time) which is also typically performed with an Evaluation and Management service. **The RUC recommends a work RVU of 1.00 for code 98927.**

98928 Osteopathic manipulative treatment (OMT); 7-8 body regions involved

The RUC reviewed the survey results of 222 osteopathic physicians and determined that a work RVU of 1.25 provides the appropriate increment (0.25 work RVUs) and magnitude estimation between this family of services to account for the 5 additional minutes of intra-service time required for the additional body regions involved. Additionally, the recommended work RVU of 1.25 is supported by the survey 25th percentile work RVU of 1.29.

To further support a work RVU of 1.25 the RUC compared 98928 to key reference service 99214 *Office visit, established patient* (work RVU = 1.50 and 25 minutes intra-service time), MPC code 99238 *Hospital discharge day management; 30 minutes or less* (work RVU = 1.28) and similar service 45330 Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) (work RVU = 0.96 and 17 minutes intra-service time) and determined that these services require similar physician work and time.

The RUC agreed that the intra-service time of 25 minutes appropriately accounts for the time required to perform this service and places this service in the proper rank order among this family and similar services. The RUC specifically discussed the pre-service and post-service physician work and determined that 3 minutes pre and 3 minutes post-time were separate from the Evaluation and Management service reported on the same day as the surveyed code and requires explaining the regions to address and positioning, discussion of potential adverse effects, post procedure instructions and separate documentation. To further support 3 minutes of immediate post-service time, the RUC referenced code 20552 *Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)* (work RVU = 0.66 and 3.5 minutes of post-service time) which is also typically performed with an Evaluation and Management service. **The RUC recommends a work RVU of 1.25 for code 98928.**

98929 Osteopathic manipulative treatment (OMT); 9-10 body regions involved

The RUC reviewed the survey results of 222 osteopathic physicians and determined that the survey 25th percentile work RVU of 1.50 provides the appropriate increment (0.25 work RVUs) and magnitude estimation between this family of services to account for the 5 additional minutes of intra-service time required for the additional body regions involved.

To further support the survey 25^{th} percentile work RVU of 1.50 the RUC compared 98929 to key reference service 99214 *Office visit, established patient* (work RVU = 1.50 and 25 minutes intra-service time) and MPC codes 99238 *Hospital discharge day management; 30 minutes or less* (work RVU = 1.28) and 99232 *Subsequent hospital care, per day, for the evaluation and management the a patient* (work RVU = 1.39) and determined that these service all require similar physician work and time.

The RUC agreed that the intra-service time of 30 minutes appropriately accounts for the time required to perform this service and places this service in the proper rank order among this family and similar services. The RUC specifically discussed the pre-service and post-service

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physician work and determined that 3 minutes pre and 3 minutes post-time were separate from the Evaluation and Management service reported on the same day as the surveyed code and requires explaining the regions to address and positioning, discussion of potential adverse effects, post procedure instructions and separate documentation. To further support 3 minutes of immediate post-service time, the RUC referenced code 20552 *Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)* (work RVU = 0.66 and 3.5 minutes of post-service time) which is also typically performed with an Evaluation and Management service. **The RUC recommends the survey 25th percentile work RVU of 1.50 for code 98929.**

RUC Recommendation Summary

СРТ	Rec wRVU	Eval	Posit	SDW	Intra	Immed
Code						Post
98925	0.50	2	1	0	10	3
98926	0.75	2	1	0	15	3
98927	1.00	2	1	0	20	3
98928	1.25	2	1	0	25	3
98929	1.50	2	1	0	30	3

Practice Expense:

The RUC recommends to remove the duplicate direct practice expense inputs for CPT codes 98925-98929: medical supplies SB022 gloves nonsterile, SB026 gown patient and SB037 pillow case, as these supplies are included in the Evaluation and Management service.

CPT Code (•New)	CPT Descriptor	Global Work RVU Period Recommendation									
Osteopathic manipulative treatment (OMT) is a form of manual treatment applied by a physician to eliminate or alleviate somatic dysfunction and related disorders. This treatment may be accomplished by a variety of techniques.											
Evaluation and Management services may be reported separately if, using modifier 25, the patient's condition requires a significant separately identifiable E/M service, above and beyond the usual preservice and postservice work associated with the procedure. The E/M service may be caused or prompted by the same symptoms or condition for which the OMT service was provided. As such, different diagnoses are not required for the reporting of the OMT and E/M service on the same date.											
Body regions r upper extremit	Body regions referred to are: head region; cervical region; thoracic region; lumbar region; sacral region; pelvic region; lower extremities; upper extremities; rib cage region; abdomen and viscera region.										
98925	Osteopathic manipulative treatment (OMT); 1 to 2 body regions involved	000	0.50								

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
98926	3 to 4 body regions involved	000	0.75
98927	5 to 6 body regions involved	000	1.00
98928	7 to 8 body regions involved	000	1.25
98929	9 to 10 body regions involved	000	1.50

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS 2010 FIVE YEAR REVIEW SUMMARY OF RECOMMENDATION

CPT Code:98925 Tracking Number Global Period: 000 Specialty Society Recommended RVU: 0.61 RUC Recommended RVU: 0.50

CPT Descriptor: Osteopathic Manipulative Treatment (OMT); One to Two Body Regions Involved

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25 yr old female presents with right lower neck pain of two weeks duration. Somatic dysfunction of cervical and thoracic regions are identified on exam.

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 1%, In the ASC 0%, In the office 99%

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? 1%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated moderate sedation is typical in the office setting? 4%

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

Description of Pre-Service Work: The physician determines which osteopathic techniques (eg, HVLA, Muscle energy, Counterstrain, articulatory, etc) would be most appropriate for this patient, in what order the affected body regions need to be treated and whether those body regions should be treated with specific segmental or general technique approaches. The physicain explains the intended procedure to the patient, answers any preliminary questions, and obtains verbal consent for the OMT. The patient is placed in the appropriate postion on the treatment table for the initial technique and region(s) to be treated.

Description of Intra-Service Work: Patient is initially in the supine position on the treatment table. Motion restrictions of C6 and C7 are isolated through palpation and treated using muscle energy technique. Dysfunctions of T1 and T2 are treated using passive thrust (HVLA) technique. Patient position is changed as necessary for treatment of the individual somatic dysfunctions. Patient feedback and palpatory changes guide further technique application as appropriate.

Description of Post-Service Work: Post-care instructions related to the procedure are given, including side effects, treatment reactions, self-care, and follow-up. The procedure is documented in the medical record

SURVEY DAT	SURVEY DATA											
RUC Meeting Da	ate (mm/yyyy) 02/2011										
Presenter(s):	Drs. Josepł	n R. Schlecht, Ju	udith A. O'Co	onnell								
Specialty(s):	American C	steopathic Asso	ociation									
CPT Code:	98925											
Sample Size:	4880	Resp N:	295	Response	Response: 6.0 %							
Sample Type:	Random	Additional Sa	ample Infor	mation: N/A								
			Low	25 th %	Median*	<u>75th %</u>	High					
Service Perform	nance Rate		3.00	10.00	77.50	240.00	3000.00					
Survey RVW:			0.45	0.50	0.61	0.71	3.70					
Pre-Service Evalu	ation Time:				5.00							
Pre-Service Posit	ioning Time:				1.50							
Pre-Service Scrul	o, Dress, Wait	Time:			0.00							
Intra-Service Ti	me:		4.00	8.00	10.00	15.00	40.00					
Immediate Post	Service-Tim	e: <u>5.00</u>			·							
Post Operative	<u>Visits</u>	Total Min**	CPT Code	and Numbe	er of Visits							
Critical Care tim	ne/visit(s):	<u>0.00</u>	99291x 0.0	0 99292x	0.00							
Other Hospital t	ime/visit(s):	0.00	99231x 0.0	0 99232x	0.00 99233x	0.00						
Discharge Day	Mgmt:	0.00	99238x 0.0	0 99239x 0 .	00							
Office time/visit	(s):	0.00	99211x 0.0	0 12x 0.00 1	3x 0.00 14x 0.0	0 15x 0.00						
Prolonged Serv	ices:	<u>0.00</u>	99354x 0.0	0 55x 0.00	56x 0.00 57x	0.00						
Sub Obs Care:		0.00	99224x 0.0	0 99225x	0.00 99226x	0.00						

**Physician standard total <u>minutes per E/M visit</u>: 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: 5 - NF Procedure without sedation/anesthesia care

CPT	08025		Recommended Physician Work RVU: 0.61				
Code:	30320						
			Spe Recon	ecialty nmended	Specia Recomme	alty ended	Adjustments to Pre-Service Time
			Pre-Sei		Pre Time P	аскаде	
Pre-Service Evaluation T	ime:		2	2.00	7.00		-5.00
Pre-Service Positioning	Time:		1	.00	0.00		1.00
Pre-Service Scrub, Dress	s, Wait Tim	e:	0	0.00	0.00		0.00
Intra-Service Time:			1	0.00			
Immediate Post Servio	ce-Time:	<u>3.00</u>					
Post Operative Visits		<u>Total Min**</u>	CPT Co	de and Nu	umber of Vis	sits_	
Critical Care time/visit	:(s):	<u>0.00</u>	99291x	0.00 992	92x 0.00		
Other Hospital time/vi	sit(s):	0.00	99231x	0.00 992	32x 0.00	99233x	0.00
Discharge Day Mgmt:		<u>0.00</u>	99238x	0.0 99239	< 0.0		
Office time/visit(s):		0.00	99211x	0.00 12x 0	.00 13x 0.00	0 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	0.00 992	25x 0.00	99226x	0.00

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99212	XXX	0.48	RUC Time

<u>CPT Descriptor</u> Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of the 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making.

KEY MPC COMPARISON CODES:

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

				Most Recent	
MPC CPT Code 1	<u>Global</u> We	ork RVU	Time Source	Medicare Utilization	
99212	XXX	0.48	RUC Time	19,660,131	
CPT Descriptor 1 Office	or other outpatien	nt visit for th	ne evaluation and manage	gement of an established patier	nt, which
requires at least 2 of the 3	key components:	A problem f	ocused history; A proble	m focused examination; Straigh	tforward
medical decision making.					
•				Most Doont	

				WIGSt Recent
MPC CPT Code 2	<u>Global</u>	Work RVU	Time Source	Medicare Utilization
65205	000	0.71	RUC Time	33,406

CPT Descriptor 2 Removal of foreign body, external eye; conjunctival surpeficial

Other Reference CPT Code	<u>Global</u>	Work RVU	Time Source
98940	000	0.45	RUC Time

CPT Descriptor Chiropractic manipulative treatment (CMT); spinal, 1-2 regions

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

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

Number of respondents who choose Key Reference Code: 109

% of respondents: 36.9 %

<u>TIME ESTIMATES (Median)</u>	CPT Code: 98925	Key Reference CPT Code: <u>99212</u>	Source of Time RUC Time
Median Pre-Service Time	3.00	2.00	
Median Intra-Service Time	10.00	10.00	
Median Immediate Post-service Time	3.00	4.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	16.00	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	3.50	3.10
management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests,	3.06	2.80
and/or other information that must be reviewed and analyzed		
) (·1
Urgency of medical decision making	2.74	2.50
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.20	3.26
Physical effort required	3 50	2.66
	5.59	2.00
<u>Psychological Stress (NIean)</u>		
The risk of significant complications, morbidity and/or mortality	2.88	2.52
	4.00	2.00
Outcome depends on the skill and judgment of physician	4.06	3.28
Estimated risk of malpractice suit with poor outcome	2.97	2.64
INTENSITY/COMDI EVITY MEASUDES	CDT Codo	Doforonaa
INTENSITI/COMPLEXITI MEASURES	<u>CFI Coue</u>	Service 1
		Service 1
<u>Time Segments (Mean)</u>		
Pre-Service intensity/complexity	2.46	2.32
Intra Sarrias intensity/approlavity	3.42	3.02
mua-service mensity/complexity	3.42	3.02
Post-Service intensity/complexity	2.40	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.*

Osteopathic manipulative treatment (OMT) code 98925 was brought forth through the Centers for Medicare and Medicaid Services (CMS) fourth Five-Year Review of the RBRVS as a Harvard-valued code to be surveyed for appropriate value consideration.

Compelling Evidence:

The current wRVU for 98925 was crosswalked from a Harvard valued HCPCS Level II code (M0702). 98925 has never been RUC surveyed. We believe that 98925 meets compelling evidence based on flawed methodology utilized in the initial valuation of the family of OMT codes 98925-98929.

Prior to the implementation of the RBRVS in 1992 there were 10 HCPCS Level II codes for OMT that described Brief, Limited, Intermediate, Extended and Comprehensive OMT services in the inpatient (M0722-M0730) and outpatient (M0702-M0710) settings. The original values were derived from Harvard surveys of 6 codes, and 4 codes were valued by Carrier Medical Directors.

We believe the methodology utilized in the valuation of the M-codes was flawed because:

- The Hsiao study only provided one reference service "A follow-up visit of a 55-year old male for management of hypertension, mild fatigue, on beta blocker/thiazide regimen." (See Hsiao Study survey instrument attachment "A") We believe that magnitude estimation based on a single reference service provides a potentially flawed valuation of the original M-codes.
- The original M-code values were derived from a combination of Harvard surveyed codes and crosswalks performed by CMD's.
- There were errors made when the work values were crosswalk from the Harvard surveyed codes to the CMD valued codes:
 - The Federal Register/Vol. 57, No. 228/Wednesday, November 25, 1992/Notices page 55947 (See Federal Register attachment **"B"**) states "Osteopathic manipulation (CPT) code M0704 and 0728. These two codes were revised so that the inpatient manipulation services would have equivalent work RVUs to the office manipulation services. Code M0704 was increased from 0.66 to 0.69 and code M0708 was increased from 1.07 to 1.08." However, in the same volume located on the same date (page 56146) the work RVU for M0704 increased to 0.67 not 0.69 and the work RVU for M0708 decreased from 1.07 to 1.05.
- Because the methodology used in the valuation of the M-codes was flawed and there was a flaw in crosswalk assumptions of the M-codes, when the 10 M-codes were compressed into 5 CPT codes the same flaws that existed in the M-codes exist in the current CPT codes for OMT services.
- In addition, the global period was changed from XXX to 000 in 1993; there was no discussion of this decision in the final rule. (See tables below)

HCPCS	Description	1991-1992 Work RVUs	Global	Source of Work RVUs	Harvard Vignette
M0702	Brief, Osteopathic Manip Therapy	0.47	XXX	Harvard RBRVS	Includes up to two body regions

CPT Code: 98925

M0704	Limited, Osteopathic Manip Therapy	0.66	XXX	Harvard RBRVS	Includes up to four body regions
M0706	Intermediate Osteopathic Manip Therapy	0.92	XXX	Harvard RBRVS	Includes up to six body regions
M0708	Extended Osteopathic Manip Therapy	1.08	XXX	HCFA (CMDs)	
M0710	Comprehensive Osteopathic Manip	1.25	XXX	Harvard RBRVS	Includes up to ten body regions
M0722	Brief Inpatient Hospital OMT	0.47	XXX	HCFA (CMDs)	
M0724	Limited Inpatient Hospital OMT	0.69	XXX	Harvard RBRVS	Includes up to four body regions
M0726	Intermediate Inpatient Hospital OMT	0.92	XXX	HCFA (CMDs	
M0728	Extended Inpatient Hospital OMT	1.07	XXX	Harvard RBRVS	Includes up to eight body regions
M0730	Comprehensive Inpatient Hospital OMT	1.25	XXX	HCFA (CMDs	

HCPCS	Description	1993 Work RVUs*	Global
M0702	Brief, Osteopathic Manip Therapy	0.46	000
M0704	Limited, Osteopathic Manip Therapy	0.67	000
M0706	Intermediate Osteopathic Manip Therapy	0.89	000
M0708	Extended Osteopathic Manip Therapy	1.05	000
M0710	Comprehensive Osteopathic Manip	1.22	000
M0722	Brief Inpatient Hospital OMT	0.46	000
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*Work RVUs adjusted from 1992 to maintain budget neutrality

			Global	Harvard Time
СРТ	Description	1994 Work RVUs*		(Total only)
98925	OMT; 1 to 2 body regions involved	0.45	000	13 min
98926	OMT; 3 to 4 body regions involved	0.66	000	18 min
98927	OMT; 5 to 6 body regions involved	0.88	000	25 min
98928	OMT; 7 to 8 body regions involved	1.04	000	29 min
98929	OMT; 9 to 10 body regions involved	1.20	000	33 min

*Work RVUs adjusted from 1992 to maintain budget neutrality

In 1994, the M-codes were replaced by the new CPT codes (98925-98929) for OMT with new descriptors and deletion of the site of service designation. The new CPT codes were not RUC surveyed and the values were cross walked from the deleted M-codes. There are no vignettes or pre-service, intra-service and post-service descriptions available. The only time listed in the RUC database is the original total Harvard time.

Because the existing Harvard time values are reported as total time only, the distribution of pre-, intra-, and post-service work remains unquantified. This has been an ongoing issue with CMS and private payers.

Therefore, we believe there was flawed methodology in the determination of the initial values and compelling standards are met in order to proceed with presentation of RUC surveyed data for valuation of CPT codes 98925-98929.

The American Osteopathic Association (AOA) requested and received responses from the following specialty colleges indicating their willingness to have their members included in the RUC OMT survey of physician work:

The American College of Osteopathic Family Physicians (ACOFP) The American Academy of Osteopathy (AAO) The American College of Osteopathic Internists (ACOI) The American College of Osteopathic Pediatricians (ACOP) The American Osteopathic College of Physical Medicine & Rehabilitation (AOCPMR) The American Osteopathic Academy of Sports Medicine (AOASM) The American College of Osteopathic Surgeons (ACOS)

A survey of code 98925 was electronically distributed to a random sample of 4880 physicians from the above specialty colleges. The distribution of the respondents was reflective of the dominant providers of OMT contained in the Medicare Claims Data. Although the number of responses was less than anticipated, sufficient responses were obtained to meet the number required by the RUC for a valid survey. (See the below chart which provides a detail reporting of the number of physicians that completed the survey by specialty.)

$\mathbf{r} = \mathbf{r} + \mathbf{r}$					
Specialty	Number of Physicians Responded (N=295)	Percentage %			
Family Medicine (ACOFP)	141	48%			
Osteopathic Manipulative Medicine (AAO)	112	38%			
Physical Medicine & Rehabilitation (AOCPMR)	23	8%			
Sport Medicine (AOASM)	8	3%			
Internal Medicine (ACOI)	7	2%			
Pediatrics (ACOP)	4	1%			

Survey Response by Specialty for Code 98925

Pre-Service Time:

The expert panel chose pre-service package 5-NF Procedure without sedation/anesthesia care. Although an E/M is typically provided with this procedure, non-E/M time is still required: One minute (1) for pre-service evaluation, two (1) minutes to communicate with the patient and/or family (Discuss procedure/obtain consent), and one (1) minute for patient positioning which will vary depending on the technique and body region(s) being treated. The four (3) total minutes of pre-time is less than the surveyed pre-time of 6.5 minutes, 1 minute greater than the key reference service 99212 and 98940 but is less than the other MPC and 000-day comparative codes listed.

Intra-Service Time:

The expert panel supports the median survey intra-service time of 10 minutes and notes that it is comparable to the key reference service 99212, MPC code 11000 and 69210. It is also important to note that 10 minutes is the same intra-service time reported from the 2002 P/E survey of 161 responses which was accepted by the RUC and CMS.

Work RVU Recommendations:

Code 98925 is being valued using magnitude estimation. The expert panel reviewing the data agreed that the magnitude difference between 98925 and 99212 is correct as supported by the current survey of osteopathic physicians familiar with this procedure. Although the intra-service time is the same as the key reference service there is an additional 1 minute of pre-service and the increased complexity and intensity measures justifies the increased value.

CPT Code: 98925

CPT Code	Field	Low	5th%	25th%	Median	75th%	95th%	High	Arithmetic Mean	Mode	Geometric Mean
	Work										
98925	RVU	0	0.48	0.5	0.61	0.715	1.86	99212	1202.8305	0.5	0.8353
98925	Intra Time	0	3.7	8	10	15	30	120	13.4661	10	11.2604

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.)

Multiple codes are used to maintain consistency with similar codes. Historical precedents.

physician work using different codes.

Other reason (please explain)

Since the implementation of the RBRVS the relationship between the OMT services and E/M services using the -25 modifier has been consistent as demonstrated by the following:

The surveyed code is an add-on code or a base code expected to be reported with an add-on code. Different specialties work together to accomplish the procedure; each specialty codes its part of the

Multiple codes allow flexibility to describe exactly what components the procedure included.

1) When OMT codes were surveyed for physician work by the Harvard studies it was requested that the information provided by the surveyed physicians represent only the actual work of the OMT procedure, and that E/M services would be evaluated separately.

2) On June 23, 1992 DHHS issued a memorandum to their regional offices on the proper use of Modifier-25 with E/M services and OMT. The memorandum instructed carriers that "a documented, separately, identifiable related service is to be paid for. We have defined related as being caused or prompted by the same symptoms or conditions". Thus, carriers should not deny claims for OMT and an E/M service with a Modifier-25 simply because they both are reported with the same diagnosis code. This policy applies whether or not it is a first or subsequent encounter with the patient. (See Booth memorandum attachment "C")

3) In July 1994 the Office of Payment Policy for the Department of Health & Human Services (DHHS) issued a similar memorandum to all Associate Regional Administrators for Medicare to clarify how osteopathic manipulative treatment (OMT) and evaluation and management (E/M) services provided on the same date are to be reported and paid. (See Booth memorandum attachment "C")

4) The introductory language in CPT 2010® for codes 98925-98929 states, "Evaluation and Management services may be reported separately if, using modifier 25, the patient's condition requires a significant separately identifiable E/M service, above and beyond the usual preservice and postservice work associated with the procedure. The E/M service may be caused or prompted by the same symptoms or condition for which the OMT service was provided. As such, different diagnoses are not required for the reporting of the OMT and E/M service on the same date."

5) The proper use of OMT and E/M services has been addressed in CPT Advisor on multiple occasions, including January 1997, July 1998, August 2000, and October 2009.

As a result, a documented evaluation and management service is considered "above and beyond the usual preservice and post-service work of the OMT codes". Treating elements of E/M services as part of the pre-service and post-service work of OMT is inconsistent with the original intent as to how these services were valued, and contrary to assumptions made by both the CPT Editorial Panel and CMS. The present survey results and CPT Code: 98925 descriptors maintain this relationship. (See letter from the AMA regarding the PEAC/ RUC assumptions attachment "D")

The separate reporting of an E/M service and OMT service on the same date is an industry accepted practice and is further supported by the guidelines set forth by the CPT Editorial Panel, the Centers for Medicare and Medicaid Services (CMS), the RUC through PEAC assumption, and the National Correct Coding Initiative (NCCI) edits.

Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. 98925 is typically billed with an E/M service (either an office visit or hospital) 76.3% of the time.

Professional Liability Insurance Information (PLI)

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

If no, please select another crosswalk and provide a brief rationale. 98925

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

Compelling Evidence

The RUC operates with the initial presumption that the current values assigned to the codes under review are correct. The argument for a change must be substantial and meet the RUC's compelling evidence standards listed in the Instructions Document. Please list your compelling evidence below (if appropriate).

See rationale for the compelling evidence argument.

Five-Year Review Specific Questions

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

Has the work of performing this service changed in the past 5 years? Yes 30% No 70% A. This service represents new technology? Yes 35% No 65%

Of survey respondents, who said yes, the new technology affected the work: Less Work: 1% Same Work: 64% More Work: 35%

B. This service reflects new technology that has become more familiar: Yes 26% No 74%

C. Patients requiring this service are now:

More complex (more work) 81% Less complex (less work) 1% No change in complexity 18% D. The typical site-of-service has changed:

From outpatient to inpatient 0% From inpatient to outpatient 0% No change 100%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS 2010 FIVE YEAR REVIEW SUMMARY OF RECOMMENDATION

CPT Code:98926 Tracking Number Global Period: 000 Specialty Society Recommended RVU: 0.90 RUC Recommended RVU: 0.75

CPT Descriptor: Osteopathic manipulative treatment (OMT); 3-4 body regions involved

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 39 yr old female presents with right lower back pain of two weeks duration after a lifting injury. Somatic dysfunction of lumbar, pelvis and sacral regions are identified on exam.

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

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

Percent of survey respondents who stated they perform the procedure; In the hospital 1%, In the ASC 0%, In the office 99%

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? 1%

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? 5%

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

Description of Pre-Service Work: The physician determines which osteopathic techniques (eg, HVLA, Muscle energy, Counterstrain, articulatory, etc) would be most appropriate for this patient, in what order the affected body regions need to be treated and whether those body regions should be treated with specific segmental or general technique approaches. The physicain explains the intended procedure to the patient, answers any preliminary questions, and obtains verbal consent for the OMT. The patient is placed in the appropriate postion on the treatment table for the initial technique and region(s) to be treated.

Description of Intra-Service Work: The patient is initially in the prone position on the treatment table. Motion restrictions of sacrum and pelvis are isolated through palpation and treated using muscle energy and articulatory techniques. Dysfunctions of L1 and L5 are treated using passive thrust (HVLA) technique. Patient position is changed as necessary for treatment of the individual somatic dysfunctions. Patient feedback and palpatory changes guide further technique application as appropriate.

Description of Post-Service Work: Post-care instructions related to the procedure are given, including side effects, treatment reactions, self-care, and follow-up. The procedure is documented in the medical record

SURVEY DAT	SURVEY DATA						
RUC Meeting Da	ate (mm/yyyy	02/2011					
Presenter(s):	Drs. Joseph	R. Schlecht, Ju	udith A. O'C	onnell			
Specialty(s):	American C	steopathic Asso	ociation				
CPT Code:	98926						
Sample Size:	4902	Resp N:	253	Response	: 5.1 %		
Sample Type:	Random	Additional Sa	ample Infor	mation: N/A			
			Low	25 th %	Median*	<u>75th %</u>	High
Service Perform	ance Rate		3.00	40.00	150.00	500.00	1201.00
Survey RVW:			0.48	0.75	0.90	1.00	3.90
Pre-Service Evalu	ation Time:				5.00		
Pre-Service Posit	ioning Time:				2.00		
Pre-Service Scrul	o, Dress, Wait	Time:			0.00		
Intra-Service Ti	ne:		4.00	8.00	15.00	20.00	45.00
Immediate Post	Service-Tim	e: <u>5.00</u>					
Post Operative	Visits	Total Min**	CPT Code	and Number	er of Visits		
Critical Care tim	ne/visit(s):	<u>0.00</u>	99291x 0 .	99292x	0.00		
Other Hospital t	ime/visit(s):	0.00	99231x 0.	99232 99232	0.00 99233x	0.00	
Discharge Day	Mgmt:	0.00	99238x 0 .)0 99239x 0 .	00		
Office time/visit	(s):	0.00	99211x 0 .	00 12x 0.00	13x 0.00 14x 0.0	0 15x 0.00	
Prolonged Serv	ices:	<u>0.00</u>	99354x 0 .	00 55x 0.00	56x 0.00 57x	0.00	
Sub Obs Care:		0.00	99224x 0 .	99225 99225 00	0.00 99226x	0.00	

**Physician standard total <u>minutes per E/M visit</u>: 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: 5 - NF Procedure without sedation/anesthesia care

СРТ	Recommended Physician Work RVU: 0.90				0.90
Code:	30320			1	
			Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation T	ime:		2.00	7.00	-5.00
Pre-Service Positioning	Time:		1.00	0.00	1.00
Pre-Service Scrub, Dress	s, Wait Tim	e:	0.00	0.00	0.00
Intra-Service Time:			15.00		
Immediate Post Servic	e-Time:	<u>3.00</u>			
Post Operative Visits		<u>Total Min**</u>	CPT Code and N	umber of Visits	
Critical Care time/visit	(s):	<u>0.00</u>	99291x 0.00 992	292x 0.00	
Other Hospital time/vis	sit(s):	<u>0.00</u>	99231x 0.00 992	232x 0.00 99233x	0.00
Discharge Day Mgmt:		<u>0.00</u>	99238x 0.0 99239	x 0.0	
Office time/visit(s):		<u>0.00</u>	99211x 0.00 12x (0.00 13x 0.00 14x 0	.00 15x 0.00
Prolonged Services:		<u>0.00</u>	99354x 0.00 55x	0.00 56x 0.00 57x	0.00
Sub Obs Care:		0.00	99224x 0.00 992	225x 0.00 99226x	0.00

KEY REFERENCE SERVICE:

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

<u>CPT Descriptor</u> Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of the 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity.

KEY MPC COMPARISON CODES:

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

				Most Recent	
MPC CPT Code 1	<u>Global</u> Wo	ork RVU	Time Source	Medicare Utilization	
99212	XXX	0.48	RUC Time	19,660,131	
CPT Descriptor 1 Office	or other outpatier	nt visit for th	ne evaluation and mana	gement of an established patient	, which
requires at least 2 of the 3	key components:	A problem f	ocused history; A probl	em focused examination; Straight	forward
medical decision making.		-		-	
0				Most Recent	

				MOSt Recent
MPC CPT Code 2	<u>Global</u>	Work RVU	Time Source	Medicare Utilization
65205	000	0.71	RUC Time	33,406

CPT Descriptor 2 Removal of foreign body, external eye; conjunctival surpeficial

Other Reference CPT Code	<u>Global</u>	Work RVU	Time Source
20551	000	0.75	RUC Time

<u>CPT Descriptor</u> Injection(s); single tendon orgin/insertion

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

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

Number of respondents who choose Key Reference Code: 99

% of respondents: 39.1 %

<u>TIME ESTIMATES (Median)</u>	CPT Code: 98926	Key Reference CPT Code: <u>99213</u>	Source of Time RUC Time
Median Pre-Service Time	3.00	3.00	
Median Intra-Service Time	15.00	15.00	
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	21.00	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	3.64	3.45
management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests.	3.36	3.22
and/or other information that must be reviewed and analyzed	0.00	0.22
Urgency of medical decision making	3.01	2.94
<u>Technical Skill/Physical Effort (NIean)</u>		
Technical skill required	4.30	3.24
Physical effort required	4.08	2.70
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.16	2.90
) (- 1	
Outcome depends on the skill and judgment of physician	4.23	3.49
Estimated risk of malpractice suit with poor outcome	2 95	2.88
Estimated risk of malphedice suit with poor outcome	2.00	2.00
INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference
		<u>Service 1</u>
Time Segments (Mean)		
	0.70	0.50
Pre-Service intensity/complexity	2.70	2.59
Intra-Service intensity/complexity	3.86	3.27
		L]
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.

Background: Why is this code being reviewed?

CPT Code: 98926

Osteopathic manipulative treatment (OMT) code 98926 was initially identified through the Relative Value Update Committee (RUC) Relativity Assessment Workgroup formerly known as the Five Year-Identification Workgroup screening of Harvard Value codes with utilization over 100,000. It is also within the family of OMT codes that CMS included in the fourth Five-year review as a Harvard valued code.

Compelling Evidence:

The current wRVU for 98926 was crosswalked from a Harvard valued HCPCS Level II code (M0704). 98926 has never been RUC surveyed. We believe that 98926 meets compelling evidence based on flawed methodology utilized in the initial valuation of the family of OMT codes 98925-98929.

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CPT Code: 98926

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98929	OMT; 9 to 10 body regions involved	1.20	000	33 min

*Work RVUs adjusted from 1992 to maintain budget neutrality

In 1994, the M-codes were replaced by the new CPT codes (98925-98929) for OMT with new descriptors and deletion of the site of service designation. The new CPT codes were not RUC surveyed and the values were cross walked from the deleted M-codes. There are no vignettes or pre-service, intra-service and post-service descriptions available. The only time listed in the RUC database is the original total Harvard time.

Because the existing Harvard time values are reported as total time only, the distribution of pre-, intra-, and post-service work remains unquantified. This has been an ongoing issue with CMS and private payers.

Therefore, we believe there was flawed methodology in the determination of the initial values and compelling standards are met in order to proceed with presentation of RUC surveyed data for valuation of CPT codes 98925-98929.

The American Osteopathic Association (AOA) requested and received responses from the following specialty colleges indicating their willingness to have their members included in the RUC OMT survey of physician work:

The American College of Osteopathic Family Physicians (ACOFP) The American Academy of Osteopathy (AAO)

- The American College of Osteopathic Internists (ACOI)
- The American College of Osteopathic Pediatricians (ACOP)

The American Osteopathic College of Physical Medicine & Rehabilitation (AOCPMR)

The American Osteopathic Academy of Sports Medicine (AOASM)

The American College of Osteopathic Surgeons (ACOS)

A survey of OMT code 98926 was electronically distributed to a random sample of 4902 physicians from the above specialty colleges. The distribution of the respondents was reflective of the dominant providers of OMT contained in the Medicare Claims Data. Although the number of responses was less than anticipated, sufficient responses were obtained to meet the number required by the RUC for a valid survey. (See the below chart which provides a detail reporting of the number of physicians that completed the survey by specialty.)

Specialty	Number of Physicians Responded (N=253)	Percentage %
Family Medicine(ACOFP)	120	47%
Osteopathic Manipulative Medicine (AAO)	108	42%
Physical Medicine & Rehabilitation (AOCPMR)	10	4%
Sport Medicine (AOASM)	6	3%
Internal Medicine (ACOI)	5	2%
Pediatrics (ACOP)	4	2%

Survey Response by Specialty for Code 98926

Pre-Service Time:

The expert panel chose pre-service package 5-NF Procedure without sedation/anesthesia care. Although an E/M is typically provided with this procedure, non-E/M time is still required: One minute (1) for pre-service evaluation, two (1) minutes to communicate with the patient and/or family (Discuss procedure/obtain consent), and one (1) minute for patient positioning which will vary depending on the technique and body region(s) being treated. The four (3) total minutes of pre-time is less than the surveyed pre-time of 7 minutes, is the same as the key reference service 99213 and is less than the comparative codes 65205 and 20551 and other MPC and 000 day global comparative codes.

Intra-Service Time:

The expert panel supports the median survey intra-service time of 15 minutes and notes that it is comparable to the key reference service 99213 and MPC codes 92012 and 45330. It is also important to note that 15 minutes is the same intra-service time reported from the 2002 P/E survey of 253 responses which was accepted by the RUC and CMS.

Post-Service Time:

The surveyed post-service time of 3 minutes is consistent with the physician work provided and supported by similar 000 global codes in the MPC code list.

CPT Code: 98926

Code 98926 was valued using magnitude estimation. The expert panel reviewing the data agreed that the magnitude difference between 98926 and 99213 is correct and is supported by the current survey of osteopathic physicians familiar with this procedure.

Additional requested statistics:

СРТ									Arithmetic		Geometric
Code	Field	Low	5th%	25th%	Median	75th%	95th%	High	Mean	Mode	Mean
	Work										
98926	RVU	0.48	0.65	0.75	0.95	1.08	2.93	99213	2220.6446	0.75	1.3077
	Intra-										
	Service										
98926	Time	0	5	11	15	20	30.8	60	17.3597	15	15.0625

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.)



 \boxtimes

The surveyed code is an add-on code or a base code expected to be reported with an add-on code. Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.

Multiple codes allow flexibility to describe exactly what components the procedure included.

Multiple codes are used to maintain consistency with similar codes.

Historical precedents.

Other reason (please explain)

Since the implemenation of the RBRVS the relationship between the OMT services and E/M services using the -25modifier has been consistent as demonstrated by the following:

1) When OMT codes were surveyed for physician work by the Harvard studies it was requested that the information provided by the surveyed physicians represent only the actual work of the OMT procedure, and that E/M services would be evaluated separately.

2) On June 23, 1992 DHHS issued a memorandum to their regional offices on the proper use of Modifier-25 with E/M services and OMT. The memorandum instructed carriers that "a documented, separately, identifiable related service is to be paid for. We have defined related as being caused or prompted by the same symptoms or conditions". Thus, carriers should not deny claims for OMT and an E/M service with a Modifier-25 simply because they both are reported with the same diagnosis code. This policy applies whether or not it is a first or subsequent encounter with the patient. (See Booth memorandum attachment "C")

3) In July 1994 the Office of Payment Policy for the Department of Health & Human Services (DHHS) issued a similar memorandum to all Associate Regional Administrators for Medicare to clarify how osteopathic manipulative treatment (OMT) and evaluation and management (E/M) services provided on the same date are to be reported and paid. (See Booth memorandum attachment "C")

4) The introductory language in CPT 2010® for codes 98925-98929 states, "Evaluation and Management services may be reported separately if, using modifier 25, the patient's condition requires a significant separately identifiable E/M service, above and beyond the usual preservice and postservice work associated with the procedure. The E/M service may be caused or prompted by the same symptoms or condition for which the OMT service was provided. As such, different diagnoses are not required for the reporting of the OMT and E/M service on the same date."

5) The proper use of OMT and E/M services has been addressed in CPT Advisor on multiple occasions, including January 1997, July 1998, August 2000, and October 2009.

As a result, a documented evaluation and management service is considered "above and beyond the usual preservice and post-service work of the OMT codes". Treating elements of E/M services as part of the pre-service and post-service work or OMT is inconsistent with the original intent as to how these services were valued, and contrary to assumptions made by both the CPT Editorial Panel and CMS. The present survey results and descriptors maintain this relationship. (See letter from the AMA regarding the PEAC/ RUC assumptions attachment "D")

The separate reporting of an E/M service and OMT service on the same date is an industry accepted practice and is further supported by the guidelines set forth by the CPT Editorial Panel, the Centers for Medicare and Medicaid Services (CMS), the RUC through PEAC assumption, and the National Correct Coding Initiative (NCCI) edits.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. 98926 is billed with an E/M service (either an office visit or hospital visit) 78.8% of the time.

Professional Liability Insurance Information (PLI)

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

If no, please select another crosswalk and provide a brief rationale. 98926

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

Compelling Evidence

The RUC operates with the initial presumption that the current values assigned to the codes under review are correct. The argument for a change must be substantial and meet the RUC's compelling evidence standards listed in the Instructions Document. Please list your compelling evidence below (if appropriate). See rationale for the compelling evidence argument.

Five-Year Review Specific Questions

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

Has the work of performing this service changed in the past 5 years? Yes 19% No 81% A. This service represents new technology? Yes 37% No 63%

Of survey respondents, who said yes, the new technology affected the work: Less Work: 1% Same Work: 64% More Work: 35%

B. This service reflects new technology that has become more familiar: Yes 24% No 76%

C. Patients requiring this service are now:

More complex (more work) 81% Less complex (less work) 1% No change in complexity 18%

D. The typical site-of-service has changed:

From outpatient to inpatient 0% From inpatient to outpatient 0% No change 100%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS 2010 FIVE YEAR REVIEW SUMMARY OF RECOMMENDATION

CPT Code:98927 Tracking Number Global Period: 000 Specialty Society Recommended RVU: 1.05 RUC Recommended RVU: 1.00

CPT Descriptor: Osteopathic manipulative treatment (OMT); 5-6 body regions involved

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 17 year old male presents with pain in the neck, upper and lower back, right shoulder, and right chest following an injury in a high school football game two days ago. Somatic dysfunctions of the right glenohumeral and acromioclavicular joints, as well as the lower cervical, upper thoracic, right upper costal and lumbar areas are identified on exam.

Percentage of Survey Respondents who found Vignette to be Typical: 74%

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? 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? 5%

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

Description of Pre-Service Work: The physician determines which osteopathic techniques (eg, HVLA, Muscle energy, Counterstrain, articulatory, etc) would be most appropriate for this patient, in what order the affected body regions need to be treated and whether those body regions should be treated with specific segmental or general technique approaches. The physicain explains the intended procedure to the patient, answers any preliminary questions, and obtains verbal consent for the OMT. The patient is placed in the appropriate position on the treatment table for the initial technique and region(s) to be treated.

Description of Intra-Service Work: The patient is initially in a side-lying position on the treatment table. Motion restrictions of identified joints are isolated through palpation and treated using a variety of techniques as follows: acromioclavicular joint is treated with articulatory technique; glenohumeral and costal dysfunctions are treated with muscle energy technique; cervical spine is treated with counterstrain technique; thoracic and lumbar dysfunctions are treated with passive thrust (HVLA) technique. Patient position is changed as necessary for treatment of the individual somatic dysfunctions. Patient feedback and palpatory changes guide further technique application as appropriate.

Description of Post-Service Work: Post-care instructions related to the procedure are given, including side effects, treatment reactions, self-care, and follow-up. The procedure is documented in the medical record.

SURVEY DAT	A								
RUC Meeting Dat	e (mm/yyyy) 02/2011							
Presenter(s):	Drs. Joseph	n R. Schlecht, Ju	udith A. O'C	Conr	nell				
Specialty(s):	American C	steopathic Asso	ociation						
CPT Code:	98927								
Sample Size:	4906	Resp N:	233		Response	: 4.7 %			
Sample Type:	Random	Additional Sa	ample Info	orma	tion: N/A	L.			
			Low		25 th %	Med	lian*	<u>75th %</u>	High
Service Performa	ance Rate		3.00		49.25	20	0.00	705.00	4100.00
Survey RVW:			0.48		0.97	1.	05	1.30	4.10
Pre-Service Evalua	ation Time:					6.	00		
Pre-Service Position	oning Time:					2.	00		
Pre-Service Scrub	, Dress, Wait	Time:				0.	00		
Intra-Service Tim	ne:		5.00		15.00	20	.00	30.00	45.00
Immediate Post	Service-Tim	e: <u>5.00</u>				•			•
Post Operative V	<u>′isits</u>	Total Min**	CPT Code	e ar	nd Numbe	er of Visi	ts		
Critical Care time	e/visit(s):	<u>0.00</u>	99291x 0 .	.00	99292x	0.00			
Other Hospital ti	me/visit(s):	0.00	99231x 0 .	.00	99232x	0.00	99233x	0.00	
Discharge Day N	lgmt:	0.00	99238x 0 .	.00	99239x 0 .	00			
Office time/visit(s):	0.00	99211x 0 .	.00	12x 0.00	13x 0.00	14x 0.0	0 15x 0.00	
Prolonged Servio	ces:	<u>0.00</u>	99354x 0 .	.00	55x 0.00	56x 0.0	0 57x	0.00	
Sub Obs Care:		0.00	99224x 0 .	.00	99225x	0.00	99226x	0.00	

**Physician standard total <u>minutes per E/M visit</u>: 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: 5 - NF Procedure without sedation/anesthesia care

СРТ	98927		Recommended Physician Work RVU: 1.05				1.05
Code:	30321						
			Specialt Recommer Pre-Service	ty nded Time	Speci Recomm Pre Time F	alty ended Package	Adjustments to Pre-Service Time
Pre-Service Evaluation T	ime:		2.00		7.0	0	-5.00
Pre-Service Positioning	Time:		1.00		0.0	0	1.00
Pre-Service Scrub, Dress	s, Wait Tim	e:	0.00		0.0	0	0.00
Intra-Service Time:			20.00				
Immediate Post Servic	e-Time:	<u>3.00</u>					
Post Operative Visits		<u>Total Min**</u>	CPT Code a	nd Nu	umber of Vi	<u>sits</u>	
Critical Care time/visit	(s):	<u>0.00</u>	99291x 0.00	992	92x 0.00		
Other Hospital time/vis	sit(s):	0.00	99231x 0.00	992	32x 0.00	99233x	0.00
Discharge Day Mgmt:		<u>0.00</u>	99238x 0.0 9	99239	× 0.0		
Office time/visit(s):		0.00	99211x 0.00	12x 0	.00 13x 0.0	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	992	25x 0.00	99226x	0.00

KEY REFERENCE SERVICE:

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

<u>CPT Descriptor</u> Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of the 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity.

KEY MPC COMPARISON CODES:

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

			Most Recent
Global	Work RVU	Time Source	Medicare Utilization
000	0.71	RUC Time	33,406
oreign body	y, external eye; co	njunctival superfical	
			Most Recent
lobal	Work RVU	Time Source	Medicare Utilization
000	0.96	RUC Time	73,206
	<u>Global</u> 000 oreign bod lobal 000	<u>Global</u> <u>Work RVU</u> 000 0.71 Foreign body, external eye; co <u>Blobal</u> <u>Work RVU</u> 000 0.96	Global 000Work RVU 0.71Time Source RUC TimeSoreign body, external eye; conjunctival superficalSlobal 000Work RVU 0.96Time Source RUC Time

CPT Descriptor 2 Sigmoidiscopy, flexible; diagnostic with or without collection of specimen(s) by brushing or washing

Other Reference CPT Code	<u>Global</u>	Work RVU	Time Source
99238	XXX	1.28	RUC Time

CPT Descriptor Hospital discharge day management; 30 minutes or less

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

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

Number of respondents who choose Key Reference Code: 112

% of respondents: 48.0 %

<u>TIME ESTIMATES (Median)</u>	CPT Code: 98927	Key Reference CPT Code: <u>99213</u>	Source of Time RUC Time
Median Pre-Service Time	3.00	3.00	
Median Intra-Service Time	20.00	15.00	
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	26.00	23.00	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

(of those that selected Key Reference code)

<u>Mental Effort and Judgment (Mean)</u>		
The number of possible diagnosis and/or the number of	4.04	3.61
management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests,	3.64	3.30
and/or other information that must be reviewed and analyzed		
		0.40
Urgency of medical decision making	3.48	3.16
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.49	3.38
Physical effort required	4.21	2.79
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.42	2.99
Outcome depends on the skill and judgment of physician	4.39	3.62
E-diment of mile of molecular and a mild more and a mo	2.17	2.97
Estimated risk of maipractice suit with poor outcome	3.17	2.07
INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference
		Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.03	2.67
5 1 5		
Intra-Service intensity/complexity	4.21	3.41
Post-Service intensity/complexity	2.89	2.65
	-	

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: <u>Why is this code being reviewed?</u>

Osteopathic manipulative treatment (OMT) code 98927 was identified through the Relative Value Update Committee (RUC) Relativity Assessment Workgroup formerly known as the Five Year-Identification Workgroup screening of Harvard Value codes with utilization over 100,000. It is also within the family of OMT codes that CMS included in the fourth Five-year Review as a Harvard valued code.

Compelling Evidence:

The current wRVU for 98927 was crosswalked from a Harvard valued HCPCS Level II code (M0706). 98927 has never been RUC surveyed. We believe that 98927 meets compelling evidence based on flawed methodology utilized in the initial valuation of the family of OMT codes 98925-98929.

Prior to the implementation of the RBRVS in 1992 there were 10 HCPCS Level II codes for OMT that described Brief, Limited, Intermediate, Extended and Comprehensive OMT services in the inpatient (M0722-M0730) and outpatient (M0702-M0710) settings. The original values were derived from Harvard surveys of 6 codes, and 4 codes were valued by Carrier Medical Directors.

We believe the methodology utilized in the valuation of the M-codes was flawed because:

- The Hsiao study only provided one reference service "A follow-up visit of a 55-year old male for management of hypertension, mild fatigue, on beta blocker/thiazide regimen." (See Hsiao Study survey instrument attachment "A") We believe that magnitude estimation based on a single reference service provides a potentially flawed valuation of the original M-codes.
- The original M-code values were derived from a combination of Harvard surveyed codes and crosswalks performed by CMD's.
- There were errors made when the work values were crosswalked from the Harvard surveyed codes to the CMD valued codes:
 - The Federal Register/Vol. 57, No. 228/Wednesday, November 25, 1992/Notices page 55947 (See Federal Register attachment **"B"**) states "Osteopathic manipulation (CPT) codes M0704 and M0728. These two codes were revised so that the inpatient manipulation services would have equivalent work RVUs to the office manipulation services. Code M0704 was increased from 0.66 to 0.69 and code M0708 was increased from 1.07 to 1.08." However, in the same volume located on the same date (page 56146) the work RVU for M0704 increased to 0.67 not 0.69 and the work RVU for M0708 decreased from 1.07 to 1.05.
- Because the methodology used in the valuation of the M-codes was flawed and there was a flaw in crosswalk assumptions of the M-codes, when the 10 M-codes were compressed into 5 CPT codes the same flaws that existed in the M-codes exist in the current CPT codes for OMT services.
- In addition, the global period was changed from XXX to 000 in 1993; there was no discussion of this decision in the final rule. (See tables below)

			Source of Work	
HCPCS	Description	1991-1992 Work Global	RVUs	Harvard Vignette

CPT Code: 98927

		RVUs			
M0702	Brief, Osteopathic Manip Therapy	0.47	XXX	Harvard RBRVS	Includes up to two body regions
M0704	Limited, Osteopathic Manip Therapy	0.66	XXX	Harvard RBRVS	Includes up to four body regions
M0706	Intermediate Osteopathic Manip Therapy	0.92	XXX	Harvard RBRVS	Includes up to six body regions
M0708	Extended Osteopathic Manip Therapy	1.08	XXX	HCFA (CMDs)	
M0710	Comprehensive Osteopathic Manip	1.25	XXX	Harvard RBRVS	Includes up to ten body regions
M0722	Brief Inpatient Hospital OMT	0.47	XXX	HCFA (CMDs)	
M0724	Limited Inpatient Hospital OMT	0.69	XXX	Harvard RBRVS	Includes up to four body regions
M0726	Intermediate Inpatient Hospital OMT	0.92	XXX	HCFA (CMDs	
M0728	Extended Inpatient Hospital OMT	1.07	XXX	Harvard RBRVS	Includes up to eight body regions
M0730	Comprehensive Inpatient Hospital OMT	1.25	XXX	HCFA (CMDs	

HCPCS	Description	1993 Work RVUs*	Global
M0702	Brief, Osteopathic Manip Therapy	0.46	000
M0704	Limited, Osteopathic Manip Therapy	0.67	000
M0706	Intermediate Osteopathic Manip Therapy	0.89	000
M0708	Extended Osteopathic Manip Therapy	1.05	000
M0710	Comprehensive Osteopathic Manip	1.22	000
M0722	Brief Inpatient Hospital OMT	0.46	000
M0724	Limited Inpatient Hospital OMT	0.67	000
M0726	Intermediate Inpatient Hospital OMT	0.89	000
M0728	Extended Inpatient Hospital OMT	1.05	000
M0730	Comprehensive Inpatient Hospital OMT	1.22	000

*Work RVUs adjusted from 1992 to maintain budget neutrality

			Global	Harvard Time
СРТ	Description	1994 Work RVUs*		(Total only)
98925	OMT; 1 to 2 body regions involved	0.45	000	13 min
98926	OMT; 3 to 4 body regions involved	0.66	000	18 min
98927	OMT; 5 to 6 body regions involved	0.88	000	25 min
98928	OMT; 7 to 8 body regions involved	1.04	000	29 min
98929	OMT; 9 to 10 body regions involved	1.20	000	33 min

*Work RVUs adjusted from 1992 to maintain budget neutrality

In 1994, the M-codes were replaced by the new CPT codes (98925-98929) for OMT with new descriptors and deletion of the site of service designation. The new CPT codes were not RUC surveyed and the values were cross walked from the deleted M-codes. There are no vignettes or pre-service, intra-service and post-service descriptions available. The only time listed in the RUC database is the original total Harvard time.

Because the existing Harvard time values are reported as total time only, the distribution of pre-, intra-, and postservice work remains unquantified. This has been an ongoing issue with CMS and private payers.

Therefore, we believe there was flawed methodology in the determination of the initial values and compelling standards are met in order to proceed with presentation of RUC surveyed data for valuation of CPT codes 98925-98929.
CPT Code: 98927

The American Osteopathic Association (AOA) requested and received responses from the following specialty colleges indicating their willingness to have their members included in the RUC OMT survey of physician work:

The American College of Osteopathic Family Physicians (ACOFP)

- The American Academy of Osteopathy (AAO)
- The American College of Osteopathic Internists (ACOI)
- The American College of Osteopathic Pediatricians (ACOP)
- The American Osteopathic College of Physical Medicine & Rehabilitation (AOCPMR)
- The American Osteopathic Academy of Sports Medicine (AOASM)

The American College of Osteopathic Surgeons (ACOS)

A survey of OMT code 98927 was electronically distributed to a random sample of 4906 physicians from the above specialty colleges. The distribution of the respondents was reflective of the dominant providers of OMT contained in the Medicare Claims Data. Although the number of responses was less than anticipated, sufficient responses were obtained to meet the number required by the RUC for a valid survey. (See the below chart which provided a detail reporting of the number of physicians that completed the survey by specialty.)

Specialty	Number of Physicians Responded (N=233)	Percentage %
Family Practice (ACOFP)	113	48%
Osteopathic Manipulative Medicine (AAO)	97	41%
Physical Medicine & Rehabilitation (AOCPMR)	14	6%
Internal Medicine (AOCI)	5	2%
Pediatrics (ACOP)	3	2%
Sport Medicine (AOASM)	1	1%

Survey Response by Specialty for Code 98927

Pre-Service Time:

The expert panel chose pre-service package 5-NF Procedure without sedation/anesthesia care. Although an E/M is typically provided with this procedure, non-E/M time is still required: One minute (1) for pre-service evaluation, two (1) minutes to communicate with the patient and/or family (Discuss procedure/obtain consent), and one (1) minute for patient positioning which will vary depending on the technique and body region being treated. The three (3) total minutes of pre-time is less than the surveyed pre-time of 8 minutes, is the same as the key reference service 99213 and is less than the comparative codes 45330 and 99238 and other MPC and 000 day global comparative codes.

Intra-Service Time:

The expert panel supports the median survey intra-service time of 20 minutes and notes that it is 5 minutes greater than the key reference service 99213 and comparable to MPC codes 99238 and 62270. It is also important to note that 20 minutes is the same intra-service time reported from the 2002 P/E survey of 161 responses which was accepted by the RUC and CMS.

Post-Service Time:

The surveyed post-service time of 3 minutes is similar to the key reference service and is consistent with the physician work provided and supported by similar 000 global and MPC codes.

Work RVU Recommendations:

Code 98927 was valued using magnitude estimation. The expert panel reviewing the data agreed that the magnitude difference between 98927 and 99213 is correct as supported by the current survey of osteopathic physicians familiar

CPT Code: 98927

with this procedure. We also note that the intra-time estimated by physicians during the 2002 Practice Expense study has not changed. The pre and the post times of 98927 is comparable to the reference service code 99213 with the increase of 5 minutes of intra-service time and the increased complexity and intensity measures justifies the increased value.

СРТ									Arithmetic		Geometric
Code	Field	Low	5th%	25th%	Median	75th%	95th%	High	Mean	Mode	Mean
	Work										
98927	RVU	0	0.85	0.97	1.05	1.3	3.52	99238	1814.2678	0.97	1.5175
	Intra-										
	Service										
98927	Time	1	9.2	15	20	30	45	60	22.4142	20	19.9889

Additional requested statistics:

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.)



 \boxtimes

The surveyed code is an add-on code or a base code expected to be reported with an add-on code. Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.

Multiple codes allow flexibility to describe exactly what components the procedure included.

Multiple codes are used to maintain consistency with similar codes.

Historical precedents.

Other reason (please explain)

Since the implementation of the RBRVS the relationship between the OMT services and E/M services using the -25modifier has been consistent as demonstrated by the following:

1) When OMT codes were surveyed for physician work by the Harvard studies it was requested that the information provided by the surveyed physicians represent only the actual work of the OMT procedure, and that E/M services would be evaluated separately.

2) On June 23, 1992 DHHS issued a memorandum to their regional offices on the proper use of Modifier-25 with E/M services and OMT. The memorandum instructed carriers that "a documented, separately, identifiable related service is to be paid for. We have defined related as being caused or prompted by the same symptoms or conditions". Thus, carriers should not deny claims for OMT and an E/M service with a Modifier-25 simply because they both are reported with the same diagnosis code. This policy applies whether or not it is a first or subsequent encounter with the patient. (See Booth memorandum attachment "C")

3) In July 1994 the Office of Payment Policy for the Department of Health & Human Services (DHHS) issued a similar memorandum to all Associate Regional Administrators for Medicare to clarify how osteopathic manipulative treatment (OMT) and evaluation and management (E/M) services provided on the same date are to be reported and paid. (See Booth memorandum attachment "C")

4) The introductory language in CPT 2010® for codes 98925-98929 states, "Evaluation and Management services may be reported separately if, using modifier 25, the patient's condition requires a significant separately identifiable E/M service, above and beyond the usual preservice and postservice work associated with the procedure. The E/M service may be caused or prompted by the same symptoms or condition for which the OMT service was provided. As such, different diagnoses are not required for the reporting of the OMT and E/M service on the same date."

5) The proper use of OMT and E/M services has been addressed in CPT Advisor on multiple occasions, including January 1997, July 1998, August 2000, and October 2009.

As a result, a documented evaluation and management service is considered "above and beyond the usual preservice and post-service work of the OMT codes". Treating elements of E/M services as part of the pre-service and post-service work or OMT is inconsistent with the original intent as to how these services were valued, and contrary to assumptions made by both the CPT Editorial Panel and CMS. The present survey results and descriptors maintain this relationship. (See letter from the AMA regarding the PEAC/ RUC assumptions attachment "D")

The separate reporting of an E/M service and OMT service on the same date is an industry accepted practice and is further supported by the guidelines set forth by the CPT Editorial Panel, the Centers for Medicare and Medicaid Services (CMS), the RUC through PEAC assumption, and the National Correct Coding Initiative (NCCI) edits.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. 98927 is typically billed with an E/M service (either an office visit or hospital visit) 77.0% of the time.

Professional Liability Insurance Information (PLI)

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

If no, please select another crosswalk and provide a brief rationale. 98927

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

Compelling Evidence

The RUC operates with the initial presumption that the current values assigned to the codes under review are correct. The argument for a change must be substantial and meet the RUC's compelling evidence standards listed in the Instructions Document. Please list your compelling evidence below (if appropriate).

See rationale for the compelling evidence argument.

Five-Year Review Specific Questions

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

Has the work of performing this service changed in the past 5 years? Yes 23% No 77% A. This service represents new technology? Yes 25% No 75%

Of survey respondents, who said yes, the new technology affected the work: Less Work: 1% Same Work: 78% More Work: 21%

B. This service reflects new technology that has become more familiar: Yes 27% No 73%

C. Patients requiring this service are now:

More complex (more work) 61% Less complex (less work) 1% No change in complexity 38%

D. The typical site-of-service has changed:

From outpatient to inpatient 0% From inpatient to outpatient 0% No change 100%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS 2010 FIVE YEAR REVIEW SUMMARY OF RECOMMENDATION

CPT Code:98928 Tracking Number Global Period: 000 Specialty Society Recommended RVU: 1.50 RUC Recommended RVU: 1.25

CPT Descriptor: Osteopathic manipulative treatment (OMT); 7-8 body regions involved

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 64 year old female in rehabilitation following a left total knee replacement presents with swelling in the left lower leg, pain in her low back hips and pelvis with muscle spasms and numbness and bilateral wrist pain with use of a walker. She has a history of widespread degenerative joint disease with stiffness and pain making it difficult for her to actively participate in her rehabilitation program. Somatic dysfunctions of the lumbar, thoracic and cervical spine, sacrum, pelvis, right leg, and bilateral wrist joints are identified on exam.

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 1%, In the ASC 0%, In the office 99%

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? 2%

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? 5%

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

Description of Pre-Service Work: The physician determines which osteopathic techniques (eg, HVLA, Muscle energy, Counterstrain, articulatory, etc) would be most appropriate for this patient, in what order the affected body regions need to be treated and whether those body regions should be treated with specific segmental or general technique approaches. The physicain explains the intended procedure to the patient, answers any preliminary questions, and obtains verbal consent for the OMT. The patient is placed in the appropriate postion on the treatment table for the initial technique and region(s) to be treated.

Description of Intra-Service Work: The patient is initially in the supine position on the treatment table. Motion restrictions of identified joints are isolated through palpation and treated using a variety of techniques as follows: radiocarpal joints are treated using articulatory and myofascial release techniques; dysfunctions of L3, L5 and SI joints are treated using balanced ligamentous tension technique; dysfunction of C5 through T3, the pelvis and lower extremity are treated with muscle energy technique. Lower extremity edema is treated with lymphatic drainage techniques. Patient position is changed as necessary for treatment of the individual somatic dysfunctions. Patient feedback and palpatory changes guide further technique application as appropriate.

Description of Post-Service Work: Post-care instructions related to the procedure are given, including side effects, treatment reactions, self-care, and follow-up. The procedure is documented in the medical record.

SURVEY DATA									
RUC Meeting Da	RUC Meeting Date (mm/yyyy) 02/2011								
Presenter(s):	Presenter(s): Drs. Joseph R. Schlecht, Judith A. O'Connell								
Specialty(s):	American Osteopathic Association								
CPT Code:	98928								
Sample Size: 4905 Resp N:			222	222 Response: 4.5 %					
Sample Type:	Random	Additional Sa	ample Infor	mation: N/A	۱.				
			Low	25 th %	Median*	75th %	High		
Service Perform	ance Rate		3.00	50.00	200.00	600.00	3750.00		
Survey RVW:			0.48	1.29	1.50	1.67	4.70		
Pre-Service Evalu	ation Time:				10.00				
Pre-Service Posit	ioning Time:				4.00				
Pre-Service Scrul	o, Dress, Wait	Time:			0.00				
Intra-Service Ti	ne:		7.00	20.00	25.00	30.00	50.00		
Immediate Post	Service-Tim	e: <u>5.00</u>			·				
Post Operative	Visits	Total Min**	CPT Code	and Numb	er of Visits				
Critical Care tim	ne/visit(s):	<u>0.00</u>	99291x 0.0	0 99292x	0.00				
Other Hospital t	ime/visit(s):	0.00	99231x 0.0	0 99232x	0.00 99233x	0.00			
Discharge Day I	Mgmt:	0.00	99238x 0.0	0 99239x 0 .	.00				
Office time/visit	(s):	0.00	99211x 0.0	0 12x 0.00	13x 0.00 14x 0.0	0 15x 0.00			
Prolonged Serv	ices:	<u>0.00</u>	99354x 0.0	0 55x 0.00	56x 0.00 57x	0.00			
Sub Obs Care:		0.00	99224x 0.0	0 99225x	0.00 99226x	0.00			

**Physician standard total <u>minutes per E/M visit</u>: 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: 5 - NF Procedure without sedation/anesthesia care

CPT	08028		Recommended Physician Work RVU: 1.50				
Code:	30320				•		
			Spo	ecialty	Specialty Becommond	od	Adjustments to
			Pre-Se	rvice Time	Pre Time Pack	age	Pre-Service Time
Pre-Service Evaluation 1	lime:		1	2.00	7.00		-5.00
Pre-Service Positioning	Time:			1.00	0.00		1.00
Pre-Service Scrub, Dres	s, Wait Tim	e:		0.00	0.00		0.00
Intra-Service Time:			2	5.00			
Immediate Post Servio	ce-Time:	<u>3.00</u>					
Post Operative Visits		<u>Total Min**</u>	CPT Co	de and Nu	umber of Visits		
Critical Care time/visit	t(s):	<u>0.00</u>	99291x	0.00 992	92x 0.00		
Other Hospital time/vi	sit(s):	0.00	99231x	0.00 992	32x 0.00 992	233x	0.00
Discharge Day Mgmt:		<u>0.00</u>	99238x	0.0 99239	× 0.0		
Office time/visit(s):		0.00	99211x	0.00 12x 0	.00 13x 0.00 14	4x 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	0.00 992	25x 0.00 992	226x	0.00

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99214	XXX	1.50	RUC Time

<u>CPT Descriptor</u> Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these key components: A detail history; A detail examination; Medical decision making of moderate complexity.

KEY MPC COMPARISON CODES:

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

				Most Recent
MPC CPT Code 1	<u>Global</u> W	/ork RVU	Time Source	Medicare Utilization
99238	XXX	1.28	RUC Time	5,172,096
CPT Descriptor 1 Hosp	ital discharge day m	anagement; 30 r	ninutes or less	
				Most Recent
MPC CPT Code 2	<u>Global</u>	Work RVU	Time Source	Medicare Utilization
99232	XXX	1.39	RUC Time	50,022,518

CPT Descriptor 2 Subsequent hospital care, per day, for the evaluation and management of a patient

Other Reference CPT Code	<u>Global</u>	Work RVU	<u>Time Source</u>
45330	XXX	0.97	RUC Time

CPT Descriptor Sigmoidoscopy, flexible; diagnostic with or without collection of specimen(s) by brushing or washing

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

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

Number of respondents who choose Key Reference Code: 141

% of respondents: 63.5 %

<u>TIME ESTIMATES (Median)</u>	CPT Code: 98928	Key Reference CPT Code: <u>99214</u>	Source of Time RUC Time
Median Pre-Service Time	3.00	5.00	
Median Intra-Service Time	25.00	25.00	l
Median Immediate Post-service Time	3.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	31.00	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	4.40	4.14
management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests,	4.20	4.01
and/or other information that must be reviewed and analyzed		
	·1	·
Urgency of medical decision making	3.62	3.57
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.77	3.80
*		
Physical effort required	4.53	3.17
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.85	3.67
Outcome depends on the skill and judgment of physician	4.67	4.08
Estimated risk of malpractice suit with poor outcome	3.50	3.46
		LI
		D 4
INTENSITY/COMPLEXITY MEASURES	<u>CPT Code</u>	<u>Reference</u> Service 1
		<u>Service 1</u>
<u>Time Segments (Mean)</u>		
Pre-Service intensity/complexity	3.38	3.15
		[]
Intra-Service intensity/complexity	4.52	4.07
Post-Service intensity/complexity	3.29	3.12
, , , , , , , , , , , , , , , , , , ,		

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: Why is this code being reviewed?

Osteopathic manipulative treatment (OMT) code 98928 was brought forth through the Centers for Medicare and Medicaid Services (CMS) fourth Five-Year Review of the RBRVS as a Harvard valued code to be surveyed for appropriate value consideration.

Compelling Evidence:

The current wRVU for 98928 was crosswalked from a CMD valued HCPCS Level II code (M0708). 98928 has never been RUC surveyed. We believe that 98928 meets compelling evidence based on flawed methodology utilized in the initial valuation of the family of OMT codes 98925-98929.

Prior to the implementation of the RBRVS in 1992 there were 10 HCPCS Level II codes for OMT that described Brief, Limited, Intermediate, Extended and Comprehensive OMT services in the inpatient (M0722-M0730) and outpatient (M0702-M0710) settings. The original values were derived from Harvard surveys of 6 codes, and 4 codes were valued by Carrier Medical Directors.

We believe the methodology utilized in the valuation of the M-codes was flawed because:

- The Hsiao study only provided one reference service "A follow-up visit of a 55-year old male for management of hypertension, mild fatigue, on beta blocker/thiazide regimen." (See attachment "A" Hsiao Study survey instrument) We believe that magnitude estimation based on a single reference service provides a potentially flawed valuation of the original M-codes.
- The original M-code values were derived from a combination of Harvard surveyed codes and crosswalks performed by CMD's.
- There were errors made when the work values were crossed walked from the Harvard surveyed codes to the CMD valued codes:
 - The Federal Register/Vol. 57, No. 228/Wednesday, November 25, 1992/Notices page 55947 (See Federal Register attachment **"B"**) states "Osteopathic manipulation (CPT) codes M0704 and M0728. These two codes were revised so that the inpatient manipulation services would have equivalent work RVUs to the office manipulation services. Code M0704 was increased from 0.66 to 0.69 and code M0708 was increased from 1.07 to 1.08." However, in the same volume located on the same date (page 56146) the work RVU for M0704 increased to 0.67 not 0.69 and the work RVU for M0708 decreased from 1.07 to 1.05.
- Because the methodology used in the valuation of the M-codes was flawed and there was a flaw in crosswalk assumptions of the M-codes, when the 10 M-codes were compressed into 5 CPT codes the same flaws that existed in the M-codes exist in the current CPT codes for OMT services.
- In addition, the global period was changed from XXX to 000 in 1993; there was no discussion of this decision in the final rule. (See tables below)

CPT Code: 98928

		RVUs		RVUs	
M0702	Brief, Osteopathic Manip Therapy	0.47	XXX	Harvard RBRVS	Includes up to two body regions
M0704	Limited, Osteopathic Manip Therapy	0.66	XXX	Harvard RBRVS	Includes up to four body regions
M0706	Intermediate Osteopathic Manip Therapy	0.92	XXX	Harvard RBRVS	Includes up to six body regions
M0708	Extended Osteopathic Manip Therapy	1.08	XXX	HCFA (CMDs)	
M0710	Comprehensive Osteopathic Manip	1.25	XXX	Harvard RBRVS	Includes up to ten body regions
M0722	Brief Inpatient Hospital OMT	0.47	XXX	HCFA (CMDs)	
M0724	Limited Inpatient Hospital OMT	0.69	XXX	Harvard RBRVS	Includes up to four body regions
M0726	Intermediate Inpatient Hospital OMT	0.92	XXX	HCFA (CMDs	
M0728	Extended Inpatient Hospital OMT	1.07	XXX	Harvard RBRVS	Includes up to eight body regions
M0730	Comprehensive Inpatient Hospital OMT	1.25	XXX	HCFA (CMDs	

HCPCS	Description	1993 Work RVUs*	Global
M0702	Brief, Osteopathic Manip Therapy	0.46	000
M0704	Limited, Osteopathic Manip Therapy	0.67	000
M0706	Intermediate Osteopathic Manip Therapy	0.89	000
M0708	Extended Osteopathic Manip Therapy	1.05	000
M0710	Comprehensive Osteopathic Manip	1.22	000
M0722	Brief Inpatient Hospital OMT	0.46	000
M0724	Limited Inpatient Hospital OMT	0.67	000
M0726	Intermediate Inpatient Hospital OMT	0.89	000
M0728	Extended Inpatient Hospital OMT	1.05	000
M0730	Comprehensive Inpatient Hospital OMT	1.22	000

*Work RVUs adjusted from 1992 to maintain budget neutrality

			Global	Harvard Time
СРТ	Description	1994 Work RVUs*		(Total only)
98925	OMT; 1 to 2 body regions involved	0.45	000	13 min
98926	OMT; 3 to 4 body regions involved	0.66	000	18 min
98927	OMT; 5 to 6 body regions involved	0.88	000	25 min
98928	OMT; 7 to 8 body regions involved	1.04	000	29 min
98929	OMT; 9 to 10 body regions involved	1.20	000	33 min

*Work RVUs adjusted from 1992 to maintain budget neutrality

In 1994, the M-codes were replaced by the new CPT codes (98925-98929) for OMT with new descriptors and deletion of the site of service designation. The new CPT codes were not RUC surveyed and the values were cross walked from the deleted M-codes. There are no vignettes or pre-service, intra-service and post-service descriptions available. The only time listed in the RUC database is the original total Harvard time.

Because the existing Harvard time values are reported as total time only, the distribution of pre-, intra-, and post-service work remains unquantified. This has been an ongoing issue with CMS and private payers.

Therefore, we believe there was flawed methodology in the determination of the initial values and compelling standards are met in order to proceed with presentation of RUC surveyed data for valuation of CPT codes 98925-98929.

The American Osteopathic Association (AOA) received responses from the following specialty colleges indicating their willingness to have their members included in the RUC OMT survey of physician work:

The American College of Osteopathic Family Physicians (ACOFP) The American Academy of Osteopathy (AAO) The American College of Osteopathic Internists (ACOI) The American College of Osteopathic Pediatricians (ACOP) The American Osteopathic College of Physical Medicine & Rehabilitation (AOCPMR) The American Osteopathic Academy of Sports Medicine (AOASM) The American College of Osteopathic Surgeons (ACOS)

The AOA received databases from the above specialty colleges that totaled over 12,000 members. We narrowed the list to include 5000 physicians in order to obtain a valid and cross representations of physicians that utilize OMT in their practices.

A survey of OMT code 98928 was electronically distributed to a random sample of 4880 physicians from the above specialty colleges. The distribution of the respondents was reflective of the dominant providers of OMT contained in the Medicare Claims Data. Although the number of responses was less than anticipated, sufficient responses were obtained to meet the number required by the RUC for a valid survey. (See the below chart which provides a detail reporting of the number of physicians that completed the survey by specialty.)

Survey Response by Speciarty for Code 70720							
Specialty	Number of Physicians Responded	Percentage %					
	(N=222)						
Family Medicine (ACOFP)	83	37%					
· · · ·							
Osteopathic Manipulative	111	50%					
Medicine (AAO)							
Physical Medicine &	15	6%					
Rehabilitation (AOCPMR)							
Internal Medicine (ACOI)	9	4%					
Sport Medicine (AOASM)	3	2%					
Pediatrics (ACOP)	1	1%					

Survey Response by Specialty for Code 98928

Pre-Service Time:

Although an E/M is typically provided with this procedure, non-E/M time is still required: (1) minutes for preservice evaluation, (1) minutes to communicate with the patient and/or family (Discuss procedure/obtain consent), and one (1) minute for patient positioning which will vary depending on the technique and body region being treated. The 3 total minutes of pre-time reflects the increase time required for planning the treatment approach (technique selection and sequencing) for a higher number of affected regions.

Intra-Service Time:

The expert panel supports the median survey intra-service time of 25 minutes and notes that this is comparable to the key reference service 99214, MPC code 99243 and 000 day global comparative code 27096. It is also important to note the 25 minutes is the same intra-service time reported from the 2002 P/E survey of 161 responses which was accepted by the RUC and CMS.

Post-Service Time:

The surveyed post-service of 3 minutes is less than the key reference service code 99214 but is consistent with the physician work provided and supported by similar 000 global codes in the MPC list.

CPT Code: 98928

Code 98928 was valued using magnitude estimation. The expert panel reviewing the data agreed that the magnitude difference between 98929 and 99214 is correct as supported by the current survey of osteopathic physicians familiar with this procedure.

Additional requested statistics:

СРТ									Arithmetic		Geometric
Code	Field	Low	5th%	25th%	Median	75th%	95th%	High	Mean	Mode	Mean
	Work										
98928	RVU	0	0.981	1.3	1.5	1.665	2.7375	99214	1028.6648	1.5	1.7656
	Intra-										
	Service										
98928	Time	0	15	20	25	30	46.9	90	27.2613	30	25.0281

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)

Since the implementation of the RBRVS the relationship between the OMT services and E/M services using the -25modifier has been consistent as demonstrated by the following:

1) When OMT codes were surveyed for physician work by the Harvard studies it was requested that the information provided by the surveyed physicians represent only the actual work of the OMT procedure, and that E/M services would be evaluated separately.

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3) In July 1994 the Office of Payment Policy for the Department of Health & Human Services (DHHS) issued a similar memorandum to all Associate Regional Administrators for Medicare to clarify how osteopathic manipulative treatment (OMT) and evaluation and management (E/M) services provided on the same date are to be reported and paid. (See Booth memorandum attachment "C")

4) The introductory language in CPT 2010® for codes 98925-98929 states, "Evaluation and Management services may be reported separately if, using modifier 25, the patient's condition requires a significant separately identifiable E/M service, above and beyond the usual preservice and postservice work associated with the procedure. The E/M service may be caused or prompted by the same symptoms or condition for which the OMT service was provided. As such, different diagnoses are not required for the reporting of the OMT and E/M service on the same date."

5) The proper use of OMT and E/M services has been addressed in CPT Advisor on multiple occasions, including January 1997, July 1998, August 2000, and October 2009.

As a result, a documented evaluation and management service is considered "above and beyond the usual preservice and post-service work of the OMT codes". Treating elements of E/M services as part of the pre-service and post-service work or OMT is inconsistent with the original intent as to how these services were valued, and contrary to assumptions made by both the CPT Editorial Panel and CMS. The present survey results and descriptors maintain this relationship. (See letter from the AMA regarding the PEAC/ RUC assumptionsattachment "D")

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Professional Liability Insurance Information (PLI)

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

If no, please select another crosswalk and provide a brief rationale. 98928

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

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Of survey respondents, who said yes, the new technology affected the work: Less Work: 1% Same Work: 64% More Work: 35%

- B. This service reflects new technology that has become more familiar: Yes 26% No 74%
- C. Patients requiring this service are now:
 - More complex (more work) 81% Less complex (less work) 1% No change in complexity 18%
- D. The typical site-of-service has changed:

From outpatient to inpatient 0% From inpatient to outpatient 0% No change 100%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS 2010 FIVE YEAR REVIEW SUMMARY OF RECOMMENDATION

CPT Code:98929 Tracking Number Global Period: 000 Specialty Society Recommended RVU: 1.70 RUC Recommended RVU: 1.50

CPT Descriptor: Osteopathic manipulative treatment (OMT); 9-10 body regions involved

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40 year old male presents with sub-occipital headache, and pain in the neck, upper and lower back, left shoulder and chest, and right ankle. He was involved in a rear-end MVA two weeks ago. X-rays in the ED were negative. He has been taking prescribed analgesic and muscle relaxant medications with minimal improvement. On examination, somatic dysfunction is identified at the occipitoatlantal, left glenohumeral and right tibiotalar joints, as well as the cervical, thoracic, costal, lumbar, sacral and pelvic regions.

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 96%

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? 2%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated moderate sedation is typical in the office setting? 4%

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

Description of Pre-Service Work: The physician determines which osteopathic techniques (eg, HVLA, Muscle energy, Counterstrain, articulatory, etc) would be most appropriate for this patient, in what order the affected body regions need to be treated and whether those body regions should be treated with specific segmental or general technique approaches. The physician explains the intended procedure to the patient, answers any preliminary questions, and obtains verbal consent for the OMT. The patient is placed in the appropriate postion on the treatment table for the initial technique and region(s) to be treated.

Description of Intra-Service Work: Patient is initially in the supine position on the treatment table. Motion restrictions of identified joints are isolated through palpation and treated using a variety of techniques as follows: occiptoatlantal joint and sacrum are treated using muscle energy and counterstrain techniques; right glenohumeral joint and pelvis are treated with articulatory technique; lumbar, thoracic, cervical and right ankle are treated with passive thrust (HVLA) technique; costal dysfunctions are treated using muscle energy technique. Patient position is changed as necessary for treatment of the individual somatic dysfunctions. Patient feedback and palpatory changes guide selection of further technique application as appropriate.

Description of Post-Service Work: Post-care instructions related to the procedure are given, including side effects, treatment reactions, self-care, and follow-up. The procedure is documented in the medical record

SURVEY DAT	Г А						
RUC Meeting Da	ate (mm/yyyy)	02/2011					
Presenter(s):	Presenter(s): Drs. Joseph R. Schlecht, Judith A. O'Connell						
Specialty(s):	American O	steopathic Asso	ociation				
CPT Code:	98929						
Sample Size:	4905	Resp N:	219	Response	e: 4.4 %		
Sample Type:	Random	Additional Sa	ample Infor	mation: N/A	N N		
			Low	25 th %	Median*	<u>75th %</u>	High
Service Perform	ance Rate		3.00	14.25	53.00	400.00	2500.00
Survey RVW:			0.52	1.50	1.70	1.95	4.95
Pre-Service Evalu	ation Time:				10.00		
Pre-Service Posit	ioning Time:				4.00		
Pre-Service Scrul	o, Dress, Wait	Time:			0.00		
Intra-Service Ti	ne:		8.00	23.50	30.00	40.00	58.00
Immediate Post	Service-Time	e: <u>6.00</u>					
Post Operative	Visits_	Total Min**	CPT Code	and Numb	er of Visits		
Critical Care tim	ne/visit(s):	<u>0.00</u>	99291x 0.0	0 99292x	0.00		
Other Hospital t	ime/visit(s):	<u>0.00</u>	99231x 0.0	0 99232x	0.00 99233x	0.00	
Discharge Day I	Mgmt:	<u>0.00</u>	99238x 0.0	0 99239x 0	.00		
Office time/visit	(s):	<u>0.00</u>	99211x 0.0	00 12x 0.00	13x 0.00 14x 0.0	0 15x 0.00	
Prolonged Serv	ices:	<u>0.00</u>	99354x 0.0	00 55x 0.00	56x 0.00 57x	0.00	
Sub Obs Care:		0.00	99224x 0.0	9 9225x	0.00 99226x	0.00	

**Physician standard total <u>minutes per E/M visit</u>: 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: 5 - NF Procedure without sedation/anesthesia care

СРТ	98929		Recommended Physician Work RVU: 1.70			
Code:	30323			1		
			Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time	
Pre-Service Evaluation T	ime:		2.00	7.00	-5.00	
Pre-Service Positioning 1	Fime:		1.00	0.00	1.00	
Pre-Service Scrub, Dress	s, Wait Tim	e:	0.00	0.00	0.00	
Intra-Service Time:			30.00			
Immediate Post Servic	e-Time:	<u>3.00</u>				
Post Operative Visits		<u>Total Min**</u>	CPT Code and Nu	umber of Visits		
Critical Care time/visit	(s):	<u>0.00</u>	99291x 0.00 992	292x 0.00		
Other Hospital time/vis	sit(s):	<u>0.00</u>	99231x 0.00 992	232x 0.00 99233x	0.00	
Discharge Day Mgmt:		<u>0.00</u>	99238x 0.0 99239	x 0.0		
Office time/visit(s):		<u>0.00</u>	99211x 0.00 12x 0	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 0.00 992	225x 0.00 99226x	0.00	

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99214	XXX	1.50	RUC Time

<u>CPT Descriptor</u> Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these key components: A detail history; A detail examination; Medical decision making of moderate complexity.

KEY MPC COMPARISON CODES:

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

				Most Recent				
MPC CPT Code 1	<u>Global</u> W	ork RVU	Time Source	Medicare Utilization				
99232	XXX	1.39	RUC Time	50,022,518				
CPT Descriptor 1 Subsequent hospital care per day, for the evaluation and management of a patient, which requires 2 of								
these 3 keyponents: An expanded problem focused interval history; An expanded problem focused examination; Medical								
decision making of moderate complexity.								
e				Most Recent				

				Wiest Recent
MPC CPT Code 2	<u>Global</u>	Work RVU	Time Source	Medicare Utilization
99238	XXX	1.28	RUC Time	5,172,096

<u>CPT Descriptor 2</u> Hospital discharge day management; 30 minutes of less

Other Reference CPT Code	<u>Global</u>	Work RVU	Time Source
29445	000	1.78	RUC Time

CPT Descriptor Application of rigid total contact leg cast

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

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

Number of respondents who choose Key Reference Code: 135

% of respondents: 61.6 %

<u>TIME ESTIMATES (Median)</u>	CPT Code: 98929	Key Reference CPT Code: <u>99214</u>	Source of Time RUC Time
Median Pre-Service Time	3.00	5.00	
Median Intra-Service Time	30.00	25.00	
Median Immediate Post-service Time	3.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	36.00	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	4.63	4.27
management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests,	4.51	4.16
and/or other information that must be reviewed and analyzed		
Urgency of medical decision making	4.07	3.76
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.90	3.96
Physical effort required	4.73	3.42
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.11	3.75
Outcome depends on the skill and judgment of physician	4.84	4.19
	2.04	0.50
Estimated risk of malpractice suit with poor outcome	3.81	3.50
INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference
		<u>Service 1</u>
Time Segments (Mean)		
Pre-Service intensity/complexity	3.90	3.47
~ * * *		
Intra-Service intensity/complexity	4.84	4.21
·····		
		[]
Post-Service intensity/complexity	3.66	3.36

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: Why is this code being reviewed?

Osteopathic manipulative treatment (OMT) code 98929 was brought forth through the Centers for Medicare and Medicaid Services (CMS) fourth Five-Year Review of the RBRVS as a Harvard valued code to be surveyed for appropriate value consideration.

Compelling Evidence:

The current wRVU for 98929 was crosswalked from a Harvard valued HCPCS Level II code (M0710). 98929 has never been RUC surveyed. We believe that 98929 meets compelling evidence based on flawed methodology utilized in the initial valuation of the family of OMT codes 98925-98929.

Prior to the implementation of the RBRVS in 1992 there were 10 HCPCS Level II codes for OMT that described Brief, Limited, Intermediate, Extended and Comprehensive OMT services in the inpatient (M0722-M0730) and outpatient (M0702-M0710) settings. The original values were derived from Harvard surveys of 6 codes, and 4 codes were valued by Carrier Medical Directors.

We believe the methodology utilized in the valuation of the M-codes was flawed because:

- The Hsiao study only provided one reference service "A follow-up visit of a 55-year old male for management of hypertension, mild fatigue, on beta blocker/thiazide regimen." (See attachment "A" Hsiao Study survey instrument) We believe that magnitude estimation based on a single reference service provides a potentially flawed valuation of the original M-codes.
- The original M-code values were derived from a combination of Harvard surveyed codes and crosswalks performed by CMD's.
- There were errors made when the work values were crossed walked from the Harvard surveyed codes to the CMD valued codes:
 - The Federal Register/Vol. 57, No. 228/Wednesday, November 25, 1992/Notices page 55947 (See Federal Register attachment **"B"**) states "Osteopathic manipulation (CPT) codes M0704 and M0728. These two codes were revised so that the inpatient manipulation services would have equivalent work RVUs to the office manipulation services. Code M0704 was increased from 0.66 to 0.69 and code M0708 was increased from 1.07 to 1.08." However, in the same volume located on the same date (page 56146) the work RVU for M0704 increased to 0.67 not 0.69 and the work RVU for M0708 decreased from 1.07 to 1.05.
- Because the methodology used in the valuation of the M-codes was flawed and there was a flaw in crosswalk assumptions of the M-codes. When the 10 M-codes were compressed into 5 CPT codes the same flaws that existed in the M-codes exist in the current CPT codes for OMT services.
- In addition, the global period was changed from XXX to 000 in 1993; there was no discussion of this decision in the final rule. (See tables below)

HCPCS	Description	1991-1992 Work RVUs	Global	Source of Work RVUs	Harvard Vignette
M0702	Brief, Osteopathic Manip Therapy	0.47	XXX	Harvard RBRVS	Includes up to two body regions

CPT Code: 98929

M0704	Limited, Osteopathic Manip Therapy	0.66	XXX	Harvard RBRVS	Includes up to four body regions
M0706	Intermediate Osteopathic Manip Therapy	0.92	XXX	Harvard RBRVS	Includes up to six body regions
M0708	Extended Osteopathic Manip Therapy	1.08	XXX	HCFA (CMDs)	
M0710	Comprehensive Osteopathic Manip	1.25	XXX	Harvard RBRVS	Includes up to ten body regions
M0722	Brief Inpatient Hospital OMT	0.47	XXX	HCFA (CMDs)	
M0724	Limited Inpatient Hospital OMT	0.69	XXX	Harvard RBRVS	Includes up to four body regions
M0726	Intermediate Inpatient Hospital OMT	0.92	XXX	HCFA (CMDs	
M0728	Extended Inpatient Hospital OMT	1.07	XXX	Harvard RBRVS	Includes up to eight body regions
M0730	Comprehensive Inpatient Hospital OMT	1.25	XXX	HCFA (CMDs	

HCPCS	Description	1993 Work RVUs*	Global
M0702	Brief, Osteopathic Manip Therapy	0.46	000
M0704	Limited, Osteopathic Manip Therapy	0.67	000
M0706	Intermediate Osteopathic Manip Therapy	0.89	000
M0708	Extended Osteopathic Manip Therapy	1.05	000
M0710	Comprehensive Osteopathic Manip	1.22	000
M0722	Brief Inpatient Hospital OMT	0.46	000
M0724	Limited Inpatient Hospital OMT	0.67	000
M0726	Intermediate Inpatient Hospital OMT	0.89	000
M0728	Extended Inpatient Hospital OMT	1.05	000
M0730	Comprehensive Inpatient Hospital OMT	1.22	000

*Work RVUs adjusted from 1992 to maintain budget neutrality

			Global	Harvard Time
СРТ	Description	1994 Work RVUs*		(Total only)
98925	OMT; 1 to 2 body regions involved	0.45	000	13 min
98926	OMT; 3 to 4 body regions involved	0.66	000	18 min
98927	OMT; 5 to 6 body regions involved	0.88	000	25 min
98928	OMT; 7 to 8 body regions involved	1.04	000	29 min
98929	OMT; 9 to 10 body regions involved	1.20	000	33 min

*Work RVUs adjusted from 1992 to maintain budget neutrality

In 1994, the M-codes were replaced by the new CPT codes (98925-98929) for OMT with new descriptors and deletion of the site of service designation. The new CPT codes were not RUC surveyed and the values were cross walked from the deleted M-codes. There are no vignettes or pre-service, intra-service and post-service descriptions available. The only time listed in the RUC database is the original total Harvard time.

Because the existing Harvard time values are reported as total time only, the distribution of pre-, intra-, and post-service work remains unquantified. This has been an ongoing issue with CMS and private payers.

Therefore, we believe there was flawed methodology in the determination of the initial values and compelling standards are met in order to proceed with presentation of RUC surveyed data for valuation of CPT codes 98925-98929.

The American Osteopathic Association (AOA) received responses from the following specialty colleges indicating their willingness to have their members included in the RUC OMT survey of physician work:

The American College of Osteopathic Family Physicians (ACOFP) The American Academy of Osteopathy (AAO) The American College of Osteopathic Internists (ACOI) The American College of Osteopathic Pediatricians (ACOP) The American Osteopathic College of Physical Medicine & Rehabilitation (AOCPMR) The American Osteopathic Academy of Sports Medicine (AOASM) The American College of Osteopathic Surgeons (ACOS)

The AOA received databases from the above specialty colleges that totaled over 12,000 members. We narrowed the list to include 5000 physicians in order to obtain a valid and cross representations of physicians that utilize OMT in their practices.

A survey of OMT code 98929 was electronically distributed to a random sample of 4905 physicians from the above specialty colleges. The distribution of the respondents was reflective of the dominant providers of OMT contained in the Medicare Claims Data. Although the number of responses was less than anticipated, sufficient responses were obtained to meet the number required by the RUC for a valid survey. (See the below chart which provides a detail reporting of the number of physicians that completed the survey by specialty.)

Specialty	Number of Physicians Responded (N=219)	Percentage %
Family Medicine (ACOFP)	86	39%
Osteopathic Manipulative Medicine (AAO)	109	50%
Physical Medicine & Rehabilitation (AOCPMR)	15	6%
Internal Medicine (ACOI)	8	4%
Pediatrics (ACOP)	1	1%

Survey Response by Specialty for Code 98929

Pre-Service Time:

Although an E/M is typically provided with this procedure, non-E/M time is still required: (1) minutes for preservice evaluation, (1) minutes to communicate with the patient and/or family (Discuss procedure/obtain consent), and one (1) minute for patient positioning.

Intra-Service Time:

The expert panel supports the median survey intra-service time of 30 minutes and notes that this is 5 minutes greater than the key reference service 99214. It is also important to note the 30 minutes is the same intra-service time reported from the 2002 P/E survey of 161 responses which was accepted by the RUC and CMS.

Post-Service Time:

The surveyed post-service time of 3 minutes less than the key reference service 99214 but is consistent with the physician work provided and supported by similar 000 global codes in the MPC code list.

Work RVU Recommendations:

Code 98929 was valued using magnitude estimation. The expert panel reviewing the data agreed that the magnitude difference between 98929 and 99214 is correct as supported by the current survey of osteopathic physicians familiar with this procedure. The intra-service time of 98929 is 5 minutes longer and the increased complexity and intensity measure compared to 99214 justifies the increased value.

Additional requested statistics:

CPT	Field	Law	Eth0/	25+60/	Madian	75+60/	05+60/	llich	Arithmetic	Mada	Geometric
Code	Field	LOW	5tn%	2511%	wedian	75tn%	95tn%	High	iviean	wode	iviean
	Work										
98929	RVU	0	1.25	1.5	1.72	2	3.431	99214	1505.4028	1.5	2.1834
	Intra- Service										
98929	Time	1	15	25	30	40	60	90	32.2973	30	29.3553

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)

Since the implementation of the RBRVS the relationship between the OMT services and E/M services using the -25 modifier has been consistent as demonstrated by the following:

1) When OMT codes were surveyed for physician work by the Harvard studies it was requested that the information provided by the surveyed physicians represent only the actual work of the OMT procedure, and that E/M services would be evaluated separately.

2) On June 23, 1992 DHHS issued a memorandum to their regional offices on the proper use of Modifier-25 with E/M xervices and OMT. The memorandum instructed carriers that "a documented, separately, identifiable related service is to be paid for. We have defined related as being caused or prompted by the same symptoms or conditions". Thus, carriers should not deny claims for OMT and an E/M service with a Modifier-25 simply because they both are reported with the same diagnosis code. This policy applies whether or not it is a first or subsequent encounter with the patient. (See Booth memorandum attachment "C")

3) In July 1994 the Office of Payment Policy for the Department of Health & Human Services (DHHS) issued a similar memorandum to all Associate Regional Administrators for Medicare to clarify how osteopathic manipulative treatment (OMT) and evaluation and management (E/M) services provided on the same date are to be reported and paid. (See Booth memorandum attachment "C")

4) The introductory language in CPT 2010® for codes 98925-98929 states, "Evaluation and Management services may be reported separately if, using modifier 25, the patient's condition requires a significant separately identifiable E/M service, above and beyond the usual preservice and postservice work associated with the procedure. The E/M service may be caused or prompted by the same symptoms or condition for which the OMT service was provided. As such, different diagnoses are not required for the reporting of the OMT and E/M service on the same date."

5) The proper use of OMT and E/M services has been addressed in CPT Advisor on multiple occasions, including January 1997, July 1998, August 2000, and October 2009.

CPT Code: 98929 As a result, a documented evaluation and management service is considered "above and beyond the usual preservice and post-service work of the OMT codes". Treating elements of E/M services as part of the pre-service and post-service work or OMT is inconsistent with the original intent as to how these services were valued, and contrary to assumptions made by both the CPT Editorial Panel and CMS. The present survey results and descriptors maintain this relationship. (See letter from the AMA regarding the PEAC/ RUC assumptionsattachment "D")

The separate reporting of an E/M service and OMT service on the same date is an industry accepted practice and is further supported by the guidelines set forth by the CPT Editorial Panel, the Centers for Medicare and Medicaid Services (CMS), the RUC through PEAC assumption, and the National Correct Coding Initiative (NCCI) edits.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. 989299 is typically billed with an E/M service (either an office visit or hospital visit) 84.0 % of the time.

Professional Liability Insurance Information (PLI)

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

If no, please select another crosswalk and provide a brief rationale. 98929

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

Compelling Evidence

The RUC operates with the initial presumption that the current values assigned to the codes under review are correct. The argument for a change must be substantial and meet the RUC's compelling evidence standards listed in the Instructions Document. Please list your compelling evidence below (if appropriate).

See rationale for the complelling argument.

Five-Year Review Specific Questions

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

Has the work of performing this service changed in the past 5 years? Yes 37% No 63% A. This service represents new technology? Yes 35% No 65%

Of survey respondents, who said yes, the new technology affected the work: Less Work: 1% Same Work: 64% More Work: 35%

B. This service reflects new technology that has become more familiar: Yes 22% No 78%

C. Patients requiring this service are now:

More complex (more work) 72% Less complex (less work) 1% No change in complexity 27%

D. The typical site-of-service has changed:

From outpatient to inpatient 0% From inpatient to outpatient 0% No change 100%

Attachment A: Hsiao Study

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RVIEWER				
TERVIEWER ID#				

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FOR OFFICE USE

A-1

NATIONAL PHYSICIANS SURVEY

(OSTEOPATHIC MEDICINE)

Center for Survey Research University of Massachusetts-Boston

and

Harvard School of Public Health

TIME NOW:

A. SERVICE TIME

First. I'd like you to tell me how many minutes it usually takes you to perform services in your specialty. I will ask you to estimate the amount of time you spend during the performance of each service. In addition, we will also ask you to estimate the total time you spend for the services indicated with an asterisk (*). The total time includes the time <u>during</u> and <u>before</u> and <u>after</u> the service. Have you reviewed the yellow sheet with the definitions of <u>during</u> and <u>before</u> and <u>after</u> the <u>service</u>? (if NO please ask RESPONDENT to take a minute to review this information).

In all cases we want you to consider your time for the average or typical patient for the described service. For the visit and consultative services do not include your time performing OMT (osteopathic manipulative treatment). I will ask you to estimate the time of these services separately.

On average, how long does it take during the performance of (the/a/an) (READ EACH)....

(FOR ALL THE SERVICES INDICATED WITH AN ASTERISK, ...)

And on average, how long does it take to perform the total service, including minutes during and before and after this service....

		MINS DURING	MINS TOTAL
*Ala.1)	Follow-up visit of a 55-year-old male for management of hypertension, mild fatigue, on beta blocker/thiazide regimen.		
*Ala.)	Initial office consultation for a 65-year-old male with chronic low back pain radiating to the leg.	an an a	
*Alb.)	Initial office visit for a 25-year-old female, visiting from out of town, who needs her hayfever prescription refilled.		÷.
*Alc.)	Home visit for a 66-year-old female one week after release from the hospital for a CVA (cerebral vascular accident) with right hemiparesis (not including travel time).	140. AD-DINTERNO	
*Ald.).	Initial office visit for a 70-year-old patient with recent back sprain.	an a	÷.
+ 			

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For the remaining services we would like you to estimate only your time spent performing the OMT service, including any cursory history or palpatory examination. In particular, do not include your time assessing a new problem, obtaining an initial history or performing an initial physical examination. Have you reviewed the yellow sheet with the definition of the service period for OMT services? (if NO please ask RESPONDENT to take a minute to review this information)

MINUTES

On average, how long does it take you to perform (a/an) ...

- Alo.) Brief OMT (osteopathic manipulative treatment) performed in the office for a 25-year-old female with frontal area headache (includes up to two body regions).
- Alp.) Limited OHT (osteopathic manipulative treatment) performed in the office for a 30-year-old secretary complaining of posterior (occipital area) headache and upper back/shoulder area tightness (includes up to four body regions).
- Alq.) Intermediate ONT (osteopathic manipulative treatment) performed in the office for a 40-year-old laborer with acute lumbar strain/sprain and inguinal pain and lower extremity paresthesia (includes up to six body regions).
- Alr.) Comprehensive OMT (osteopathic manipulative treatment) performed in the office for a 28-year-old male 3 weeks post auto accidentsustained sprain and strain of cervical, dorsal and lumbosacral spine and has frozen right shoulder (includes up to ten body regions).
- Als.) Limited OMT (osteopathic manipulative treatment) performed in the hospital for a 65-year-old male 2 days post abdominal surgery, who complains of arthralgia and myalgia (includes up to four body regions).
- Alt.) Extended OMT (osteopathic manipulative treatment) performed in the hospital for a 70-year-old female who has been bedridden for 7 days. Patient has generalized body stiffness and pain (includes up to eight body regions)

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B1. HAGNITUDE ESTIMATION

Next let's talk about how much work is involved <u>during</u> these services. The packet we sent to you discussed the method we would like you to use for comparing the services. If you have the packet handy, it would be helpful for you to look at a description of the magnitude estimation method as I review it briefly.

The reference service for all the ratings will be a follow-up visit of a 55year-old male for management of hypertension, mild fatigue, on beta blocker/thiazide regimen. Call this 100. Now with the reference service as 100, compare it to each of the other services as I read them to you. If the service I mention is twice as much work, then your answer would be 200. A service half as much work would be 50, five times as much work would be 500 and so on.

I am going to ask you to compare each of the services to the reference service on work. In your estimation of work, please consider the time it takes to perform the service and the three dimensions that reflect the intensity of that time -- technical skill and physical effort, mental effort and judgment, and stress.

In all cases, we want you to try to respond in terms of the work during the described service for the average or typical patient. Do not count your work either before or after the service. For the visit and consultative services do not include your work performing OMT (osteopathic manipulative treatment). I will ask you to estimate the work of these services separately.

Do you have any questions about the way I want you to compare the services, or what we mean by work during the service?

O.K. let's start,

If the work during a follow-up visit of a 55-year-old male for management of hypertension, mild fatigue, on beta blocker/thiazide regimen has a rating of 100, what number would you assign to the work during (the/a/an) (READ EACH)....

RATING OF WORK DURING THE SERVICE

*Bla.) Initial office consultation for a 65-year-old male with chronic low back pain radiating to the leg.

> INTERVIEWER CHECK: So this service requires about ______ times the amount of work as the reference service?

*Blb.) Initial office visit for a 25-year-old female, visiting from out of town, who needs her hayfever prescription refilled.

INTERVIEWER CHECK: So this service requires about _____ times the amount of work as the reference service?

A-4

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l	For the remaining services we would like you to estimate performing the OMT service, including any cursory histor examination. In particular, do not include your work as obtaining an initial history or performing an initial ph O.K. let's start. If the work during a follow-up visit of a 55-year-old ma hypertension, mild fatigue, on beta blocker/thiazide reg: 100, what number would you assign to the work during (the	e only the work spen ry or palpatory ssessing a new probl hysical examination le for management of imen has a rating of a/a/an) (READ EACH)
Blo.)	Brief OMT (osteopathic manipulative treatment) performed in the office for a 25-year-old female with frontal area headache (includes up to two body regions).	RATING OF WORK
Blp.)	<u>Limited OMT</u> (osteopathic manipulative treatment) performed in the office for a 30-year-old secretary complaining of posterior (occipital area) headache and upper back/shoulder area tightness (includes up to four body regions).	· • • • • • • • • • • • • • • • • • • •
Blq.)	Intermediate OMT (osteopathic manipulative treatment) performed in the office for a 40-year-old laborer with acute lumbar strain/sprain and inguinal pain and lower extremity paresthesia (includes up to six body regions).	Manufacture Concerne
Blr.)	<u>Comprehensive OMT</u> (osteopathic manipulative treatment) performed in the office for a 28-year-old male 3 weeks post auto accident- sustained sprain and strain of cervical, dorsal and lumbosacral spine and has frozen right shoulder (includes up to ten body and	
Bls.) <u> </u> 2 a r	Limited OMT (osteopathic manipulative treatment) performed in the hospital for a 65-year-old male days post abdominal surgery, who complains of withralgia and myalgia (includes up to four body	, Therefore
Blc.) <u>E</u> pe wi ge ei	xtended OMT (osteopathic manipulative treatment) erformed in the hospital for a 70-year-old female no has been bedridden for 7 days. Patient has eneralized body stiffness and pain (includes up to ght body regions)	

A:-5

97C,

(10) EEG monitoring, with drug activation (CPT code 95954). The current work RVUs for this procedure are 0.96. A specialty and subspecially society recommended work RVUs of 4.20. There was considerable variation in the individual panel members' ratings, which ranged from 1.70 to 3.50. We discussed this procedure with our review panel and, based on a consensus that the service is significantly undervalued, we have raised the work RVUs to 2.58.

p. Osteopathic manipulation (CPT codes M0704 and M0728). These two codes were revised so that the inpatient manipulation services would have equivalent work RVUs to the office manipulation services. Code M0704 was increased from 0.66 to 0.69 and code M0708 was increased from 1.07 to 1.08.

4. RVU changes due to changes in global periods

We received several comments on the global fee periods assigned to a variety of surgical procedures. In addition, during implementation of the fee schedule, we identified some surgical procedures for which the work RVUs appeared to be inconsistent with the global fee period. The types of comments and problems generally fall into one of two categories. The first category includes procedures for which it was argued that the patient typically would be followed for reasons unrelated to the procedure itself. For example, the codes which are used to report the implantation of ventricular catheters or

intracranial pressure recording devices (codes 61107 and 61210) have global periods of 90 days. Commenters stated that a 90-day global period is inappropriate for these procedures because virtually all of the follow-up care provided by the surgeon is directed toward the management of the underlying condition, which is often extensive and complex (for example, the management of a severe closed head injury). The second category includes procedures for which it was argued that the work RVUs were too low relative to the global fee period. For example, the work RVUs for a thoracoscopy (CPT code 32700) are 5.75 and the global fee period is 90 days. Commenters noted that this value is based on a Harvard result that did not include work RVUs for post-operative work beyond the day of the procedure.

We used a panel of CMDs and medical consultants to review the global fee periods in question. Approximately 50 procedures were reviewed.

Our decisions generally fell into one of two categories. For procedures for which it was argued that the patient typically would be followed for reasons unrelated to the procedure itself, we have reduced the global fee period from 90 days to 10 or 0 days or from 10 days to 0 days. We have reduced the work RVUs for these procedures by removing work RVUs that were attributable to the follow-up period. For example, the work RVUs for the implantation of ventricular catheters or intracranial pressure recording devices (codes 61107 and 81210) were reduced from 8.69 and 8.89 to 4.59 and 4.87, respectively, to be consistent with a global fee period of 0 days. The new work RVUs are based on the Harvard study data for pre-operative and post-operative work on the day of the procedure only plus the intra-service work. Subsequent visits by the surgeon will now be reported using the appropriate evaluation and management code. If we had not reduced the work RVUs for the procedures, we would have made duplicate payments for work performed in the post-operative period.

The second category included procedures for which it was argued that the work RVUs were too low relative to the global fee period. For example, we reviewed the work RVUs for a thoracoscopy (CPT code \$2700) and noted that the value of 5.75 was based on a Harvard study result that did not include work RVUs for post-operative work beyond the day of the procedure. Therefore, we have reduced the global fee period to 0 days. In this situation, no work RVU change was made because the work RVUs of 5.75 are based on the Harvard study data for pre-operative and post-operative work on the day of the procedure only plus the intra-service work. With this change, subsequent visits by the surgeon will now be reported using the appropriate evaluation and management code.

The following table lists the codes for which the global periods have been revised.

SILLENG CODE 4120-01-S

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TABLE 1	•
Codes Included in the Refinement F	Process

HOPOS	DESCRIPTION	1992 <u>WORK RVU</u>	REQUESTED WORK RVU	1993 WORK RVU**	BASIS FOR DECISION
A2000	MANIPULATION OF SPINE	0.38		0.46	2
M0702	BRIEF. OSTEOPATHIC MANIP THERAPY	0.47	1.25	X	1
M0704	LIMITED, OSTEOPATHIC MANIP THERAPY	0.66	2.5	0.67	3
M0706	INTERMEDIATE OSTEOPATHIC MANIP THER	0.92	3.75	· X	1
M0708	EXTENDED OSTEOPATHIC MANIP THERAPY	1.08	5	Х	1
840710	COMPREHENSIVE OSTEOPATHIC MANIP	1.25	6.25	X	1.
M0722	RRIFF INPATIENT HOSPITAL OMT	0.47	1.25	· .X	1.
140724	LIMITED INPATIENT HOSPITAL OMT	0.69	2.5	X	1
M0726	INTERMEDIATE INPATIENT HOSPITAL OMT	0.92	3.75	· X	1
M0728	EXTENDED INPATIENT HOSPITAL OMT	1.07	5	1.05	3
M0730	COMPREHENSIVE INPATIENT HOSP OMT	1.25	.6.25	X	1

** Reflects downward adjustment of 2.8 percent for budget neutrality

BILLING CODE 4120-01-0

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TABLE 2

REVISIONS TO GLOBAL PERIODS

.

			INITIAL GLOBAL FEE	REVISED GLOBAL FEE
•	HCPCS*	DESCRIPTION	PERIOD	PERIOD
	11040	SURGICAL CLEANSING, ABRASION	010	000
	11041	SURGICAL CLEANSING OF SKIN	010	000
	11042	CLEANSING OF SKIN/TISSUE	010	000
	11043	CLEANSING OF TISSUE/MUSCLE	090	010
	11044	CLEANSING OF TISSUE/MUSCLE/BONE	090	010
	11900	INJECTION INTO SKIN LESIONS	010	000
	11901	ADDED SKIN LESION INJECTIONS	010	000
	21550	INJECT TENDON/LIGAMENT/CYST	010	000
	20660	APPLY, REMOVE FIXATION DEVICE	090	000
	30901	CONTROL OF NOSEBLEED	010	000
	30903	CONTROL OF NOSEBLEED	010	000
·	30905	CONTROL OF NOSEBLEED	010	000
	30906	REPEAT CONTROL OF NOSEBLEED	010	.000
	31600	INCISION OF WINDPIPE	090	000
•	31601	INCISION OF WINDPIPE	090	000
	32002	TREATMENT OF COLLAPSED LUNG	010	000
	32005	TREAT LUNG CHEMICALLY	010	000
	32020	INSERTION OF CHEST TUBE	010	000
	32700	VISUALIZE CHEST CAVITY	090	000
	32705	INSPECT/BIOPSY CHEST CAVITY	090	000
	36010	PLACE CATHETER IN VEIN	XXX	000
	43460	PRESSURE TREATMENT ESOPHAGUS	090	000
	43750	PLACE GASTROSTOMY TUBE	090	010
•	47000	NEEDLE BIOPSY OF LIVER	010 .	000
	54220	TREATMENT OF PENIS LESION	010	000
	59840	ABORTION	090	010
	59841	ABORTION	090 💡	:010
	61107	DRILL SKULL FOR IMPLANTATION	090 👘	000
	61210	PIERCE SKULL; IMPLANT DEVICE	090	000
	64600	INJECTION TREATMENT OF NERVE	090	010
	64605	INJECTION TREATMENT OF NERVE	090	010
	64610	INJECTION TREATMENT OF NERVE	090	010
	65205	REMOVE FOREIGN BODY FROM EYE	010	000
	65210	REMOVE FOREIGN BODY FROM EYE	010	000
	65220	REMOVE FOREIGN BODY FROM EYE	010	000
	-65222	REMOVE FOREIGN-BODY FROM EYE	010	000
	69610	REPAIR OF EARDRUM	090	010
	•			

* All numeric CPT HCPCS Copyright 1992 American Medical Association

SILLING CODE 4120-01-C

Federal Register / Vol. 56, No. 227 / Monday, November 25, 1991 / Rules and Regulations 59781

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RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION

*CPCS	HCO	status	DESCRIPTION	york Rvjs	PRACTICE EXPERSE RVUs	RAL- PRACTICE RVU4	TOTAL EVAN	SOURCE OF WORK RVUS	GLOBAL FEE PERIOD
#0072		Ð	IMANOTHERAPY FOR MALICMENT DIREAS	0.00	6 60	A 45	n n4		
H0075		Ň	CELLULAR THERAPY	0.00	8 60	0.00	6.00		3222
N0076		K	PROLOTHERAPY	0.00	0.00	0,00	0.00		2023
x0030		₽	NYPERTHERMIA THERAPY	0.00	0.00	0.00	0.00		XXX
901CD		銊	INTRAGASTRIC NYPOTHERKIA	0.00	0.00	6.00	0.00		XXX
NO101		A	Cutting or removal of corks	0.18	0.36	0.03	0.77	2	XXX
N0300		¥	IV CHELATION THERAPY	0.00	0.00	0.00	0.00		XXX
194341 147273		87 14	PARKIC WAPPING OF AROCRINAL AREDR	0.00	0.00	0.00	0.00		XXX
80520		M A	REALEMENT OF CARDIAC COTPUT	0.00	0.00	0.00	0.00		XXX
#0525		Ď	EINGLE LEAD FEG WITH ANALYSIS	0.00	6.00	0.00	0,00		3.5.2 WWW
10526		ō	COMPUTER TRACING AND INTERPRETATIO	0.00	0,00	0.00	0.00		2001
K0530		Ø	CARDIAC EVENTS RECORDER. ECG	0.00	0.00	0.00	0.00		100
10535		10 ·	CARDIAC EVERTS RECORDER, ECO	0.00	0.00	0.00	0.00		XXX
N0540		Q	SIGNAL-AVERAGING EKG	0.00	0.00	0.00	0.00		XXX
80560		0	PHELBODLETRYSNOGRAPHY VEHOUS OCCLU	0.80	00.00	0.00	0.00		KXXX
16J7/3 MAK 84		0	ELECTROENCEPHALOXIRAN (EEG), INTERP	0.60	0.00	0.00	0.00		KACK.
N010V N0585		v		00,0	0.00	6.00	6.90		XXXX
H0590		Ď	WHITCHING FCC. FEC OF DEFSSIRE	0.00	0,00	6.00	9.00 8.60		XXX XXX
N0601		5	PSYCHOLOGICAL TESTING, WITH REPORT	5.80	0.00	0.00	0.00		XXX XXX
M0702		A	BRIEF, OSTEOPATHIC HANIP THEKAPY	0.47	0.25	0.02	0.76	۴ -	XXX
M0704		*	LINITED, OSTEOPATHIC MANIP THERAPY	0.66	0.41	0.03	1.10	1	YXX
R0706		A	INTERMEDIATE OSTEOPATHIC HANTP THE	54.0	0.40	0.03	1.35	1	XXXX
N0708		A	EXTENDED OSTEOPATHIC MAHIP THERAPY	80.7	0.45	.6.04	1.57	2	XXX
M071D		Ą.	COMPREHENSIVE OSTEOPATHIC MARIP	1.25	0.40	0.03	1.68	1	XXX
RU/22		A.	BRIEF INPATIENT HOSPITAL ONT	0.47	0.62	0.05	1.14	2	XXX
RV164		A A	LINITED INPALLER MOSPITAL ONI	0.69	0.85	0.07	1.61	1	XXX
NO720		R	TRIERPEUTATE TAPATTENT MARKATAL CA	0.92	0.82	0.06	1.80	2	2022
M0730		Â	COMPREMENSIVE INDATIENT MARPINE COMPREMENSIVE	1.07	0.39	0.05	1.8/	1	AXX
10799		đ	PHYSICAL MEDICINE, MOC	1.60	0.00	0.04	n.no	4	884 777
NG900		Ă	EXCISION, REVISION OF A-V SHIRT	2.34	5.30	1.00	8.73	2	600
80910		8	INSERTION CATHETERS FENCEAL VEIN	0.00	6.00	0.00	0.00	•	XXX
P2028		x	CEPHALIN FLOQULATION, BLOOD	0.00	0.00	0.00	0.00		XXX
P2029		X	CONGO RED, SLOOD	0.00	0.00	0.00	0.00		XXX
P2031		Ř	HAIR ANALYSIS (EXCLUDING ARSENIC)	0.00	0.00	6.00	0.00		XXX
F6036 B3081		8	ICIERUS IRDER, ELDOD	6.00	6.05	6.00	0.00		XXX
82038		¥	Intral (CASIDIIT, SCOOL) SEPTEMBETTETS BITTO (CERTSFORM)	0.00	0.00	0.00	6.60		XXX
3000		÷.	RESERVICE BAD ENGLE PERVIPEI	4,00 6 65	0,00 0.00	0.00	0.00 0.60		886 VVV
3001		r	ECHERVING PAP SHEAP, CERVICAL	0.00	0.00	0.00	A 60		800 800
P3001	26	A	SCREENING PAP DEAR, CERVICAL	0.44	0.33	0.06	0.81	2	XXX
7001		x	CLATURE, BACTERIAL, URINE	0.00	0.00	0.00	0.00	-	XXX
7020		D	VACCINE, AUTOGENOUS	0.00	0.00	0.00	6.00		XXX
9005		Ð	Administration fee sy a provider	0.00	0.00	6,00	0.00		XXX
P007		8	KANDLING CHARGE FOR PURCHASED LAE	0.00	0.00	0.20	0,00		XXX
9010		Ę	ELOOD (WHOLE), FOR TRANSFUELOW	0.00	6.00	6.00	0.00		XXX
77411 200112		2	BLOUD (SPLIT UNIT), SPECIFY ANDUNT	0.00	6.00	0.00	9.00		XXX
5100		5	STORTHYCE WIT	0.00	0.00	6.00	0.00 0.65		888 999
9014		£	ALORULTH, CANNA	0.00	0.00	0.00	0.00		XXX
9015		Ē	GLOSERIN, RH INNRE.	0.00	8.00	0.00	0.00		KNX
9016		Ē	LEUROCYTE POOR BLOOD, EACH UNIT	0.00	0.00	0.00	0.00		XXX
9017		E	PLASMA, SINGLE DONOR, FRESH FROZEN	0.00	0.00	0.00	0.00		XXX
2018		E	PLASHA PROTEIN FRACTION, EACH UNIT	0.00	0.00	0.00	0.00		- XXX
9019		£	PLATELET CONCENTRATE, EACH UNIT	0.00	0.00	0,00	0.00		XXX
5020		÷.	PLATELET RICH PLASMA, EACH UNIT	0.00	0.00	0.00	0.00		XXX
9021		Ĕ.	RED BLOOD CELLS, EACH WRIT	0.00	0.00	Q.QQ	0.00		XXX
7V62 0072		5	WASHED RED BLUED CELLS, EACH UNIT	U.00	0,00	0.00	8.00		KRX WVV
0026		2 8	PALICE VIII LUNCERIKALE, LTUPRIL.	0.00	0.00	0.00	0.00		XXX VVV
9603		ž	TRAVEL ALLOWANCE ONE LINY - LAB	¢.00	0.00	0.00	0.60		XXX
9604		x	TRAVEL ALLOWANCE ONE MAY + LAR	0.00	0.00	0.00	0.00		XXX
9605		× X	ROUTINE VENIFUNCTURE	0.00	0.00	0,00	0.00		XXXX
9610		X	CATHETERIZATION SPECIMEN COLLECT	0.00	0.00	0.00	0.00		XXXX
9615		X	CATHETERIZATION SPECINEN COLLECT	0.00	0.00	0,00	0.00		X301
0034		X	ADMINISTRATION - INFLUENZA VACUINE	0.00	0.00	8.00	0.00	-	XXX
2235		A	CARD I CKYMOGRAPHY	0.18	6.42	0.03	8463	2	XXX

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ADDENDLAT B

RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION

	•				PRACTICE	MAL-	TATAL	GLOBAL	SURGICAL/
		*****	nerroiotian	NORK	EKPENSE Biata	PKALIJUE	RVUS	PERICO	UPDATE
*******		318103						******	<i>ىلەن الىلىكان ئە</i> بلېلىكىسىسىسىسى
10/230		E	RECREORETHANTHE HCL	0.00	0.00	Ó.,QO	0,00	XXX	0
19240		Ē	NEDROYPROGESTERONE ACETATE	0.00	0.00	0.00	0.00	XXX	Ŭ A
19259		ō	KETHOTREXATE SOOTUN HIK	0.00	0.60	6.00	6,00	· XXX	9 A
19260		E	RETROTREXATE SODILIN MIX	0.00	0.00	0.00	0.00	XXX 999	U 6
19270		Ē	PLICANYCIN (NITHRANYCIN)	0.00	0.00	0.00	8,90 8 AA	888 VVV	ġ,
19280		3	MITOMYCIN	0.00	0.00	0.00	0.00	AAR VVV	ň
19290		- Đ	KITCHYCIN	0,00	0.00	0,00	ົກ 65	YYY	Č
19291		0		0.00	0,00	0.00	6.00	XXX	Ó
39293		影	INJELIUR, MINAANKUNE HLL Datumeterika	8.60	6.00	0.00	0.00	XXX	0
19293		5	PLATESTRADICA PROSPERIE	5.00	0.00	0.00	0.00	XXXX	Ů.
4 7 .000		e P	(c)1980.000 100 (c)1980.000 100	0.00	0.00	0.00	0.00	XXX	¢.
10760		e e	TWIOTEPA	0.00	0.00	6.09	0°.00	XXX	0
30340		÷.	VINBLASTINE SULFATE	0.00	0,00	0,00	0.00	XXX	Ç
J9370		Ē	VINCRISTIKE SULFATE	0.00	0.00	0.00	0.00	XXXX	U O
19375		ō	VINCRISTINE SULFATE	0.00	0,00	0.00	0.60	XXX	V.
19380		b,	VINCRISTINE GULFATE	0.00	0.00	0.00	0.00	XXX	Š.
J\$999		E	NOT OTHERWISE CLASSIFIED DRUCS	0.00	0.00	8.00	6 4 3	VYY	. 12
N0005		A	OFFICE VISITS . THO OR HORE HODAL.	0,78	0.31	6.03	0.40	XXX	1
M0006		Ą	OFFICE VISITS - VITH ONE WORALITY	4,72	2.17 17 19	0.06	1.62	2000	ž.
10007		A	Objice AI211 COMMUNATION OF NAME:	6 53	8.11	0.01	0.64	XXX	x
HOORS		Å	WHILE VISIL CANDINATION OF MANA-	0.37	6.10	0.03	0.59	XXX	# .
195009 .		A .u	WHITCH A ARCALLET ME ALON ALON.	0.00	0.00	9.00	0.00	XXXX	0
200012 60075		54 140	DBU ULTEBERA	0.00	0.00	0.00	0.00	XXX	0
-100100		Å.	INTRACASTRIC HYPOTHERMIA	0.00	0.00	0.08	0.00	XXX	0
80101		Å	CUTTING OR RENOVAL OF CORNS	0.37	0.35	0.03	0.75	XXX	
20300		`¥	IV CHELATION THERAPY	0.00	0.00	0.00	0.00	XXX	
N0301		· N [*]	FABRIC URAPPING OF ABOOMINAL AMELE.	0.00	0.00	0.00	0.00	KAA.	ů.
N0302		1	ASSESSMENT OF CARDIAC OUTPUT	0.00	0.00	0.00	0.00	AAA 600	LE C
M0702		- A	BRIEF, OSTEOPATHIC NAMIP THERAPY	0.40	U.24 0.40	8.46 ·	\$ \$0	000	ы. Е
H0704		A	LINITED, OSTEOPATHIC MARIP INERAPY	U.G/ // #0	6 TO	0.03	1.31	000	- M
10706	-	, A	INTERACTIALE USIECTAINIC MARIE INCK	4.07	8.14	0.06	1.53	666	Ŵ
N0703	,	, <u>A</u> .	EXIENDED USIEURAINIU PARLY INGRAFI	1.22	8.39	0.03	1.66	000	K
HU(10			ABTER INDETIENT MACDITAL AND	0.46	0.60	0.05	1.11	000	N ·
HU166 '		A .	I THITTED INDATIFUT KOSPITAL ONT	0.67	0.83	0.07	1.57	000	· N
140724		Â	INTERMEDIATE INPATIENT NOSPITAL ONT	0.89	0.60	0.06	1.75	000	K
10778		Å	EXTENDED INPATIENT HOSPITAL ONT	1.05	0.35	0.03	1.43	000	R.
10730		Å	COMPREMENSIVE INPATIENT HOSP ONT	1.22	0.53	0.04	1.79	000	義
N0900		Å	EXCISION, REVISION OF A-V SHENT	2.27	5.15	1.06	8.48	UQU 1000	- FE
P2028		X	CEPHALIH FLOCULATION, BLOOD	0.00	0.00	0.00	0.00	AAR WWW	. U
F2029 -		X	congo red, blood	0.00	0.00	0.00	0.64		å ·
P2031		饍	HAIR ANALYSIS (EXCLUDING ARSENIC)	0.00	0.00	6.00	0.00	XXX	· ð
P2033		X	TRYNCL TURBIBITY, SLOAD	8 00	0.00	0.00	0.00	· XXX	0
P2038		. X		0.00	0.00	0.00	0.00	XXX ·	0
P3000	94	*	CORECTING DAD CHEAD CROWICH	0.43	0.32	0.04	0.79	XXX	X.
P2001	20	Ŷ	SCOPENING PAP SHEAR, CERVICAL	0.00	. 0.00	0.00	0.00	XXX	6
P7061		Ŷ	CULTURE, BACTERIAL, URINE	0.90	0.00	0.00	0.00	XXX	-02
P9010 -		Ē	BLOOD (WHOLE), FOR TRANSFLISION	0.00	0.00	0400	0.00	XXX	U A
09011		E	BLOOD (SPLIT UNIT), SPECIFY ANOUNT	0.00	0.00	0.00	0,00	XXX JULY	
P9012		E	CRYOPRECIPITATE, EACH UNIT	0.00	0.00	0.00	0.00	AXA VVV	n a
P9013		ε	FIBRIHOGEN UNIT	0.00	0.00	0.00	0.00	· 222	à
P9014		E	glosulie, canka	0.00	0.00	0.00 A 06	A M	XXX	ā.
P9015		E	GLOBULIE, RH LARKKE.	0.00	ሳ ሰሳ ሰ ሰሳ	0.00 8.00	0.00	XXXX	õ
P9016		£	LEUROCYTE POOR BLOOD, EACH UNIT	0.00	0.00	0.00	0.00	XXX	Ď.
P9017		3	PLASRA, BINGLE DUNK, MICH PRICEN	0.00	0.00	0.00	0.00	XXX	0
P9018		E,	PLAZEA PRUIEIN FRAGIAUN, EACH UNII Menteur prucentrate farm imit	0.00	0.00	0.00	0.00	XXXX	Q
PYV19		2	PLATELET GUNGERIAALEY LAWN WILL . DIATELET BICK PLASMA FACH LWIT	0.00	0.00.	0.00	0,00	XXX	σ.
PYUCU 160021		É.	PED BLOOD CELLE. EACH UNIT	0.00	0,00	0.00	0.00	XOX	0
P9022	•	2	WASHED RED BLOOD CELLS, EACH UNIT	0.00	0.00	0.00	0.00	XXXX	. 0
20%94		x	TRAVEL ALLOWANCE ONE WAY . LAB	0.00	0.00	0.00	0.00	XXX'	U A
P9604		X	TRAVEL ALLONANCE ORE WAY - LAS	0,03	0.00	00,00	V.UU A AA		ő
296.05	•	X	AOUTINE VENIPUNCTURE	0.00	0,00	4.04	4400	AAA	-

8+158·

Date

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Memorandum

. JUL 0 6 1994

From Director Office of Payment Policy, BPD

Subject Policy Issues Related to Osteopathic Manipulative Treatment

All Associate Regional Administrators

To for Medicare

We have been asked to clarify how osteopathic manipulative treatment (OMT) and evaluation and management (E/M) services provided on the same date are to be reported and paid. We have heard allegations that some carriers are routinely rejecting claims submitted with both an E/M code and an OMT code.

In addition, we have been asked to clarify how OMT is reported and whether it is necessary for OMT and an E/M service on the same date to be unrelated to each other in order for payment to be made for both services. To reiterate previous directives and to further clarify our policies, please note the following:

 <u>CPT 1994</u> includes new codes for OMT. They replace HCPCS codes M0702 - M0730 which have been deleted and are no longer valid. The CPT codes and the introductory paragraphs preceding them are as follows:

"Osteopathic manipulative treatment is a form of manual treatment applied by a physician to eliminate or alleviate somatic dysfunction and related disorders. This treatment may be accomplished by a variety of techniques.

Body regions referred to are: head region; cervical region; thoracic region; lumbar region; sacral region; pelvic region; lower extremities; upper extremities; rib cage region; abdomen and viscera region.

- 98925 Osteopathic manipulative treatment (OMT); one to two body regions involved
- 98926 three to four body regions involved
- 98927 five to six body regions involved

-65-

- 98928 seven to eight body regions involved
- 98929 nine to ten body regions involved"

These are the correct codes to report OMT services. OMT should not be reported by physicians with the codes in the Physical Medicine section of CPT (97260 and 97261) and claims for OMT submitted with the OMT codes should not be recoded to 97260 and 97261.

- The work RVUs assigned to the OMT codes are consistent with the definitions above. For example, OMT on the cervical, thoracic, and lumbar regions would be reported with code 98926 since 3 different regions were treated.
- 3. Some physicians seem to believe the RVUs assigned to the OMT codes represent only the work of OMT and that any type of evaluation and management (E/M) service on the same date should be separately reported and paid. On the other hand, some carriers seem to believe that the OMT codes have been valued to include E/M services and therefore they will not pay a claim for an E/M service on the same date as an OMT service.

Neither point of view is completely correct. The actual instructions provided to physicians who participated in the Harvard Resource Based Relative Value Scale (RBRVS) study and who rated the work of OMT were as follows:

"For these services, the service period includes your work for the OMT from the time you begin the service until you complete it. Please consider only your work performing the OMT service, including any cursory history or palpatory examination. In particular, do not include your work assessing a new problem".

Because the work values include some services that could otherwise be reported with an E/M code, i.e., "any cursory history or palpatory examination", we decided to prohibit payment for E/M services on the same date as OMT <u>unless</u> the patient's condition required a significant, separately identifiable E/M service above and beyond the usual E/M services that are integral to the provision of OMT. To implement this policy, we instructed carriers to deny payment for E/M services on the same date as OMT <u>unless</u> the E/M code was appended with a -25 modifier.

4. On June 23, 1992 we issued a memorandum to our regional offices on the issue of the -25 modifier. It had come to our attention that some carriers were not paying for E/M codes . with a -25 modifier unless they were "unrelated" to the OMT. We indicated in the memo that was not correct and stated: "A

documented, separately identifiable <u>related</u> service is to be paid for. We would define related as being caused or prompted by the same symptoms or conditions". Thus, carriers should not deny claims for OMT and an E/M service with a -25 modifier simply because they both are reported with the same diagnosis code. This policy applies whether or not it is a first or subsequent encounter with the patient.

5. When OMT and a significant separately identifiable E/M service are performed on the same date, they should be reported as described above, Physicians should not "upcode" the E/M service and omit the code for the OMT service. Neither should they report different diagnoses for the two services if both services are provided for the same diagnosis.

Please convey this information to the carriers in your region.

Childrette

Charles R. Booth

American Medical Association

Physicians dedicated to the health of America

Sherry L. Smith Committee Secretary AMA/Specialty Society RVS Update Committee 515 North State Street Chicago, Illinois 60610 312 464-5604 312 464-5849 Fax sherry_smith@ama-assn.org

March 10, 2003



Yolanda L. Doss, RHIA Assistant Director Coding and Reimbursement American Osteopathic Association 142 East Ontario Street Chicago, Illinois 60611-2864

Dear Ms. Doss:

I am responding to your letter of February 24, 2003 regarding clarification of the resources currently included in the Osteopathic Manipulative Treatment (OMT) CPT codes 98925-98929. Specifically, you are seeking any data or explanation to clarify that Evaluation and Management Services are not incorporated into the OMT codes.

As you stated in your correspondence, CPT codes 98925-98929 were cross-walked from HCPCS Level II codes (M0702-M0730) in 1994. At this time, the specialty proposed cross-walking the relative values from these old codes to the new CPT codes, and the AMA/Specialty Society RVS Update Committee (RUC) agreed that this would be appropriate. The RUC did not review survey data or other rationale regarding the new OMT codes. The physician time that is currently utilized for the OMT codes was also cross-walked from the HCPCS Level II codes, which was based on survey data from the Harvard studies.

I have attached the RUC's standardized survey document instructions which specifically describe the elements of physician work and defines pre-, intra-, and post-service activities. Please note that on page four of the survey, a definition of the pre-service period specifically states that distinct evaluation and management services provided in addition to the procedure (reported with a modifier -25) are <u>not</u> included in the pre-service work for the service.

The RUC's Practice Expense Advisory Committee (PEAC) recently reviewed the OMT codes at its September 2002 meeting. The RUC has since approved these recommendations and has submitted them to the Centers for Medicare and Medicaid Services (CMS). It is expected that CMS will publish its consideration of the PEAC recommendations for this cycle in the Spring 2003 Proposed Rule and changes will be implemented on January 1, 2004.


Yolanda L. Doss, RHIA March 10, 2003 Page Two

As you know, the PEAC/RUC assumed that in the typical scenario, a separate E/M service would be reported on the same date as an OMT service. Therefore, the PEAC/RUC limited the resources (clinical staff time, medical supplies, and medical equipment) to those that are directly attributed to the OMT service. I have attached both the standard PEAC/RUC direct practice expense inputs for the E/M services and the recent recommendations for the OMT codes to this letter.

I hope that this information is helpful in providing additional clarification regarding the resources, both physician work and practice expense, that are currently included in the OMT codes. Please contact me if you require further assistance.

Sincerely, herry 2hut Sherry L. Smith

Cc: Boyd R. Buser, DO David F. Hitzeman, DO Joseph R. Schlecht, DO Robert J. Stomel, DO

The American Medical Association/Specialty Society RVS Update Committee

PHYSICIAN WORK RVS Update Survey

New/Revised CPT Code:

Global Period: 000

CPT Code Descriptor:

Typical Patient/Service:

INTRODUCTION

Why should I complete this survey?

The AMA/Specialty Society RVS Update Committee (RUC) and the ______needs your help to assure relative values will be accurately and fairly presented to CMS during this revision process. This is important to you and other physicians because these values determine the rate at which Medicare and other payers reimburse for procedures.

What if I have a question?

Contact: {Include Specialty Society Contact}

How is This Surveyed Organized?

Each new/revised code must be surveyed (i.e., **there is one questionnaire per code**), so you may have several questionnaires to complete. Each questionnaire is organized the same and is comprised of questions relating to physician work.



The following information must be provided by the physician responsible for completing the questionnaire.

Physician Name:	
Business Name:	
Business Address:	
City:	
State:	
Zip:	
Business Phone:	()
Business Fax:	()
E-mail Address:	
Physician Specialty:	
Years Practicing Specialty:	
Primary Geographic Practice Setting:	Rural Suburban Urban
Primary Type of Practice:	Solo Practice Single Specialty Group Multispecialty Group Medical School Faculty Practice Plan

PHYSICIAN WORK

INTRODUCTION

"Physician work" includes the following elements:

- Physician time it takes to perform the service
- Physician mental effort and judgment
- Physician technical skill and physical effort, and
- Physician psychological stress that occurs when an adverse outcome has serious consequences

All of these elements will be explained in greater detail as you complete this survey.

"Physician work" does **not** include the services provided by support staff who are employed by your practice and cannot bill separately, including registered nurses, licensed practical nurses, medical secretaries, receptionists, and technicians; these services are included in the practice cost relative values, a different component of the RBRVS.

Page 3

Background for Question 1

Attached is a list Reference Services that have been selected for use as comparison services for this survey because their relative values are sufficiently accurate and stable to compare with other services. The "2002 Work RVU" column presents current Medicare RBRVS work RVUs (relative value units). Select one code which is most similar to the new/revised CPT code descriptor and typical patient/service described on the cover of this questionnaire.

It is very important to consider the global period when you are comparing the new/revised code to the reference services. A service paid on a global basis includes:

- visits and other physician services provided within 24 hours prior to the service;
- provision of the service; and
- visits and other physician services for a specified number of days after the service is provided.

The global periods listed on the cover of the survey refer to the number of <u>post-service</u> days of care that are included in the payment for the service as determined by the Health Care Financing Administration for Medicare payment purposes.

Categories of *Global Period:*

- **090** 90 days of post-service care are included in the work RVU
- **010** 10 days of post-service care are included in the work RVU
- 000 0 days of post-service care are included in the work RVU
- **ZZZ** This code is reported in addition to a primary procedure and only the additional work to perform this service is included in the work RVU
- **XXX** A global period does not apply to the code and evaluation and management and other diagnostic tests or minor services performed, may be reported separately on the same day
- QUESTION 1: Which of the Reference Services on the attached list is most similar to the new/revised CPT Code Descriptor and Typical Patient Service described on the cover of this questionnaire?

CPT Code

Background for Questions 2 & 3 SURGERY (000 Global Period)

PRE-SERVICE PERIOD

The pre-service period includes physician services provided from the day <u>before</u> the operative procedure until the time of the operative procedure and <u>may</u> include the following:

- Hospital admission work-up.
- The pre-operative evaluation may include the procedural work-up, review of records, communicating with other professionals, patient and family, and obtaining consent.
- Other pre-operative work may include dressing, scrubbing, and waiting before the operative procedure, preparing patient and needed equipment for the operative procedure, position-ing the patient and other non "skin-to-skin" work in the OR.

The following services are <u>not included</u>:

- Consultation or evaluation at which the decision to provide the procedure was made (reported with modifier -57).
- Distinct evaluation and management services provided in addition to the procedure (reported with modifier -25).
- Mandated services (reported with modifier –32).

INTRA-SERVICE PERIOD

The intra-service period includes all "skin-to-skin" work that is a necessary part of the procedure.

POST-SERVICE PERIOD

The post-service period includes services provided on the day of the procedure if the global period is 000, post-service period <u>may</u> include the following:

• <u>Day of Procedure</u>: Post-operative care on day of the procedure, includes non "skin-to -skin" work in the OR, patient stabilization in the recovery room or special unit, communicating with the patient and other professionals (including written and telephone reports and orders), and patient visits on the day of the operative procedure.

The following services are <u>not included:</u>

- Unrelated evaluation and management service provided during the postoperative period (reported with modifier -24)
- Return to the operating room for a related procedure during the postoperative period (reported with modifier -78)
- Unrelated procedure or service performed by the same physician during the postoperative period (reported with modifier -79)

QUESTION 2: How much of <u>your</u> own time is required per patient treated for each of the following steps in patient care related to this procedure? Indicate your time for the new/revised code on the front cover. (*Refer to definitions*)

a) <u>Day Preceding</u> Procedure	New/Revised Code
Pre-service evaluation time:	minutes
b) <u>Day of</u> Procedure	
Pre-service evaluation:	minutes
Pre-service positioning time:	minutes
Pre-service scrub, dress, wait time:	minutes
Intra-service time:	minutes
Immediate post-service time*	minutes

*Post-operative care on day of the procedure, includes non "skin-to-skin" work in the OR, patient stabilization in the recovery room or special unit and communicating with the patient and other professionals (including written and telephone reports and orders). Include patient visits on the day of the operative procedure (e.g., in their hospital room or in the ICU) in section c below for 90-day global procedures.

QUESTION 3: For the New/Revised CPT code and for the reference service you chose, rate the AVERAGE pre-, intra-, and post service *complexity/intensity* on a scale of 1 to 5 (circle one: 1 = low; 3 medium 5 = high). Please base your rankings on the universe of codes your specialty performs.

	New/Revised CPT:					Reference Service CPT:				
PRE-service	1	2	3	4	5	1	2	3	4	5
INTRA-service	1	1 2 3			5	1	2	3	4	5
POST-service	1	2	3	4	5	1	2	3	4	5

Background for Question 4

In evaluating the work of a service, it is helpful to identify and think about each of the components of a particular service. Focus only on the work that **you** perform during each of the identified components. The descriptions below are general in nature. Within the broad outlines presented, please think about the specific services that you provide.

Physician work includes the following:

Time it takes to perform the service.

Mental Effort and Judgment necessary with respect to the amount of clinical data that needs to be considered, the fund of knowledge required, the range of possible decisions, the number of factors considered in making a decision, and the degree of complexity of the interaction of these factors.

Technical Skill required with respect to knowledge, training and actual experience necessary to perform the service.

Physical Effort can be compared by dividing services into tasks and making the direct comparison of tasks. In making the comparison, it is necessary to show that the differences in physical effort are not reflected accurately by differences in the time involved; if they are, considerations of physical effort amount to double counting of physician work in the service.

Psychological Stress – Two kinds of psychological stress are usually associated with physician work. The first is the pressure involved when the outcome is heavily dependent upon skill and judgment and an adverse outcome has serious consequences. The second is related to unpleasant conditions connected with the work that are not affected by skill or judgment. These circumstances would include situations with high rates of mortality or morbidity regardless of the physician's skill or judgment, difficult patients or families, or physician physical discomfort. Of the two forms of stress, only the former is fully accepted as an aspect of work; many consider the latter to be a highly variable function of physician personality.

QUESTION 4: For the New/Revised CPT code and for the reference service you chose, rate the intensity for each component listed on a scale of 1 to 5. (circle one: 1= low; 3 medium 5 = high). Please base your rankings on the universe of codes your specialty performs.

Mental Effort and Judgment	New/Revised CPT:					Ref. Service CPT:				
The range of possible diagnoses and/or management options that must be considered	1	2	3	4	5	1	2	3	4	5
The amount and/or complexity of medical records, diagnostic tests, or other information that must be analyzed	1	2	3	4	5	1	2	3	4	5
Urgency of medical decision making	1	2	3	4	5	1	2	3	4	5
Technical Skill/Physical Effort										
Technical skill required	1	2	3	4	5	1	2	3	4	5
Physical effort required	1	2	3	4	5	1	2	3	4	5
Psychological Stress										
The risk of significant complications, morbidity and/or mortality	1	2	3	4	5	1	2	3	4	5
Outcome depends on skill and judgment of physician	1	2	3	4	5	1	2	3	4	5
Estimated risk of malpractice suit with poor outcome	1	2	3	4	5	1	2	3	4	5

QUESTION 5: How many times have you personally performed these procedures in the past year? New/Revised Code: _____ Reference Service Code: _____

QUESTION 6: Is your typical patient for this procedure similar to the typical patient described on the cover?

No 🗖

If no, please describe your typical patient for this procedure:

Yes 🗖

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For example, if the new/revised code involves the same amount of physician work as the reference service you choose, you would assign the same work RVU. If the new/revised code involves twice as much (or half as much) work as the reference service, you would calculate and assign a work RVU value that is twice as much (or half as much) as the work RVU of the reference service. This methodology attempts to set the work RVU of the new or revised service relative to the work RVU of comparable and established reference services.

	Δ	Р					<u> </u>		1	1	K	1	N/
1	A	В		9892	<u>⊢</u> 25	 	<u> </u>	9892	27	J 9892	<u> </u>		29
	Meeting Date: February 2011			Osteopa	athic	Osteop	oathic	Osteop	athic	Osteop	athic	Osteop	athic
				manipulative	treatment	manipulative	e treatment	manipulative	treatment	manipulative	treatment	manipulative	treatment
				(OMT); 1-	2 body	(OMT); 3-4 bo	ody regions	(OMT); 5-	6 body	(OMT); 7-	8 body	(OMT); 9-′	10 body
				regions in	volved	invol	ved	regions ir	volved	regions ir	ivolved regions involved		nvolved
2		CMS	Staff										
3		Code	Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD	0040	. ypc	iten i denity	raomy		raomy		raomy		raomy		raomy
5	TOTAL CLINICAL LABOR TIME			14.0	0.0	17.0	0.0	20.0	0.0	22.0	0.0	24.0	0.0
5	TOTAL DDE SEDV CLINICAL LADOD TIME			14.0	0.0	17.0	0.0	20.0	0.0	22.0	0.0	24.0	0.0
6	IOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			14.0	0.0	17.0	0.0	20.0	0.0	22.0	0.0	24.0	0.0
8	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
9	PRE-SERVICE												
10	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												
10	End: When patient enters office/facility for surgery/procedure	2											
18	SERVICE PERIOD												
19	Start: When patient enters office/facility for surgery/procedur	e: Servi	ces Prior t	o Procedure		-							
	Greet patient, provide gowning, ensure appropriate medical		RN/LPN/										
20	records are available Obtain vital signs	L037D	MIA	1		1		1		1		1	
22	Provide pre-service education/obtain consent												
	· · · · · · · · · · · · · · · · · · ·		RN/LPN/			-							
23	Prepare room, equipment, supplies	L037D	MTA	1		1		1		1		1	
24	Setup scope (non facility setting only)	-											
25	Prepare and position patient/ monitor patient/ set up IV		KIN/LPIN/ MTA	1		1		1		1		1	
26	Sedate/apply anesthesia			•		·		•		•		•	
27	Intra-service												
			RN/LPN/					10				10	
28	Assist physician in performing procedure	L037D	MIA	6		9		12		14		16	
29	Monitor of following service/check tubes monitors drains												
50			RN/LPN/										
31	Clean room/equipment by physician staff	L037D	MTA	3		3		3		3		3	
32	Clean Scope												
33	Clean Surgical Instrument Package												
35	Review/read X-ray, lab, and pathology reports												
	Check dressings & wound/ home care instructions /coordinate		RN/LPN/										
36	office visits /prescriptions	L037D	MTA	2		2		2		2		2	
37	Discharge day management												
39	End: Patient leaves office												
40	POST-SERVICE Period												
41	Start: Patient leaves office/facility												
42	Conduct phone calls/call in prescriptions												
43	List Number and Level of Office Visits			nre		nost		nost		nost		nost	
45	99211 16 minutes		16	pro		poor		poor				poor	
46	99212 27 minutes		27										
47	99213 36 minutes		36										
48	99214 53 MINUTES 99215 63 minutes		53 63										
50	99238 12 minutes		12										
51	Total Office Visit Time			0	0	0	0	0	0	0	0	0	0
52	Other Activity (please specify)						-						
53	End: with last office visit before end of global period		l loció		0		0		0		0		0
54			Unit										
56	Equipment												
57	table, mobilization-manipulation	EF029		14.0		17.0		20.0		22.0		24.0	
58													
59			I										

AMA/Specialty Society RVS Update Committee Summary of Recommendations Fourth Five-Year Review

February 2011

Observation Care

In the 4th Five-Year Review of the RBRVS, CMS identified CPT codes 99218-99220 as potentially misvalued through the Harvard-Valued – Utilization Over 30,000 screen. The American College of Physicians (ACP) also submitted public comment identifying 99218-99220 to be reviewed in the 4th Five-Year Review. The American College of Emergency Physicians (ACEP) identified 99234-99236 as part of the family of services for RUC review as the valuation for 99234-99236 are based on 99218-99220.

In October 2010, the RUC reviewed and provided recommendations to CMS for codes 99218-99220. However, when the RUC reviewed the survey results for CPT codes 99234, 99235 and 99236, they agreed with the specialty societies that the survey results were flawed, as the time estimates were grossly inaccurate compared to the current times and among similar services. The RUC recommended that CPT codes 99234-99236 maintain the current work RVUs as interim and the specialty societies work with the Research Subcommittee to develop a survey to appropriately capture the work and time required to perform these services. The specialty societies utilized a RUC approved, modified survey instrument to resurvey 99234-99236.

In February 2011, the specialty societies indicated and the RUC agreed that there is compelling evidence demonstrating that the observation or inpatient care services (including admission and discharge services on the same date) were previously valued based on surveys by the specialties of Pediatrics and Emergency Medicine but now these services are primarily provided by Internal Medicine and Family Physicians. In 1997, the RUC previously established that codes 99234-99236 are equivalent to the value of the corresponding initial observation care codes (99218-99220) plus the value of a hospital discharge day service (99238). Since the RUC recommended new work RVUs for the corresponding initial observation codes in October 2010, the RUC determined that the observation or inpatient care services should be similarly reviewed.

99234 Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date

In February 2011, the RUC reviewed the survey results from 50 internal medicine, family, geriatric and emergency physicians. The specialty societies indicated and the RUC agreed that survey results appeared flawed again. The specialty societies determined that the inability to accurately survey the physician time and work required to perform this service was due to the fact that observation same day admit/discharge services are typically performed by hospitalists (primarily internists) or emergency physicians who work in shifts. Therefore, the physician performing the admission is typically not the same physician who performs the discharge and the survey respondents were not including the physician time and work for both parts of the service.

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

The specialty societies indicated and the RUC agreed to use a similar methodology as was established to value these services in 1997, by taking the corresponding initial observation care code, 99218 *Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit. (RUC recommended work RVU = 1.92, pre-time = 10 minutes, intra-time = 30 minutes and post-time = 10 minutes) plus half the value of a hospital discharge day service, 99238 (work RVU = 1.28, pre-time = 8 minutes, intra-time = 20 minutes and post-time = 10 minutes) which appropriately accounts for the physician work and time required to perform this service. Therefore, for CPT code 99234, the RUC recommends maintaining the work RVU of 2.56 as using the aforementioned methodology produces the same result. The RUC also agreed with the specialty societies that to appropriately capture the physician time requires the same methodology, taking the time associated with a 99218 and half the time associated with a 99238. For additional support to the value of 2.56, the RUC noted that key reference service 99221 <i>Initial hospital care evaluation and management* (work RVU = 1.92) and MPC codes 99204 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 2.43) 99222 *Initial hospital care evaluation and management* (work RVU = 2.61) are similar services and maintain the relativity between these services. **The RUC recommends maintaining the current work RVU of 2.56 for**

СРТ	Pre-Eval	Intra	Immed Post	work RVU
Code				
99218	10	30	10	1.92
$+ \frac{1}{2} 99238$	4	10	5	0.64
99234	14	40	15	2.56

99235 Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date

The RUC reviewed the survey results from 33 internal medicine, family, geriatric and emergency physicians. The specialty societies indicated and the RUC agreed that survey results appeared flawed again. The specialty societies determined that the inability to accurately survey the physician time and work required to perform this service was due to the fact that observation same day admit/discharge services are typically performed by hospitalists (primarily internists) or emergency physicians who work in shifts. Therefore, the physician performing the admission is typically not the same physician who performs the discharge and the survey respondents were not including the physician time and work for both parts of the service.

The specialty societies indicated and the RUC agreed to use a similar methodology as was established to value these services in 1997, by taking the corresponding initial observation care code, 99219 *Initial observation 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 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 problem(s) requiring admission to "observation status" are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit. (RUC recommended work RVU = 2.60, pre-time = 10 minutes, intra-time = 40 minutes and post-time = 14.5 minutes) plus half the value of a hospital discharge day service, 99238 (work RVU = 1.28, pre-time = 8 minutes, intra-time = 20 minutes and post-time = 10 minutes) which appropriately accounts for the physician work and time required to perform this service. Therefore, for CPT code 99235, the RUC recommends a work RVU of 3.24. The RUC also agreed with the specialty societies that to appropriately capture the physician time requires the same methodology, the time associated with a 99219 and half the time associated with a 99238. For additional support to the value of 3.24, the RUC noted that key reference service 99222 *Initial hospital care evaluation and management* (work RVU = 2.61) and MPC codes 99205 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 3.17) and 99223 *Initial hospital care evaluation and management* (work RVU = 3.86) are similar services and maintain the relativity between these services. **The RUC recommends a work RVU of 3.24 for CPT code 99235**.

СРТ	Pre-Eval	Intra	Immed Post	work RVU
Code				
99219	10	40	14.50	2.60
$+ \frac{1}{2} 99238$	4	10	5	0.64
99235	14	50	19.50	3.24

99236 Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date

The RUC reviewed the survey results from 33 internal medicine, family, geriatric and emergency physicians. The specialty societies indicated and the RUC agreed that survey results appeared flawed again. The specialty societies determined that the inability to accurately survey the physician time and work required to perform this service was due to the fact that observation same day admit/discharge services are typically performed by hospitalists (primarily internists) or emergency physicians who work in shifts. Therefore, the physician performing the admission is typically not the same physician who performs the discharge and the survey respondents were not including the physician time and work for both parts of the service.

The specialty societies indicated and the RUC agreed to use a similar methodology as was established to value these services in 1997, by taking the corresponding initial observation care code, 99220 *Initial observation 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 to "observation status" are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit. (RUC recommended work RVU = 3.56, pre-time = 15 minutes, intra-time = 45 minutes and post-time = 15 minutes) plus half the value of a hospital discharge day service, 99238 (work RVU = 1.28, pre-time = 8 minutes, intra-time = 20 minutes and post-time = 10 minutes) appropriately accounts for the physician work and time required to perform this*

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service. Therefore, for CPT code 99236, the RUC recommends a work RVU of 4.20. The RUC also agreed with the specialty societies that to appropriately capture the physician time requires the same methodology, the time associated with a 99220 and half the time associated with a 99238. For additional support to the value of 4.20, the RUC noted that key reference service 99223 *Initial hospital care evaluation and management* (work RVU = 3.86) and MPC codes 99255 *Inpatient consultation for a new or established patient* (work RVU = 4.00) and 99285 *Emergency department visit for the evaluation and management of a patient* (work RVU = 3.80) are similar services and maintain the relativity between these services. **The RUC recommends a work RVU of 4.20 for CPT code 99236**.

СРТ	Pre-Eval	Intra	Immed Post	work RVU
Code				
99220	15	45	15	3.56
$+ \frac{1}{2} 99238$	4	10	5	0.64
99236	19	55	20	4.20

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
The following same date of se initial hospital observation sta	codes are used to report observation or inpatient hospital care services provided to patients admi ervice. When a patient is admitted to the hospital from observation status on the same date, the p care code. The initial hospital care code reported by the admitting physician should include the stus services he/she provided on the same date of inpatient admission.	tted and dis hysician sh services rela	scharged on the ould report only the ated to the
When "observa office, nursing "observation st should include when provided For patients ad and 99238 992	ation status" is initiated in the course of an encounter in another site of service (eg, hospital emer facility) all evaluation and management services provided by the supervising physician in conju- tatus" are considered part of the initial observation care when performed on the same date. The o the services related to initiating "observation status" provided in the other sites of service as well by the same physician. mitted to observation or inpatient care and discharged on a different date, see codes 99218-9922	gency depa nction with bservation ll as in the c 0 and 9921	rtment, physician's initiating care level of service observation setting 7, or 99221-99223
99234	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components:	XXX	2.56 (No Change)
	• A detailed or comprehensive history;		

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
	• A detailed or comprehensive examination; and		
	• Medical decision making that is straightforward or of low complexity.		
	Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.		
	Usually the presenting problem(s) requiring admission are of low severity.		
99235	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components:	XXX	3.24
	•A comprehensive history;		
	• A comprehensive examination; and		
	Medical decision making of moderate complexity.		
	Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.		
	Usually the presenting problem(s) requiring admission are of moderate severity.		
99236	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components:	XXX	4.20
	• A comprehensive history;		
	• A comprehensive examination; and		
	• Medical decision making of high complexity.		
	Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.		
	Usually the presenting problem(s) requiring admission are of high severity.		

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS 2010 FIVE YEAR REVIEW SUMMARY OF RECOMMENDATION

CPT Code:99234 Tracking Number Global Period: XXX Specialty Society Recommended RVU: 2.56 RUC Recommended RVU: 2.56

CPT Descriptor: Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of low severity.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 19-year-old pregnant patient (9-weeks gestation) presents to the ED complaining of persistent vomiting for 2 days. The patient is admitted for observation and discharged later on the same day.

Percentage of Survey Respondents who found Vignette to be Typical: 66%

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:

o Review data not available on the unit (e.g. diagnostic and imaging studies)

o Communicate with other professionals and with patient or patient's family

o Obtain and review necessary past results or records not available on the unit

o Perform evaluation/management in other sites of service (e.g., office or emergency department) earlier the same day

Description of Intra-Service Work:

- o Review medical records and data available on the unit
- o Obtain a detailed or comprehensive history
- o Perform a detailed or comprehensive physical exam
- o Consider relevant data, options, and risks and formulate a diagnosis and develop a treatment plan, including making the decision for discharge (straightforward or low complexity medical decision making)
- o Write/review observation admission orders including ordering/arranging for necessary diagnostic testing, consultation and therapeutic intervention(s)
- o Complete medical record documentation and discharge and aftercare forms
- o Provide care coordination for the transition including instructions for aftercare to caregivers

o Order/arrange for post discharge follow-up professional services and testing

o Reconcile medications with attention to pre-admission therapy, observation therapy and outpatient formulary and write prescriptions

Description of Post-Service Work:

o Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management related to this hospitalization

o Receive and respond to any interval testing results or correspondence, including obtaining any results pending at discharge

o Revise treatment plan(s) and communicate with patient and/or caregiver, as necessary

o Complete subsequent discharge records

o Handle (with the help of clinical staff) any treatment failures or adverse reactions to medications that may occur after discharge

SURVEY DAT	ГА									
RUC Meeting Da	ate (mm/yyyy	02/2011								
Presenter(s):	Drs. Larry N	lartinelli, Thoma	as Weida, A	lan Lazaroff,	Jennifer Wiler					
Specialty(s):	ACP, AAFP	, AGS, ACEP								
CPT Code: 99234										
Sample Size: 2650 Resp N:			50	Response	Response: 1.8 %					
Sample Type:	Random	Additional Sa	ample Info	mation: con	isensus panel					
			Low	25 th %	Median*	<u>75th %</u>	High			
Service Perform	nance Rate		0.00	4.25	14.00	50.00	1200.00			
Survey RVW:			1.25	1.73	2.09	2.96	5.00			
Pre-Service Evalu	ation Time:				12.50					
Pre-Service Posit	ioning Time:				0.00					
Pre-Service Scrul	o, Dress, Wait	Time:			0.00					
Intra-Service Ti	me:		10.00	21.25	30.00	45.00	720.00			
Immediate Post	Service-Tim	e: <u>15.00</u>								
Post Operative	<u>Visits</u>	Total Min**	CPT Code	and Numb	er of Visits					
Critical Care tim	ne/visit(s):	<u>0.00</u>	99291x 0 .	00 99292x	0.00					
Other Hospital t	ime/visit(s):	<u>0.00</u>	99231x 0 .	00 99232x	0.00 99233x	0.00				
Discharge Day	Mgmt:	<u>0.00</u>	99238x 0 .	00 99239x 0	.00					
Office time/visit	(s):	<u>0.00</u>	99211x 0 .	00 12x 0.00	13x 0.00 14x 0.0	0 15x 0.00				
Prolonged Serv	ices:	<u>0.00</u>	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 <u>minutes per E/M visit</u>: 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	0023/		Recommended Physician Work RVU: 2.56					
Code:	33234							
			Specialty Recommended Pre-Service Time			Red Pre T	Specialty commended Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:			1	4.00			0.00	14.00
Pre-Service Positioning	Time:			0.00			0.00	0.00
Pre-Service Scrub, Dres	s, Wait Tim	e:		0.00			0.00	0.00
Intra-Service Time:				0.00				
Immediate Post Servio	ce-Time:	<u>15.00</u>						
Post Operative Visits		<u>Total Min**</u>	CPT Code and Number of Visits					
Critical Care time/visit	t(s):	<u>0.00</u>	99291x	0.00	992	92x (0.00	
Other Hospital time/vi	sit(s):	0.00	99231x	0.00	992	32x (0.00 99233x	0.00
Discharge Day Mgmt:		<u>0.00</u>	99238x	0.0 9	9239>	× 0.0		
Office time/visit(s):		<u>0.00</u>	99211x	0.00	12x 0	.00 1	3x 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	992	25x (0.00 99226x	0.00

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99221	XXX	1.92	RUC Time

<u>CPT Descriptor</u> Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1
99204Global
XXXWork RVU
2.43Time Source
RUC TimeMedicare Utilization
3,426,345CPT Descriptor 1
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 moderate
complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the
nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high
severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

				Most Recent
MPC CPT Code 2	<u>Global</u>	Work RVU	Time Source	Medicare Utilization
99222	XXX	2.61	RUC Time	2,854,030

<u>CPT Descriptor 2</u> 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 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 problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.

Other Reference CPT Code	<u>Global</u>	Work RVU	Time Source
99326	XXX	2.63	RUC Time

<u>CPT Descriptor</u> Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes with the patient and/or family or caregiver.

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including existing time 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 % Source of Time **Key Reference** TIME ESTIMATES (Median) **CPT Code: RUC Time CPT Code:** 99234 <u>99221</u> Median Pre-Service Time 14.00 10.00 40.00 30.00 Median Intra-Service Time

Median Immediate Post-service Time	15.00	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	69.00	50.00
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Intra-Service intensity/complexity

Post-Service intensity/complexity

(of those that selected Key Reference code)

<u>Mental Effort and Judgment (Mean)</u>		
The number of possible diagnosis and/or the number of	2.54	2.54
management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests,	2.54	2.46
and/or other information that must be reviewed and analyzed		
Urgency of medical decision making	2.69	2.46
<u>Technical Skill/Physical Effort (Mean)</u>		
Technical skill required	2.08	2.00
1		
[]		
Physical effort required	2.15	2.08
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.69	2.46
Outcome depends on the skill and judgment of physician	2.46	2 38
Sucone depends on the skin and judgment of physician	2.40	2.50
Estimated risk of malpractice suit with poor outcome	2.92	2.77
INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference
		Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.08	2 15
The Service intensity/complexity	2.00	2.10

2.69

2.15

2.69

2.00

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.

99234 Rationale

General:

The survey data for the observation or inpatient care services (including admission and discharge services) codes, 99234-6, once again appear to be flawed. The specialty societies worked with the Research Subcommittee after the October 2010 RUC Meeting to modify the survey instrument in an attempt to more accurately capture the time and work involved in performing these services. Despite these efforts, we do not feel that we were able to accurately survey the time and work it takes to perform the services of this family of codes.

Physician Work:

We continue to believe that the survey results for 99234-36 reflect that these services are being performed differently now than when they were last surveyed in 1997. Observation same day admit/discharge services are largely being performed by hospitalists (primarily internists) or emergency physicians who work in shifts. This means that the physician performing the admission is typically not the same physician who performs the discharge. This is why we believe the surveys are flawed; the respondents did not include the time and work for both parts of the service. We cannot explain the discrepancy of the wRVU of the two surveys done only a few months apart, and drawn from a similar pool of physicians.

We do not feel that the survey respondents accounted for the additional work of the discharge involved in this code. In addition, the median wRVU of the current survey (2.09) is only 80% of the median wRVU of the survey done in July 2010 (2.60). The current 99234 survey median wRVU (2.09) is only 0.18 more than the wRVU of the recently approved base code 99218. (1.92)

This is not a realistic increment to account for the additional work of the discharge that occurs with 99234.

When these codes were valued previously by the RUC, the work values were derived by adding the work value of an admission (99221-99223) to the work value of a discharge service (99238).

Time:

November 2010 survey respondents for 99234 added no additional intra-service time to account for the work of completing the discharge when compared to the intra-service time for 99218. They added 2.5 minutes of preand 5 minutes of post-service time to the value of 99218 to account for the additional time necessary to complete the discharge work.

Key Reference Service:

99221 (initial hospital visit)

- Requires 3/3 key components; detailed or comprehensive history and exam; medical decision making of straightforward or low complexity.
- wRVU 1.92
- Pre-service time 10 minutes
- Intra-service time 30 minutes
- Post-service time 10 minutes
- Total time 50 minutes

CPT code 99221 was chosen as the key reference service by 26% of the respondents. 99221 has significantly less intra-service and total time than the proposed times for 99234. 99234 and 99221 have the same documentation and medical decision-making requirements for the initial evaluation of the patient.

The respondents rated 99234 as more intense/complex than 99221. 99221 describes an initial evaluation only and does not require the work of discharge inherent to 99234.

Multispecialty Points of Comparison (MPC):

MPC code 99204 (initial office visit)

- Requires 3/3 key components; comprehensive history and exam; medical decision-making moderate complexity)
- wRVU 2.43
- Pre-service time 5 minutes
- Intra-service time 30 minutes
- Post-service time 10 minutes
- Total time 45 minutes

MPC code 99204 has a lower wRVU (2.43) than the proposed work value of 2.56, and less intraservice and total time than 99234 (which has proposed times of 15/40/15).

MPC 99204 includes the evaluation of only a stable outpatient. 99234 describes a patient with enough diagnostic uncertainty and/or clinical instability to require admission to observation. In addition, 99204 does not include the discharge work inherent to 99234.

The intra-service time of 99204 is 10 minutes less than that proposed for 99234; however, the presenting problems of 99204 are of higher complexity, and 99204 requires a higher level of medical decision-making than 99234.

MPC code 99222 (initial hospital visit)

- Requires 3/3 key components; comprehensive history and exam; medical decision-making moderate complexity
- wRVU 2.61
- Pre-service time 15 minutes
- Intra-service time 40 minutes
- Post-service time 20 minutes
- Total time 75 minutes

MPC code 99222 has an intra-service time that is equal to the proposed time for 99234; however, it has higher levels of 3/3 key components than is required of 99234.

MPC code 99222 has 5 minutes more total time than 99234.

MPC code 99222 describes only the initial evaluation of a patient and does not include the discharge work inherent to 99234. 99234 requires both admission and discharge work, albeit with a lower level of medical decision-making.

MPC code 99326 (domiciliary or rest home visit, new patient)

- Requires 3/3 key components; detailed history and exam; medical decision-making moderate complexity
- wRVU 2.63
- Pre-service time 15 minutes
- Intra-service time 45 minutes
- Post-service time 17 minutes
- Total time 77 minutes

CPT Code: 99234 MPC code 99326 describes a domiciliary or rest home visit to a new patient with the same or less history and exam as 99234, and medical decision-making that is higher (moderate vs. straightforward or low complexity).

Surveyed code 99234, however, has 5 fewer minutes of intra-service time and 7 fewer minutes of total time than MPC 99326. MPC code 99326 describes a patient who is clinically stable and does not have the diagnostic uncertainty and/or clinical instability described by 99234.

In addition, surveyed code 99234 also contains the discharge work inherent to the code. The work of 99234 is more complex than the work of MPC code 99326.

Building Block Method:

Representatives of ACP, AAFP, ACEP, AGS and SHM convened a consensus panel to discuss the current and previous survey data and to arrive at a rational and fair assessment of the 99234-99236 family of codes. The Panel examined possible explanations why two separate surveys, done only a few months apart failed to provide what the Panel felt to be an accurate valuation for the 99234-99236 code family. In addition to the fragmentation of work noted above, this family of codes describes a bundled service, admission and discharge. There are no other comparable E&M codes to use as references. The survey respondents would not have realized that a building block approach is the appropriate method to value these codes. Thus, the respondents valued this code family using the single "best" code that describes the work of 99234-99236, as instructed. This is one of the reasons that the surveys times and work values are inappropriate.

The consensus panel reviewed the current and previous survey results and proposes the following building block approach. The panel started with the premise that the surveys and values of 99218-99220 assigned by the RUC at the October 2010 meeting are correct. The panel used a method similar to the one used to value 99234-99236 when this family of codes was last evaluated by the RUC in 1997.

We believe a more accurate reflection of the time and work involved in providing the service of 99234 is obtained by adding one-half of the intra-service time and work associated with 99238 (hospital discharge day management) to the approved times and work value of the recently RUC-approved 99218.

The current survey added an additional 2.5 minutes of pre- and 5 minutes of post-service to the times of base code 99218; we feel that the additional 5 minutes of post-service time should be added to post-service time of 99218. We do not feel that the additional 2.5 minutes of pre-service time is appropriate to this service compared to the base code 99218.

			Pre	Intra	Post	Total
99218 times			10	30	10	50
99238 time additions			0	10	0	10
99234 survey time add'ns (vs	s. 99218	3)	0	0	5	0
99234 times (proposed)			10	40	15	65
99218 wRVU		1.92				
+ 99238 wRVU x .50	0.64					
Proposed wRVU	2.56					

These adjustments make the times and work value for 99234 more accurate in terms of the service being described by the code.

The current survey median wRVU of 2.09 represents a substantial decrease in both the current value of 99234 (2.56) as well as from the survey performed in July 2010 (median wRVU 2.60). As noted above, we do not feel an increment of 0.18 wRVU from 99218 is an accurate reflection of the additional work involved in performing the discharge services of 99234. We propose using the building block method shown above to arrive at a value for 99234.

Recommended Values

Our recommended wRVU is almost the same value as was proposed in the October 2010 Summary of Recommendations and close to the current value of 99234 (2.60).

99218 wRVU 1.92, plus one-half 99238 wRVU (1.28/2=0.64) yields a wRVU for 99234 of 2.56.

The proposed times are 10/40/15/65.

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.

Professional Liability Insurance Information (PLI)

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

If no, please select another crosswalk and provide a brief rationale. 99234

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

Compelling Evidence

The RUC operates with the initial presumption that the current values assigned to the codes under review are correct. The argument for a change must be substantial and meet the RUC's compelling evidence standards listed in the Instructions Document. Please list your compelling evidence below (if appropriate).

The Observation or Inpatient Care Services (Including Admission and Discharge Services) codes were valued based on surveys by the specialties of Pediatrics and Emergency Medicine but in actuality these services are primarily provided by Internal Medicine and Family Physicians. The RUC has previously established, in 1997, that codes 99234-99236 are equivalent to the value of the corresponding initial observation care code plus the value of a 99238 (1.28 work RVUs), hospital discharge day service. For instance, 99234 (2.56 work RVUs) is currently equivalent to the value of 99218 plus 99238. Thus, to the extent that the initial observation care codes have an anomalous relationship with initial hospital care, which is inconsistent with prior RUC determinations related to observation care, so do the codes for observation or inpatient care services that include admission and discharge on the same date. This provides compelling evidence to reconsider the current values of 99234-99236.

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

Has the work of performing this service changed in the past 5 years? Yes 45% No 55% A. This service represents new technology? Yes 30% No 70%

Of survey respondents, who said yes, the new technology affected the work: Less Work: 0% Same Work: 0% More Work: 100%

- B. This service reflects new technology that has become more familiar: Yes 10% No 90%
- C. Patients requiring this service are now:

More complex (more work) 80% Less complex (less work) 0% No change in complexity 20% D. The typical site-of-service has changed:

From outpatient to inpatient 20% From inpatient to outpatient 50% No change 30%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS 2010 FIVE YEAR REVIEW SUMMARY OF RECOMMENDATION

CPT Code:99235 Tracking Number Global Period: XXX Specialty Society Recommended RVU: **3.24** RUC Recommended RVU: **3.24**

CPT Descriptor: Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 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) requiring admission are of moderate severity.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48-year-old patient presents to the ED with a history of asthma in moderate respiratory distress. The patient is admitted for observation and discharged later on the same day.

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

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

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

Description of Pre-Service Work:

o Review data not available on the unit (e.g. diagnostic and imaging studies)

o Communicate with other professionals and with patient or patient's family

o Obtain and review necessary past results or records not available on the unit

o Perform evaluation/management in other sites of service (e.g., office or emergency department) earlier the same day

Description of Intra-Service Work:

o Review medical records and data available on the unit

- o Obtain a comprehensive history
- o Perform a comprehensive physical exam

o Consider relevant data, options, and risks and formulate a diagnosis and develop a treatment plan, including making the decision for discharge (moderate complexity medical decision making)

o Discuss diagnosis and treatment options with the patient and/or family

o Write/review observation admission orders including ordering/arranging for necessary diagnostic testing, consultation and therapeutic intervention(s)

o Complete medical record documentation and discharge and aftercare forms

o Provide care coordination for the transition including instructions for aftercare to caregivers

o Order/arrange for post discharge follow-up professional services and testing

o Reconcile medications with attention to pre-admission therapy, observation therapy and outpatient formulary and write prescriptions

Description of Post-Service Work:

o Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management related to this hospitalization

o Receive and respond to any interval testing results or correspondence, including obtaining any results pending at discharge

o Revise treatment plan(s) and communicate with patient and/or caregiver, as necessary

o Complete subsequent discharge records

o Handle (with the help of clinical staff) any treatment failures or adverse reactions to medications that may occur after discharge

SURVEY DAT	ГА						
RUC Meeting Da	ate (mm/yyyy)	02/2011					
Presenter(s):	Drs. Larry M	lartinelli, Thoma	as Weida, Al	an Lazaroff a	nd Jennifer Wile	r	
Specialty(s):	ACP, AAFP	, AGS, ACEP					
CPT Code:	99235						
Sample Size:	2655	Resp N:	33	Response:	: 1.2 %		
Sample Type:	Random	Additional Sa	ample Infor	mation: cons	sensus panel		
			Low	25 th %	Median*	<u>75th %</u>	High
Service Perform	nance Rate		0.00	5.00	20.00	50.00	1000.00
Survey RVW:			1.45	2.50	2.75	3.70	5.00
Pre-Service Evalu	ation Time:				15.00		
Pre-Service Posit	ioning Time:				0.00		
Pre-Service Scrul	o, Dress, Wait	Time:			0.00		
Intra-Service Ti	me:		10.00	25.00	40.00	50.00	120.00
Immediate Post	Service-Time	e: <u>15.00</u>					
Post Operative	Visits	Total Min**	CPT Code	and Numbe	r of Visits		
Critical Care tim	ne/visit(s):	<u>0.00</u>	99291x 0.0	0 99292x	0.00		
Other Hospital t	ime/visit(s):	<u>0.00</u>	99231x 0.0	0 99232x	0.00 99233x	0.00	
Discharge Day	Mgmt:	<u>0.00</u>	99238x 0.0	0 99239x 0.0	00		
Office time/visit	(s):	<u>0.00</u>	99211x 0.0	0 12x 0.00 1	3x 0.00 14x 0.0	0 15x 0.00	
Prolonged Serv	ices:	<u>0.00</u>	99354x 0.0	0 55x 0.00	56x 0.00 57x	0.00	
Sub Obs Care:		0.00	99224x 0.0	0 99225x	0.00 99226x	0.00	

**Physician standard total <u>minutes per E/M visit</u>: 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	99235		Recom	mended Ph	ysician Worl	k RVU:	3.24
Code:	33233						
			Sp Recor Pre-Se	ecialty nmended rvice Time	Special Recomme Pre Time Pa	lty nded ackage	Adjustments to Pre-Service Time
Pre-Service Evaluation Ti	ime:		1	4.00	0.00		14.00
Pre-Service Positioning 1	lime:			0.00	0.00		0.00
Pre-Service Scrub, Dress	, Wait Tim	e:	(0.00	0.00		0.00
Intra-Service Time:			5	50.00			
Immediate Post Servic	e-Time:	<u>19.50</u>					
Post Operative Visits		<u>Total Min**</u>	CPT Co	de and Nu	umber of Visi	<u>its</u>	
Critical Care time/visit	(s):	<u>0.00</u>	99291x	0.00 992	292x 0.00		
Other Hospital time/vis	sit(s):	<u>0.00</u>	99231x	0.00 992	232x 0.00	99233x	0.00
Discharge Day Mgmt:		<u>0.00</u>	99238x	0.0 99239	x 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 0.0	00 57x	0.00
Sub Obs Care:		0.00	99224x	0.00 992	225x 0.00	99226x	0.00

Most Recent

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99222	XXX	2.61	RUC Time

<u>CPT Descriptor</u> 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 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 problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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	<u>Global</u> Wo	rk RVU	Time Source	Medicare Utilization
99205	XXX	3.17	RUC Time	1,018,170
CPT Descriptor 1 Office or of	ther outpatient v	visit for the ev	aluation and managen	nent of a new patient, which requires these
3 key components: A compre	hensive history;	A comprehen	nsive examination; Me	dical decision making of high complexity.
Counseling and/or coordinati	on of care with	other provid	lers or agencies are p	rovided consistent with the nature of the
problem(s) and the patient's	and/or family's	needs. Usual	ly, the presenting pro	blem(s) are of moderate to high severity.
Physicians typically spend 60	minutes face-to	-face with the	patient and/or family	
			- ·	Mast Dagast

				Most Recent
MPC CPT Code 2	<u>Global</u>	Work RVU	Time Source	Medicare Utilization
99223	XXX	3.17	RUC Time	5,749,046

<u>CPT Descriptor 2</u> nitial 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.

Other Reference CPT Code	<u>Global</u>	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: 10

% of respondents: 30.3 %

<u>TIME ESTIMATES (Median)</u>	CPT Code: 99235	Key Reference CPT Code: <u>99222</u>	Source of Time RUC Time
Median Pre-Service Time	14.00	15.00	
Median Intra-Service Time	50.00	40.00	
Median Immediate Post-service Time	19.50	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	

Other time if appropriate		
Median Total Time	83.50	75.00
Median Subsequent Observation Care Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Office Visit Time	0.0	0.00

INTENSITY/COMPLEXITY MEASURES (Mean)

(of those that selected Key Reference code)

Mental Effort and Judgment (Mean)

3.56	3.44
J	
,	[]
3.56	3.50
]	
3.83	3.67
3.39	3.39
3.22	3.22
3.78	3.67
3.72	3.50
3.72	3.56
CPT Code	Reference
	Service 1
2.89	2.83
3.56	3.50
3.17	3.06
	3.56 3.56 3.56 3.56 3.83 3.83 3.39 3.39 3.39 3.72 3.72 3.72 CPT Code 2.89 3.56 3.17

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.*

99235 Rationale

General:

The survey data for the observation or inpatient care services (including admission and discharge services) code, 99235, once again appear to be flawed. The specialty societies worked with the Research Subcommittee after the October 2010 RUC Meeting to modify the survey instrument in an attempt to more accurately capture the time and work involved in performing these services. Despite these efforts, we do not feel that we were able to accurately survey the time and work it takes to perform the services of this family of codes.

Survey respondents for 99235 added zero minutes of additional intra-service time to account for the work of completing the discharge when compared to the Intra-service time of the base CPT code 99219. The survey respondents added only 0.1 wRVU to the base code 99219 to account for the additional work of the discharge inherent to 99235. This is neither logical nor accurate.

Physician Work:

We believe that the survey results for 99234-36 show that these services are being performed differently now then when they were last surveyed in 1997. Observation with same day admit/discharge services are largely being performed by hospitalists (primarily Internists) or by emergency physicians who work in shifts. This means that the physician performing the admission is typically not the same physician who performs the discharge. This is why we believe the surveys are flawed: the respondents did not include the time and work for both parts of the service.

The current survey median wRVU of 2.70 represents a substantial decrease in both the current value of 99235 (3.41) as well as from the survey performed in July 2010 (median wRVU 3.50). We do not feel an increment of 0.10 wRVU from 99219 – a mirror-comparison of the observation services -- is an accurate reflection of the additional work involved in performing the discharge services of 99235. We propose using a building block method to arrive at a value for 99235. This is discussed in detail below.

Time:

The survey respondents added an additional 5 minutes of pre-service time to the pre-service time of the base code 99219. There is only one half minute of additional post-service time in 99234 in the current survey compared to 99219. The Societies stated during the October 2010 presentation of the Observation Admission codes that we feel the time and work of the Observation Admission and Initial Hospital Visit codes are the same. We do not feel that the work of discharge inherent to 99235 can be done without additional Intra-service time and only 30 seconds of Post-service time when compared to the base code 99219.

Key Reference Service:

- Key Reference Service **99222** (initial hospital visit)
- Requires 3/3 key components; comprehensive history and exam; medical decision making moderate decision making
- wRVU 2.61
- Pre-service time 15 minutes
- Intra-service time 40 minutes
- Post-service time 20 minutes
- Total time 75 minutes

99222 was the key reference service chosen by 30.3% of the respondents. The intensity/complexity measures rated 99235 as more intense/complex than key reference code 99222. The times of the codes are similar; however, 99235 has 10 more minutes of proposed Intra-service time. Both codes require 3/3 key components of history, exam and medical decision making. Key reference service 99222 describes a patient of similar acuity and complexity; however, 99235 describes both admission and discharge work.

Multispecialty Points of Comparison (MPC)

MPC code **99205** (new office patient)

- Requires 3/3 key components; a comprehensive history and exam; high complexity medical decision making
- wRVU 3.17
- Pre-service time 7 minutes
- Intra-service time 45 minutes
- Post-service time 15 minutes
- Total time 67 minutes

MPC code 99205 describes a new office patient with moderate to high severity problems. The proposed intraservice time of survey code 99235 is 5 minutes longer than 99205. The patient described by 99205, while having severe problems, is sent home on the day of evaluation. 99235, however, describes a patient who has diagnostic uncertainty and/or clinical instability such that they require admission for observation. The problems are able to be resolved quickly enough for the patient to be discharged the same day; however, this level of service is significantly intense. 99235 describes both admission and discharge work.

MPC code 99223 (initial hospital visit)

- Requires 3/3 comprehensive history and exam; medical decision making high complexity
- wRVU 3.86
- Pre-service time 15 minutes
- Intra-service time 55 minutes
- Post-service time 20 minutes
- Total time 90 minutes

MPC 99223 describes a new inpatient evaluation of a patient with problems of high severity. The proposed intra-service time of 99235 is 5 minutes less than 99223 and the proposed total time is 5 minutes shorter. The patient described by 99223 is more severely ill than 99235; however, 99235 describes a patient who is moderately ill and receives an intensity of service sufficient to resolve their problems and be discharged the same day.

Building Block Method:

Representatives of ACP, AAFP, ACEP, AGS and SHM convened a consensus panel to discuss the current and previous survey data and to arrive at a rationale and fair assessment of the 99234-99236 family of codes. The Panel examined possible explanations why two separate surveys, done only a few months apart failed to provide what the Panel felt to be an accurate valuation for the 99234-99236 code family. In addition to the fragmentation of work noted above, this family of codes describes a bundled service, admission and discharge. There are no other comparable E&M codes to use as references. The survey respondents would not have realized that a building block approach is the appropriate method to value these codes. Thus, the respondents valued this code family using the single "best" code that describes the work of 99234-99236, as instructed. This is one of the reasons that the surveys times and work values are inappropriate.

The consensus panel reviewed the current and previous survey results and proposes the following building block approach. The panel started with the premise that the surveys and values of 99218-99220 assigned by the RUC at the October 2010 meeting are correct. The panel used a method similar to the method used to value 99234-99236 when this family of codes was last evaluated by the RUC in 1997.

We believe a more accurate reflection of the time and work involved in providing the service of 99235 is obtained by adding one-half of the intra-service time and work associated with 99238 (hospital discharge day management) to the approved times and work value of the recently RUC-approved 99219. We feel that an additional 5 minutes of post-service time should be added to the survey value of 99235 to account for the

Using 99219 as the base code (wRVU 2.60, times 10/40/14.5/64.5) and one half of a discharge service (99238, wRVU 1.28, intra-service time 20 minutes) would arrive at the following value for 99235:

99219 times 99238 time adjustments	Pre 10 0	Intra 40 10	Post 14.5 5.0
99235 times (proposed)	15	50	19.5
99219 wRVU 99238 wRVU 1.28 x .50 Proposed wRVU	2.60 <u>0.64</u> 3.24		

The building block wRVU is a significant decrease from both the current value of 3.41 and the July 2010 median survey value of 3.50. We do not feel that the current survey data and the deliberations of the Consensus Panel support a higher value for 99235.

Recommended Values

99219 wRVU 2.60, plus one-half 99238 wRVU (1.28/2=0.64) yields a wRVU for 99234 of 3.24.

The recommended times are 15/50/19.5/84.5.

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.

Professional Liability Insurance Information (PLI)

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

If no, please select another crosswalk and provide a brief rationale. 99235

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

Compelling Evidence

The RUC operates with the initial presumption that the current values assigned to the codes under review are correct. The argument for a change must be substantial and meet the RUC's compelling evidence standards listed in the Instructions Document. Please list your compelling evidence below (if appropriate).

The Observation or Inpatient Care Services (Including Admission and Discharge Services) codes were valued based on surveys by the specialties of Pediatrics and Emergency Medicine but in actuality these services are primarily provided by Internal Medicine and Family Physicians. The RUC has previously established, in 1997, that codes 99234-99236 are equivalent to the value of the corresponding initial observation care code plus the value of a 99238 (1.28 work RVUs), hospital discharge day service. For instance, 99234 (2.56 work RVUs) is currently equivalent to the value of 99218 plus 99238. Thus, to the extent that the initial observation care codes have an anomalous relationship with initial hospital care, which is inconsistent with prior RUC determinations related to observation care, so do the codes for observation or inpatient care services that include admission and discharge on the same date. This provides compelling evidence to reconsider the current values of 99234-99236.

Five-Year Review Specific Questions

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

Has the work of performing this service changed in the past 5 years? Yes 56% No 44%

A. This service represents new technology? Yes 40% No 60%

Of survey respondents, who said yes, the new technology affected the work: Less Work: 0% Same Work: 0% More Work: 100%

- B. This service reflects new technology that has become more familiar: Yes 40% No 60%
- C. Patients requiring this service are now:

More complex (more work) 100% Less complex (less work) 0% No change in complexity 0%

D. The typical site-of-service has changed:

From outpatient to inpatient 0% From inpatient to outpatient 40% No change 60%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS 2010 FIVE YEAR REVIEW SUMMARY OF RECOMMENDATION

CPT Code:99236 Tracking Number Global Period: XXX Specialty Society Recommended RVU: **4.20** RUC Recommended RVU: **4.20**

CPT Descriptor: Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 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 presenting problem(s) requiring admission are of high severity.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 52-year-old patient comes to the ED because of chest pain. The patient is admitted for observation and discharged later on the same day.

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:

o Review data not available on the unit (e.g. diagnostic and imaging studies)

o Communicate with other professionals and with patient or patient's family

o Obtain and review necessary past results or records not available on the unit

o Perform evaluation/management in other sites of service (e.g., office or emergency department) earlier the same day

Description of Intra-Service Work:

o Review medical records and data available on the unit

o Obtain a comprehensive history

o Perform a comprehensive physical exam

o Consider relevant data, options, and risks and formulate a diagnosis and develop a treatment plan, including making the decision for discharge (high complexity medical decision making)

o Discuss diagnosis and treatment options with the patient and/or familyo Communicate with other health care professionals

o Write/review observation admission orders including ordering/arranging for necessary diagnostic testing, consultation and therapeutic intervention(s)

o Complete medical record documentation and discharge and aftercare forms

o Provide care coordination for the transition including instructions for aftercare to caregivers

o Order/arrange for post discharge follow-up professional services and testing

o Reconcile medications with attention to pre-admission therapy, observation therapy and outpatient formulary and write prescriptions

Description of Post-Service Work:

o Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management related to this hospitalization

o Receive and respond to any interval testing results or correspondence, including obtaining any results pending at discharge

o Revise treatment plan(s) and communicate with patient and/or caregiver, as necessary

o Complete subsequent discharge records

o Handle (with the help of clinical staff) any treatment failures or adverse reactions to medications that may occur after discharge
SURVEY DAT	ΓA									
RUC Meeting Da	ate (mm/yyyy)	02/2011								
Presenter(s):	esenter(s): Drs. Larry Martinelli, Thomas Weida, Alan Lazaroff and Jennifer Wiler									
Specialty(s):	ACP, AAFP	ACP, AAFP, AGS, ACEP								
CPT Code: 99236										
Sample Size:	2655	Resp N:	33		Response	:: 1.2 %				
Sample Type:	Random	Additional Sa	ample Info	orma	ation: con	sensus pa	nel			
			Low		25 th %	Media	an*	<u>75th %</u>	High	
Service Perform	nance Rate		0.00		2.00	20.0	0	80.00	500.00	
Survey RVW:			1.00		3.00	3.8	6	4.25	6.00	
Pre-Service Evalu	ation Time:					15.0	0			
Pre-Service Posit	ioning Time:					0.0	D			
Pre-Service Scrul	o, Dress, Wait	Time:				0.0	D			
Intra-Service Ti	me:		15.00		30.00	45.0	0	60.00	80.00	
Immediate Post	Service-Time	e: <u>20.00</u>								
Post Operative	<u>Visits</u>	Total Min**	CPT Code	e ar	nd Numb	er of Visits	6			
Critical Care tim	ne/visit(s):	<u>0.00</u>	99291x 0	.00	99292x	0.00				
Other Hospital t	99231x 0	.00	99232x	0.00 99	9233x	0.00				
Discharge Day	99238x 0	.00	99239x 0 .	.00						
Office time/visit	99211x 0	.00	12x 0.00	13x 0.00 14	x 0.00) 15x 0.0 0				
Prolonged Serv	ices:	<u>0.00</u>	99354x 0	.00	55x 0.00	56x 0.00	57x C	0.00		
Sub Obs Care:		0.00	99224x 0	.00	99225x	0.00 99	9226x	0.00		

**Physician standard total <u>minutes per E/M visit</u>: 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	00236		Recommended Physician Work RVU: 4.20					
Code:	99230							
			Specialty Recommended Pre-Service Time		Spec Recomr Pre Time	ialty nended Package	Adjustments to Pre-Service Time	
Pre-Service Evaluation T	ime:		1	9.00	0.0	00	19.00	
Pre-Service Positioning	Time:			0.00	0.0	00	0.00	
Pre-Service Scrub, Dress	s, Wait Tim	e:	0.00		0.0	00	0.00	
Intra-Service Time:				55.00				
Immediate Post Servio	ce-Time:	<u>20.00</u>						
Post Operative Visits		<u>Total Min**</u>	CPT Code and Number of Visits					
Critical Care time/visit	:(s):	<u>0.00</u>	99291x	0.00 99	292x 0.00			
Other Hospital time/vi	sit(s):	0.00	99231x	0.00 99	232x 0.00	99233x	0.00	
Discharge Day Mgmt:		<u>0.00</u>	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 99	225x 0.00	99226x	0.00	

Most Recent

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source	
99223	XXX	3.86	RUC Time	

<u>CPT Descriptor</u> 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.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the 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	<u>Global</u> Wo	rk RVU	Time Source	Medicare Utilization	
99255	XXX	4.00	RUC Time	2,849,126	
CPT Descriptor 1 Inpatient	nt consultation for	a new or e	stablished patient, wh	nich requires these 3 key componer	its: A
comprehensive history; A	comprehensive e	xamination;	and Medical decision	making of high complexity. Couns	seling
and/or coordination of care	e with other provid	lers or agenci	es are provided consis	stent with the nature of the problem(s	s) and
the patient's and/or family's	s needs. Usually, th	e presenting	problem(s) are of mod	lerate to high severity. Physicians typ	ically
spend 110 minutes at the b	edside and on the p	atient's hospi	ital floor or unit.		
				Mast Descut	

				Most Recent
MPC CPT Code 2	Global	Work RVU	Time Source	Medicare Utilization
99285	XXX	3.80	RUC Time	8,567,326

<u>CPT Descriptor 2</u> Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

Other Reference CPT Code	<u>Global</u>	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: 18

% of respondents: 54.5 %

<u>TIME ESTIMATES (Median)</u>	CPT Code: 99236	Key Reference CPT Code: <u>99223</u>	Source of Time RUC Time
Median Pre-Service Time	19.00	15.00	
Median Intra-Service Time	55.00	55.00	
Median Immediate Post-service Time	20.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	

Other time if appropriate		
Median Total Time	94.00	90.00
Median Subsequent Observation Care Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00

INTENSITY/COMPLEXITY MEASURES (Mean)

(of those that selected Key Reference code)

Mental Effort and Judgment (Mean)

4.78	4.78
4.70	4.70
4.72	4.72
4.72	4.67
4.61	4.50
4.22	4.17
4.89	4.89
4.83	4.83
4.78	4.67
CPT Code	Reference
	Service 1
3.89	3.83
	 4.78 4.72 4.72 4.61 4.61 4.22 4.89 4.83 4.78 <u>CPT Code</u> 3.89

Intra-Service intensity/complexity	4.83	4.67
Post-Service intensity/complexity	4.17	4.06

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.

99236 Rationale

General:

The survey data for the observation or inpatient care services (including admission and discharge services) codes, 99234-6, once again appear to be flawed. The specialty societies worked with the Research Subcommittee after the October 2010 RUC Meeting to modify the survey instrument in an attempt to more accurately capture the time and work involved in performing these services. Despite these efforts, we do not feel that we were able to accurately survey the time and work it takes to perform the services of this family of codes.

Survey respondents for 99236 added zero minutes of additional intra-service time to account for the work of completing the discharge when compared to the Intra-service time of the base CPT code 99220. The survey respondents added only 0.3 wRVU to the base code 99220 to account for the additional work of the discharge inherent to 99236. This is neither logical nor accurate.

Physician Work:

We believe that the survey results for 99234-36 show that these services are being performed differently now then when they were last surveyed in 1997. Observation with same day admit/discharge services are largely being performed by hospitalists (primarily Internists) or by emergency physicians who work in shifts. This means that the physician performing the admission is typically not the same physician who performs the discharge. This is why we believe the surveys are flawed: the respondents did not include the time and work for both parts of the service.

The current survey median wRVU of 3.86 represents a substantial decrease in both the current value of 99236 (4.26), but is very similar to the survey performed in July 2010 (median 3.90). The current median survey wRVU represents an increment of 0.30 wRVU from 99220. We do not feel that this is an accurate reflection of the additional work involved in performing the discharge services of 99236.

Time:

The survey respondents added no additional minutes of pre-service time to the pre-service time of the base code 99220. There are 5 minutes of additional post-service time in survey code 99236 compared to 99220. The additional post-service time for 99236 appears appropriate in view of the work of discharge being performed in 99236 that is not a part of 99220. The respondents added no additional intra-service time to 99220 in the current survey for 99236.

Key Reference Service

- MPC code **99223** (initial hospital visit)
- Requires 3/3 comprehensive history and exam; high complexity medical decision making
- wRVU 3.86
- Pre-service time 15 minutes
- Intra-service time 55 minutes
- Post-service time 20 minutes
- Total time 90 minutes

99223 was chosen as the key reference service by 54.5% of the respondents. The intensity/complexity measures rated 99223 lower than 99236. Key reference code 99223 describes a new inpatient evaluation of a patient with problems of high severity. The documentation and medical decision making components of 99223 and 99236 for the initial evaluation of the patient are the same. Both describe severely ill patients. 99223 only

CPT Code: 99236 accounts for admission work, while 99236 describes both the admission and discharge work of a severely ill patient who can be sent home the same day. The proposed 99236 times are the same as the 99223 times, however 99236 includes both the admission and discharge work of a severely ill patient.

Multispecialty Points of Comparison

MPC code 99285 (ED visit)

- Requires 3/3 key components; a comprehensive history and exam; high complexity medical decision making
- wRVU 3.80
- Pre-service time 8 minutes
- Intra-service time 40 minutes
- Post-service time 15 minutes
- Total time 63 minutes

MPC comparison code 99285 and survey code 99236 have equivalent history, exam and medical decision making requirements. 99236 (proposed) has 7 minutes of additional pre-service, 15 minutes of additional intra-service, 5 additional minutes post-service time and 27 minutes additional total time. 99236 describes both admission and discharge work, which is quite intense, since a severely ill patient is able to have their problem(s) resolved and be dismissed the same day as admission.

MPC code 99255 (inpatient consultation)

- Requires 3/3 comprehensive history and exam; high complexity medical decision making
- wRVU 4.00
- Pre-service time 20 minutes
- Intra-service time 60 minutes
- Post-service time 25 minutes
- Total time 105 minutes

MPC code 99255 describes a new initial inpatient consultation for a severely ill patient. Although this code is no longer recognized by CMS for payment purposes, 99255 was recently reviewed and valued by the RUC (Feb 2006) and remains on the MPC list for comparison purposes. MPC 99255 continues to be published in the RUC database and recognized as a valid descriptor of work by private payers. 99255 has 5 minutes more intra-service time than survey code 99236 (proposed) and 15 minutes more total time than 99236. The work of survey code 99236 is more intense than that of MPC code 99255, since 99255 describes only an initial evaluation and 99236 involves both admission and discharge work of a patient who presents severely ill and is able to be discharged the same day.

We note that there is no existing code that is directly comparable to 99236, since 99236 is essentially a combined service. We suggest that 99236 be compared to MPC codes 99285 and 99255 (and to key reference service 99223) with added consideration of the work in observation discharge code 99238.

Building Block Method

Representatives of ACP, AAFP, ACEP, AGS and SHM convened a consensus panel to discuss the current and previous survey data and to arrive at a rationale and fair assessment of the 99234-99236 family of codes. The Panel examined possible explanations why two separate surveys, done only a few months apart failed to provide what the Panel felt to be an accurate valuation for the 99234-99236 code family. In addition to the fragmentation of work noted above, this family of codes describes a bundled service, admission and discharge. There are no other comparable E&M codes to use as references. The survey respondents would not have realized that a building block approach is the appropriate method to value these codes. Thus, the respondents valued this code family using the single "best" code that describes the work of 99234-99236, as instructed. This is one of the reasons that the surveys times and work values are inappropriate.

The consensus panel reviewed the current and previous survey results and proposes the following building block approach. The panel started with the premise that the surveys and values of 99218-99220 assigned by the RUC at the October 2010 meeting are correct. The panel used a method similar to the method used to value 99234-99236 when this family of codes was last evaluated by the RUC in 1997.

We believe a more accurate reflection of the time and work involved in providing the service of 99236 is obtained by adding one-half of the intra-service time and work associated with 99238 (hospital discharge day management) to the approved times and work value of the recently RUC-approved 99220. These adjustments make the times and work value for 99235 more accurate in terms of the service being described by the code.

Because of the complexity of these patients and the time required to perform the observation admission/discharge services, we believe a more accurate reflection of the work involved with this service is achieved by adding the one half of the intra-service time associated with 99238 (*Hospital discharge day management; 30 minutes or less*) to the recently RUC-approved intra-service time 99220 (*Initial observation care, per day, for the evaluation and management of a patient*). We feel that the survey respondents were correct in adding 5 additional minutes of post-service time vs. 99220 to account for the additional time and work of the discharge inherent to 99236.

99220 wRVU	3.56
99238 wRVU 1.28 x .50	0.64
Proposed wRVU	4.20

These adjustments make the times and work value for 99236 more accurate in terms of the service being described by the code.

The Consensus Panel noted that there is no existing code that is directly comparable to 99236, since 99236 is a combined service. We suggest that 99236 be compared to MPC codes 99285 and 99255 (and to key reference service 99223) with added consideration of the work in observation discharge code 99238.

Recommended Values

We are recommending a *wRVU* for 99236 of 4.20, and 19 minutes pre-service time, 55 minutes intra-service time, and 20 minutes post-service time.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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



The surveyed code is an add-on code or a base code expected to be reported with an add-on code. Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.

Multiple codes allow flexibility to describe exactly what components the procedure included. Multiple codes are used to maintain consistency with similar codes.

Historical precedents.

Other reason (please explain)

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

Professional Liability Insurance Information (PLI)

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

If no, please select another crosswalk and provide a brief rationale. 99236

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

Compelling Evidence

The RUC operates with the initial presumption that the current values assigned to the codes under review are correct. The argument for a change must be substantial and meet the RUC's compelling evidence standards listed in the Instructions Document. Please list your compelling evidence below (if appropriate).

The Observation or Inpatient Care Services (Including Admission and Discharge Services) codes were valued based on surveys by the specialties of Pediatrics and Emergency Medicine but in actuality these services are primarily provided by Internal Medicine and Family Physicians. The RUC has previously established, in 1997, that codes 99234-99236 are equivalent to the value of the corresponding initial observation care code plus the value of a 99238 (1.28 work RVUs), hospital discharge day service. For instance, 99234 (2.56 work RVUs) is currently equivalent to the value of 99218 plus 99238. Thus, to the extent that the initial observation care codes have an anomalous relationship with initial hospital care, which is inconsistent with prior RUC determinations related to observation care, so do the codes for observation or inpatient care services that include admission and discharge on the same date. This provides compelling evidence to reconsider the current values of 99234-99236.

Five-Year Review Specific Questions

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

Has the work of performing this service changed in the past 5 years? Yes 79% No 21% A. This service represents new technology? Yes 33% No 67% Of survey respondents, who said yes, the new technology affected the work:

Less Work: 0% Same Work: 10% More Work: 90%

- B. This service reflects new technology that has become more familiar: Yes 67% No 33%
- C. Patients requiring this service are now:

More complex (more work) 93% Less complex (less work) 0% No change in complexity 7%

D. The typical site-of-service has changed:

From outpatient to inpatient 0% From inpatient to outpatient 40% No change 60%

SUBSEQUENT OBSERVATION SERVICES WITH SAME-DAY DISCHARGE

Issue

CPT		Low	5th%	25th%	Median	75łb%	Q5th%	High	Arithmatic	Mode	Geometric Mean	Specialty societies may provide other points of cental tendency, eg harmonic mean (Optional)
Coue		LOW	51170	250170	Wealan	7 50170	35(1170	ingn	Wicall	Widde	Weall	(Optional)
	Work RVU	1.25	1.33	1.73	2.09	2.96	3.81	5.00	2.36	3.00	2.21	
99234	Intra-Service Time	10.0	12.3	21.3	30.0	45.0	60.0	720.0	465.0	30.0	31.3	
	Work RVU	1.45	2.00	2.50	2.75	3.70	4.55	5.00	3.02	2.50	2.91	
99235	Intra-Service Time	10.0	20.0	25.0	40.0	50.0	64.0	120.0	40.0	20.0	35.6	
	Work RVU	1.00	1.96	3.00	3.86	4.25	5.48	6.00	3.74	2.90	3.53	
99236	Intra-Service Time	15.0	19.2	30.0	45.0	60.0	72.0	80.0	44.8	50.0	41.3	

AMA/Specialty Society RVS Update Committee Moderate Sedation Practice Expense Recommendation

Direct Input Expense for Moderate Sedation Recommendation

In February 2010, The American Gastroenterological Association (AGA), the American Society for Gastrointestinal Endoscopy (ASGE), and the American College of Gastroenterology (ACG) recommended that the RUC revisit the supplies and equipment needed to perform medical procedures involving moderate sedation safely and effectively in the non-facility setting. The RUC formed a moderate sedation practice expense workgroup which carefully reviewed and reaffirmed the existing supplies and equipment, and provided a recommendation for three additional equipment items; a table for equipment, a pulse oxymetry monitor recording software (prolonged monitoring), and a blood pressure monitor. Below is the complete RUC standard package of moderate sedation practice expense inputs which includes these additional equipment items.

Clinical Labor:

RN - 2 minutes to initiate sedation RN - 100% of the physician intra-service work time RN - 15 minutes of follow every hour for post-service patient monitoring

Medical Supplies:

Standard Moderate Sedation Package: The contents of this package are:

	Code	Unit	Qty	Unit price
pack, conscious sedation	SA044	pack		17.311
angiocatheter 14g-24g		item	1	1.505
bandage, strip 0.75in x 3in		item	1	0.043
catheter, suction		item	1	0.620
dressing, 4in x 4.75in (Tegaderm)		item	1	1.771
electrode, ECG (single)		item	3	0.090
electrode, ground		item	1	0.445
gas, oxygen		liter	200	0.003
gauze, sterile 4in x 4in		item	4	0.159
gloves, sterile		pair	1	0.840
gown, surgical, sterile		item	1	4.671
iv infusion set		item	1	1.112
kit, iv starter		kit	1	1.368
oxygen mask (1) and tubing (7ft)		item	1	0.963
pulse oximeter sensor probe wrap		item	1	0.617
stop cock, 3-way		item	1	1.175
swab-pad, alcohol		item	2	0.013
syringe 1ml		item	1	0.140
syringe-needle 3ml 22-26g		item	2	0.160
tape, surgical paper 1in (Micropore)		inch	12	0.002
tourniquet, non-latex 1in x 18in		item	1	0.226

Equipment:

EF027* table, instrument, mobile
EQ011 ECG, 3-channel (with SpO2, NIBP, temp, resp)
EQ032 IV infusion pump
EQ212* pulse oxymetry recording software (prolonged monitoring)
EQ269* blood pressure monitor, ambulatory, w-battery charger

* indicates additional equipment specifically added in this recommendation

The AMA CPT Editorial panel currently has a list of CPT codes where moderate sedation is inherent. This list of services is attached to this recommendation so that you may assure that their direct practice expense inputs include these items.

0200T	33214	36583	43226	43453	45321	50021	93318	93651
0201T	33216	36585	43227	43456	45327	50200	93451	93652
0250T	33217	36590	43228	43458	45332	50382	93452	94011
0251T	33218	36870	43231	44360	45333	50384	93453	94012
19298	33220	37183	43232	44361	45334	50385	93454	94013
20982	33222	37184	43234	44363	45335	50386	93455	
22520	33223	37185	43235	44364	45337	50387	93456	-
22521	33233	37186	43236	44365	45338	50592	93457	-
22526	33234	37187	43237	44366	45339	50593	93458	-
22527	33235	37188	43238	44369	45340	57155	93459	-
31615	33240	37203	43239	44370	45341	58823	93460	
31620	33241	37210	43240	44372	45342	66720	93461	-
31622	33244	37215	43241	44373	45345	69300	93462	-
31623	33249	37216	43242	44376	45355	77371	93463	
31624	35471	37220	43243	44377	45378	77600	93464]
31625	35472	37221	43244	44378	45379	77605	93505]
31626	35475	37222	43245	44379	45380	77610	93530	-
31627	35476	37223	43246	44380	45381	77615	93561	-
31628	36147	37224	43247	44382	45382	92953	93562	-
31629	36148	37225	43248	44383	45383	92960	93563	-
31634	36200	37226	43249	44385	45384	92961	93564	-
31635	36245	37227	43250	44386	45385	92973	93565	-
31645	36426	37228	43251	44388	45386	92974	93566	
31646	36427	37229	43255	44389	45387	92975	93568	-
31656	36481	37230	43256	44390	45391	92978	93571	
31725	36555	37231	43257	44391	45392	92979	93572	
32201	36557	37232	43258	44392	47000	92980	93609	
32405	36558	37233	43259	44393	47011	92981	93613	
32550	36560	37234	43260	44394	47382	92982	93615	
32551	36561	37235	43261	44397	47525	92984	93616	
32553	36563	43200	43262	44500	48511	92986	93618	
33010	36565	43201	43263	44901	49021	92987	93619	
33011	36566	43202	43264	45303	49041	92995	93620	
33206	36568	43204	43265	45305	49061	92996	93621	
33207	36570	43205	43267	45307	49411	93312	93622	
33208	36571	43215	43268	45308	49418	93313	93624	
33210	36576	43216	43269	45309	49440	93314	93640]
33211	36578	43217	43271	45315	49441	93315	93641]
33212	36581	43219	43272	45317	49442	93316	93642	
33213	36582	43220	43273	45320	49446	93317	93650	