FEBRUARY 1996/APRIL 1996 RUC RECOMMENDATIONS AND HCPAC RECOMMENDATIONS

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS RECOMMENDATIONS

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RUC RECOMMENDATIONS - NEW AND REVISED CODES FOR CPT 1997

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CPT 1997 RUC Recommendations

19-Jun-96

CPT Code	Global Period	CPT Action	CPT Meeting	CPT Tab	RUC Issue	Track No.	RUC Meeting	RUC Tab	SS Rec	RUC Rec	Same Value as 1996?	Code in MFS?	Other Comments
		~											
11010	010	New	Feb 96	N	Debridement of Musculoskeletal Open Injury	Ll	April 96	14	4.15	4.15		Yes	
11011	000	New	Feb 96	N	Debridement of Musculoskeletal Open Injury	L2	April 96	14	4.95	4.95		Yes	
11012	000	New	Feb 96	N	Debridement of Musculoskeletal Open Injury	L3	April 96	14	6.88	6.88		Yes	
15755	090	Deleted	Feb 96	М	Microvascular Anastomosis	N1	April 96	24				Yes	
15756	090	New	Feb 96	Μ	Microvascular Anastomosis	N2	April 96	24	36.25	33.23		Yes	
15757	090	New	Feb 96	М	Microvascular Anastomosis	N3	April 96	24	36.25	33.23		Yes	
15758	090	New	Feb 96	М	Microvascular Anastomosis	N4	April 96	24	35.00	33.23		Yes	
20150	090	New	Feb 96	Q	Excision of Epiphyseal Bar	P1	April 96	17	13.00	13.00		Yes	
20956	090	New	.Feb 96	М	Microvascular Anastomosis	N5	April 96	24	37.58	37.00		Yes	
20957	090	New	Feb 96	М	Microvascular Anastomosis	N6	April 96	24	38.00	38.33		Yes	
20960	090	Deleted	Feb 96	М	Microvascular Anastomosis	N7	April 96	24				Yes	
20962	090	Revised	Feb 96	М	Microvascular Anastomosis	N8	April 96	24				Yes	Carrier Price
20969	090	Revised	Feb 96	Μ	Microvascular Anastomosis	N9	April 96	24	42.08	42.08	Yes	Yes	
20970	090	Revised	Feb 96	М	Microvascular Anastomosis	N10	April 96	24	41.22	41.22	Yes	Yes	
20971	090	Deleted	Feb 96	М	Microvascular Anastomosis	N11	April 96	24				Yes	

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CPT Code	Global Period	CPT Action	CPT Meeting	CPT Tab	F RUC Issue	Track No.	RUC Meeting	RUC Tab	SS Rec	RUC Rec	Same Value as 1996?	Code in MFS?	Other Comments
22845	ZZZ	Revised	Feb 96	EC	Spine Procedures	SS1	LOI		5.98	5.98	Yes	Yes	
24149	090	New	Feb 96	Ll	Hand Surgery	Q1	April 96	15	13.25	13.25	<u>∽.</u>	Yes	
24341	090	New	Feb 96	Ml	Hand and Arm Surgery	R1	April 96	16	7.33	7.33		Yes	
24342	090	Revised	Feb 96	M1	Hand and Arm Surgery	R2	April 96	16	10.13	10.13	Yes	Yes	
25330	090	Deleted	Feb 96	L1	Hand Surgery	Q2	April 96	15				Yes	
25331	090	Deleted	Feb 96	L1	Hand Surgery	Q3	April 96	15				Yes	
25332	090	Revised	Feb 96	Ll	Hand Surgery	Q4	April 96	15	10.83	10.83	Yes	Yes	
26040	090	Revised	Feb 96	Ll	Hand Surgery	Q5	April 96	15	3.09	3.09	Yes	Yes	
26060	090	Revised	Feb 96	L1	Hand Surgery	Q6	April 96	15	2.71	2.71	Yes	Yes	
26070	090	Revised	Feb 96	LI	Hand Surgery	Q7	April 96	15	3.34	3.34	Yes	Yes	
26121	090	Revised	Feb 96	M1	Hand and Arm Surgery	R4	April 96	16	7.34	7.34	Yes	Yes	
26123	090	Revised	Feb 96	M1	Hand and Arm Surgery	R5	April 96	16	8.64	8.64	Yes	Yes	
26125	090	Revised	Feb 96	Ml	Hand and Arm Surgery	R6	April 96	16	4.61	4.61	Yes	Yes	
26185	090	New	Feb 96	Ml	Hand and Arm Surgery	R3	April 96	16	5.00	5.00)	Yes	
26540	090	Revised	Feb 96	Ll	Hand Surgery	Q9	April 96	15	6.03	6.03	Yes	Yes	
26541	090	Revised	Feb 96	Ll	Hand Surgery	Q10	April 96	15	8.20	8.20	Yes	Yes	
26546	090	New	Feb 96	Ŀı	Hand Surgery	Q8	April 96	15	8.50	8.50)	Yes	

CPT Code	Global Period	CPT Action	CPT Meeting	CPT Tab	RUC Issue	Track No.	RUC Meeting	RUC Tab	SS Rec	RUC Same Value Rec as 1996?	Code in MFS?	Other Comments
26551	090	New	Feb 96	M	Microvascular Anastomosis	N12	April 96	24	48.00	44.31	Yes	
26552	090	Deleted	Feb 96	М	Microvascular Anastomosis	N16	April 96	24			Yes	
26553	090	New	Feb 96	М	Microvascular_Anastomosis	N13	April 96	24	44.31	44.00	Yes	
26554	090	New	Feb 96	М	Microvascular Anastomosis	N14	April 96	24	50.00	52.50	Yes	
26556	090	New	Feb 96	М	Microvascular Anastomosis	N15	April 96	24	45.00	44.75 -47 : 75	Yes	
26557	090	Deleted	Feb 96	М	Microvascular Anastomosis	N17	April 96	24			Yes	
26558	090	Deleted	Feb 96	М	Microvascular Anastomosis	N18	April 96	24			Yes	
26559	090	Deleted	Feb 96	М	Microvascular Anastomosis	N19	April 96	24			Yes	
27036	090	New	Feb 96	Р	Release of Hip Flexor Deformity	S 1	April 96	18	12.00	12.00	Yes	
32491	090	New	Nov 95	I	Lung Volume Reduction	H1	Feb 96	25	21.25	21.25	Yes	
33234	090	Revised	Feb 96	R	Pacemaker	T1	April 96	22	5.72	5.72	Yes	
33235	090	Revised	Feb 96	R	Pacemaker	T2	April 96	22	6.96	6.96	Yes	
37250	ZZZ	New	Aug 95	F	Intravascular Ultrasound	A1	April 96	6	4.00	2.10	Yes	
37251	ZZZ	New	Aug 95	F -	Intravascular Ultrasound	A2	April 96	6	4.00	1.60	Yes	
42880	090	Deleted	Feb 96	5	Nasopharyngeal Lesion Resection.Excision	Z2	April 96	25			Yes	
43496	090	New	Feb 96	М	Microvascular Anastomosis	N20	April 96	24	38.50		Yes	Referred back to Specialty Society
49020	090	Revised	Feb 96	S	Drainage of Abscess	U9	April 96	29	16.50	14.25	Yes	

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CPT Code	Global Period	CPT Action	CPT Meeting	CPT Tab	RUC Issue	Track No.	RUC Meeting	RUC Tab	SS Rec	RUC Rec	Same Value as 1996?	Code in MFS?	Other Comments
49021	?	New	Feb 96	S	Drainage of Abscess	U10	April 96	29	9.06			Yes	Tabled until September
49906	090	New	Feb 96	М	Microvascular Anastomosis	N21	April 96	24	35.00			Yes	Referred back to Specialty Society
52300	000	Revised	Feb 96	W	Pediatric Cystourethroscopy	V2	April 96	19	5.35	5.31		Yes	
52301	000	New	Feb 96	W	Pediatric Cystourethroscopy	V3	April 96	19	5.51	5.51		Yes	
52340	000	Revised	Feb 96	W	Pediatric Cystourethroscopy	V1	April 96	19	9.00	9.00		Yes	
53640	000	Deleted	Feb 96	Ζ	Dilation of Urethral Stricture	W1	LOI					Yes	
56300	010	Revised	Nov 95	J	Laparoscopy/Peritoneoscopy	I1	Feb 96	26	5.00	5.00		Yes	
56305	010	Revised	Nov 95	J	Laparoscopy/Peritoneoscopy	I2	Feb 96	26	5.30	5.30		Yes	
56360	000	Deleted	Nov 95	J	Laparoscopy/Peritoneoscopy	13	Feb 96	26				Yes	
56361	000	Deleted	Nov 95	J	Laparoscopy/Peritoneoscopy	I4	Feb 96	26				Yes	
56362	000	Revised	Nov 95	J	Laparoscopy/Peritoneoscopy	15	Feb 96	26	4.89	4.89	Yes	Yes	
56363	000	Revised	Nov 95	J	Laparoscopy/Peritoneoscopy	16	Feb 96	26	5.18	5.18	Yes	Yes	
56399	YYY	Revised	Nov 95	J	Laparoscopy/Peritoneoscopy	17	Feb 96	26				Yes	Carrier Price
57160	000	Revised	Feb 96	I	Insertion of Bladder Neck Prosthesis	X1	LOI		0.89	0.89	Yes	Yes	
59525	MMM	Revised	Feb 96	EC	Hysterectomy	TT1	LOI		8.54	8.54	Yes	Yes	
59866	000	New	Feb 96	4	Multifetal Pregnancy Reduction	13	April 96	13	4.00	4.00		Yes	
61586	090	New	Feb 96	5	Nasopharyngeal Lesion Resection/Excision	25	April 96	Z 1	23.60	23.60		Yes	

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CPT Code	Global Period	CPT Action	CPT Meeting	CPT Tab	RUC Issue	Track No.	RUC Meeting	RUC Tab	SS Rec	RUC Rec	Same Value as 1996?	Code in MFS?	Other Comments
61793	090	Revised	Feb 96	6	Stereotactic Radiosurgery	AA1	LOI		16.7 0	16.70	Yes	Yes	
68800	010	Deleted	Aug 95	N	Nasolacrimal Duct Probe	C1	April 96	30				Yes	
68801	010	New	Aug 95	N	Nasolacrimal Duct Probe	ĊC2	April 96	30	0.89	0.89	,	Yes	
68810	010	New	Aug 95	N	Nasolacrimal Duct Probe	C3	April 96	30	1.27	1.27		Yes	
68811	010	Nęw	Aug 95	N	Nasolacrimal Duct Probe	C5	April 96	30	2.25	2.25		Yes	
68815	010	New	Aug 95	N	Nasolacrimal Duct Probe	C7	April 96	30	3.00	3.00	ı	Yes	
68820	010	Deleted	Aug 95	N	Nasolacrimal Duct Probe	C4	April 96	30				Yes	
68825	010	Deleted	Aug 95	N	Nasolacrimal Duct Probe	C6	April 96	30				Yes	
68830	010	Deleted	Aug 95	N	Nasolacrimal Duct Probe	C8	April 96	30				Yes	
69801	090	Revised	Feb 96	Ql	Transtympanic Perfusion of Innter Ear	BBI	LOI		8.19	8.19	Yes	Yes	
75554	xxx	Revised	Feb 96	14	Nuclear Cardiology	CC1	April 96	23	1.83	1.83	Yes	Yes	
75555	xxx	Revised	Feb 96	14	Nuclear Cardiology	CC2	April 96	23	1.74	1.74	Yes	Yes	
75945	XXX	New	Aug 95	F	Intravascular Ultrasound	A3	April 96	6	1.00	0.40	1	Yes	
75946	XXX	New	Aug 95	F	Intravascular Ultrasound	A4	April 96	6	1.00	0.40	I	Yes	
76825	XXX	Revised	Feb 96	28	Echocardiography	KK1	April 96	21	2.32			Yes	Tabled
76826	xxx	Revised	Feb 96	28	Echocardiography	KK2	April 96	21	1.46			Yes	Tabled
76827	xxx	Deleted	Feb 96	28	Echocardiography	KK3	April 96	21				Yes	

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CPT Code	Global Period	CPT Action	CPT Meeting	CPT Tab	RUC Issue	Track No.	RUC Meeting	RUC Tab	SS Rec	RUC Rec	Same Value as 1996?	Code in MFS?	Other Comments
76828	xxx	Deleted	Feb 96	28	Echocardiography	KK4	April 96	21				Yes	X
78445	xxx	Revised	Feb 96	14	Nuclear Cardiology	CC3	_April 96	23	0.49	0.49	Yes	Yes	
78460	xxx	Revised	Feb 96	14	Nuclear Cardiology	CC4	April 96	23	0.86	0.86	Yes	Yes	
78461	xxx	Revised	Feb 96	14	Nuclear Cardiology	CC5	April 96	23	1.23	1.23	Yes	Yes	
78464	xxx	Revised	Feb 96	14	Nuclear Cardiology	CC6	April 96	23	1.09	1.09	Yes	Yes	
78465	xxx	Revised	Feb 96	14	Nuclear Cardiology	CC7	April 96	23	1.46	1.46	Yes	Yes	
78469	xxx	Revised	Feb 96	14	Nuclear Cardiology	CC8	April 96	23	0.92	0.92	Yes	Yes	
78481	xxx	Revised	Feb 96	14	Nuclear Cardiology	CC1	April 96	23	0.98	0.98	Yes	Yes	
78483	xxx	Revised	Feb 96	14	Nuclear Cardiology	CC1	April 96	23	1.47	1.47	Yes	Yes	
80197	XXX	New	May 95	J	Tacrolimus	E1	LOI					No	
82523	xxx	New	Feb 96	19	Collagen Crosslinks	DD1	LOI					No	
83719	xxx	Revised	Nov 95	L	LDL Cholesterol Testing	J 1	LOI					No	
83721	xxx	Revised	Nov 95	L	LDL Cholesterol Testing	J2	LOI					No	
83890	xxx	Revised	May 95	L	Molecular Diagnostics	F1	LOI					No	
83892	xxx	Revised	May 95	L	Molecular Diagnostics	F2	LOI					No	
83894	XXX	Revised	May 95	L	Molecular Diagnostics	F3	LOI			•		No	
83896	xxx	Revised	May 95	L	Molecular Diagnostics	F4	LOI					No	

CPT Code	Global Period	CPT Action	CPT Meeting	CPT Tab	RUC Issue	Track No.	RUC Meeting	RUC Tab	SS Rec	RUC Rec	Same Value as 1996?	Code in MFS?	Other Comments
83898	xxx	Revised	May 95	L	Molecular Diagnostics	F5	LOI					No	
83902	xxx	New	May 95	L	Molecular Diagnostics	F6	LOI					No	
83912	xxx	Revised	May 95	L	Molecular Diagnostics	F7	LOI					No	
84479	xxx	Revised	Feb 96	20	Thyroid Hormone	EE1	LOI					No	
84480	xxx	Revised	Feb 96	20	Thyroid Hormone	EE2	LOI					No	
84484	xxx	New	May 95	М	Troponin	Gl	LOI					No	
90911	000	Revised	Feb 96	22	Biofeedback	FF9	LOI		2.15	2.15	Yes	Yes	
92240	xxx	New	Aug 95	G	Indocyanine-Green Angiography	D 1	Feb 96	28	1.10	1.10	I.	Yes	
92548	xxx	New	Feb 96	К	Computerized Dynamic Posturography	GG1	April 96	26	1.40	0.50	I.	Yes	
92978	ZZZ	New	Aug 95	F	Intravascular Ultrasound	A5	April 96	6	3.00	2.50	I.	Yes	
92979	ZZZ	New	Aug 95	F	Intravascular Ultrasound	A6	April 96	6	2.65	2.00	I	Yes	
92995	000	Revised	Feb 96	24	Percutaneous Atherectomy	HH1	LOI		12.09	12.09	Yes	Yes	
93201	xxx	Deleted	Feb 96	26	Phonocardiography	II1	LOI					Yes	
93202	xxx	Deleted	Feb 96	26	Phonocardiography	II2	LOI					Yes	
93204	xxx	Deleted	Feb 96	26	Phonocardiography	113	LOI					Yes	
93205	xxx	Deleted	Feb 96	26	Phonocardiography	II4	LOI					Yes	
93208	xxx	Deleted	Feb 96	26	Phonocardiography	115	LOI					Yes	

CPT Code	Global Period	CPT Action	CPT Meeting	CPT Tab	' RUC Issue	Track No.	RUC Meeting	RUC Tab	SS Rec	RUC Rec	Same Value as 1996?	Code in MFS?	Other Comments
93209	xxx	Deleted	Feb 96	26	Phonocardiography	II6	LOI					Yes	
93210	xxx	Deleted	Feb 96	26	Phonocardiography	II7	LOI					Yes	
93220	xxx	Deleted	Feb 96	27	Vectorcardiography	JJ1	LOI					Yes	
93221	xxx	Deleted	Feb 96	27	Vectorcardiography	JJ2	LOI					Yes	
93222	xxx	Deleted	Feb 96	27	Vectorcardiography	JJ3	LOI					Yes	
93301	xxx	New	Feb 96	28	Echocardiography	KK5	April 96	21	1.51			Yes	Tabled
93302	xxx	New	Feb 96	28	Echocardiography	KK6	April 96	21	0.75			Yes	Tabled
93303	xxx	New	Feb 96	29	Pediatric Echocardiography	LL1	April 96	20				Yes	Tabled
93304	xxx	New	Feb 96	29	Pediatric Echocardiography	LL2	April 96	20				Yes	Tabled
93307	xxx	Deleted	Feb 96	28	Echocardiography	KK7	April 96	21				Yes	
93308	xxx	Deleted	Feb 96	28	Echocardiography	KK8	April 96	21				Yes	
93312	xxx	Revised	Feb 96	28	Echocardiography	KK9	April 96	21	2.84			Yes	Tabled
93313	xxx	Revised	Feb 96	28	Echocardiography	KK1	April 96	21	1.70			Yes	Tabled
93314	xxx	Revised	Feb 96	28	Echocardiography	KK1	April 96	21	1.70			Yes	Tabled
93315	xxx	New	Feb 96	29	Pediatric Echocardiography	LL3	April 96	20				Yes	Tabled
93316	XXX	New	Feb 96	29	Pediatric Echocardiography	LL4	April 96	20				Yes	Tabled
93317	xxx	New	Feb 96	29	Pediatric Echocardiography	LL5	April 96	20				Yes	Tabled

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CPT Code	Global Period	CPT Action	CPT Meeting	CPT Tab	RUC Issue	Track No.	RUC Meeting	RUC Tab	SS Rec	RUC Rec	Same Value as 1996?	Code in MFS?	Other Comments
93320	xxx	Deleted	Feb 96	28	Echocardiography	KK1	April 96	21				Yes	
93321	xxx	Deleted	Feb 96	28	Echocardiography	KK1	April 96	21				Yes	
93325	xxx	Deleted	Feb 96	28	Echocardiography	KK1	April 96	21				Yes	
93350	xxx	Revised	Feb 96	28	Echocardiology	KK1	April 96	21	1.51			Yes	Tabled
93619	000	Revised	Feb 96	30	Comprehensive Electrophysiology	MM1	LOI		7.32	7.32	Yes	Yes	
93620	000	Revised	Feb 96	30	Comprehensive Electrophysiology	MM2	LOI		11.59	11.59	Yes	Yes	
93975	xxx	Revised	Feb 96	25	Duplex Scan of Testes	NN1	LOI		1.80	1.80	Yes	Yes	
93976	xxx	Revised	Feb 96	25	Duplex Scan of Testes	NN2	LOI		1.21	1.21	Yes	Yes	
94150	xxx	Revised	Feb 96	B1	Vital Capacity	001	Apil 96	27	0.11	0.07	Yes	Yes	
94160	XXX	Deleted	Feb 96	Bl	Vital Capacity	002	Apil 96	27				Yes	
95921	xxx	New	Feb 96	J	Autonomic Testing	PP1	- April 96	28	0.90	0.90		Yes	
95922	xxx	New	Feb 96	J	Autonomic Testing	PP2	April 96	28	0.96	0.96		Yes	
95923	xxx	New	Feb 96	J	Autonomic Testing	PP3	April 96	28	0.90	0.90		Yes	
95950	xxx	Revised	Nov 95	м	Video EEG Monitoring	KI	LOI		1.51	1.51	Yes	Yes	
05051	vvv	Revised	Nov 95	M	Video EEG Monitoring	к?	LOI		3.80	1.91 7 .80	Ves	Ves	
75751	ΛΛΛ		1100 75	141		124	201		6.00	6.00	Renseo	in 5	Jear

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AMA SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATIONS FEBRUARY 1996

Lung Volume Reduction - Tab 25

The RUC recommends a work relative value of 21.25 for 32491 *Removal of lung, other than pneumonectomy; excision-plication of emphysematous lung(s) (bullous or non-bullous) for lung volume reduction, sternal split or transthoracic approach, with or without any pleural procedure which is based on a survey of 32 thoracic surgeons. The intra-service work is greater than 32550 Wedge resection, single or multiple (13.10) and comparable to that of a 32480 Single lobectomy (16.84). However, the postoperative management performed by the surgeon is much more intensive. The patient is closely managed postoperatively and requires a longer stay in the ICU. A typical hospital stay is three weeks and then the patient is seen in the office three or four times following rehabilitation for examination, x-ray review, wound care, and prescription management.*

CPT Code (• New)	Tracking Number	CPT Descriptor	Global Period	RVW Recommendation
•32491	H1	Removal of lung, other than pneumonectomy; excision- plication of emphysematous lung(s) (bullous or non-bul- lous) for lung volume reduction, sternal split or transtho- racic approach, with or without any pleural procedure	090	21.25

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Global Period: 090 Recommended Work RVU: 21.25

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CPT Descriptor: Removal of lung, other than total pneumonectomy; excision-plication of emphysematous lung(s) (bullous or non-bullous) for lung volume reduction, sternal split or transthoracic approach, with or without any pleural procedure

Vignette Used in Survey:

CPT Code:
 324XX Tracking Number: H1

Typical Service/Patient: A 63 year old man, a former smoker was diagnosed with chronic lung disease. The patient was on nocturnal oxygen for 2 years and required 3 liters of oxygen with exertion. Post bronchodilator FEV, was 1% of predicted value, total lung capacity was 145% of predicted value and residual volume was 280% of predicted value. Room air PO2 was 55 and PCO2 was 48. The patient was medicated with 10 mg of prednisone per day, albuterol, Atrovent, and Azmacort inhalers 4 times a day, and oral theophylline. Six minute walk test was 1100 feet with no stops, using 4 liters of oxygen. Quantitative V/Q scan and CT scan showed marked upper lobe destruction with moderate emphysematous changes in the middle lobe, lingula, and lower lobes. The patient was evaluated and admitted for lung volume reduction surgery. One day prior to the operation the surgeon reviews the scans, pulmonary function studies, and walk test. The surgeon re-coursels the family on risks of the procedure, projected results, and postoperative care. The patient is taken to the operating room and anesthetized. A median sternotomy incision is performed. The right lung is collapsed and and the right pleura is then incised vertically to enter the right pleural space. A stapling device is then applied to the medial aspect of the right upper lobe. Using the staplers, approximately 50% of the right upper lobe is excised. Upon completion the chest is filled with saline and the anesthetist gently inflates the residual right lung, confirming absence of air leak. The left lung is then suspended and the same type of procedure is performed. Upon completion of the left lung dissection, the right lung is checked for air leaks. Two chest tubes are placed into either pleural space. The pleural incision is closed. Both lungs are reinflated. Sternal wires are placed and the sternum closed. The patient is transferred to the recovery area for 2.5 hours. The surgeon and anesthetist go to the recovery area for an hour to stabilize the patient. The patient is transferred to the intensive care unit where he remains for 96 hours. Chest xrays are reviewed twice daily. Microbiology results of daily gram stains are reviewed and antibiotic coverage adjusted. Bolus doses of steroids are ordered as necessary. Examinations are conducted two to three times per day and blood gases and x-rays reviewed. Each of four chest tubes is removed when the airleak ceases. The surgeon coordinates care with physicial therapists for a daily exercise program and necessary chest physical therapy. The patient is discharged on the 16th postoperative day. The patient makes daily visits to a rehabilitation unit and his progress is reviewed by the surgeon. He is seen by the surgeon on the day of discharge. The patient is seen in the office following rehab for examination, x-ray review, wound care, and prescription management.

Description of Pre-Service Work: The patient is admitted the day before operation and is reevaluated by the surgeon, who conducts a physical examination and reviews the medical history. The surgeon reviews x-rays, V/Q and CT scans, pulmonary function studies, and test walk. The surgeon recounsels the patient and family on risks and benefits of the procedure, projected results, and postoperative care. Informed consent is obtained if not previously done. The planned procedure is discussed with the anesthesiologist. The surgeon scrubs and gowns.

Description of Intra-Service Work: Epidural and double-lumen tube anesthesia are started. A standard median sternotomy incision is performed. Prior to division of the sternum, retrosternal dissection is carried out from below to sweep the pleura to either side. The right lung is collapsed and an apical "pleural tent" (pleurolysis) is dissected on the right side. The right pleura is then incised vertically to enter the right pleural space. Adhesions between the chest wall and lung are taken down with cautery. The pulmonary ligament is divided. After 10 minutes of suspended ventilation to the right lung, the right upper lobe is punctured with a cautery to deflate it. A stapling device is then applied to the medial aspect of the right upper lobe beginning just above the horizontal fissure and aiming toward the apex of the chest. Using successive applications of five staplers, approximately 50% of the right upper lobe is excised. Upon completion the chest is filled with saline and the anesthetist gently inflates the residual right lung, confirming absence of air leak. The left lung is then suspended. A left pleural tent is then created. The heart is displaced, affording visualization of the left inferior pulmonary ligament, which is then divided with cautery. Using successive applications of the linear stapler, buttressed with strips of bovine pericardium, the upper portion of the left upper lobe is removed, beginning on the medial aspect of the left upper lobe. Five to six applications are required. Further dissection of the pleural tent is carried out because of persistent apical space. Upon

completion of the left lung dissection, the right lung is checked for air leaks. Two chest tubes are placed into either pleural space. The right lung is deflated and the pleural incision is closed. The right lung is deflated and the left lung collapsed, allowing closure of the pleural incision. Sternal wires are placed and the sternum closed.

Description of Post-Service Work: After 30 minutes of observation in the operating room, the patient is transferred to the recovery area for 2.5 hours. The surgeon and anesthetist go to the recovery area for an hour to stabilize the patient. A chest x-ray is reviewed by the surgeon. A second x-ray is taken one hour later and reviewed by the surgeon. The patient is transferred to the intensive care unit and the surgeon counsels the family on the recovery process. That evening a third chest x-ray is taken and reviewed by the surgeon. The patient remains in the ICU for 96 hours. Chest x-rays are reviewed twice daily. Intravenous or tube nutritional supplementation is ordered. Microbiology results of daily gram stains are reviewed and antibiotic coverage reviewed. Steroids are ordered. Two to three examinations are conducted daily for 16 days at which time the patient is discharged. The patient makes daily visits to a rehabilitation unit and his progress is reviewed by the surgeon. The patient is seen in the office 3 or 4 times following rehab for examination, x-ray review, wound care, and prescription management.

SURVEY DATA:

Specialty:Society of Thoracic Surgeons
Sample Size: Response Rate (%): Median RVU: 21.25
25th Percentile RVU: <u>18.21</u> 75th Percentile RVU: <u>24.00</u> Low: <u>15</u> High: <u>32</u>
Median Pre-Service Time:90 min Median Intra-Service Time:150 min
25th Percentile Intra-Svc Time: <u>135 min</u> 75th Percentile Intra-Svc Time: <u>180 min</u> Low: <u>110 min</u> High: <u>180</u>
Median Post-Service Time: <u>Total Time</u> <u>Number of Visits</u>
Day of Procedure: 60 min
ICU: <u>120 min</u> 8
Other Hospital: <u>160 min</u> <u>15</u>
Office: <u>60 min 3</u>
CPT Code:324XX
KEV REFERENCE SERVICE(S).

	CPT Code	CPT Descriptor	Work RVU
1)	32141	Thoracotomy, major; with excision-plication of bullae, with or without any pleural procedure	12.14
2)	32500	Wedge resection, single or multiple	13.10
3)	32440	Removal of lung, total pneumonectomy	19.15
4)	32480	Single lobectomy	16.84

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

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

The intraservice work of lung volume reduction surgery is somewhat greater than a wedge resection (32500) and comparable to that of a lobectomy (32480). However, the postoperative management on the part of the surgeon requires much more time and intense work effort. The patient must be closely managed postoperatively. The time in the ICU is longer than 32500 and 32480 and many more visits by the surgeon are required. The time in the hospital is generally considerably longer, with more visits and interventions required than for 32500 and 32480. Finally, more office visits are required. Finally, we believe that the work effort for this procedure is close to that of a total pneumonectomy (32440), but again, because of the substantial postoperative management, even exceeds the work of 32440.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternataive method instead of the survey results, or other data besides the survey data are available, please explain any additional rationale for the RVUs.

FREQUENCY INFORMATION

How was this service previously reported? 32141. 32500; 32655, 32657, 32999
How often do physicians in your specialty perform this service? Commonly _X_ Sometimes Rarely
Estimate the number of times this service might be provided nationally in a one-year period?
Is this service performed by many physicians across the United States? X Yes No





AMA SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATIONS FEBRUARY 1996

Laparoscopy/Peritoneoscopy - Tab 26

The RUC recommends that the work RVUs for 56300 *Laparoscopy (peritoneoscopy), diagnostic; (separate procedure)* be increased from 3.58 to 5.00. The recommendation is based on the survey median of 38 gynecologists. The survey median appears appropriate when confirmed by the following calculation:

Pre-Service Work	99215	1.51
ntra-Service Work	45 min. x .06 intensity	2.70
Post-Service Work	Average of 99213/99214	<u>.74</u>
Fotal Work		4.95

In addition, 56360 *Peritoneoscopy; without biopsy* (4.04) has been deleted. 56300 requires identical intra-service work but has a 10 day global period and includes a follow-up office visit that would not have been included in 56360.

The recommended increment between 56300 and 56305 Laparoscopy, surgical; with biopsy (single or multiple) is .30 which is similar to the current increment between 56360 Peritoneoscopy; without biopsy (4.04) and 56361 Peritoneoscopy; with biopsy (4.32).

CPT Code (• New)	Tracking Number	CPT Descriptor	Global Period	RVW Recommendation
LAPAROS	COPY/ PERI	TONEOSCOPY/HYSTEROSCOPY		
56300	I1	Laparoscopy (peritoneoscopy), diagnostic; (separate proce- dure)	010	5.00

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CPT Code (• New)	Tracking Number	CPT Descriptor	Global Period	RVW Recommendation
56305	12	Laparoscopy, surgical; with biopsy of peritoneal surface(s), (single or multiple)	010	5.30
56360	13	Peritoneoscopy; without biopsy (56360 has been deleted. To report, use 56300)	000	N/A
56361	I4	with biopsy 56361 has been deleted. To report, use 56305)	000	N/A
56362	15	Peritoneoscopy Laparoscopy with guided transhepatic cholan- giography; without biopsy	000	4.89 (no change)
56363	I6 .	with biopsy	000	5.18 (no change)
56399	17	Unlisted procedure, laparoscopy, peritoneoscopy, hysteros- copy	YYY	N/A

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CPT 56300

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: <u>56300</u> Global Period: <u>010</u> Current RVW: <u>3.58</u> Recommended RVW: <u>5.00</u>

CPT Descriptor: Laparoscopy (peritoneoscopy), diagnostic (separate procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old female with a known history of endometriosis presented with right lower quadrant pain, with direct rebound tenderness and an elevated white count. The following day, her white count had returned to normal, but she still had direct and rebound tenderness. She was taken to the operating room and underwent laparoscopy. There was no evidence of acute appendicitis, mesenteric lymph adenitis, or obvious endometriosis. The entire intraperitoneal inspection was normal and nothing surgically was indicated. Postoperatively she improved and was subsequently discharged from the hospital on the third postoperative day.

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work:

A bimanual pelvic examination is done to assess uterine size, position, and mobility before insertion of an uterine cannula. Exposure of the cervix is obtained. The anterior lip of the cervix is grasped with a tenaculum attached to an intrauterine cannula. Pneumoperitoneum is achieved by insertion of a Veress or Touhy needle at the inferior rim of the umbilicus through a 2 mm incision. The peritoneal space is insufflated with carbon dioxide gas to a pressure of 10 mm HG. Once satisfactory displacement of organs is achieved, the 2 mm incision is extended to 1 cm and the laparoscope trocar and sleeve are inserted through the rectus fascia. The trocar is removed from the sleeve, proper placement is documented as the operating laparoscope is advanced down the trocar sleeve into the pelvis. The gas hose is then connected to the trocar. Once the laparoscope has been inserted a second trocar may be placed for ancillary instruments. The entire abdomen and pelvis is viewed systematically and pathology noted. It may be photodocumented. Upon completion of the exploration, secondary trocars are removed under direct vision and the sites are observed for bleeding. The abdomen is deflated. The fascia may be closed separately, the skin wounds are closed. The patient is transferred to a stretcher and escorted to the recovery room.

Description of Post-Service Work:

Following the procedure, the physician writes orders for post-operative care, accompanies the patient to the recovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage catheters are normally removed on post op day 1 and the patient is monitored for normal voiding. The physician visits the patient in the hospital for 3 days. The patient is discharged on post op day 3 with instructions for follow-up care. The patient is reevaluated once post operatively.

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SURV	YEY DATA:						
Specia	alty: <u>ACO</u>	G			_		
Sampl	le Size:10	0 Response Rate (9	%): <u>38 (38%)</u>	Median RVW:	_5		
25th F Media	25th Percentile RVW: 4.04 75th Percentile RVW: 7 Low: 4 High: 10.5 Median Pre-Service Time: 40 Median Intra-Service Time: 45						
25th F	ercentile Intra-S	Svc Time: <u>30</u> 75th Per	rcentile Intra-Svc T	ime: <u>49</u> Low: <u>30</u>) High: <u>90</u>		
Media	n Post-Service	Time:	<u>Total Time</u> N	umber of Visits			
	Day of Procee	lure:	30				
	ICU:						
	Other Hospita	l:	40	2			
	Office:		15	1			
KEY	REFERENCE	SERVICE(S):	······································				
1)	<u>CPT Code</u> 56360	<u>CPT Descriptor</u> Peritoneoscopy without b	biopsy	<u>RVW</u> 4.04			
2)	49000	Exploratory laparotomy		8.99			
3)	56308	LAVH		13.87			

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

4)

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

CPT 56300 is identical to CPT 56360 except that since the typical patient for CPT 56300 is female, the physician must insert an instrument to grasp the cervix, then insert a uterine manipulator prior to making the incision and inserting the laparoscope. In addition, CPT 56300 has a 10 day global period and typically includes a follow-up office visit that would not be included for CPT 56360. Therefore the survey median seems reasonable.

RATIONALE

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

Pre-service	99215	1.51
Intra-service	45 x .06	2.70
Office	Average of 99213 and 99214	.74
		4.95

Note: The 1992 Medicare RBRVS assigned the same RVUs to 56300 and 56360 but HCFA lowered the RVUs for CPT56300 in response to an ACOG comment that several surgical laparoscopy codes were inappropriately valued lower than CPT56300.

FREQUENCY INFORMATION

How was this service previously reported? _____NA

How often do physicians in your specialty perform this service? X Commonly Sometimes Rarely

Estimate the number of times this service might be provided nationally in a one-year period? <u>1994 BMAD data</u> indicate 11,814 claims for CPT 56300. Total volume would be significantly higher since the service is performed frequently in the non-Medicare population.

...

Is this service performed by many physicians across the United States? <u>x</u> Yes <u>No</u>

FAX NO. 2024847480

CPT 56305

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: <u>56305</u> Global Period: <u>010</u> Current RVW: <u>3.80</u> Recommended RVW: <u>5.3</u>

CPT Descriptor: Laparoscopy, surgical; with biopsy, single or multiple

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old G2P2 is evaluated for increasing dysmcnorrhea unresponsive to NSAIDS. She is intolerant to oral contraceptives. Diagnostic laparoscopy demonstrates probable endometriosis with powerburn and red-berry lesions identified in the cul de sac and broad ligaments. At the same operative session, biopsies of these areas are performed. The patient receives routine office follow-up care during the 10 day global period.

Description of Pre-Service Work

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Scrvice Work:

A bimanual pelvic examination is done to assess uterine size, position, and mobility before insertion of an uterine cannula. Exposure of the cervix is obtained. The anterior lip of the cervix is grasped with a tenaculum attached to an intrauterine cannula. Pneumoperitoneum is achieved by insertion of a Veress or Touhy needle at the inferior rim of the umbilicus through a 2 mm incision. The peritoneal space is insufflated with carbon dioxide gas to a pressure of 10 mm HG. Once satisfactory displacement of organs is achieved, the 2 mm incision is extended to 1 cm and the laparoscope trocar and sleeve are inserted through the rectus fascia. The trocar is removed from the sleeve, proper placement is documented as the operating laparoscope is advanced down the trocar sleeve into the pelvis. The gas hose is then connected to the trocar.

Once the laparoscope has been inserted a second trocar may be placed for ancillary instruments. The entire abdomen and pelvis is viewed systematically and pathology noted. It may be photodocumented. Upon completion of the exploration, areas of abnormal pathology are selected for biopsy. Scissors, electrosurgical instruments, lasers or biopsy forceps are introduced through accessory trocars and biopsies obtained. Hemostasis is achieved as needed.

Secondary trocars are removed under direct vision and the sites are observed for bleeding. The abdomen is deflated. The fascia may be closed separately, then the skin wounds are closed. The patient is transferred to a stretcher and escorted to the recovery room.

Description of Post-Service Work:

following the procedure, the physician writes orders for post-operative care, accompanies the patient to the ecovery room, and talks with the patient's family. The patient is then evaluated in the recovery room. The physician dictates the operative procedure and makes periodic checks on the patient's condition. Any drainage







catheters are normally removed when the patient is ambulatory and she is monitored for normal voiding. The physician visits the patient in the hospital for 1 day. The patient is discharged on post op day 1 with instructions for follow-up care. The patient is reevaluated once post operatively.

SURVEY DATA:

Specialty: <u>ACOG</u>	·
Sample Size: 100 Response Rate (%	6.00 Median RVW: 6.00
25th Percentile RVW: <u>5.00</u> 75th Percent	ile RVW: <u>6.5</u> Low: <u>4.04</u> High: <u>10.5</u>
Median Pre-Service Time:45	Median Intra-Service Time:45
25th Percentile Intra-Svc Time: <u>31</u> 75th Perc	centile Intra-Svc Time: <u>60</u> Low: <u>30</u> High: <u>90</u>
Median Post-Service Time:	Total Time Number of Visits
Day of Procedure:	30
ICU:	
Other Hospital:	151
Office:	151

KEY REFERENCE SERVICE(S):

1)	<u>CPT Code</u> 56361	<u>CPT Descriptor</u> Peritoneoscopy with biopsy	<u>RVW</u> 4.32
2)	56360	Peritoneoscopy without biopsy	4.04
3)	49000	Exploratory laparotomy	8.99
4)			

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above. Essentially equivalent to CPT56361, but intra-service work is greater because of intrauterine manipulation. Also post-service work is greater because of the office visit included in the 10 day global period for CPT56305. CPT56361 has a 0 day global period.

...



RATIONALE

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

Pre-service	99215	1.51
Intra service	50 min x 0.06	3.00
Office	avg. between 99213/99214	<u>.74</u> 5.23

Note: The recommended RVU is 0.30 RVUs higher than recommendation for CPT56300. This increment is about equal to the current difference between 56300 and 56305 and between 56360 and 56361.

 FREQUENCY INFORMATION

 How was this service previously reported? ______

 How often do physicians in your specialty perform this service? _x____

 Commonly ______

 Sometimes ______

 Rarely

Estimate the number of times this service might be provided nationally in a one-year period? <u>1994 BMAD data</u> indicate 1.389 claims for CPT 56305. Total volume would be significantly greater because the service is performed frequently in the non-Medicare population.

Is this service performed by many physicians across the United States? <u>x</u> Yes <u>No</u>





AMA SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATIONS FEBRUARY 1996

Indocyanine-Green Angiography - Tab 28

The RUC recommends a work relative value unit of 1.10 for 92240 *Indocyanine-green angiography (includes multiframe imaging) with interpretation and report*, which represents new technology that is only performed by 15-20% of retinal specialists. ICG and 92235 *Fluorescein angiography (includes multiframe imaging) with interpretation and report* (0.81) both involve the injection of a photochemical dye into the back of the eye, followed by photography of the affected area in order to diagnose the condition of the retina. The work for ICG, however, is more time-consuming and more intense than for fluorescein angiography (FA). ICG requires more pre-service time because a detailed review of a previous FA is performed when the FA was not sufficient for a diagnosis. The intra-service work is more intense and time-consuming because all frames of an ICG are reviewed more closely than for FA and it is more difficult to arrive at a diagnosis. In addition, the images must initially be viewed and manipulated on a computer, in contrast to FA, which may be viewed from individual prints. ICG also generates significantly more psychological stress than FA, because the dye used for ICG is more dangerous, and more likely to cause life-threatening adverse reactions. In contrast, FA rarely produced adverse reactions, and those that occur are almost always mild.

CPT Code (• New)	Tracking Number	CPT Descriptor	Global Period	RVW Recommendation
92240	D1	Indocyanine-green angiography (includes multiframe imaging) with interpretation and report	XXX	1.10

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

	<u></u>			
CPT Code: <u>922xx</u>	Tracking Number:	Global Period:	Recommended Work RVU: 1.10	
CPT Descriptor:	Indocyanine-green ang	riography (includes multif	rame imaging) with interpretation and report	rt

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67 year old gentleman presets to his ophthalmologist with sudden loss of vision in an otherwise normal eye. The patient is found to have a subretinal hemorrhage in the posterior pole, obscuring examination of the deeper ocular elements. Intravenous fluorescein angiography cannot demonstrate any abnormalities of the posterior pole. The patient undergoes indocyanine-green video angiography which detects a treatable subretinal neovascular membrane. The subretinal neovascular membrane is treated with laser photocoagulation.

Description of Pre-Service Work: Patient's pupils are dilated, and vision checked. Informed consent is obtained. Patient is seated in photography area as computer is set up and dye is drawn up.

Description of Intra-Service Work: Procedure explained to patient. Placement of intravenous line. Red-free (visual image) photographs are taken. Physician injects dye. Photographer takes series of photographs. Physician reviews, manipulates, and digitally enhances photographic images by computer, mapping images onto red-free photographs. Enhanced images are evaluated in conjunction with examination observations and previous angiography studies.

Description of Post-Service Work: Patient monitored for allergic reaction. Results and treatment implications explained to patient.

SURVEY DATA:					
Specialty: <u>Americ</u>	an Academy of Ophthalmological	ogy			
Sample Size	0 Response Rate	(%): <u>16</u>	Median RVU:1.1	·	
25th Percentile RV	U: <u>.83</u> 75th Perce	ntile RVU: <u>2.74</u>	Low: <u>.21</u>	High: <u>13</u>	
Median Pre-Service	e Time: <u>30</u>	Median Intra-	-Service Time: <u>30</u>		
25th Percentile Intr	a-Svc Time: <u>26.25</u> 75th	Percentile Intra-Svo	: Time: <u>41.25</u> Low: _	<u>10</u> High: <u>90</u>	
Median Post-Servio Day of Pro	e Time: xedure:	<u>Total Time</u> 20	Number of Visits		
ICU:			, 		
Other Hos	pital:				
Office:		90	2	-	

CPT Code: <u>922xx</u>



KEY REFERENCE SERVICE(S):

	CPT_Code	CPT Descriptor	Work RVU
1)	92235	Fluorescein angiography (includes multiframe imaging) with interpretation and report.	0.81
2)	76511	Ophthalmic ultrasound, echography, diagnostic; A-scan only, with amplitude quantification.	0.94
3)	93555	Imaging supervision, interpretation and report for injection procedure(s) during cardiac catherization; ventricular and/c atrial angiography.	u 0.81 or

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

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

Indocyanine-green angiography ("ICG") and fluorescein angiography ("FA," service code 92235) both involve the injection of a photochemical dye into the back of the eye, followed by photography of the affected area in order to diagnose the condition of the retina. The work for ICG, however, is both more time-consuming and more intense than for FA.

ICG illuminates retinal features behind those which are shown by FA. Accordingly, ICG is performed when FA is not sufficient for a diagnosis. Thus, the pre-service work preceding ICG requires a detailed review of a previously-performed FA.

ICG is more intense than FA because ICG is generally used on patients with more complex problems, such as, but not limited to, age-related macular degeneration. Physicians face a multifactorial problem as they must correlate their observations of the eye with the findings of FA and ICG.

ICG is also more time-consuming because it is a new technology, with which physicians are less familiar. Consequently, all frames of an ICG are reviewed more closely than for FA, and it is more difficult to arrive at a diagnosis.

Evaluation of ICG is also more time-consuming because ICG images must initially be viewed and manipulated on a computer, in contrast to FA, which may be viewed from individual prints:

Finally, ICG generates significantly more psychological stress than FA, because the dye used for ICG is more dangerous, and more likely to cause life-threatening adverse reactions. In contrast, FA rarely produces adverse reactions, and those that occur are almost always mild.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results, or other data besides the survey data are available, please explain any additional rationale for the RVUs.

The distinctions set forth above confirm the survey results which indicated that ICG involves more work than FA.

FREQUENCY INFORMATION

How was this service previously reported? <u>Some Practices use code 92235 (fluorescein angiography) with a -22</u> modifier. Others require direct payments from patients.

How often do physicians in your specialty perform this service? ____ Commonly X___ Sometimes ____ Rarely

Estimate the number of times this service might be provided nationally in a one-year period: <u>Utilization is increasing as</u> new techniques are being developed. Frequency estimates vary widely, ranging from below 100,000 to 600,000, a substantial proportion of the number of FA procedures.

Is this service performed by many physicians across the United States? ____ Yes X No





AMA SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATIONS APRIL 1996

Intravascular Ultrasound - Tab 6

The RUC based the following recommended values for intravascular ultrasound on the ultrasound portion of 43259 Upper gastrointestinal endoscopy with endoscopic ultrasound examination (work rvu = 4.89). If the relative value for 43235 Upper gastrointestinal endoscopy without ultrasound (work rvu = 2.39) is subtracted from the 43259 the result is 2.50 RVUs (4.89 - 2.39 = 2.50). The RUC suggests that the value of 92978 should be set equal to the ultrasound portion of 43259. The calculated IWPUT for the ultrasound component of 43259 is .08. which is similar to the RUC recommendation of .10.

The RUC also based it recommendations on 93503 Insertion and placement of flow directed catheter (eg. Swan-Ganz) for monitoring purposes (work rvu = 2.43). The work involved in providing this service is similar to the intravascular ultrasound codes. The IWPUT for 93503 is .08. which is comparable to the IWPUT for 92978.

Once the RUC arrived at a value for the most difficult of the intravascular ultrasound service, the remainder of the codes were reduced so as to maintain a rank order that the RUC felt was appropriate.

These recommendations represent a significant reduction from the levels initially presented by the specialties, which were based on survey results. Surveys of add-on codes are often problematic.

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CPT Code (• New)	Tracking Number	CPT Descriptor	Global Period	IWPUT	RVW Recommendation		
INTRAVAS	CULAR ULT	RASOUND SERVICES		•			
(Intravascula both before	(Intravascular ultrasound services include all transducer manipulations and repositioning within the specific vessel being examined, both before and after therapeutic intervention (eg, stent placement)						
Vascular acc	ess for intrava	scular ultrasound performed during a therapeutic intervention	n is not rep	orted separa	ttely)		
(For radiolog	gical supervision	on and interpretation see 759X1, 759X2)					
•37250	A1	Intravascular ultrasound (non-coronary vessel) during therapeutic intervention; initial vessel	ZZZ	.09	2.10		
•37251	A2	each additional vessel	ZZZ	.08	1.60		
●75945	A3	Intravascular ultrasound (non-coronary vessel), radiologi- cal supervision and interpretation, initial vessel	XXX	.02	.40		
●75946	A4	Intravascular ultrasound each additional non-coronary vessel, radiological supervision and interpretation (For procedure, see 37XX3, 37XX4)	XXX	.02	.40		
●92978	A5	Intravascular ultrasound (coronary vessel or graft) during therapeutic intervention including imaging supervision, interpretation and report; initial vessel	ZZZ	.10	2.50		
•92979	A6	each additional vessel	ZZZ	.08	2.00		
(Intravascular ultrasound services include all transducer manipulations and repositioning within the specific vessel being examined, both before and after therapeutic intervention (eg, stent placement))							

SUMMARY OF RECOMMENDATION				
CPT Code: <u>37XX3</u> Tracking Number: AZ Global Period: ZZZ Recommended Work RVU:				
CPT Descriptor: Intravascular ultrasound (non-coronary vessel), during therapeutic intervention; initial vessel				
(Intravascular ultrasound services include all transducer manipulations and repositioning within the specific vessel being examined, both before and after therapeutic intervention (eg. stent placement)				
(For radiological supervision and interpretation, see 7594X, 7594X)				

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 58-year-old man with life-style limiting one block claudication underwent diagnostic aortography and lower extremity arteriography one day earlier, which showed complete occlusion of the right common iliac artery and a 30 percent stenosis of the left common iliac artery at its origin. The patient undergoes primary recanalization of the right common iliac artery via the right common femoral artery approach. The common iliac artery occlusion is stented and follow-up arteriography demonstrates slow flow through the stented segment. There is a complex spiral dissection involving the distal aorta, which comprises the lumen of the left common iliac artery. IVUS is needed to determine the morphology of the lesion and to evaluate the stent placement. An intravascular ultrasound probe is placed through the existing sheath and manipulated across the area in question in the right common iliac artery and aorta. The examination shows that there has been subintimal placement of the stent and further stents are necessary to achieve intraluminal stent placement into the aorta. A second stent is placed to achieve intraluminal position within the aorta and arteriography shows good flow. Intravascular ultrasound probe is manipulated through the stented segment and into the aorta for follow-up evaluation. That examination shows a satisfactory result with good stent placement and adequate luminal diameter.

Description of Pre-Service Work:

Description of Intra-Service Work: See vignette above.

Description of Post-Service Work:

SURVEY DATA:

Specialty: Society of Cardiovascular & Interventional Radiology						
Sample Size: 49 Response	Rate: 29 (59%)	Median RVU: 4.0				
25th Percentile RVU: 3.35 7	5th Percentile RVU:	5.04 Low: 1.5	High: 7.0			
Median Pre-Service Time: 11.25	Median Pre-Service Time: 11.25 Median Intra-Service Time: 22.5					
25th Percentile Intra-Svc Time: 1	25th Percentile Intra-Svc Time: 16.25 75th Percentile Intra-Svc Time: 30 Low: 5 High: 120					
Median Post-Service Time: 0	Total Time	Number of Visits				
Day of Procedure:	N/A	N/A				
ICU:	N/A	N/A				

Other	·Hospital:	N/A	N/A		
Office:		<u>N/A</u> N/A			
KEY REFER	RENCE SERVICE(5):	·		
<u>CPT Code</u>	CPT Descriptor			Work RVU	,
1) 36200	Introduction of ne	edle or intracathe	ster, aorta	3.02	
2)_36245	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family		5.07		
3) 36217	Selective catheter order thoracic or family; initial thin brachiocephalic b	placement, arteri brachiocephalic b d order or more a ranch, within a va	al system; each first ranch, within a vascular selective thoracic or ascular family	6.3	
4) 32020	Tube thoracoston abscess, hemotho	ny with or withou rax, empyema) (s	t water seal (eg, for eparate procedure)	3.98	

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

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

Intravascular ultrasound of a noncoronary vessel (37XX3) compares quite closely with 36200 and 36245 in that both reference services involve arterial catheter placement with manipulation of a catheter into a nonselective or selective position. 37XX3 involves the manipulation of an ultrasound transducer on a catheter through an abnormal vascular segment and the skill, time, and intensity of the service relate to the degree of difficulty of the abnormal vascular air segment. The total work for 37XX3 is, however, less than the total work for 36200 and 36245 for the following reasons: 1) initial arterial access is not part of this procedure 2) The area has usually been previously catheterized 3) There is much less preservice work and essentially no post service work as opposed to significant pre- and postservice work for 36200 and 36245.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results, or other data besides the survey data are available, please explain any additional rationale for the RVUs.

The survey respondents gave a median RVW for this service of 4.0, which would place it between two major reference services 36200 and 36245. We, however, have reason to believe that many of the survey participants did not fully understand (despite careful explanation) that 37XX3 did <u>not</u> include initial arterial access. For this reason, we believe that the total work for 37XX3 should be less than 36200 (work RVU 3.02). We also consulted with our colleagues at the American College of Cardiology; physicians from both specialties who are familiar with both coronary and non coronary intravascular ultrasound agreed that the <u>total</u> work for 929X1 is 3.0 RVW. We therefore arrived at a consensus value of 2.5 RVW, which together with the recommended RVWs for the supervision and interpretation code paired with 37XX3 (359X1) of 0.5 yields a total work RVU of 3.0.

FREQUENCY INFORMATION -

How was this service previously reported?	As unlisted exam or using a variety of vascular ultrasound codes
	with or without modifiers.

How often do physicians in your specialty perform this service? ____ Commonly X___ Sometimes ____ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? Not Available

Is this service performed by many physicians across the United States? X Yes No

SUMMARY OF RECOMMENDATION

CPT Code: <u>37XX4</u> Tracking Number: A Global Period: ZZZ Recommended Work RVU: 2.15

CPT Descriptor: Intravascular ultrasound (non-coronary vessel), during therapeutic intervention; each additional vessel

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 58-year-old man with right common iliac artery occlusion and left common iliac 30 percen stenosis undergoes recanalization for occlusion of the right common iliac artery with subsequent stent placement. The stent placement results in a complex dissection, which involves the comon iliac arteries. After intervention and restenting on the right, which results in good flow, intervention in the left common iliac artery is necessary and access to the left common femoral artery is obtained. A sheath is placed in the left common femoral artery. Intravascular ultrasound for identification of the components of the dissection and the length of involvement (as well as the luminal diameter) is carried out. An intravascular ultrasound probe is placed through the sheath and negotiated through the spiral dissection, which involves the left common iliac artery. The imaging shows extensive dissection involving the distal aorta and the common iliac artery, and a stont is placed as a result.

After stenting, intravascular ultrasound is performed as a follow-up by placing a probe through the sheath and manipulating the probe across the stented segment. This examination shows an excellent result with good restoration of luminal patency and adequate stent diameter.

Description of Pre-Service Work:

Description of Intra-Service Work: See vignette above.

Description of Post-Service Work:

SURVEY DATA:

Specialty: Society of Cardiovascular & Interventional Radiology							
Sample Size: 49 Response Rate: 29 (59%) Median RVU: 4.0							
25th Percentile RVU: 3.11 75th Pe	25th Percentile RVU: 3.11 75th Percentile RVU: 4.79 Low: 1 High: 110						
Median Pre-Service Time: 5.75 N	Aedian Intra-Servi	ce Time: 20					
25th Percentile Intra-Svc Time: 16.25 75th Percentile Intra-Svc Time: 28.75 Low: 5 High: 60							
Median Post-Service Time: 1.0		Total Time Number of Visits					
Day of Procedure:	N/A	N/A					
ICU:	N/A	N/A					
Other Hospital:	N/A	N/A					
Office:	N/A	N/A					

KEY REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Work RVU
1) 36200	Introduction of needle or intracatheter, aorta	3.02
2) 36245	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family	5.07
3) 36217	Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family	6.3
4) 32020	Tube thoracostomy with or without water seal (eg, for abscess, hemothorax, empyema) separate procedure)	3.98

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

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

As in 37XX3, this code is closely related to the work involved in 36200 and 36245 for the reasons given for 37XX3. We, however, believe that the total work for an additional vessel is less since vascular access has initially been obtained and slightly less catheter manipulation would be involved in examining the additional vessel.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternataive method instead of the survey results, or other data besides the survey data are available, please explain any additional rationale for the RVUs.

The survey respondents gave a median RVW for this service of 4.0, which would place it between two major reference services 36200 and 36245. We, however, have reason to believe that many of the survey participants did not fully understand (despite careful explanation) that 37XX3 did <u>not</u> include initial arterial access. For this reason, we believe that the total work for 37XX3 should be less than 36200 (work RVU 3.02). After consultation with our colleagues at the American College of Cardiology, it was felt that the <u>total</u> RVWs for 37XX4 plus 759X2 should be equal to the total value of the coronary service (929X2) or 2.65. Therefore, the value for 37XX4 was set at 2.15.



FREQUENCY INFORMATION -

How was this service previously reported? <u>As unlisted exam or using a variety of vascular ultrasound codes</u> with or without modifiers.

How often do physicians in your specialty perform this service? ____ Commonly _X__ Sometimes _____ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? Not Available

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Is this service performed by many physicians across the United States? X Yes No

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Radiological supervision and interpretation including image production and reporting of imaging findings for the vignette below

intra-enice

CLINICAL DESCRIPTION OF SERVICE:

Nignette Used in Survey A 58-year-old man with life-style limiting one block claudication underwent diagnostic aortography and lower extremity arteriography one day earlier, which showed complete occlusion of the right common iliac artery and a 30 percent stenosis of the left common iliac artery at its origin. The patient undergoes primary recanalization of the right common iliac artery via the right common femoral artery approach. The common iliac artery occlusion is stented and follow-up arteriography demonstrates slow flow through the stented segment. There is a complex spiral dissection involving the distal aorta, which compromises the lumen of the left common iliac artery. IVUS is needed to determine the morphology of the lesion and to evaluate stent placement. An intravascular ultrasound probe is placed through the existing sheath and manipulated across the area in question in the right common iliac artery and aorta. The examination shows that there has been subintimal placement of the stent and further stents are necessary to achieve intraluminal stent placement into the aorta. A second stent is placed to achieve intraluminal position within the aorta and arteriography shows good flow. Intravascular ultrasound is again performed as a follow-up. The diagnostic catheter is withdrawn, and the intravascular ultrasound probe is manipulated through the stented segment and into the aorta for follow-up evaluation. That examination shows a satisfactory result with good stent placement and adequate luminal diameter.

Description of Pre-Service Work:

Description of Intra-Service Work: See vignette above.

Description of Post-Service Work:

SURVEY DATA:

D

Specialty: Society of Cardiovascular & Interventional Radiology

Median RVU: 1.0 Response Rate: 29 (59%) Sample Size: 49

25th Percentile RVU: 0.73 75th Percentile RVU: 1.16 Low: 1 High: 10.07

Median Pre-Service Time: 5 Median Intra-Service Time: 20

25th Percentile Intra-Svc Time: 10 75th Percentile Intra-Svc Time: 20 Low: 1 High: 60

Median Post-Service Time: 4.25 Number of Visits Total Time

Day of Procedure: N/A N/A ICU: N/A N/A





Other Hospital:	N/A	N/A
Office:	N/A	N/A

KEY REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Work RVU
1) 75625	Aortography, abdominal, by serialography, radiological supervision and interpretation	1.14
2) 75960	Transcatheter introduction of intravascular stent(s), (non-coronary vessel), percutaneous and/or open, radiological supervision and interpretation, each vessel	.82
3) 76942	Ultrasonic guidance for needle biopsy, radiological supervision and interpretation	.67
4) 76830	Doppler echocardiography, fetal, cardiovascular system, pulsed wave and/or continuous wave with spectral display; echography, transvaginal	.69

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

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

The key references for this service include supervision and interpretation of vascular diagnostic and interventional procedures (75625, 75960) and ultrasound guidance or imaging codes (76942 and 76830). The total work for image interpretation, however, is felt to be slightly less than for the interventional vascular codes which involve considerably more intraprocedural and postprocedural work.

ADDITIONAL RATIONALE For example, if recommended RVUs are based on an alternative method instead of the survey results, or other data besides the survey data are available, please explain any additional rationale for the RVUs.

Although the survey participants' median value was 1.0, the RUC Advisory Panel of SCVIR believed that the work of image interpretation during intravascular ultrasound was more equivalent to the work involved with conventional ultrasound image interpretation for ultrasound (diagnostic or therapeutic) and therefore felt the value to be most appropriate at 0.50 RVWs.

FREQUENCY INFORMATION -

How was this service previously reported? <u>As unlisted exam or using a variety of vascular ultrasound codes</u> with or without modifiers.

How often do physicians in your specialty perform this service? ____ Commonly X Sometimes ____ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? Not Available

Is this service performed by many physicians across the United States? X Yes No

CPT Code: 759X2 Tracking Number: A4 Global Period: XXX Recommended Work RVU: 0.5

CPT Descriptor: Intravascular ultrasound (non-coronary vessel), radiologic supervision and interpretation; each additional vessel

Radiological supervision and interpretation for the scenario listed below. (For procedure, see 37XX3, 37XX4)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 58-year-old man with right common iliac artery occlusion and left common iliac 30 percent stenosis undergoes recanalization for occlusion of the right common iliac artery with subsequent stent placement. The stent placement results in a complex dissection, which involves the comon iliac arteries. After intervention and restenting on the right, which results in good flow, intervention in the left common iliac artery is necessary and access to the left common femoral artery is obtained. A sheath is placed in the left common femoral artery. Intravascular ultrasound for identification of the components of the dissection and the length of involvement (as well as the luminal diameter) is carried out. An intravascular ultrasound probe is placed through the sheath and negotiated through the spiral dissection, which involves the left common iliac artery. The imaging shows extensive dissection involving the distal aorta and the common iliac artery, and a stent is placed as a result.

After stenting, intravascular ultrasound is performed as a follow-up by placing a probe through the sheath and manipulating the probe across the stented segment. This examination shows an excellent result with good. 7

Description of Pre-Service Work:

Description of Intra-Service Work: See vignette above.

Description of Post-Service Work:

SURVEY DATA:

Specialty: Society of Cardiovascular & Interventional Radiology

Sample Size: 49 Response Rate	: 29 (59%)	Median RVU: 1.0				
25th Percentile RVU: 0.69 75th Pe	ercentile RVU: 1	.07 Low: 1 High: 10.07				
Median Prc-Service Time: 5	Median Intra-Serv	ice Time: 20				
25th Percentile Intra-Svc Time: 11.25	75th Percenti	le Intra-Sve Time: 25 Low: 5 High: 60				
Median Post-Service Time: 2.75	Median Post-Service Time: 2.75 <u>Total Time</u> <u>Number of Visits</u>					
Day of Procedure:	N/A	N/A				
ICU:	N/A	N/A				
Other Hospital:	N/A	N/A				
Office:	N/A	N/A				

KEY REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Work RVU
1) 75625	Aortography, abdominal, by serialography, radiological supervision and interpretation	1.14
2) 75960	Transcatheter introduction of intravascular stent(s), (non-coronary vessel), percutaneous and/or open, radiological supervision and interpretation, each vessel	.82
3) 76942	Ultrasonic guidance for needle biopsy, radiological supervision and interpretation	.67
4) 76830	Doppler echocardiography, fetal, cardiovascular system, pulsed wave and/or continuous wave with spectral display; echography, transvaginal	.69

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

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

The key references for this service include supervision and interpretation of vascular diagnostic and interventional procedures (75625, 75960) and ultrasound guidance or imaging codes (76942 and 76830). The total work for image interpretation, however, is felt to be slightly less than for the interventional vascular codes which involve considerably more intraprocedural and postprocedural work.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results, or other data besides the survey data are available, please explain any additional rationale for the RVUs.

Although the survey participants' median value was 1.0, the RUC Advisory Panel of SCVIR believed that the work of image interpretation during intravascular ultrasound was more equivalent to the work involved with conventional ultrasound image interpretation for ultrasound (diagnostic or therapeutic) and therefore felt the value to be most appropriate at 0.50 RVWs.

FREQUENCY INFORMATION -

How was this service previously reported? <u>As unlisted exam or using a variety of vascular ultrasound codes</u> with or without modifiers.

How often do physicians in your specialty perform this service? ____ Commonly X___ Sometimes ____ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? Not Available

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Is this service performed by many physicians across the United States? X Yes No



Global Period: ZZZ Recommended Work RVU: 3.0 CPT Code: •929X1 Tracking Number (A5) Intravascular ultrasound (coronary vessel or graft) during therapeutic intervention CPT Descriptor: including imaging supervision, interpretation and report; initial vessel

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey.

A 55 year old male is hospitalized for unstable angina pectoris. Coronary angiography reveals two severe. discrete stenoses in the proximal segments of the right and left anterior descending coronary arteries. The patient consents for percutaneous coronary intervention. After obtaining femoral artery access, a guide catheter is positioned in the left main coronary artery. Under fluoroscopic guidance, a steerable wire is advanced into the left anterior descending artery, across and distal to the stenotic segment. An ultrasound catheter is threaded over the wire until it is distal to the narrowed segment. The catheter is activated and a cross-sectional image of the coronary artery is generated as the catheter is withdrawn through the coronary artery into the guide catheter. The diameter of the coronary artery is determined. After an intracoronary stent is deployed (reported separately), intracoronary ultrasound of the stented segment demonstrates suboptimal stent deployment. A larger, high-pressure balloon *f*atheter is then used for further stent expansion. Repeat ultrasound imaging now shows excellent stent apposition against the arterial wall.

Description of Pre-Service Work:

The physician reviews existing data to determine the need for and feasibility of intravascular ultrasound. The physician prepares the intravascular ultrasound catheter.

Description of Intra-Service Work: See vignette above. ſΧ

Description of Post-Service Work:

The physician reviews video-taped images of the vessel examined and prepares a report of the procedure.



SURVEY DATA:

Specialty <u>American College of Cardiology</u>						
Sample Size 75 Response Rate (%) 31 (41%) Median RVU: 3.88						
25th Percentile RVU: <u>2.98</u> 75th Percentile	e RVU: <u>4.75</u>	Low:High: 18.00				
Median Pre-Service Time: <u>10 min.</u>	Median Intra-Sei	rvice Time: <u>25 min</u>				
25th Percentile Intra-Svc Time: <u>19 min.</u> 75th Per min.	rcentile Intra-Svo	: Time: <u>30 min.</u> Low: <u>10 min.</u> High: <u>60</u>				
Median Post-Service Time:	<u>Total Time</u>	Number of Visits				
Day of Procedure:	<u>10 min.</u>	<u>N/A</u>				
ICU:	N/A	<u>N/A</u>				
Other Hospital:	N/A	<u>N/A</u>				
Office [.]	N/A	<u>N/A</u>				

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	Work RVU
1)	92984	Percutaneous transluminal balloon coronary angioplasty; each additional vessel	2.97
1)	36217	Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family.	6.30
2)	92980	Transcathter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel	14.84

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement, technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Code 929X1 describes intravascular ultrasound as an adjunct to a coronary artery intervention. As such, the work involved most closely corresponds to that of code 92984--angioplasty, each additional vessel. The guide-wire to be used for the interventional catheter is in place and is used during the ultrasound procedure. Intravascular ultrasound images are typically obtained before, during and following the therapeutic intervention. The recommended work RVU reflects this typical number of image acquisition "passes".

FREQUENCY INFORMATION

How was this service previously reported? Unlisted code 93799

How often do physicians in your specialty perform this service? _ Commonly X Sometimes _ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? <u>To be provided</u>

Is this service performed by many physicians across the United States? X Yes No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

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CPT Code: •929X2 Tracking Number: (A6) Global Period: ZZZ Recommended Work RVU: 2.65

CPT Descriptor: Intravascular ultrasound (coronary vessel or graft) during therapeutic intervention including imaging supervision, interpretation and report; each additional vessel

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

During the same procedure described for code A5, intravascular ultrasound imaging of the right coronary artery demonstrates extensive calcification of the stenotic segment. Consequently, rotational atherectomy is performed (reported separately). Repeat ultrasound shows a large, circular lumen and no significant narrowing.

Description of Pre-Service Work:

Pre-service work for this service is captured in the initial vessel code.

Description of Intra-Service Work: See vignette above.

Description of Post-Service Work: The physician reviews video-taped images of the vessel examined and prepares a report of the procedure.

SURVEY DATA:

Specialty: <u>American College of Cardiology</u>					
Sample Size: <u>75</u> Response Rate (%): <u>31 (41%)</u> Median RVU: <u>2.65</u>					
25th Percentile RVU: <u>1.69</u> 75th Percentile RVU. <u>3.50</u> Low: <u>0.35</u> High <u>7.49</u>					
Median Pre-Service Time: <u>10 min.</u> Median Intra-Service Time: <u>25 min</u>					

25th Percentile Intra-Svc Time. <u>15 min.</u> 75th Percentile Intra-Svc Time: <u>30 min.</u> Low: <u>5 min.</u> High: <u>60 min.</u>

Median Post-Service Time:	Total Time	Number of Visits
Day of Procedure:	<u>10 min.</u>	<u>N/A</u>
ICU:	<u>N/A</u>	<u>N/A</u>
Other Hospital.	<u>N/A</u>	N/A
Office	<u>N/A</u>	<u>N/A</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	Work RVU
1)	92984	Percutaneous transluminal balloon coronary angioplasty; each additional vessel	2.97
2)	92980	Transcathter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel	4.17
3)	36245	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family	5.07

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement, technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The physician work involved in performing intravascular ultrasound in additional vessels varies from the work involved in the initial vessel study only by the lack of pre-service work. The number of imaging "passes" made with the catheter, real-time and subsequent image review and report preparation are essentially the same for each vessel studied.



FREQUENCY INFORMATION

How was this service previously reported? Unlisted code 93799

How often do physicians <u>in your specialty</u> perform this service? ___ Commonly <u>____ X</u> Sometimes ____ Rarely

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

Is this service performed by many physicians across the United States? X Yes No



AMA SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATIONS APRIL 1996

Multifetal Pregnancy Reduction- Tab 13

The RUC recommendation of 4.00 for multifetal pregnancy reduction(s) (MPR) is based on a survey median of obstetricians and comparison to 59012 *Cordocentesis (intrauterine), any method* (work RVU = 3.45). MPR requires more pre-service and intra-service time than 59012, as well as more physician effort/technical skill because more than one needle stick will typically be required.

CPT Code	Tracking	CPT Descriptor	Global	RVW
(New)	Number		Period	Recommendation
•59866	Y1	Multifetal pregnancy reduction(s) (MPR)	000	4.00

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: <u>598XX</u> Tracking Number: Global Period: 000

CPT Descriptor: Multifetal pregnancy reduction(s) (MPR)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old pregnant female with no medical problems presents with a quadruplet gestation at 12 weeks gestation. The pregnancy is the result of infertility treatment. You perform a reduction of her pregnancy from quadruplets to twins. Note: ultrasound coded separately,

Description of Pre-Service Work:

Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician prepares records and chart, checks on the patient, and reviews records prior to the procedure. The physician scrubs for the procedure and waits while the patient is prepared. The patient typically undergoes an ultrasound examination (which is coded separately) and receives IV antibiotics.

Description of Intra-Service Work:

Under continuous sterile ultrasound guidance a 22 g spinal needle is inserted into the fetal thoracic cavity and potassium chloride is injected. Following a cessation of the fetal heart beat, the needle is withdrawn into the amniotic sac and the fluid surrounding the terminated fetus is removed. The procedure is repeated for each fetus to be reduced. The needle is withdrawn from the patient's abdomen and the patient is taken to the recovery room.

Description of Post-Service Work:

follow-up care and discharges her.

Following the procedure, the physician writes orders for post-procedure care, accompanies the patient to the recovery room, and talks with the patient's family. The patient may remain in the recovery room for up to two hours. Successful completion of the procedure is confirmed via ultrasound. The physician gives the patient instructions for recovery and

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SURVEY DATA:

Specialty:American College of Obstetrician	s and Gynecologists
Sample Size: 55 Response Rate (%	6): <u>44% (24/55)</u> Median RVU: <u>4</u>
25th Percentile RVU: <u>3.2</u> 75th Percentile	RVU: <u>4.96</u> Low: <u>1.4</u> High: <u>7</u>
Median Pre-Service Time: 52.5	Median Intra-Service Time:30
25th Percentile Intra-Svc Time: <u>20</u> 75th Perc	centile Intra-Svc Time: <u>43.1</u> Low: <u>15</u> High: <u>120</u>
Median Post-Service Time:	Total Time Number of Visits
Day of Procedure:	_30
ICU:	
Other Hospital: Office:	



Recommended Work RVU: 4.00

F	KEY REFERENCE SERVICE(S):				
1	l)	<u>CPT Code</u> 59012	<u>CPT Descriptor</u> Cordocentesis (intrauterine), any method		Work RVU 3.45
2	2)				
3	3)				
4	4)				

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

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

Nearly all survey respondents chose CPT 59012 (Cordocentesis) as the primary reference service. Multifetal pregnancy reduction (MPR) requires more pre-service and intra-service time. MPR also entails more physician effort/technical skill because more than one needle stick will typically be required. In addition, respondents rated the mental effort and psychological stress associated with MPR higher than that associated with cordocentesis. Therefore, the survey median seems reasonable.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results, or other data besides the survey data are available, please explain any additional rationale for the RVUs.

Evaluation of the components of the service validates the survey results.

Pre-service work	99215	1.51
Intra-service work	30 min. x .06 RVUs per minute	1.80
Post-service work	99232	<u>0.88</u>
		4.19

FREQUENCY INFORMATION

How was this service previously reported? 59850, 59899

How often do physicians in your specialty perform this service? ____ Commonly X___ Sometimes ____ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? <u>114/100,000</u>

Is this service performed by many physicians across the United States? X Yes No



AMA SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATIONS APRIL 1996

Debridement of Musculoskeletal Open Injury(s)- Tab 14

The American Academy of Orthopaedic Surgeons commented in the five-year review process that the debridement CPT codes 11042-11044 were undervalued. The RUC reviewed survey data presented by AAOS and determined that debridement typically performed by orthopaedic surgeons was more extensive than debridement not associated with open fractures. The RUC referred the issue to CPT and a coding proposal was adopted by the Editorial Panel to differentiate these services.

The RUC agreed with the recommendations presented by the orthopaedic surgeons which were based on the 25th percentile of a estimated work RVU from 33 survey respondents. The RUC also considered CPT code 20103 *Exploration of penetrating wound (separate procedure); extremity* (work RVU = 4.95) to be an appropriate reference service for this family of codes. 20103 is comparable, but slightly more work, than **11010**. The total time for 11010 (125 minutes) is slightly less than CPT code 20103 (130 minutes) and the descriptor of 11010 implies a lessor degree of trauma than the <u>CPT 1996</u> introduction to the Wound Exploration codes including 20103. **11011** is equivalent in work to 20103. The total time for 11011 (150 minutes) is greater than 20103, however, the global period for 20103 is longer (010 days). **11013** is more intense and requires more time than 20103 (210 minutes versus 130 minutes).

The RUC proposes that the global period for 11010 Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin and subcutaneous tissues be 010 to minimize the potential for overutilization of this code. The RUC also noted that modifier -51 and the multiple surgery rules would apply when these services were performed on the same day as treatment of the open fracture.

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

CPT Code (• New)	Tracking Number	CPT Descriptor	Global Period	RVW Recommendation							
REPAIR (C	REPAIR (CLOSURE)										
3. (For <u>and/</u> (For <u>asso</u> 1012	 3. (For extensive debridement of soft tissue and/or bone, not associated with open fracture(s) and/or dislocation(s) resulting from penetrating and/or blunt trauma, see 11040-11044. (For extensive debridement of subcutaneous tissue, muscle fascia, muscle, and/or bone associated with open fracture(s) and/or dislocation(s), see 110X1-110X32). 10120* Incision and removal of foreign body, subcutaneous tissues: simple 										
1012	10120 <i>complicated</i> (To report wound exploration due to penetrating trauma without laparotomy or thoracotomy, use 20100-20103, as appropriate)										
	<u>110X1-11</u>	0X3, as appropriate)									
•11010	▶11010 L1 Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin and subcutane-ous tissues		010	4.15							
•11011	L2	skin, subcutaneous tissue, muscle fascia, and muscle	000	4.95							
•11012	L3	skin, subcutaneous tissue, muscle fascia, muscle, and bone	000	6.88							

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

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CPT Code: (11010) Tracking Number: L1 Global Period: 000 Recommended RVW: 4.15

Descriptor: Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin and subcutaneous tissues

CLINICAL DESCRIPTION OF SERVICE:

Typical Patient: A 28-year-old male falls from a ladder and sustains an open tibial and fibular fracture with foreign material contamination of the skin and subcutaneous tissues, necessitating debridement. (*Note: When estimating an RVW and providing time estimates below, please consider ONLY the physician work associated with the <u>debridement</u>. The work to correct the fracture(s) would be separately billable under a different CPT code/descriptor.)*

Pre-service work: The patient is evaluated in the emergency department, and a complete history is taken with particular attention to pre-existing or comorbid factors, which would predispose to infection, and to symptoms of other injuries. A thorough physical exam is performed, including: examination of the wound to assess the extent of injury; careful neurological and vascular exam distal to the open injury; evaluation for injury to joints above and below the fracture (knee and ankle in this case); and a search for other injuries in the same extremity or in other locations, which may have been overlooked in light of the rather dramatic presentation of an open fracture. Radiographs are ordered and interpreted by the orthopaedic surgeon. Additionally, if indicated, other diagnostic studies, such as angiograms, compartment pressure measurement, or Doppler vascular evaluation may be ordered and evaluated. The prognosis, treatment options, risks of surgery, expected outcomes, and future course of treatment must be explained in detail to the patient and/or his family, and consent obtained for surgery, anesthesia, and possible blood transfusion. Coordination with other medical specialties must be done if there are other injuries, and discussion with anesthesia is required to determine the proper method of anesthesia for the case. A splint or other form of temporary stabilization is applied in the emergency department, along with a clean dressing after the wound is examined. Antibiotics and tetanus prophylaxis must be ordered. The surgery must be scheduled, with the urgency of rapid operation explained to the nursing and anesthesia staff, particularly if this occurs on a weekend or evening. The correct surgical instruments must be collected and verified. Once in the operating room, the patient must be correctly positioned on the appropriate operating table, tourniquet applied, and the prepping and draping is performed or supervised by the surgeon, to insure that the extremity is handled in such a manner as to avoid further injury.

Intra-service work: The wound is inspected and cultures may be taken. A tentative plan is made regarding the type of closure or coverage which will be required and subsequent debridement decisions are made with that plan in mind. The open area of skin is inspected and crushed or devitalized skin is sharply debrided, attempting to be conservative and retain whatever skin is viable and useful for coverage. The wound is irrigated with sterile fluid, often containing antibiotics, with a power, pulsatile lavage system. Foreign material in the subcutaneous tissue is meticulously removed by sharp debridement, or by picking it out with forceps, which can be a tedious and time-consuming task if the material consists of small bits of grit or dirt. The wound may be carefully extended proximally and distally to allow better access to deeper structures, with thought given to incision placement so as not to compromise later flaps. Muscle fascia, nerves and vessels are inspected. The bone ends are exposed and cleaned with adequate irrigation. Hemostasis is obtained. When the wound is judged be adequately cleaned and debrided, a decision must be made as to how the wound will be dressed, and how the eventual closure or coverage will be accomplished. This requires significant experience and judgment to choose a plan which will avoid infection and minimize disability. Once an appropriate technique is chosen, dressings are applied. This may entail partial wound closure, use of drains, use of rubber bands or special devices to maintain skin position, or special dressing material. Splints may be applied.

Post-service work: Specific postoperative instructions for wound care and dressing changes must be written and communicated to the nursing staff verbally in many cases. The patient will need repeat neurovascular examinations in the recovery room and at intervals for the next 24 hours to monitor for the development of compartment syndrome, with appropriate documentation. This requires at least one and possibly several physician visits on the day of surgery. The patient and family will be told of the operative findings and educated about the plan for future care. Antibiotic treatment decisions must be made and pain medication managed. There may be communication required with other medical specialties, insurers, referring doctors, or workman's compensation nurses.



Specialty(s): American Academy of Orthopaedic Surgeons; Orthopaedic Trauma Association

Survey n:	171		PRE	INTRA	POST						
Response (%): 3	3 (19%)				Day 1	ICU (n	ot day 1)	Hosp (n	ot day 1)	Of	fice
Experience: m range = 1	ned = 50 5 to 300	RVW	total min	total min	total min	total min	# visits	total min	# visits	total min	# visits
	low	1.56		20							
	25th%	4.15		30							
	med ·	4.50	45	50	30		does n	ot apply	- 000 glot	oal period	
	75th%	6.00		60							
_	high	8.00		120							-

Reference service data:

CPT	Data Source	96rvw	PRE	INTRA	Post-HOSP	Post-OFF	Resp n	IWPUT (1)
11043	Harvard (PH3)	1.83	33*	49	30*	35*	9	0.020
20103	RUC (1995)	4.95	30	60	30	10	33	0.055
27603	Harvard (PH3)	4.41	44	25	39	44	14	0.048

An asterisk indicates times were "predicted," not surveyed.

(1) IWPUT for 11043 and 27603 represent Harvard Phase 3 final work values scaled to the 1996 MFS. IWPUT for 20103 is calculated based on RUC survey data.

Reference service(s) cited most frequently by survey respondents:

<u>1996 RVW</u>	<u>Global</u>	<u>Count</u>	<u>CPT</u>	Descriptor
4.41	090	13	27603	Incision and drainage, leg or ankle; deep abscess or hematoma
4.95	010	12	20103	Exploration of penetrating wound (separate procedure); extremity

KEY REFERENCE SERVICE(S):

<u>1996 RVW</u>	<u>Global</u>	<u>CPT</u>	Descriptor
4.95	010	20103	Exploration of penetrating wound (separate procedure); extremity
1.83	010	11043	Debridement; skin, subcutaneous tissue, and muscle

Relationship of code being reviewed to key reference service(s): Compare the pre-, intra-, and post-service time and the intensity of the service you are rating to the key reference services listed above.

New Code: L1 Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin and subcutaneous tissues

Recommended RVW: 4.15 (survey 25th percentile) IWPUT: 0.051

• The total work of L1 (global=000) is less than the total work of CPT 20103 (global=010). The total time for L2 (125 minutes) is slightly less than CPT 20103 (130 minutes). Intra-service time for L2 is 50 minutes compared with 60 minutes for 20103. The descriptor of L1 implies a lessor degree of trauma than the <u>CPT '96</u> manual discussion of *Wound Exploration* codes including CPT 20103. Consequently, an RVW of 4.15 (survey 25th percentile) is recommended rather than the median RVW of 4.50. (Note: The comparison of the family of codes L1, L2 and L3 further suggests gradation of RVW more consistent with 25th percentile than with the survey median RVW of 4.50 for L1.) The following discussion compares and contrasts the pre-, intra-, and post-operative work for L1 and CPT 20103:



Pre-operative: Although the <u>intensity</u> of the pre-operative work is similar for trauma patients requiring L1 or CPT 20103, patients with an open fracture (hence, an unstable extremity) typically require more pre-operative evaluation and management <u>time</u> prior to wound exploration in the operating room.

Intra-operative: L1 and CPT 20103 are both distinctly different from CPT 11043 *Debridement; skin, subcutaneous tissue, and muscle* in that the former are intended to report extensive debridement in trauma patients who require emergent exploratory operations. As reported in 1994 Medicare Part B site of service data, CPT 11043 was performed in the office approximately 50% of the time. The most common diagnosis given for claims-level information was chronic ulcer of the skin. While general surgery was identified as the highest user (48.3%) of this code when examining "specialty mix," orthopaedic surgery represented only 7.7%. L1 is to be reported for <u>debridement, including exploration, associated with open fracture(s) and/or dislocation(s)</u>. CPT 20103 is to be reported for <u>exploration, including debridement, resulting from penetrating and/or blunt trauma</u>. The depth and breadth of wound exposure is likely somewhat less in L1 than CPT 20103, as supported by the text included in the AMA/RVS Summary of Recommendation intra-service description for CPT 20103 (April 1995): "...Any necessary debridement, removal of foreign body(s), ligation or coagulation of minor subcutaneous and/or muscular blood vessel(s), of the <u>subcutaneous tissue, muscle fascia, and/or muscle...</u>"

Post-operative: Survey data for CPT 20103 (global = 10 days) includes 30 minutes hospital postservice time and one level 2 office visit at 10 minutes on post-discharge day 7. This total time of 40 minutes is greater than the survey post-service time of 30 minutes on the day of service for L1 (global = 0 days).

Complexity/intensity: The following table, which presents mean survey response data, provides a comparison of the survey respondent's estimation of the overall work complexity/intensity for L1 and CPT 20103:

CPT	Mental effort Judgment	Technical skill Physical effort	Psychological stress	Response n	Median Experience
L1	3.29	2.81	2.94	33	50
20103	3.11	3.33	2.56	12	10

It is important to point out that extensive debridement associated with open treatment of fractures (ie, extensive debridement without immediate primary closure) has always been separately reportable work, and, therefore, was not factored into the original valuation of these codes in the Medicare fee schedule. The following text appeared under *Repair* in the *Musculoskeletal System* section of the CPT manual, through <u>CPT '94</u>: (For debridement as a separate procedure (eg, traumatic wound) involving soft tissue and/or bone, see 11042-11044).

Additionally, as part of the MFS 5-year review, CPT 11043 and 11044 were identified as possibly undervalued, but were referred to the CPT Editorial Panel as "CPT issues." [Note: The Carrier Medical Directors commented that "...CPT 11044 was undervalued relative to CPT 11043" (February 1995). This comment was made before presentation of CPT 20103 at the RUC (April 1995).] L1 (similar to CPT 20103) was developed and is intended to distinguish the more intensive work effort for exploration and debridement of a traumatic open fracture wound compared to the debridement of a non-traumatic lesion (eg, chronic ulcers of the skin).

Additional rationale: (If recommended RVW is not based on the survey results.)

None.



FREQUENCY INFORMATION

How was this service previously reported?

11042-22 Debridement; skin, subcutaneous tissue, and muscle

How often do physicians in your specialty perform this service?

Sometimes.

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

A small percentage of cases reporting CPT 11042 may involve the intensive work L1.

Is this service performed by many physicians across the United States?

This service would be familiar to trauma surgeons, hand surgeons, orthopaedic surgeons, general surgeons, and plastic and reconstructive surgeons.





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CPT Code: (11011) Tracking Number: L2 Global Period: 000 Recommended RVW: 4.95

Descriptor: Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin, subcutaneous tissues, muscle fascia, and muscle

CLINICAL DESCRIPTION OF SERVICE:

A motorcyclist involved in an accident sustains an open tibial and fibular fracture with foreign material **Typical Patient:** contamination and devitalization of the skin, subcutaneous tissues, muscle fascia, and muscle, necessitating debridement. (Note: When estimating an RVW and providing time estimates below, please consider ONLY the physician work associated with the debridement. The work to correct the fracture(s) would be separately billable under a different CPT code/descriptor.)

Pre-service work: The patient is evaluated in the emergency department, and a complete history is taken with particular attention to pre-existing or comorbid factors, which would predispose to infection, and to symptoms of other injuries. A thorough physical exam is performed, including: examination of the wound to assess the extent of injury; careful neurological and vascular exam distal to the open injury; evaluation for injury to joints above and below the fracture (knee and ankle in this case); and a search for other injuries in the same extremity or in other locations, which may have been overlooked in light of the rather dramatic presentation of an open fracture. Particular attention is paid to an assessment of possible compartment syndrome. Radiographs are ordered and interpreted by the orthopaedic surgeon. Additionally, if indicated, other diagnostic studies, such as angiograms, compartment pressure measurement, or Doppler vascular evaluation may be ordered and evaluated. The prognosis, treatment options, risks of surgery, expected outcomes, and future course of treatment must be explained in detail to the patient and/or his family, and consent obtained for surgery, anesthesia, and possible blood transfusion. Coordination with other medical specialties must be done if there are other injuries, and discussion with anesthesia is required to determine the proper method of anesthesia for the case. A splint or other form of temporary stabilization is applied in the emergency department, along with a clean dressing after the wound is examined. Antibiotics and tetanus prophylaxis must be ordered. The surgery must be scheduled, with the urgency of rapid operation explained to the nursing and anesthesia staff, particularly if this occurs on a weekend or evening. The correct surgical instruments must be collected and verified. Once in the operating room, the patient must be correctly positioned on the appropriate operating table, tourniquet applied, and the prepping and draping is performed or supervised by the surgeon, to insure that the extremity is handled in such a manner as to avoid further injury.

Intra-service work: The wound is inspected and cultures may be taken. A tentative plan is made regarding the type of closure or coverage which will be required and subsequent debridement decisions are made with that plan in mind. The open area of skin is inspected and crushed or devitalized skin is sharply debrided, attempting to be conservative and retain whatever skin is viable and useful for coverage. The wound is irrigated with sterile fluid, often containing antibiotics, with a power, pulsatile lavage system. Foreign material in the subcutaneous tissue is meticulously removed by sharp debridement, or by picking it out with forceps, which can be a tedious and time-consuming task if the material consists of small bits of grit or dirt. The wound may be carefully extended proximally and distally to allow better access to deeper structures, with thought given to incision placement so as not to compromise later flaps. Muscle fascia, nerves and vessels are inspected. The bone ends are exposed and cleaned with adequate irrigation. Damaged and non-viable muscle and muscle fascia is sharply debrided back to healthy tissue, as determined by color, consistency, contraction and bleeding. This requires experience and judgement to debride only the dead tissue without taking away any viable muscle, which would worsen the functional recovery potential. Hemostasis is obtained. Then the wound is judged to be adequately cleaned and debrided, a decision must be made as to how the wound will be dressed, and how the eventual closure or coverage will be accomplished. This requires significant experience and judgment to choose a plan which will avoid infection and minimize disability. Once an appropriate technique is chosen, dressings are applied. This may entail partial wound closure, use of drains, use of rubber bands or special devices to maintain skin position, or special dressing material. Splints may be applied.

Post-service work: Specific postoperative instructions for wound care and dressing changes must be written and communicated to the nursing staff verbally in many cases. The patient will need repeat neurovascular examinations in the recovery room and at intervals for the next 24 hours to monitor for the development of compartment syndrome, with appropriate documentation. This requires at least one and possibly several physician visits on the day of surgery. The patient and family will be told of the operative findings and educated about the plan for future care. Antibiotic treatment decisions must be made and pain medication managed. There may be communication required with other medical specialties, insurers, referring doctors, or workman's compensation nurses.



IWPUT (1)

0.020

0.055

0.047

13



SURVEY DATA:

Specialty(s): American Academy of Orthopaedic Surgeons; Orthopaedic Trauma Association

Survey n:	171		PRE	INTRA	POST						
Response (%): 3	3 (19%)				Day 1	ICU (n	ot day 1)	Hosp (not day 1)	Of	fice
Experience: n	ned = 40		total	total	total	total	#	total	#	total	#
range =	8 to 250	RVW	min	min	min	min	visits	min	visits	min	visits
	low	2.00		25							
	25th%	4.95		45							
	med	6.00	45	60	45		does n	ot apply	- 000 gloł	bal period	
	75th%	7.24		75							
	high	12.69		120							
Selected data fo	r surveve	d service	and ke	v referenc	e service	:(s):					

INTRA CPT 96rvw PRE **Post-OFF Data Source** Post-HOSP Resp n 11043 Harvard (PH3) 1.83 33* 49 30* 35* 9 20103 DITC (1005) 20 30 10 1 05 33

20105	ROC (1775)	4.75	50	00	50	10
24066	Harvard (PH3)	4.95	35*	51	24*	39*
			1 11 .			

An asterisk indicates times were "predicted," not surveyed.

(1) IWPUT for 11043 and 24066 represent Harvard Phase 3 final work values scaled to the 1996 MFS. IWPUT for 20103 is calculated based on RUC survey data.

Reference service(s) cited most frequently by survey respondents:

<u>1996 RVW</u>	<u>Global</u>	<u>Count</u>	CPT	Descriptor
4.95	010	12	20103	Exploration of penetrating wound (separate procedure); extremity
4.95	090	7	24066	Biopsy, soft tissue of upper arm or elbow area; deep

KEY REFERENCE SERVICE(S):

<u>1996 RVW</u>	<u>Global</u>	CPT	Descriptor
4.95	010	20103	Exploration of penetrating wound (separate procedure); extremity
4.95	090	24066	Biopsy, soft tissue of upper arm or elbow area; deep
1.83	010	11043	Debridement; skin, subcutaneous tissue, and muscle

Relationship of code being reviewed to key reference service(s): Compare the pre-, intra-, and post-service time and the intensity of the service you are rating to the key reference services listed above.

New Code: L2 Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin, subcutaneous tissues, muscle fascia, and muscle Recommended RVW: 4.95 (survey 25th percentile) IWPUT: 0.048

• Although the global periods are different, the <u>total work</u> of L2 (global=000) is equal to the <u>total work</u> of CPT 20103 (global=010). The <u>total time</u> for L2 (150 minutes) is greater than CPT 20103 (130 minutes). Consequently, an RVW of 4.95 (survey 25th percentile), which is equal to the RVW for CPT 20103, is recommended. The following discussion compares and contrasts the pre-, intra-, and post-operative work for L2 and CPT 20103;



Pre-operative: Although the <u>intensity</u> of the pre-operative work is similar for trauma patients requiring L2 or CPT 20103, patients with an open fracture (hence, an unstable extremity secondary to a high energy injury) typically require more pre-operative evaluation and management <u>time</u> prior to wound exploration in the operating room.

Intra-operative: L2 and CPT 20103 are both distinctly different from CPT 11043 Debridement; skin, subcutaneous tissue, and muscle in that the former are intended to report extensive debridement in trauma patients who require emergent exploratory operations. As reported in 1994 Medicare Part B site of service data, CPT 11043 was performed in the office approximately 50% of the time. The most common diagnosis given for claims-level information was chronic ulcer of the skin. While general surgery was identified as the highest user (48.3%) of this code when examining "specialty mix," orthopaedic surgery represented only 7.7%. L2 is to be reported for debridement, including exploration, associated with open fracture(s) and/or dislocation(s). CPT 20103 is to be reported for exploration, including debridement, resulting from penetrating and/or blunt trauma. Intra-operative time is the same for both L2 and CPT 20103. The depth and breadth of wound exposure is the same for both procedures, as supported by the text included in the AMA/RVS Summary of Recommendation intraservice description for CPT 20103 (April 1995): "...Any necessary debridement, removal of foreign body(s), ligation or coagulation of minor subcutaneous and/or muscular blood vessel(s), of the subcutaneous tissue, muscle fascia, and/or muscle ..." Although intra-operative exposure for L2 and CPT 20103 may be similar: for L2, more time is spent debriding a wound that is very irregular and contaminated with significant foreign material; while for CPT 20103, the wound is "less contaminated," but requires wound closure.

Post-operative: Survey data for CPT 20103 (global = 10 days) includes 30 minutes hospital postservice time and one level 2 office visit at 10 minutes on post-discharge day 7. This total time of 40 minutes is comparable to the survey post-service time of 45 minutes on the day of service for L2 (global = 0 days). For patients requiring L2, periodic monitoring for compartment syndrome is critical during the immediate postoperative period and more time is required to assess how closure or coverage will be ultimately accomplished.

Complexity/intensity: The following table, which presents mean survey response data for questionnaire L2, provides a comparison of the survey respondent's estimation of the overall work complexity/intensity for L2 and CPT 20103:

CPT	Mental effort	Technical skill	Psychological	Response	Median
	Judgment	Physical effort	stress	n	Experience
L2	3.83	3.21	3.34	33	40
20103	3.56	3.44	2.89	12	25

• Although, the "predicted" post-service work of CPT 24066 may be greater than L2, the intra-operative work (both time and intensity) of L2 is greater than CPT 24066.

It is important to point out that extensive debridement associated with open treatment of fractures (ie, extensive debridement without immediate primary closure) has always been separately reportable work, and, therefore, was not factored into the original valuation of these codes in the Medicare fee schedule. The following text appeared under *Repair* in the *Musculoskeletal System* section of the CPT manual, through <u>CPT '94</u>: (For debridement as a separate procedure (eg, traumatic wound) involving soft tissue and/or bone, see 11042-11044).

Additionally, as part of the MFS 5-year review, CPT 11043 and 11044 were identified as possibly undervalued, but were referred to the CPT Editorial Panel as "CPT issues." [Note: The Carrier Medical Directors commented that "...CPT 11044 was undervalued relative to CPT 11043" (February 1995). This comment was made before presentation of CPT 20103 at the RUC (April 1995).] L2 (similar to CPT 20103) was developed and is intended b distinguish the more intensive work effort for exploration and debridement of a traumatic open fracture wound compared to the debridement of a non-traumatic lesion (eg, chronic ulcers of the skin).

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Additional rationale: (If recommended RVW is not based on the survey results.)

None.

FREQUENCY INFORMATION

How was this service previously reported?

11043-22 Debridement; skin, subcutaneous tissue, and muscle

How often do physicians in your specialty perform this service?

Sometimes.

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

Using "place of service" and "specialty" frequency Medicare Part B data, it is estimated that 10% of cases reporting CPT 11043 may involve the intensive work L2.

Is this service performed by many physicians across the United States?

This service would be familiar to trauma surgeons, hand surgeons, orthopaedic surgeons, general surgeons, and plastic and reconstructive surgeons.





CPT Code: (11012) **Tracking Number:** L3 **Global Period**: 000 **Recommended RVW:** 6.88

Descriptor: Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin, subcutaneous tissues, muscle fascia, muscle, and bone

CLINICAL DESCRIPTION OF SERVICE:

Typical Patient: A pedestrian struck by an auto sustains an open tibial and fibular fracture with significant foreign material contamination and extensive devitalization of the skin, subcutaneous tissues, muscle fascia, muscle, and bone, necessitating debridement. (Note: When estimating an RVW and providing time estimates below, please consider ONLY the physician work associated with the <u>debridement</u>. The work to correct the fracture(s) would be separately billable under a different CPT code/descriptor.)

Pre-service work: The patient is evaluated in the emergency department, and a complete history is taken with particular attention to pre-existing or comorbid factors, which would predispose to infection, and to symptoms of other injuries. A thorough physical exam is performed, including: examination of the wound to assess the extent of injury; careful neurological and vascular exam distal to the open injury; evaluation for injury to joints above and below the fracture (knee and ankle in this case); and a search for other injuries in the same extremity or in other locations, which may have been overlooked in light of the rather dramatic presentation of an open fracture. Particular attention is paid to an assessment of possible compartment syndrome. Radiographs are ordered and interpreted by the orthopaedic surgeon. Additionally, if indicated, other diagnostic studies, such as angiograms, compartment pressure measurement, or Doppler vascular evaluation may be ordered and evaluated. The prognosis, treatment options, risks of surgery, expected outcomes, and future course of treatment must be explained in detail to the patient and/or his or her family, and consent obtained for surgery, anesthesia, and possible blood transfusion. A decision must be made between the surgeon and the patient and/or his or her family to attempt limb salvage or perform amputation, considering the patient's needs, desires, and injury severity. This may require extensive, frank discussion. Coordination with other medical specialties must be done if there are other injuries, and discussion with anesthesia is required to determine the proper method of anesthesia for the case. A splint or other form of temporary stabilization is applied in the emergency department, along with a clean dressing after the wound is examined. Antibiotics and tetanus prophylaxis must be ordered. The surgery must be scheduled, with the urgency of rapid operation explained to the nursing and anesthesia staff, particularly if this occurs on a weekend or evening. The correct surgical instruments must be collected and verified. Once in the operating room, the patient must be correctly positioned on the appropriate operating table, tourniquet applied, and the prepping and draping is performed or supervised by the surgeon, to insure that the extremity is handled in such a manner as to avoid further injury.

Intra-service work: The wound is inspected and cultures may be taken. A tentative plan is made regarding the type of closure or coverage which will be required and subsequent debridement decisions are made with that plan in mind. The open area of skin is inspected and crushed or devitalized skin is sharply debrided, attempting to be conservative and retain whatever skin is viable and useful for coverage. The wound is irrigated with sterile fluid, often containing antibiotics, with a power, pulsatile lavage system. Foreign material in the subcutaneous tissue is meticulously removed by sharp debridement, or by picking it out with forceps, which can be a tedious and time-consuming task if the material consists of small bits of grit or dirt. The wound may be carefully extended proximally and distally to allow better access to deeper structures, with thought given to incision placement so as not to compromise later flaps. Muscle fascia, nerves and vessels are inspected. The bone ends are exposed and cleaned with adequate irrigation. Damaged and non-viable muscle and muscle fascia is sharply debrided back to healthy tissue, as determined by color, consistency, contraction and bleeding. This requires experience and judgement to debride only the dead tissue without taking away any viable muscle, which would worsen the functional recovery potential. The viability of bony fragments must be ascertained, and decisions made as to which bone fragments are completely devitalized and/or so severely contaminated that they should be debrided to prevent infection. Consideration must also be given concerning the removal of these bone fragments which will affect stability, potential for healing, and reconstruction options. Hemostasis is obtained. After complete debridement, the decision to salvage or amputate may be reconsidered. When the wound is judged to be adequately cleaned and debrided, a decision must be made as to how the wound will be dressed, and how the eventual closure or coverage will be accomplished. This requires significant experience and judgment to choose a plan which will avoid infection and pinimize disability. Once an appropriate technique is chosen, dressings are applied. This may entail partial wound closure, se of drains, use of rubber bands or special devices to maintain skin position, or special dressing material. Splints may be applied.

AMA/Specialty Society RVS Update Process Summary of Recommendation

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Post-service work: Specific postoperative instructions for wound care and dressing changes must be written and communicated to the nursing staff verbally in many cases. The patient will need repeat neurovascular examinations in the recovery room and at intervals for the next 24 hours to monitor for the development of compartment syndrome, with appropriate documentation. This requires at least one and possibly several physician visits on the day of surgery. The patient and family will be told of the operative findings and educated about the plan for future care. Antibiotic treatment decisions must be made and pain medication managed. There may be communication required with other medical specialties, insurers, referring doctors, or workman's compensation nurses.

SURVEY DATA:

Survey	n: '	171	[PRE	INTRA		-		POS	<u></u> Т	· · ·	
Response (%): 33 (19%)					Dav 1	ICU (n	ICU (not day 1)		not day 1)	Office		
Experience: $med = 40$ range = 8 to 500		RVW	total min	total min	total min	total min	# visits	total min	# visits	total min	# visits	
	-	low	2.20		25			<u> </u>		1		
		25th%	6.88		60					1		
med		7.50	60	90	60	does not apply - 000 global period					L	
		75th%	10.00		90						_	
		high	14.90		120					· .		
Selected	data fo	r surveye	ed service	and ke	y reference	e service	e(s):		• • • • • •			
CPT	Data S	Source	96rvw	PRE	INTRA	Post-	HOSP	Post	-OFF	Resp n	IWPUT	(1)
11044	Harvard	d (PH3)	2.28	36*	79	3.	4*	3	9*	9	0.020	
20103	RUC	(1995)	4.95	30	60	3	30	1	0	33	0.055	
27635	Harvard	d (PH3)	7.29	49*	85	3.	4*	4	6*	9	0.045	
27792	Harvard	d (PH3)	7.04	46*	83	4	7*	4	7*	10	0.037	

Specialty(s): American Academy of Orthopaedic Surgeons; Orthopaedic Trauma Association

An asterisk indicates times were "predicted," not surveyed.

(1) IWPUT represents Harvard Phase 3 final work values scaled to the 1996 MFS. IWPUT for 20103 is calculated based on RUC survey data.

Reference service(s) cited most frequently by survey respondents:

<u>1996 RVW</u>	<u>Global</u>	<u>Count</u>	<u>CPT</u>	Descriptor
7.29	090	12	27635	Excision or curettage of bone cyst or benign tumor, tibia or fibula;
7.04	090	9	27792	Open treatment of distal fibular fracture (lateral malleolus), with or without internal or external fixation

KEY REFERENCE SERVICE(S):

<u>1996 RVW</u>	<u>Global</u>	<u>CPT</u>	Descriptor
4.95	010	20103	Exploration of penetrating wound (separate procedure); extremity
2.28	010	11044	Debridement; skin, subcutaneous tissue, muscle, and bone

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Relationship of code being reviewed to key reference service(s): Compare the pre-, intra-, and post-service time and the intensity of the service you are rating to the key reference services listed above.

New Code: L3 Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin, subcutaneous tissues, muscle fascia, muscle, and bone **Recommended RVW**: 6.88 (survey 25th percentile) **IWPUT**: 0.044

The AAOS advisory committee discussed this family of debridement codes (L1, L2 and L3) at great length. It seemed most appropriate to consider these three codes as a continuum of severity of injury with L1 being the least and L3 being the most severe. This is supported by the following table, which presents mean survey response data for complexity/intensity:

CPT	Mental effort Judgment	Technical skill Physical effort	Technical skillPsychologicalPhysical effortstress		Median Experience	
L1	3.29	2.81	2.94	33	50	
L2	3.83	3.21	3.34	33	40	
L3	4.43	3.79	3.89	33	40	

Therefore, the following discussion compares L3 to the similar reference services compared with L1 and L2.

• Although the global periods are different, the <u>total work</u> of L3 (global=000) is greater than the <u>total work</u> of CPT 20103 (global=010). The <u>total time</u> for L3 (210 minutes) is greater than CPT 20103 (130 minutes). The descriptor of L3 implies a greater degree of trauma than the CPT manual discussion of Wound Exploration codes including CPT 20103. Consequently, an RVW of 6.88 (survey 25th percentile) is recommended. (Note: The comparison of the family of codes L1, L2 and L3 further suggests a gradation of RVW more consistent with 25 th percentile than with the survey median RVW of 7.50 for L3.) The following discussion compares and contrasts the pre-, intra-, and post-operative work for L3 and CPT 20103.

Pre-operative: The <u>intensity</u> of the pre-operative work is greater for trauma patients requiring L3 than for CPT 20103. Patients with this severe an open fracture, requiring L3, will have an unstable extremity secondary to a high energy injury. They typically require more pre-operative evaluation and management <u>time</u> prior to wound exploration in the operating room.

Intra-operative: L3 and CPT 20103 are both distinctly different from CPT 11044 Debridement; skin, subcutaneous tissue, muscle, and bone in that the former are intended to report extensive debridement in trauma patients who require emergent exploratory operations. As reported in 1994 Medicare Part B site of service data, CPT 11044 was performed in the office approximately 35% of the time. The most common diagnosis given for claims-level information was chronic ulcer of the skin, osteomyelitis, and diabetes mellitus. L3 is to be reported for debridement, including exploration, associated with open fracture(s) and/or dislocation(s). CPT 20103 is to be reported for exploration, including debridement, resulting from penetrating and/or blunt trauma. Intra-operative time is significantly greater for L3 (90 minutes) as compared to 20103 (60 minutes). The depth and breadth of wound exposure is likely greater in L3 which includes the debridement of bone, as supported by the text included in the AMA/RVS Summary of Recommendation intra-service description for CPT 20103 (April 1995): "... Any necessary debridement, removal of foreign body(s), ligation or coagulation of minor subcutaneous and/or muscular blood vessel(s), of the subcutaneous tissue, muscle fascia, and/or muscle..." The intra-operative exposure is likely greater for L3 and more time is spent debriding a wound that is very irregular and contaminated with significant foreign material, while for CPT 20103, the wound is "less contaminated" and smaller. The intra-operative decision making process concerning whether or not to remove devitalized bone requires considerable experience.





It is important to point out that extensive debridement associated with open treatment of fractures (ie, extensive debridement without immediate primary closure) has always been separately reportable work, and, therefore, was not factored into the original valuation of these codes in the Medicare fee schedule. The following text appeared under *Repair* in the *Musculoskeletal System* section of the CPT manual, through <u>CPT '94</u>: (For debridement as a separate procedure (eg, traumatic wound) involving soft tissue and/or bone, see 11042-11044).

Additionally as part of the MFS 5-year review, CPT 11043 and 11044 were identified as possibly undervalued, but were referred to the CPT Editorial Panel as "CPT issues." [Note: The Carrier Medical Directors commented that "...CPT 11044 was undervalued relative to CPT 11043" (February 1995). This comment was made before presentation of CPT 20103 at the RUC (April 1995).] L3 (similar, but of greater scope than CPT 20103) was developed and is intended to distinguish the more intensive work effort for exploration and debridement of a traumatic open fracture wound compared to the debridement of a non-traumatic lesion (eg, chronic ulcers of the skin or osteomyelitis).

Additional rationale: (If recommended RVW is not based on the survey results.)

None.

FREQUENCY INFORMATION

How was this service previously reported?

11044-22 Debridement; skin, subcutaneous tissue, muscle, and bone

How often do physicians in your specialty perform this service?

Sometimes.

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

Using "place of service" and "specialty" frequency Medicare Part B data, it is estimated that 30% of cases reporting CPT 11044 may involve the intensive work of L3.

Is this service performed by many physicians across the United States?

This service would be familiar to trauma surgeons, hand surgeons, orthopaedic surgeons, general surgeons, and plastic and reconstructive surgeons.





AMA SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATIONS APRIL 1996

Hand Surgery-Tab 15

The RUC agreed with the recommendations presented for 24149 Radical resection of capsule, soft tissue, and heterotopic bone, elbow with contracture release (separate procedure) and 26546 Repair nonunion, metacarpal or phalanx (includes obtaining bone graft with or without external or internal fixation), which were based on the survey responses of nearly 50 orthopaedic and hand surgeons.

24149 is more work than 24006 Arthrotomy of the elbow, with capsular excision for capsular release (separate procedure) (work rvu = 8.70), which <u>only</u> includes capsular and soft tissue release and does not address excision of heterotopic bone which requires the careful dissection and preservation of neurovascular structures. 24149 involves a global dissection and capsulectomy rather than only a capsular release as in 24006. 24149 is also more work than 24077 Radical resection of tumor (eg, malignant neoplasm), soft tissue of upper arm or elbow area (work rvu = 11.18), which is only indicated for neoplasms, and does not include resection of bone or contracture release and does not necessarily preserve all neurovascular structures. In addition 24149 requires two separate incisions, while 24077 requires only one. The post-service office time in 24149 is significantly higher than 24077 because of follow-up care required to recover range of motion.

26546 is more work than the combined work of 26615 Open treatment of metacarpal fracture, single, with or without internal or external fixation, each bone and 20900 Bone graft, any donor area; minor or small (eg, dowel or button) [7.70=5.18+1/2(5.03)] or 26735 Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with or without internal or external fixation, each and 20900 [8.24=5.72+1/2(5.03)]. The intra-operative work of 26546 is greater than both of these combined procedures because achieving alignment and restoring length of the metacarpal or phalanx is more difficult than in a fresh fracture. 26546 also requires more intra-service work than 28322 Repair of nonunion or malunion; metatarsal, with or without bone graft (includes obtaining graft) (work rvu = 8.03) because it involves a more critical alignment and rotational positioning of the metacarpal versus the metatarsal, as well as a more critical attention to the anatomy and function of the extensor tendons in the hand.

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

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CPT Code (• New)	Tracking Number	CPT Descriptor	Global Period	RVW Recommendation
26540	Q9	Primary <u>R</u> repair of collateral ligament, metacarpophalangeal or interphalangeal joint	090	6.03 (no change)
26541	Q10	<u>Reconstruction</u> , collateral ligament, metacarpophalangeal joint, <u>single</u> ; with tendon or fascial graft (includes obtaining graft)	090	8.20 (no change)

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CPT Code: (24XXX) Tracking Number: Q1 Global Period: 090 Recommended RVW: 13.25

Descriptor: Radical resection of capsule, soft tissue, and heterotopic bone, elbow with contracture release (separate procedure) (For capsular and soft tissue release only use 24006)

CLINICAL DESCRIPTION OF SERVICE:

Typical Patient: A young male suffers a severe head injury and develops extensive heterotopic bone about the elbow with elbow ankylosis.

Pre-service work includes obtaining and reviewing pre-procedural imaging and laboratory studies; examining the patient's arm; and communicating with the patient (and/or patient's family) to review operative risks and benefits and to obtain informed consent. The outcome to increase the range of motion in an elbow rendered stiff in functionless position must be balanced against the potential of injury to neurovascular structures during the procedure and stretch injury to nerves (especially ulnar nerve) during the postoperative period. Pre-service work also includes pre-operative scrubbing; and supervision of positioning, prepping, and draping the patient.

Intra-service work: A two-incision approach facilitates an exposure of all anatomy involved with the heterotopic bone. This includes all musculotendinous units anterior and posterior, as well as medial and ateral. Muscle must be preserved and NOT excised. All neurovascular structures must be identified and dissected free of scar and heterotopic bone. Only after this careful global dissection is completed can the heterotopic bone be dissected away from the soft tissue and excised. The anterior and posterior capsules of the elbow are excised as needed to allow the desired amount of range of motion. Further, the tension on neurovascular structures must be constantly assessed while achieving this intra-operative motion. Drains are placed and the wounds are carefully closed in layers since dead space is left by the excised pathologic bone. A bulky dressing is applied that is reinforced with a posterior mold.

Post-service work includes monitoring patient stabilization; communicating with the family and other health care professionals (including written and oral reports and orders); antibiotic and pain medication management; and ordering post-service rehabilitation, which is typically started immediately. The patient remains hospitalized under the surgeon's care until removal of the drain(s). Early postoperative irradiation and or indomethacin is used to avoid recurrence of the heterotopic ossification. Immediate postoperative passive range of motion (frequently with continuous passive motion apparatus, CPM) is always instituted. This physical therapy program must be modified if stretch injury to neurovascular structures is suspected during frequent examinations. Before discharge, the surgeon reviews wound care and planned physiotherapy with the patient and/or family. Office visits related to this procedure for 90 days after the day of the operation are considered part of the post-service work for this procedure, including the surgeon's removal of sutures at two weeks and periodic visits with the surgeon, on a weekly basis for six to eight weeks and again at 10 and 12 weeks, to monitor wound healing; assess range of motion of the joints and physiotherapy progress; and adjust exercise and medication orders.

SURVEY DATA:

Specialty(s): American Academy of Orthopaedic Surgeons; American Society for Surgery of the Hand

Survey n:	162		PRE	INTRA	POST						
Response (%): 46 (28%)				Dav I	ICU (n	ot day 1)	Hosp (not day 1)		Office		
Experience: $med = 3$ range = 0 to 30		RVW	total min	total min	total min	total min	# visits	total min	# visits	total min	# visits
	low	7.00		60							
	25th%	11.00		150							
	med	13.25	60	170	30	0	0	30	2	90	6
	75th%	14.88		180							
	high	22.00		235			1				
Deference corri	a data.						.		· · · ·		•

Reference service data:

СРТ	Data Source	96rvw	PRE	INTRA	Post-HOSP	Post-OFF	Resp n	IWPUT (1)
24006	RUC (1992)	8.70			[not surveye	:d]		n/a
24077	Harvard (PH3)	11.18	55*	135	51*	56*	12	0.051
24342	Harvard (PH3)	10.13	53*	101	41*	51*	12	0.060
25405	Harvard (PH3)	13.48	55*	126	75*	54*	12	0.065

An asterisk indicates times were "predicted," not surveyed.

(1) IWPUT represents Harvard Phase 3 final work values scaled to the 1996 MFS.

Reference service(s) cited most frequently by survey respondents:

<u>1996 RVW</u>	Global	Count	<u>CPT</u>	Descriptor
11.18	090	17	24077	Radical resection of tumor (eg, malignant neoplasm), soft tissue of upper
				arm or elbow area
13.48	090	12	25405	Repair of nonunion or malunion, radius OR ulna; with iliac or other
				autograft (includes obtaining graft)

KEY REFERENCE SERVICE(S):

<u>1996 RVW</u>	<u>Global</u>	<u>CPT</u>	Descriptor
8.70	090	24006	Arthrotomy of the elbow, with capsular excision for capsular release (separate
			procedure)
11.18	090	24077	Radical resection of tumor (eg, malignant neoplasm), soft tissue of upper arm or
			elbow area

Relationship of code being reviewed to key reference service(s): Compare the pre-, intra-, and post-service time and the intensity of the service you are rating to the key reference services listed above.

New Code: Q1 Radical resection of capsule, soft tissue, and heterotopic bone, elbow with contracture release (separate procedure) Recommended RVW: 13.25 (survey median) IWPUT: 0.047

• Q1 is more work than CPT 24006 (RVW 8.70), which <u>only</u> includes capsular and soft tissue release and does not address excision of heterotopic bone which necessitates the careful dissection and preservation of neurovascular structures. Q1 involves a global dissection and capsulectomy rather than only a capsular release as in CPT 24006.

• Q1 is more work than CPT 24077 (RVW 11.18), which is only indicated for neoplasms, and <u>does not include</u> resection of bone or contracture release and does not necessarily preserve all neurovascular structures. The latter may be sacrificed along with the enbloc excision of the tumor in CPT 24077. Intra-service time of Q1 is 26% greater than CPT 24077. The surveyed post-service office time of Q1 is 61% greater than CPT 24077 because of the careful follow-up necessary to recover range of motion.

Additional rationale: (If recommended RVW is not based on the survey results.)

None.

FREQUENCY INFORMATION

How was this service previously reported?

The following codes, <u>reported in combination</u>, may have been used to report the work of Q1: 24006 Biopsy, soft tissue of upper arm or elbow area; deep 24077 Radical resection of tumor (eg, malignant neoplasm), soft tissue of upper arm or elbow area 24999 Unlisted procedure, humerus or elbow

How often do physicians in your specialty perform this service?

Sometimes.

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

Estimated 1,000 cases annually: 30% of 24006; 10% of 24077; xx% of 24999

1994 Medicare Part B frequency:

24006 = 8224077 = 44324999 = 173

Is this service performed by many physicians across the United States?

This service would be familiar to general surgeons, hand surgeons, orthopaedic surgeons, and plastic and reconstructive surgeons.



CPT Code: (265XX) Tracking Number: Q8 Global Period: 090 Recommended RVW: 8.50

Descriptor: Repair nonunion, metacarpal or phalanx (includes obtaining bone graft with or without external or internal fixation)

CLINICAL DESCRIPTION OF SERVICE:

Typical Patient: A 23-year-old male who previously suffered a metacarpal fracture as the result of a gunshot wound develops a nonunion of the metacarpal.

Pre-service work includes obtaining and reviewing pre-procedural imaging and laboratory studies; examining the patient's hand; and communicating with the patient (and/or patient's family) to review operative risks and benefits and to obtain informed consent. Pre-service work also includes pre-operative scrubbing; supervision of positioning, prepping, and draping the involved extremity as well as prepping and draping the anterior iliac crest.

Intra-service work: The metacarpal nonunion is exposed and the adherent extensor mechanism is dissected free of the bone and protected. The periosteum is elevated and the scar and callus are excised. The bone graft is harvested from the iliac crest. The nonunion or malunion is reduced and held with internal or external fixation. Strict attention must be directed at achieving absolute anatomic length and alignment of the metacarpal to avoid an abnormal grip with overlapping fingers. The bone graft is applied. The wound is then closed in layers over a drain. A bulky dressing is applied and reinforced with a splint. A drain is placed at the iliac bone graft site and the wound is closed in layers.

Post-service work includes monitoring patient stabilization; communicating with the family and other health care professionals (including written and oral reports and orders); monitoring of the drains; and antibiotic and pain medication management. The surgeon reviews post-service wound care and planned physiotherapy with the patient and/or family before discharge. Office visits related to this procedure for 90 days after the day of the operation are considered part of the post-service work for this procedure, including a follow-up visit at one week, removal of sutures at two weeks, and ordering and reviewing imaging studies at six weeks. Office visits are necessary to monitor and supervise not only wound and bone healing but most importantly the early initiation of range of motion exercises to the hand in order that motion and strength is recovered.


SURVEY DATA:

Specialty(s): American Academy of Orthopaedic Surgeons and American Society for Surgery of the Hand

Survey n:	162		PRE	INTRA				POS	Γ		
Response (%): 48 (30%)					Day 1	ICU (not day 1)		Hosp (not day 1)		Office	
Experience: $med=6$ range = 0 to 50		RVW	total min	total min	total min	total min	# visits	total min	# visits	total min	# visits
	low	5.50		45							
	25th%	7.85		75							
	med	8.50	45	90	30	0	0	10	1	60	6
	75th%	9.16		120							
	high	12.25		180							

Reference service data:

СРТ	Data Source	96rvw	PRE	INTRA	Post-HOSP	Post-OFF	Resp n	IWPUT (1)
20900	Harvard (PH3)	5.03	45	45	34	45	11	0.057
25440	Harvard (PH3)	9.95	52*	90	40*	50*	10	0.068
26615	Harvard (PH3)	5.18	34	56	16	31	13	0.053
26735	Harvard (PH3)	5.72	34*	59	23*	37*	13	0.051
28322	Harvard (PH3)	8.03	40*	75	31*	47*	8	0.061

An asterisk indicates times were "predicted," not surveyed.

(1) IWPUT represents Harvard Phase 3 final work values scaled to the 1996 MFS.

Reference service(s) cited most frequently by survey respondents:

<u>1996 RVW</u>	<u>Global</u>	<u>Count</u>	<u>CPT</u>	Descriptor
8.03	090	18	.28322	Repair of nonunion or malunion; metatarsal, with or without bone graft
				(includes obtaining graft)
9.95	090	13	25440	Repair of nonunion, scaphoid (navicular) bone, with or without radial
				styloidectomy (includes obtaining graft and necessary fixation)
5.18	090	10	26615	Open treatment of metacarpal fracture, single, with or without internal or
		•		external fixation, each bone

KEY REFERENCE SERVICE(S):

<u>1996 RVW</u>	<u>Global</u>	<u>CPT</u>	Descriptor
5.03	090	20900	Bone graft, any donor area; minor or small (eg, dowel or button)
9.95	090	25440	Repair of nonunion, scaphoid (navicular) bone, with or without radial styloidectomy (includes obtaining graft and necessary fixation)
5.18	090	26615	Open treatment of metacarpal fracture, single, with or without internal or external fixation, each bone
5.72	090	26735	Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with or without internal or external fixation, each
8.03	090	28322	Repair of nonunion or malunion; metatarsal, with or without bone graft (includes obtaining graft)



Relationship of code being reviewed to key reference service(s): Compare the pre-, intra-, and post-service time and the intensity of the service you are rating to the key reference services listed above.

NEW CODE: Q8 Repair nonunion, metacarpal or phalanx (includes obtaining bone graft with or without external or internal fixation) **Recommended RVW**: 8.50 (survey median) **IWPUT**: 0.055

• Q8 is similar in work to CPT 25440 repair scaphoid (RVW 9.95) in terms of pre-, intra-, and post-service time.

• Q8 represents more work than the combined work of CPT codes $26615 + 20900 [7.70 = 5.18 + \frac{1}{2}(5.03)]$ or $26735 + 20900 [8.24 = 5.72 + \frac{1}{2}(5.03)]$. The intra-operative work of Q8 is greater because achieving alignment and restoring length of the metacarpal or phalanx is more difficult than in a fresh fracture (26615 or 26735).

These calculated RVWs approximate the RVW for CPT 28322 (8.03), which is a similar procedure in the foot. The slightly higher recommended RVW for Q8 can be attributed to the added intra-operative work (both time and intensity) for a more critical alignment and rotational positioning of the metacarpal versus the metatarsal, as well as a more critical attention to the anatomy and function of the extensor tendons in the hand. Cast immobilization is used postoperatively in CPT 28322, while early range of motion to recover finger function is instituted in Q8.

Additional rationale: (If recommended RVW is not based on the survey results.) None.



FREQUENCY INFORMATION

How was this service previously reported?

A small percentage of:

26615±(-22) Open treatment of metacarpal fracture, single, with or without internal or external fixation, each bone
26735-22 Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with or without internal or external fixation, each

Possibly in combination with:

20900 Bone graft, any donor area; minor or small (eg, dowel or button) 20902 Bone graft, any donor area; major or large 26989 Unlisted procedure, hands or fingers

How often do physicians in your specialty perform this service? Sometimes.

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

Estimated 1,000 cases annually: 1-3% of 26615 and 26735; xx% of 26989

1994 Medicare Part B frequency: 26615 = 3,759; 26735 = 1,712; 26989 = 362

Is this service performed by many physicians across the United States?

This procedure would be familiar to general surgeons, hand surgeons, orthopaedic surgeons, and plastic and reconstructive surgeons.



AMA SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATIONS APRIL 1996

Hand and Arm Surgery - Tab 16

The RUC agreed with the specialty recommendations presented for 24341 Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff) and 26185 Sesamoidectomy, thumb or finger (separate procedure), which were based on the survey responses of nearly 50 orthopaedic and hand surgeons.

24341 is similar to 25260/25263 Repair, tendon or muscle, flexor, forearm and/or wrist; primary/secondary, single, each tendon or muscle (work rvu = 7.33/7.37) in total physician work. 24341 is less work than 24342 Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft (work rvu = 10.13), which may require two incisions and dissection in the antecubital fossa with necessary identification and protection of neurovascular structures.

26185 is slightly more work than 28315 Sesamoidectomy, first toe (separate procedure) (work rvu = 4.60) because more intraservice work is required to protect the digital nerves and arteries which are directly over the sesamoid. The function of the digit (thumb or finger) would be significantly comprised if these digital nerves were injured.

CPT Code (• New)	Tracking Number	CPT Descriptor	Global Period	RVW Recommendation
•24341	R1	Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff)	090	7.33
24342	R2	Reinsertion or repair of ruptured or lacerated biceps or triceps tendon, distal, with or without tendon graft	090	10.13 (no change)
•26185	R3	Sesamoidectomy, thumb or finger (separate procedure)	090	5.00

CPT Code (• New)	Tracking Number	CPT Descriptor	Global Period	RVW Recommendation
26121	R4	Fasciectomy, palmar only, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft);	090	7.34 (no change)
26123	R5	<u>Fasciectomy</u> , partial palmar excision with release of single digit including proximal interphalangeal joint, with or without Z- plasty, other local tissue rearrangement, or skin grafting (in- cludes obtaining the graft)	090	8.64 (no change)
26125	R6	partial excision with release of each additional digit, including proximal interphalangeal joint (List separately in addition to code for primary procedure). (Use 26125 only for code 26123)	ZZZ (chang e from 090 in 1994)	4.61 (no change)

.

AMA/Specialty Society RVS Update Process Summary of Recommendation

CPT Code: (2434X) Tracking Number: R1 Global Period: 090 Recommended RVW: 7.33

Descriptor: Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff)

CLINICAL DESCRIPTION OF SERVICE:

Typical Patient: A 35-year-old female falls through a plate glass window and sustains a deep four-inch laceration across the mid one-third of the arm, completely lacerating the biceps muscle. Wound exploration in the operating room reveals that the only deep injury is to the biceps muscle, which is carefully repaired.

Pre-service work includes obtaining and reviewing pre-procedural imaging and laboratory studies; examining the patient's arm; and communicating with the patient (and/or patient's family) to review operative risks and benefits and to obtain informed consent. Pre-service work also includes pre-operative scrubbing; and supervision of positioning, prepping, and draping the patient.

Intra-service work: The wound is extended as needed. The biceps muscle is identified. The adjacent neurovascular structures are carefully protected. Any clot or debris is removed from the wound through irrigation. The muscle is then approximated using appropriate suture. A drain is placed, if necessary, and the skin is closed in layers. A bulky dressing is applied that is reinforced with a posterior mold to hold the elbow in flexion and the forearm in supination.

Post-service work includes monitoring patient stabilization; communicating with the family and other health care professionals (including written and oral reports and orders); and antibiotic and pain medication management. The surgeon reviews post-service wound care and planned physiotherapy with the patient and/or family before discharge. Office visits related to this procedure for 90 days after the day of the operation are considered part of the post-service work for this procedure, including the surgeon's removal of sutures at two weeks and periodic visits with the surgeon to monitor wound healing; assess range of motion of the joint and physiotherapy progress; and adjust exercise and medication orders. The patient's progress must be carefully monitored by the surgeon, since too rapid a rehabilitation could lead to rupture of the biceps.

SURVEY DATA:

Survey	n:	162		PRE	INTRA				POS	r		
Respons	se (%): 4	6 (28%)		r		Day 1	ICU (no	ot day 1)	Hosp (r	iot day I)	Of	fice
Experie	nce:	med=5		total	total	total	total	#	total	#	total	#
•	range =	= 0 to 30	RVW	min	min	min`\	min	visits [_]	min	visits	min	visits
		low	4.00		30							
		25th%	6.86		60							1
	(med-	-27-33-0	(45)	90.	(30)	0	0	15	1	60	5
		75th%	7.50		90							
		high	12.00		130							
Referen	ice servi	ce data:										
CPT	Data	Source	96rvw	PRE	INTRA	Post-	HOSP	Post	OFF	Resp n	IWPUT	(1)
24342	Harvar	d (PH3)	10.13	53*	101	4	1*	5	1* .	12	0.060	
25260	Harvar	d (PH3)	7.33	43	50	3	3	5	4	13	0.076	
25263	Harvar	d (PH3)	7.37	43*	53	31	3*	- 54	4*	.9	0.076	
25270	Harvar	d (PH3)	5.71	36*	46	2:	5*	4()*	10	0.064	
25272	Harvar	d (PH3)	6.75	38*	55	2	7*	44	4*	9	0.068	

Specialty(s): American Academy of Orthopaedic Surgeons and American Society for Surgery of the Hand

An asterisk indicates times were "predicted," not surveyed.

(1) IWPUT represents Harvard Phase 3 final work values scaled to the 1996 MFS.

Reference service(s) cited most frequently by survey respondents:

<u>1996 RVW</u>	<u>Global</u>	Count	CPT	Descriptor
7.33	090	23	25260	Repair, tendon or muscle, flexor, forearm and/or wrist; primary, single,
				each tendon or muscle
10.13	090	9	24342	Reinsertion or repair of ruptured or lacerated biceps or triceps tendon,
				distal, with or without tendon graft
6.75	090	9	25272	Repair, tendon or muscle, extensor, forearm and/or wrist; secondary,
				single, each tendon or muscle

KEY REFERENCE SERVICE(S):

<u>1996 RVW</u>	<u>Global</u>	<u>CPT</u>	Descriptor
10.13	090	24342	Reinsertion or repair of ruptured or lacerated biceps or triceps tendon, distal, with or without tendon graft
7.33	090	25260	Repair, tendon or muscle, flexor, forearm and/or wrist; primary, single, each tendon or muscle
7.37	090	25263	Repair, tendon or muscle, flexor, forearm and/or wrist; secondary, single, each tendon or muscle
5.71	090	25270	Repair, tendon or muscle, extensor, forearm and/or wrist; primary, single, each tendon or muscle
6.75	090	25272	Repair, tendon or muscle, extensor, forearm and/or wrist; secondary, single, each tendon or muscle



NEW CODE: R1 Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff) **Recommended RVW**: 7.33 (survey median) **IWPUT**: 0.042

• CPT code pairs 25260/25263 and 25270/25272 describe primary or secondary repair of flexor or extensor muscles in the forearm or wrist that comprise similar total work to the repair of muscles or tendons in the upper arm or elbow as described with new code R1.

• R1 is distinctly different from revised CPT 24342, which is for the reinsertion or repair of ruptured "distal" biceps only, not for repair of lacerated muscles above the elbow in any location other than distal. Reattaching a ruptured distal biceps or triceps (24342) may require two incisions and dissection in the antecubital fossa with necessary identification and protection of neurovascular structures. The latter can be easily injured during the repair in 24342. As such, CPT 24342 is more work than R1.

Additional rationale: (If recommended RVW is not based on the survey results.)

None

FREQUENCY INFORMATION

How was this service previously reported?

Some small percentage of:

24342 Reinsertion or repair of ruptured or lacerated biceps or triceps tendon, distal, with or without tendon graft 24999 Unlisted procedure, humerus or elbow

How often do physicians in your specialty perform this service?

Rarely.

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

Estimated 2,000 cases annually. Estimate: 25% of 24342; xx% of 24999

1994 Medicare Part B frequency: 24342 = 387; 24999 = 173

Is this service performed by many physicians across the United States?

This procedure would be familiar to general surgeons, hand surgeons, orthopaedic surgeons, and plastic and reconstructive surgeons.

CPT Code: (261XX) **Tracking Number:** R3 **Global Period**: 090 **Recommended RVW:** 5.00

Descriptor: Sesamoidectomy, thumb or finger (separate procedure)

CLINICAL DESCRIPTION OF SERVICE:

Typical Patient: A 38-year-old male presents one and one-half years following a hyperextension injury to his thumb. The thumb is painful and tender over the sesamoid of the metacarpophalangeal joint. He undergoes surgical excision of the sesamoid of the thumb to relieve the pain.

Pre-service work includes obtaining and reviewing pre-procedural imaging and laboratory studies; examining the patient's hand; and communicating with the patient (and/or patient's family) to review operative risks and benefits and to obtain informed consent. Pre-service work also includes pre-operative scrubbing; supervision of positioning, prepping, and draping the patient; and marking the patient's hand.

Intra-service work: An incision is made over the palmar aspect of the thumb. The neurovascular structures are identified and protected. The Al pulley of the thumb is released. The sesamoids are excised. The defect in the volar plate is repaired. The wound is closed and a bulky dressing applied.

Post-service work includes monitoring patient stabilization; communicating with the family and other health care professionals (including written and oral reports and orders); and antibiotic and pain medication management. The surgeon reviews post-service wound care and planned physiotherapy with the patient and/or family before discharge. Office visits related to this procedure for 90 days after the day of the operation are considered part of the post-service work for this procedure, including the surgeon's removal of sutures at two weeks and periodic visits with the surgeon - at one week, two weeks, four weeks, eight weeks, and 12 weeks - to monitor wound healing; assess range of motion of the joints and physiotherapy progress; and adjust exercise and medication orders.





Specialty(s): American Academy of Orthopaedic Surgeons; American Society for Surgery of the Hand

Survey n:	162		PRE	INTRA				POS	Г		
Response (%): 46 (23%)					Day 1	ICU (not day 1)		Hosp (not day 1)		Office	
Experience: range =	med=2 0 to 15	RVW	total min	total min	total min	total min	# visits	total min	# visits	total min	# visits
	low	4.00		30							
	25th%	4.65		40							l
	med	5.00	40	45	25	0	0	0	0	45	4
	75th%	5.16		60							
	high	7.30		90							

Reference service data:

СРТ	Data Source	96rvw	PRE	INTRA	Post-HOSP	Post-OFF	Resp n	IWPUT (1)
26615	Harvard (PH3)	5.18	34	56	16	31	13	0.053
26735	Harvard (PH3)	5.72	34*	59	23*	37*	13	0.051
28315	Harvard (PH3)	4.60	33*	39	25*	35*	8	0.053

An asterisk indicates times were "predicted," not surveyed.

(1) IWPUT represents Harvard Phase 3 final work values scaled to the 1996 MFS.

Reference service(s) cited most frequently by survey respondents:

<u>1996 RVW</u>	<u>Global</u>	<u>Count</u>	<u>CPT</u>	Descriptor
4.60	090	21	28315	Sesamoidectomy, first toe (separate procedure)
5.18	090	10	26615	Open treatment of metacarpal fracture, single, with or without internal or external fixation, each bone
5.72	090	7	26735	Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with or without internal or external fixation, each
				- · · · · · · · · · · · · · · · · · · ·

KEY REFERENCE SERVICE(S):

<u>1996 RVW</u>	<u>Global</u>	<u>CPT</u>	Descriptor
4.60	090	28315	Sesamoidectomy, first toe (separate procedure)

Relationship of code being reviewed to key reference service(s): Compare the pre-, intra-, and post-service time and the intensity of the service you are rating to the key reference services listed above.

NEW CODE: R3 Sesamoidectomy, thumb or finger (separate procedure) **Recommended RVW:** 5.00 (survey median) **IWPUT:** 0.054

The work of R3 is very comparable to CPT 28315. The slightly higher RVW can be attributed to the added work (both time and intensity) intra-operatively to protect the digital nerves and arteries which are directly over the sesamoid. The function of the digit (thumb or finger) would be significantly compromised if these digital nerves were injured.

Additional rationale: (If recommended RVW is not based on the survey results.)

None.

FREQUENCY INFORMATION

How was this service previously reported?

Some small percentage of: 26989 Unlisted procedure, hands or fingers

How often do physicians in your specialty perform this service?

Rarely.

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

Estimated 100 - 300 total cases annually.

1994 Medicare Part B frequency for 26989 is 362.

Is this service performed by many physicians across the United States?

This procedure would be familiar to hand surgeons, orthopaedic surgeons, and plastic and reconstructive surgeons.

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AMA SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATIONS APRIL 1996

Excision of Epiphyseal Bar-Tab 17

The RUC agreed with the recommendation presented for 20150 Excision of epiphyseal bar, with or without autogenous soft tissue graft obtained through same fascial incision, which was based on the survey responses of more than 60 pediatric orthopaedic surgeons.

20150 is comparable to 27365 Radical resection of tumor, bone, femur or knee (NPRM proposed work rvu = 15.00) as both services require identification of abnormal tissue and resection without damage to surrounding tissues. There is risk of tumor recurrence in 27365, however, risk of further epiphyseal damage (i.e., growth plate injury resulting in further or different deformity) is present with 20150. 20150 is more technically demanding than 27479 *Epiphyseal arrest by epiphysiodesis or stapling; combined distal femur, proximal tibia and fibula* (work rvu = 12.18) due to difficulty in localizing and removing the epiphyseal bar.

CPT Code (• New)	Tracking Number	CPT Descriptor	Global Periòd	RVW Recommenda- tion
•20150	P1	Excision of epiphyseal bar, with or without autogenous soft tissue graft obtained through same fascial incision	090	13.00

CPT Code: (202XX) Tracking Number: P1 Global Period: 090 Recommended RVW: 13.00

Descriptor: Excision of epiphyseal bar, with or without autogenous soft tissue graft obtained through same fascial incision

CLINICAL DESCRIPTION OF SERVICE:

Typical Patient: An 8-year-old patient presents with a prior growth plate injury of the distal femur with closure of 35 percent of the physeal plate. This has resulted in an increasing, significant deformity of the leg.

Pre-service work includes obtaining and reviewing hospital admission imaging and laboratory studies, with special attention to tomography and CT scans; communicating with other health care professionals; and communicating with the patient (and/or patient's family) to review operative risks and benefits and to obtain informed consent. After dressing and gowning, the surgeon positions the patient and placement of the image intensifier monitor to be certain that adequate images can be obtained intra-operatively, if necessary. The surgeon also places a tourniquet on the extremity; supervises the prepping and draping of the patient; and ensures that surgical instruments and supplies that are necessary are present and available in the operative suite.

Intra-service work: For a central physeal bar: An incision is made over the distal femur proximal to the physeal plate to allow indirect exposure through a large hole in the distal femur. The overlying structures are elevated to allow appropriate exposure of the area and identification of the lesion. The access route is identified often using pin placement through the distant metaphyseal femur to verify the proposed route of access for the bar. Once the route of access is verified, a large hole is made in the distal femur. Using burrs, drills, and curettes, the physeal bar is identified and removed. Indirect lighting with a headlight and loop magnification is necessary to verify removal of the central bar and exposure of the more normal surrounding growth plate. After the bar is appropriately localized, it is excised directly to the level of the normal growth plate. Following complete removal of the bar, the wound is thoroughly irrigated and methylmethacrylate or other foreign materials are placed to prevent reclosure of the bar. Locally obtained fat from the subcutaneous portion of the wound is often placed in the defect and sutured in place. The tourniquet is released. The wound is closed in layers over drains and sterile dressings and a splint are applied. For a peripheral physeal bar. An incision is made directly over the physeal plate and overlying structures are elevated to allow appropriate exposure of the area and identification of the lesion. The bar is identified using pre-operative studies and the intraoperative image intensifier. After the bar is appropriately localized, it is excised directly to the level of the normal growth plate. Following complete removal of the bar, the wound is thoroughly irrigated and methylmethacrylate or other foreign materials are placed to prevent reclosure of the bar. Locally obtained fat from the subcutaneous portion of the wound is often placed in the defect and sutured in place. The tourniquet is released. The wound is closed in layers over drains and sterile dressings and a splint are applied.

Post-service work includes monitoring patient stabilization; communicating with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon This includes monitoring of neurologic, vascular, and muscle function/complications; ordering and reviewing postoperative radiographs and laboratory studies; monitoring for wound infection; monitoring, care, and removal of drains; ordering ambulation with crutch or walker utilization when appropriate; and antibiotic and pain medication management. When the patient has good extremity control, there is no evidence of infection, and pain is under appropriate control, the patient is discharged to closely monitored outpatient follow-up. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures; monitoring wound healing; dressing and splint changes, as necessary; and adjustments in medication. Through the postoperative period, the surgeon additionally orders and reviews serial evaluations of the growth plate, including x-rays, tomograms, and CT scans. Calculations of resumption of leg growth and residual deformity are performed with each study. Mapping of the growth plate for potential reformation of the bar is also performed. Range of motion exercises of the knee and muscle rehabilitation is ordered, when appropriate, and rehabilitation assessed periodically, along with evaluation for the initiation of weight-bearing movement. Sometimes, physical therapy may be indicated and ordered. [It should be noted that the patient will not be ischarged from the surgeon's care at the end of the 90 day global period and will continue to require periodic studies and rehabilitation assessment.]



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SURVEY DATA:

Specialty(s): American Academy of Orthopaedic Surgeons; American Academy of Pediatrics

172		PRE	INTRA	POST						
Response (%): 61 (35%)				Day 1	ICU (not day 1)		Hosp (not day 1)		Office	
d = 5		total	total	total	total	#	total	#	total	#
to 20	RVW	min	min	min	min	visits	min	visits	min [.]	visits
ow	8.50		60							
5th%	11.54		93							
ned	13.00	60	120	30	0	0	30	2	60	3
5th%	15.50		150							
nigh	17.80		210							
	172 5%) 1 = 5 0 20 0 w th% ned th% igh	172 55%) d = 5 o 20 RVW ow 8.50 th% 11.54 ned 13.00 th% 15.50 igh 172	172 PRE 55%) total d = 5 total o 20 RVW ow 8.50 oth% 11.54 ned 13.00 oth% 15.50 igh 17.80	PRE INTRA 172 PRE INTRA 55%) total total d = 5 total min o 20 RVW min min ow 8.50 60 ith% 11.54 93 ned 13.00 60 120 ith% 15.50 150 igh 17.80 210	172 PRE INTRA 55%) total Day 1 d = 5 total total o 20 RVW min min ow 8.50 60 60 ith% 11.54 93 60 ith% 15.50 150 30 igh 17.80 210 10	172 PRE INTRA 55%) total Day 1 ICU (notal total min	172 PRE INTRA 55%) total Day 1 1 = 5 total total 0 20 RVW min min min min ow 8.50 60 60 11.54 93 ned 13.00 60 120 30 0 ith% 15.50 150 150 150	$\begin{array}{c c c c c c c c c c c c c c c c c c c $	$\begin{array}{c c c c c c c c c c c c c c c c c c c $	$\begin{array}{c ccccccccccccccccccccccccccccccccccc$

Reference service data:

CPT	Data Source	96rvw	PRE	INTRA	Post-HOSP	Post-OFF	Resp n	IWPUT (1)
27365	RUC (5-Yr)	13.84/ 15.00	75	180	120	60	39	0.046
27479	Harvard (PH3)	12.18	54*	116	51*	51*	9	0.065

An asterisk indicates times were "predicted," not surveyed.

(1) IWPUT represents Harvard Phase 3 final work values scaled to the 1996 MFS.

For CPT 27365, the 1996 RVW is 13.84, however the RUC 5-year recommendation to HCFA is an RVW of 15.00.

The IWPUT for CPT 27365 was calculated using the RUC recommended RVW of 15.00.

Reference service(s) cited most frequently by survey respondents:

<u>1996 RVW</u>	<u>Global</u>	<u>Count</u>	<u>CPT</u>	Descriptor
13.84/15.00*	090	15	27365	Radical resection of tumor, bone, femur or knee
12.18	090	10	27479	Epiphyseal arrest by epiphysiodesis or stapling; combined distal femur,
				proximal tibia and fibula

KEY REFERENCE SERVICE(S):

<u>1996 RVW</u>	<u>Global</u>	<u>CPT</u>	Descriptor
13.84/15.00*	090	27365	Radical resection of tumor, bone, femur or knee
12.18	090	27479	Epiphyseal arrest by epiphysiodesis or stapling; combined distal femur, proximal tibia and fibula

*The 1996 RVW is 13.84, however the RUC 5-year review recommendation to HCFA is an RVW of 15.00.



Relationship of code being reviewed to key reference service(s): Compare the pre-, intra-, and post-service time and the intensity of the service you are rating to the key reference services listed above.

New Code: P1 Excision of epiphyseal bar, with or without autogenous soft tissue graft obtained through same fascial incision Recommended RVW: 13.00 (survey median) IWPUT: 0.071

• P1 was compared to CPT 27365 by the majority of survey respondents with P1 being found to be similar, but less work. P1 requires the identification of abnormal tissue and it's resection without damage to surrounding tissues much the same as with CPT 27365. Risk of tumor recurrence is present in CPT 27365, however risk of further epiphyseal damage (i.e., growth plate injury resulting in further or different deformity) is attendant with P1. CPT 27365 was recently surveyed by 39 orthopaedic surgeons in 1995 as part of the MFS 5-year review. Pre-service, intra-service, and post-hospital times for CPT 27365 were all higher than the surveyed times for P1. The 1995 RVW for 27365 was 13.84. The RUC recommended RVW for CPT 27365 is 15.00. This was the value recommended by the workgroup and approved by the full RUC after this code was extracted for in-depth discussion at the August 1995 meeting.

• 27479 was chosen as a key reference service since this code describes the "creation" of epiphyseal plate closure about the knee in a pediatric patient with a leg length overgrowth. The technique of creating this closure in CPT 27479 (albeit via four short incisions) is less technically demanding than the intra-service work of P1. Although the service times are similar for P1 and CPT 27479, the survey median RVW of 13.00 is recommended for P1 to account for the greater intensity of P1 due to the difficulty in localizing and removing the bar. This is validated by the survey complexity/intensity mean responses for P1 and for CPT 27479:

CPT	Mental effort Judgment	Technical skill Physical effort	Psychological stress	Response n	Median Experience
P1	4.08	4.16	3.66	61	5
27479	3.44	2.89	3.11	10	10

Additional rationale: (If recommended RVW is not based on the survey results.)

None.

FREQUENCY INFORMATION

How was this service previously reported?

The following codes, reported in combination, may have been used to report the work of P1:

- 27328 Excision, tumor, thigh or knee area; deep, subfascial, or intramuscular
- 27360 Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis), femur, proximal tibia and/or fibula
- 27365 Radical resection of tumor, bone, femur or knee
- 27475 Epiphyseal arrest by epiphysiodesis or stapling; distal femur
- 27477 Epiphyseal arrest by epiphysiodesis or stapling; tibia and fibula, proximal
- 27479 Epiphyseal arrest by epiphysiodesis or stapling; combined distal femur, proximal tibia and fibula

low often do physicians in your specialty perform this service?

Sometimes.



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

This is a pediatric procedure performed approximately 3 to 5 times annually in large orthopaedic pediatric institutions.

This service represents less than two percent of cases currently reported using CPT codes 27328, 27360, 27365, 27475, 27477, 27479.

Is this service performed by many physicians across the United States?

This service would be familiar to pediatric orthopaedic surgeons.



AMA SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATIONS APRIL 1996

Release of Hip Flexor Deformity- Tab 18

The RUC agreed with the recommendations presented for 27036 Capsulectomy or capsulotomy of hip, with or without excision of heterotopic bone, with release of hip flexor muscles (ie, gluteus medius, gluteus minimus, tensor fascia latae, rectus femoris, sartorius, iliopsoas), which was based on the survey responses of more than 60 pediatric orthopaedic surgeons.

The intra-service and post-service intensity of work of 27036 is greater than 27025 Fasciotomy, hip or thigh, any type (work rvu = 10.19). 27025 does not include the additional intra-service work of releasing the rectus femoris, gluteus medius, gluteus minimus, or sartorius, or excision of heterotopic ossification which is a part of 27036. The intra-service intensity of 27036 is more similar to 27165 Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast (work rvu - 16.20).

CPT Code (• New)	Tracking Number	CPT Descriptor	Global Period	RVW Recommendation
•27036	S1	Capsulectomy or capsulotomy of hip, with or without excision of heterotopic bone, with release of hip flexor muscles (ie, gluteus medius, gluteus minimus, tensor fascia latae, rectus femoris, sartorius, iliopsoas)	090	12.00



Descriptor: Capsulectomy or capsulotomy of hip, with or without excision of heterotopic bone, with release of hip flexor muscles (ie, gluteus medius, gluteus minimus, tensor fascia latae, rectus femoris, sartorius, iliopsoas)

CLINICAL DESCRIPTION OF SERVICE:

Typical Patient: A 12-year-old patient with neuromuscular disease presents with severe hip flexion contracture of 110 degrees. The contracture has precluded the patient from sitting in a wheel chair or using braces for erect posture.

Pre-service work includes obtaining and reviewing hospital admission imaging, pathology, and laboratory studies; reviewing the pre-operative plan and patient history; ordering pre-operative antibiotics; communicating with other health care professionals; and communicating with the patient (and/or patient's family) to review operative risks and benefits and to obtain informed consent. After dressing and gowning, the surgeon positions the patient to allow access to the entire anterior hip; supervises the prepping and draping of the patient; and ensures that surgical instruments and supplies that are necessary are present and available in the operative suite.

Intra-service work: An incision is made from well beyond the mid-line of the iliac crest, continuing anteriorly along the iliac crest, and then distally well along the sartorius muscle toward the patella for approximately five inches. The incision is extended to allow complete release from the iliac crest of the entire tensor fascia lata tendon origin, the origin of the gluteus medius, and the gluteus minimus until the entire anterior half of the iliac crest has been exposed. Dissection is then continued well posterior to the mid-line of the iliac crest. This exposes the hip joint capsule and the rectus femoris tendons, both directly and indirectly. The sartorius muscle tendon is divided from the anterior iliac spine. The rectus femoris tendons are divided from the ilium and the iliopsoas tendon is then identified and divided from its insertion into the lesser trochanter as well as the insertions on the capsule hip joint. Extension is then attempted as much as possible. It is usually necessary to divide the anterior half of the hip capsule to allow maximum extension to be obtained. The blood supply and femoral artery pulse is evaluated to determine how much extension to allowed post-operatively. Intra-operative use of the Doppler monitor is common. The release creates a large dead space where drains are placed, with closure limited to the stain? and subcutaneous tissue. The wound is closed and sterile dressings applied.

Post-service work includes monitoring patient stabilization; communicating with the family and other health care professionals (including written and oral reports and orders); monitoring of neurologic, vascular, and muscle function; ordering and reviewing postoperative radiographs and laboratory studies; monitoring for wound infection; monitoring, care, and removal of drains; and antibiotic and pain medication management. Coordination and direction of patient positioning is critical. (The patient is maintained in a prone position to allow the wound to heal in the position with maximum extension.) Discharge day management includes the surgeon's final examination of the patient; review with the patient, family, and therapist of post-discharge continuing care, positioning, and planned physiotherapy; and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures; monitoring wound healing; periodically assessing range of motion of the joint and adjusting exercise, physiotherapy, and medication orders. Careful planning for resumption of the erect or sitting posture, as well as refitting of any necessary braces is also necessary.





SURVEY DATA:

Specialty(s): American Academy of Orthopaedic Surgeons; American Academy of Pediatrics

Survey 1	n:	172		PRE	INTRA		POST					
Respons	se (%): 6	1 (35%)				Day 1	Day 1 ICU (not day 1) Hosp (not		iot day 1)	Office		
Experience: med = 8			total	total	total	total	#	total	#	total	#	
	range =	0 to 50	RVW	min	min	min	min	visits	min	visits	min	visits
		low	9.50		60	i						
		25th%	12.00		90							
,		med	13.90	60	120	30	0	0	40	3	60	4
		75th%	15.25		150							
		high	27.00		240							
Referen	ice servio	e data:										
CPT	Data S	Source	96rvw	PRE	INTRA	Post-	HOSP	Post	OFF	Resp n	IWPUT	(1)
27005	Harvard	d (PH3)	9.00	46*	47	5	6* .	4	1*	8	0.093	
27025	Harvard	1 (PH3)	10.16	57	113	7	6	5	6	5	0.045	
27030	Harvard	i (PH3)	12.09	47*	58	8	0*	4	5*	8	0.095	
27165	Harvard	d (PH3)	16.20	55*	147	12	.7*	60)*	9	0.059	
27170	Harvard	d (PH3)	14.90	65	148	1	11	3	9	9	0.057	

An asterisk indicates times were "predicted," not surveyed.

(1) IWPUT represents Harvard Phase 3 final work values scaled to the 1996 MFS.

Reference service(s) cited most frequently by survey respondents:

<u>1996 RVW</u>	<u>Global</u>	<u>Count</u>	<u>CPT</u>	Descriptor
16.20	090	27	27165	Osteotomy, intertrochanteric or subtrochanteric including internal or
				external fixation and/or cast
10.16	090	15	27025	Fasciotomy, hip or thigh, any type
14.90	090	12	27170	Bone graft, femoral head, neck, intertrochanteric or subtrochanteric area
				(includes obtaining bone graft)

KEY REFERENCE SERVICE(S):

<u>1996 RVW</u>	<u>Global</u>	<u>CPT</u>	Descriptor
9.00	090	27005	Tenotomy, iliopsoas, open (separate procedure)
10.19	090	27025	Fasciotomy, hip or thigh, any type
12.09	090	27030	Arthrotomy, hip, for infection, with drainage
16.20	090	27165	Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast
14.90	090	27170	Bone graft, femoral head, neck, intertrochanteric or subtrochanteric area (includes obtaining bone graft)

Relationship of code being reviewed to key reference service(s): Compare the pre-, intra-, and post-service time and the intensity of the service you are rating to the key reference services listed above.

New Code: S1 Capsulectomy or capsulotomy of hip, with or without excision of heterotopic bone, with release of hip flexor muscles (ie, gluteus medius, gluteus minimus, tensor fascia latae, rectus femoris, sartorius, iliopsoas) **Recommended RVW**: 12.00 (25th percentile) **IWPUT**: 0.060

• S1 includes the work of CPT codes 27005, 27025, and 27030. However, these codes do not address additional intra-service work, including the release of the rectus femoris, gluteus medius, gluteus minimus, or sartorius, or excision of heterotopic ossification, which is also part of the work of S1. Further, the intensity of work (intra- and post-service) is greater in S1 than CPT 27025. Note too must be made that the Harvard (PH3) data identifies only 5 respondents as compared to this survey's response of 54.

• It is the opinion of the specialty RVS advisory committee that the intra-operative intensity of S1 most closely matches CPT codes 27165 and 27170 (0.059 and 0.057 respectively). In fact, 44 percent of the survey respondents chose CPT 27165 as a reference service. Consequently, the survey's 25th percentile RVW of 12.00, with and IWPUT of 0.060, is being recommended, instead of the survey median which would have a higher intra-service intensity value (0.76).

• Additionally, several comments were written on the returned surveys that indicated the *typical* patient would more likely have a less severe hip flexion contracture (i.e., less than the 110 degrees stated in the vignette). As such, it is more reasonable to use the 25th percentile RVW, instead of the median.

Additional rationale: (If recommended RVW is not based on the survey results.) None.

FREQUENCY INFORMATION

How was this service previously reported?

27005 Tenotomy, iliopsoas, open (separate procedure) 27006 Tenotomy, abductors of hip, open (separate procedure) 27025 Fasciotomy, hip or thigh, any type 27030 Arthrotomy, hip, for infection, with drainage

How often do physicians in your specialty perform this service? Sometimes.

Estimate the number of times this service might be provided nationally in a one-year period? This is a pediatric procedure performed approximately 12 times annually in large orthopaedic pediatric institutions.

This service represents approximately five percent of cases currently reported using CPT codes 27005, 27006, 27025, and 27030.

Is this service performed by many physicians across the United States? This service would be familiar to pediatric orthopaedic surgeons.



AMA SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATIONS APRIL 1996

Pediatric Cystourethroscopy - Tab 19

A comment from a CMD during the five-year review process suggested that the relative value for 52340 Cystourethroscopy with incision, fulguration, or resection of bladder neck and/or posterior urethra (congenial valves, obstructive hypertrophic mucosal folds (1996 work rvu = 7.76) be reduced to be similar to 52277 Cystourethroscopy, with resection of external sphincter (sphincterotomy) (work rvu = 6.17). The RUC reviewed this comment and determined that confusion exists between 52340, which is utilized to treat pediatric patients, and 52500 Transurethral resection of bladder neck (separate procedure (work rvu = 7.82). The RUC referred this issue to CPT and the Editorial Panel revised the language of 52340 to identify it as a pediatric service.

A survey was conducted of pediatric urologists after the CPT change to determine the appropriate work relative value for this very rare procedure (less than 300 performed annually). The RUC agreed that the time and intensity of 52340 is similar to 52601 *Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete* (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included) (work rvu = 11.51) and 52500.

CPT code 52300 Cystourethroscopy; with resection of ureterocele(s), unilateral or bilateral (1996 work rvu = 5.35) was split into two codes to differentiate between orthotopic and ectopic ureterocele(s). Only 20% of all these procedures include the resection or fulguration of the more difficult ectopic ureterocele(s). A budget neutral recommendation of 5.31 for 52300 orthotopic and 5.51 for 52301 ectopic is recommended.

CPT Code (• New)	Tracking Number	CPT Descriptor	Global Period	RVW Recommendation
52300	V2	Cystourethroscopy; with resection or fulguration of <u>orthotopic</u> ureterocele(s), unilateral or bilateral	000	5.31
- 5230X 5230/	V3	with resection or fulguration of ectopic ureterocele(s), unilateral or bilateral	000	5.51
52340	V1	Cystourethroscopy with incision, fulguration, or resection of bladder neck and/or posterior urethra(congenital posterior ure- thral valves or congenital obstructive hypertrophic mucosal folds	090	9.00

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Medicare Frequency: 9.420 Current Work RVU: 7.76 Percentage Increase: 13%

CPT Descriptor:

Cystourcthroscopy with incision, fulguration, or resection of congenital posterior urethral valves or congenital obstructive hypertrophic mucosal folds

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 2-month old boy presents with a poor stream and palpable bladder. He has major V-U reflux secondary to congenital urethral valves. Serum creatinine is elevated.

Description of Pre-Service Work:

Includes services provided from the day before the surgery or diagnostic procedure until the time of the procedure and may include: (1) obtaining and reviewing records or previous history, laboratory studies and urologic x-rays before the procedure; (2) communicating with other health professionals (e.g. family physician, anesthesiologist); (3) communicating with the patient to explain the procedure, operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (administration of general or spinal anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery or procedure and any other non "skin-to-skin" work in the operating room or procedure suite. Does not include: The consultation or evaluation at which time the decision to provide the procedure is made.

Description of Intra-Service Work:

The patient is under anesthesia. Panendoscopy is carried out. Careful visualization of the prostatic urethra, bladder neck and bladder demonstrate evidence of a trabeculated bladder and dialated ureteral orifices accounting for the patient's reflux. The pan-endoscope is withdrawn into the urethra. Endoscopic incision of the congenital valve is carried out. Care is taken to avoid damaging the infantile prostate, bladder neck and external sphincter. A silicone Foley catheter is placed.

Description of Post-Service Work:

Includes the following: (1) all post-operative care on the day of the procedure, including patient stabilization, post-operative orders, communicating with the family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the operating room; (2) all post-operative hospital visits and discharge day management; (3) all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure (including evaluation of periodic laboratory reports and medication adjustment)

Patient is monitored post-operatively. Catheter is removed at the discretion of the urologist and renal function is followed carefully. The patient is dismissed when metabollically stable.

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CPT Code <u>52340</u> SURVEY DATA: Specialty: American Urological Association Sample Size: ______ Response Rate (%): _____57%(23/40) ____ Median RVU: _____9.00 25th Percentile RVU: ______ 7.76___ 75th Percentile RVU: ______ Low: _____5.75___ High: <u>20.00</u> Median Prc-Service Time: <u>90 minutes</u> Median Intra-Service Time: <u>60 minutes</u> 25th Percentile Intra-Svc Time: <u>40 minutes</u> 75th Percentile Intra-Svc Time: <u>60 minutes</u> Low: <u>30 minutes</u> High: <u>90 minutes</u> Median Post-Service Time: Total Time Number of Visits Day of Procedure: <u>30 minutes</u> ICU: 0 minutes <u>0 visits</u> Other Hospital: 20 minutes 2 visits

60 minutes

3 visits

Office:

KEY REFERENCE SERVICE(S):

	CPT Code	CPT Descriptor	RVW	Globe
1)	52601	Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	11.51	090
2)	525(X)	Transurethral resection of bladder neck (separate procedure)	7.82	090

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

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

Survey participants responded that the procedure being surveyed, 52340 - Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves or congenital obstructive hypertropic mucosal folds, is similar in time and intensity to the above reference procedures.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternataive method instead of the survey results, or other data besides the survey data are available, please explain any additional rationale for the RVUs.

FREQUENCY INFORMATION

How was this service previously reported?Same
How often do physicians in your specialty perform this service? Commonly Sometimes $\frac{X}{X}$ Rarely
Estimate the number of times this service might be provided nationally in a one-year period?
Is this service performed by many physicians across the United States? Yes $\frac{X}{2}$ No



Tracking Number: 523XX Global Period: 000 Recommended Work RV



- WUNT HE . PI BE-71-994A

CPT Descriptor:

CPT Co

Cystourethroscopy; with resection or fulguration of ectopic ureterocele(s), unilateral or bilatera

v3

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A four year-old girl during a UTI evaluation has been found to have an ectopic ureterocele. Diagnostic evaluation demonstrates severe hydronephrosis and bilateral duplications with a large intravesical defect consistent with a ureterocele. A renal scan demonstrates good function in three of four renal segments and the absence of function in the upper pole of the left kidney. Voiding cystourethrography demonstrates grade 3 reflux to the lower pole of the left kidney and grade 1 reflux to the lower pole of the right kidney. There is no reflux into the upper pole ureters. Transurethral incision of the urcterocele is elected.

Description of Pre-Service Work:

Includes services provided from the day before the surgery or diagnostic procedure until the time of the procedure and may include: (1) obtaining and reviewing records or previous history, laboratory studies and urologic x-rays before the procedure; (2) communicating with other health professionals (e.g. family physician, anesthesiologist); (3) communicating with the patient to explain the procedure, operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (administration of general or spinal anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery or procedure and any other non "skin-to-skin" work in the operating room or procedure suite. Does not include: The consultation or evaluation at which time the decision to provide the procedure is made.

Description of Intra-Service Work:

The patient is admitted via outpatient department. At the time of endoscopy, the ureterocele is initially seen extending down the urethra, but as the bladder fills it becomes indistinct (compressed by irrigation fluid). Leaving the bladder nearly empty to prevent collapse of the ureterocele, a Bugbee electrode is inserted. An incision is carefully placed low on the front wall of the ureterocele - just above the bladder neck in an effort to decompress the ureterocele and create a flap-valve to prevent reflux. A Foley catheter is placed in the bladder.

Description of Post-Service Work:

Some of the following may apply: (1) all post procedure care on the day of the procedure and if applicable patient stabilization, post-operative orders, communication with the patient and/or family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the procedure suite; (2) other follow-up care, prescriptions before the patient is discharged, if applicable.

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The patient is dismissed when felt appropriate by the physician.

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KEY REFERENCE SERVICE(S):

	CPT Code	CPT Descriptor	RVW	Globe
1)	52235	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of MEDIUM bladder tumor 2 cm - 5 cm	5.45	000
2)	52320	Cystourethroscopy (including ureteral catheterization); with removal of ureteral calculus	4.70	000

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

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

Survey participants responded that the procedure being surveyed, Cystourethroscopy; with resection or fulguration of ectopic ureterocele(s), unilateral or bilateral, is similar to the above reference services in time and intensity.



ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternataive method instead of the survey results, or other data besides the survey data are available, please explain any additional rationale for the RVUs.

FREQUENCY INFORMATION

How was this service previously reported? _____ Not previously reported

How often do physicians in your specialty perform this service? __ Commonly __ Sometimes X Rarely



Is this service performed by many physicians across the United States? __ Yes X No

CPT Code: <u>523XX</u>

SURVEY	DATA-
JONTEI	nuru.

Specialty: The American Urological Associati	on					
Sample Size: 40 Response Rate (%): <u>60% (24/40)</u>	Median RVU:5,51				
25th Percentile RVU: _5.00 75th Perce	entile RVU: <u>6.63</u>	Low: <u>4.70</u> High: <u>11.10</u>				
Median Pre-Service Time: <u>70 minutes</u> Median Intra-Service Time: <u>45 minutes</u>						
25th Percentile Intra-Svc Time: 37.5 minutes	75th Percentile Intra-Sv	re Time: <u>56.25 minutes</u> Low: <u>20 minutes</u>				
High: <u>120 minutes</u>						
Median Post-Service Time:	<u>Total Time</u>	Number of Visits				
Day of Procedure:	30 minutes	I				
ICU:	<u>0 minutes</u>	0 visits				
Other Hospital:	<u>10 minutes</u>	1 visit				
Office:	30 minutes	_2 visits				
		/ `				



AMA SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATIONS APRIL 1996

Pacemaker - Tab 22

The CPT Editorial Panel accepted revision to the Pacemaker section to allow physicians to report the removal of a pacemaker lead system while leaving the pulse generator in place.

The RUC recommendations for 33234 *Removal of transvenous pacemaker electrodes; single lead system, atrial or ventricular* and 33235 *dual lead system* are calculated by reducing the current work relative values by 2.97 to "back out" the removal of permanent pacemaker pulse generator which is no longer included in the descriptor for these codes.

CPT Code (● New)	Tracking Number	CPT Descriptor	Global Period	RVW Recommendation
33233		Removal of permanent pacemaker pulse generator;	090	2.97 (no change)
33234	T1	with <u>Removal of</u> transvenous <u>pacemaker</u> electrode(s); single lead system, atrial or ventricular	090	5.72
33235	T2	with transvenous electrode(s), dual lead system	090	6.96



AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: <u>33234</u> Tracking Number: <u>T1</u> Global Period: <u>90</u> Recommended Work RVU: <u>5.72</u>

CPT Descriptor:

Removal of transvenous pacemaker electrode(s), single lead system, atrial or ventricular

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This revised code was not surveyed. The recommended WRVU has been calculated.

Specialty: American College of Cardiology

RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results, or other data besides the survey data are available, please explain any additional rationale for the RVUs.

This code descriptor revision was recommended by the College to allow physicians to report the removal of a pacemaker lead system while leaving the pulse generator in place. We have calculated the recommended WRVU by "backing out" the generator removal portion of the service from the formerly global code. The remainder is the work of extracting the acts.

33234 (revised)	= 33234 (current) - 33233
	≈ 8.69 - 2.97
	= 5.72

FREQUENCY INFORMATION

How was this service previously reported? 33234-52

now orten do physicians in your specialty perform this service? <u>A</u> Commonly _ Sometimes _ h

Estimate the number of times this service might be provided nationally in a one-year period? Data not available

Is this service performed by many physicians across the United States? X Yes No



AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 33235 Tracking Number: T2 Global Period: 90 Recommended Work RVU: 6.96

CPT Descriptor:

Removal of transvenous pacemaker electrode(s), dual lead system

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

This revised code was not surveyed. The recommended WRVU has been calculated.

Specialty: American College of Cardiology

RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results, or other data besides the survey data are available, please explain any additional rationale for the RVUs.

This code descriptor revision was recommended by the College to allow physicians to report the removal of a pacemaker system while leaving the pulse generator in place. We have calculated the recommended WRVU by "backing out" the generator removal portion of the service from the formerly global code. The remainder is the work of extracting the leads.

33235 (revised) = 33235 (current) - 33233= 9.93 - 2.97 = 6.96

FREQUENCY INFORMATION

How was this service previously reported? <u>33235-52</u>

How often do physicians in your specialty perform this service? X. Commonly _____ Sometimes ____ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? Data not available

Is this service performed by many physicians across the United States? ____ Yes X__ No





AMA SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATIONS APRIL 1996

Microvascular Anastomosis- Tab 24

The American Society of Plastic and Reconstructive Surgeons submitted a comment on CPT Code 15755 Free flap (microvascular transfer) (work rvu = 28.33) during the five-year review that this service is undervalued in comparison to other microvascular flap procedures, specifically, 20970 Free osteocutaneous flap with microvascular anastomosis; iliac crest (work rvu = 41.22). The RUC reviewed the ASPRS recommendation and referred the issue to CPT because the current descriptor describes a variety of procedures and needs to be clarified.

The CPT Editorial Panel approved changes to delete 15755, revise current descriptors in the family of codes, and add new codes to more accurately reflect the different types of free microvascular tissue transfer procedures that are currently performed.

The RUC recommendations for codes 15756-15758, 20956 and 20957 are based on HCFA's assumption (Federal Register, 12/8/94) that the intraoperative intensity of CPT code 20955 *Bone graft with microvascular anastomosis; fibula* (work rvu = 37.58) is 3.80 work RVUs per hour. The recommendations for 26551-26556 were also calculated based on HCFA's assumption that the intraoperative intensity of CPT code 20970 *Free osteocutaneous flap with microvascular anastomosis; iliac crest* (work RVU = 41.22) is 4.00 work RVUs per hour.

The RUC did not agree with the survey results that indicated ICU visits by the microsurgeon occurred with these services and, therefore, calculated all hospital time (both ICU and other hospital) at the Harvard intensity factor of 3.00 per hour. The survey data from the previously valued microvascular anastomosis codes did include a breakdown of ICU versus hospital time and, therefore, the RUC was unable to determine if HCFA had incorporated the appropriate amount of post-operative intensity when assigning the relative values for these services.

The RUC referred CPT codes 43496 Free jejunum transfer with microvascular anastomosis and 49906 Free omental flap with microvascular anastomosis back to the specialty societies to resurvey based on vignettes that clearly indicate what

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			pre/post intensity factors										
				0.80 ·	2.02	3.00	2.50	1					
	CPT Code	Rec RVU	INTRA time	Scrub time	Eval time	Hosp time	Off time	Pre+ Post RVU	Intra RVU	IWPUT min	IWPUT hour	% Pre+ Post	% INTRA
N2	15756	33.23	360	15	75	200	100	10.46	22.77	0.063	3.80	31%	69%
N3	15757	33.23	360	15	75	210	100	10.77	22.46	0.062	3.74	32%	68%
N4	15758	33.23	360	15	75	208	100	10.70	22.53	0.063	3.75	32%	68%
N5	20956	37.00	400	15	75	220	120	11.58	25.42	0.063	3.80	31%	69%
N6	20957	38.33	420	15	75	220	130	11.83	26.50	0.063	3.80	31%	69%
N12	26551	44.31	480	15	105	220	120	12.25	32.06	0.067	4.00	28%	72%
N13	26553	44.00	480	15	90	220	120	11.92	32.08	0.067	4.00	27%	73%
N14	26554	52.50	595	15	105	230	130	12.81	39.69	0.067	4.00	24%	76%
N15	26556	44.75	480	15	75	228	155	12.72	32.03	0.067	4.00	28%	72%

CPT Code (• New)	Tracking Number	CPT Descriptor	Global Period	RVW Recommendation
15755	N1	Free flap (microvascular transfer)	090	N/A
		(15755 has been deleted. To report, see 15756-15- 758)		
●15756	N2 .	Free muscle flap with or without skin, with micro- vascular anastomosis	090	33.23
●15757	N3	Free skin flap with microvascular anastomosis	090	33.23
●15758	N4	Free fascial flap with microvascular anastomosis	090	33.23
●20956	N5	Bone graft with microvascular anastomosis; iliac crest	090	37.00
•20957	N6	metatarsal	090	38.33
20960	N7	rib	090	N/A
		(20960 has been deleted. To report, see 20962)		
20962	N8	other bone graft <u>than fibula, iliac crest, or</u> metatarsal	090	Carrier Price
20969	N9	Free osteocutaneous flap with microvascular anas- tomosis; other than iliac crest, rib, metatarsal, or great toe	090	42.08 (no change)
20970	N10	Free osteocutaneous flap with microvascular anas- tomosis; iliac crest	090	· 41.22 (no change)
20971	N11	rib	090	N/A
		(20971 has been deleted. To report, see 20962)		

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association. -3-

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CPT Code (● New)	CPT CodeTrackingCPT Descriptor• New)Number		Global Period	RVW Recommendation
•26551	N12	Toe-to-hand transfer with microvascular anastomo- sis; great toe "wrap-around" with bone graft	090	44.31
		(For great toe with web space, use 20973)		
•26553	N13	other than great toe, single	090	44.00
•26554	N14	other than great toe, double	090	52.50
•26556	N15	Free toe joint transfer with microvascular anastomosis	090	44.75
26557	N16	Reconstruction thumb with toe	090	N/A
		(26552 has been deleted. To report, see 20973 or 26557, 26558, 26559)		
26557	N17	Toe to finger transfer; first stage	090	N/A
26558	N18	each-delay	090	N/A
26559	N19	second stage-	090	N/A
		(26557-26559 have been deleted. To report, see 20973, or 265X1, 265X2, 265X3)		
•43496	N20	Free jejunum transfer with microvascular anastomosis	090	No Recommendation at this time
•49906	N21	Free omental flap with microvascular anastomosis	090	No Recommendation at this time



CPT Code: 1575A Tracking Number: N2

Descriptor: Free muscle flap with or without skin, with microvascular anastomosis

CLINICAL DESCRIPTION OF SERVICE:

Typical Patient:

Vignette A: *with* **skin** A 25-year-old male presents with a Gustillo grade III-B open tibial fracture requiring soft tissue coverage in the distal third of his leg. After the flap is outlined, the recipient bed is prepared. This includes debridement of skin, muscle, and bone; and microdissection of recipient vessels. The latissimus dorsi myocutaneous flap is harvested. The muscle/skin flap is dissected and microdissection of the flap artery and veins is completed. The microanastomosis of one artery and one or two veins is completed. The donor defect is closed and the free flap is inset. Drains are placed at both donor and recipient sites and dressings applied. [In completing steps 1 through 5 below, consider only the work related with the <u>free muscle flap, with skin</u>, as the primary procedure.]

<u>Vignette B: without skin</u> A 25-year-old male presents with a grade III-B open tibial fracture requiring soft tissue coverage. A free latissimus dorsi flap with microvascular anastomosis, without skin is performed. Any necessary bone grafting is reported separately, using different CPT code(s). [In completing steps 1 through 5 below, consider only the work related with the <u>free muscle flap</u>, without skin, as the primary procedure.]

[NOTE: With the intention of possibly developing two separate codes, two patient vignettes (A and B above) were developed and surveyed during the five-year-review process: one for a free muscle flap, with skin; and one for a free muscle flap, without skin. However, the CPT Editorial Panel combined these two codes into one code. Please also note that although Vignette A includes terminology for the debridement of the recipient site, the sentence in brackets at the end of the vignette (which was included on the survey) instructs the survey respondent to only consider the work of performing the free muscle flap. The specialty's RVS advisory committee has compared the survey results for Vignette A with the survey results for Vignette B (which did not include this terminology) and believe that the survey respondents correctly considered only the work of performing the free muscle flap in estimating the relative work value for the service.]

Pre-service work includes obtaining and reviewing hospital admission imaging studies, including angiograms, and laboratory studies; communicating with other health care professionals; ordering preoperative antibiotics; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. (The fact that the free tissue transfer may fail and leave the patient without soft tissue coverage of an extremity, possibly leading to amputation, must be discussed at length with the patient/family and adds to the intensity and stress of the service.) Other pre-operative services include dressing, scrubbing, and waiting for surgery; supervision of positioning, prepping, and draping the patient, with special attention to padding bony prominences and applying warming devices; and ensuring that surgical instruments and supplies that are necessary are present and available in the operative suite.

Intra-service work: The latissimus dorsi muscle *without skin* is harvested through a long posterolateral incision. If a muscle flap *with skin* is required, a skin paddle is outlined over the latissimus dorsi and the dissection is carried down to the latissimus dorsi muscle, taking care to attach the skin paddle to the latissimus dorsi fascia. Meticulous dissection is carried out to free the latissimus from the surrounding soft tissues and underlying muscles and chest wall. Once the pedicle is identified, microdissection of the vascular pedicle is completed. The flap is then harvested, transferred to the recipient bed, and loosely sewn in place. The operating microscope is then used to perform the microanastomosis of one artery and one or two veins using 9-0 or 10-0 suture. Attention to detail is critical at this juncture of the procedure, as even micro-injury to the vessels will lead to failure of the flap. The insetting of the flap is then meticulously completed. A drain is placed beneath the flap. Meticulous hemostasis of the donor site is achieved and the wound closed in layers over drains. A bulky dressing is applied to the recipient site and reinforced with a plaster splint.

Post-service work includes monitoring patient stabilization; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon This includes: ICU care; monitoring and care of wound and flap circulation; ordering and reviewing postoperative radiographs and laboratory studies; monitoring, care, and removal of all drains; monitoring for management of possible infection and/or wound dehiscence; monitoring for flap failure [this generally occurs during the first 72 hours during which time the primary surgeon is continuously on call]; and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure; including removal of sutures, dressing and cast/splint changes; monitoring of multiple operative sites; assessment of rehabilitation progress; evaluation of periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments.

SURVEY DATA for:

Specialty(s):

19368

American Society for Reconstructive Microsurgery (Vignettes A and B); American Society for Plastic and Reconstructive Surgery (Vignette A only)

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				PRE	INTRA	POST						
						Day I	ICU (not day 1)		Hosp (not day 1)		Office	
			RVW	total min	total min	total min	total min	# visits	total min	# visits	total min	# visits
Combin	et ch be	low	20.00		18							
Vig. A & Survey n	k B:	25th%	33.00		300							
	n = 650	med	36.25	90	360	60	40	2	100	7	100	6
Resp = 1	04	75th%	40.00		480							
Rate = 1	6%	high	90.00		840							
		low	20.00		180			[
Vignette A data: Survey $n = 400$ Resp = 62 Rate = 16%		25th%	32.25		300							
		med	35.50	90	360	60	40	2	100	7	90	5
		75th%	40.00		480				1			
		high	90.00		840							
Vignette B data:		low	23.00	<u></u>	200							
		25th%	33.00		300							
Survey n	1 = 250	med	37.25	90	360	60	45	2	100	7	100	6
Resp = 4 Rate = 1	7%	75th%	41.50		480							
		high	· 90.00		600							
Referen	ce servic	e data:										
CPT	Data S	Source	96rvw	PRE	INTRA	Post-HOSP		Post-OFF		Resp n	IWPUT (1)	
15755	Harvard (PH4)		28.33	102*	433	130*		83*		12	0.0456	
20955	RUC ('94)		37 58	100	480	170		75		43	0.0633	

DDE NOT

An asterisk indicates times were "predicted," not surveyed.

31.15

60

420

RUC ('94)

(1) IWPUT for 15755 represents Harvard Phase 3 final work values scaled to the 1996 MFS. IWPUT for 20955 was determined by HCFA fee text under "Additional Rationale" on the next page). IWPUT for 19368 is a calculation based on RUC survey data.

90

90

24

0.0587
<u>1996 RVW</u> 37.58 31.15	<u>Count</u> 53 41	<u>CPT</u> 20955 19368	Descriptor Bone graft with microvascular anastomosis; fibula Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site; with microvascular anastomosis (supercharging)
KEY REFER	ENCE SER	VICE(S:	

Reference service(s) cited most frequently by survey respondents:

<u>1996 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
37.58	090	20955	Bone graft with microvascular anastomosis; fibula

Relationship of code being reviewed to key reference service(s): Compare the pre-, intra-, and post-service time and the intensity of the service you are rating to the key reference services listed above.

New Code: N2 Free muscle flap with or without skin, with microvascular anastomosis **Recommended RVW:** 36.25 (survey median) **IWPUT:** 0.0688

• The total work for N2 closely approximates the work of CPT 20955 [RVW = 37.58], with slightly less intraoperative work because the pedicle is more accessible than in a free fibula and no osteotomies or osteosynthesis are needed; and slightly more postoperative care because the muscle/skin flap requires more diligent monitoring and minor wound problems are frequent with these flaps as opposed to the bone flap where the flap is buried and covered by a sutured wound.

The specialty's RVS advisory committee recommends the survey median RVW of 36.25, which is the combined median for both vignettes (A and B).

Additional rationale:

[The specialty's RVS advisory committee would like to emphasize that the primary rationale for the recommended RVW for this new code is it's clinical and work relationship *relative to existing key reference services* as discussed above. The IWPUT that is provided below is an approximation of the intra-service intensity.]

For a recommended RVW of 36.25, the IWPUT for N2 is *approximately* equal to 0.0688 RVUs per minute or 4.13 RVUs per hour, compared to Harvard Study IWPUT for 15755 of 0.0456 RVUs per minute or 2.74 RVUs per hour.

The following text presents HCFA's response to previous AMA/RUC recommendations for the free flap CPT codes 20955, 20969, 20970, 20972, and 20973 (Federal Register, 12/8/94). Although HCFA discusses its use of intraoperative intensity comparisons (in RVUs per hour), no discussion regarding the RVUs for pre- and post-service work is provided, making it difficult to determine how they arrived at the final total RVW:

"We used an intraoperative intensity of 3.80 RVUs per hour for CPT codes 20955 and 20969. For CPT code 20955, the intraoperative time estimate was 8 hours, resulting in 38.00 RVUs. We used the RUC survey times for CPT code 20969 except that we reduced the preoperative time to 100 minutes because we believed the pre-service work description of CPT code 20969 was identical to CPT codes 20955 and 20970, both surveyed at 100 minutes. We also compared CPT code 20969 to CPT code 20802: CPT code 20969 is more likely to be performed on an elective basis, has more preoperative time, and is more intense. The assigned RVUs of 42.55 reflect these differences."

"We believe that the intensity of CPT code 20970 is slightly higher because this code is more difficult and riskier than CPT code 20969, and, therefore, we used an intensity of 4.00 RVUs per hour to calculate the RVUs. Because the estimated time is 40 minutes shorter than CPT code 20969, we assigned 41.68 RVUs to CPT code 20970. We also used the same intensity level to assign 44.80 RVUs to CPT code 20973."

" Using an intensity of 4.30 RVUs per hour for CPT code 20972, we assigned 42.00 RVUs to this code. This value maintains the rank order of CPT codes 20969, 20970, and 20972 that exists in the RUC-recommended RVUs."



HCFA-determined intensities (rvu's per minute / rvu's per hour):

<u>'96 RVW</u>	Intensity	<u>Graft</u>
37.58	0.0633 / 3.80	20955 Microvascular bone graft, fibular
42.08	0.0633 / 3.80	20969 Microvascular osteocutaneous graft, other
41.22	0.0667 / 4.00	20970 Microvascular osteocutaneous graft, iliac crest
41.54	0.0717/4.30	20972 Microvascular osteocutaneous graft, metatarsal
44.31	0.0667 / 4.00	20973 Microvascular ostcocutaneous graft. great toe with web space

FREQUENCY INFORMATION

How was this service previously reported?

15755 Free flap (microvascular transfer)

20999 Unlisted procedure, musculoskeletal system, general

How often do physicians in your specialty perform this service?

Frequently.

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

The frequency outside the Medicare population is difficult to determine because the indications for these procedures varies widely, and no database exists which accurately tracks their frequency. Free muscle flaps are used to reconstruct soft tissue defects caused by trauma or neoplasm everywhere on the body in all age groups.

1994 Medicare Part B Allowed Frequency							
15755	Free flap (microvascular transfer)	1,547					
20999	Unlisted procedure, musculoskeletal system, general	1,219					

Is this service performed by many physicians across the United States?

Many surgeons are familiar with this procedure. Physicians practicing reconstructive microsurgery would most likely perform this service. However, because reconstructive microsurgery is not a Medicare specialty category, physicians practicing under one of the following specialty designations may also reasonably be expected to perform this procedure: plastic and reconstructive surgery, hand surgery, orthopaedic surgery, otolaryngology, general surgery, vascular surgery, thoracic surgery, maxillofacial surgery, and surgical oncology.





CPT Code: 1575C Tracking Number: N3

Global Period: 090 Re

Recommended RVW: 36.25

Descriptor: Free skin flap with microvascular anastomosis

CLINICAL DESCRIPTION OF SERVICE:

Typical Patient: A 40-year-old female presents with a large soft tissue defect exposing the achilles tendon that requires free flap coverage. A **free scapulae flap with microvascular anastomosis** is performed. Any necessary neurorrhaphy and tendon grafting is reported separately, using different CPT code(s). [In completing steps 1 through 5 below, consider only the work related with the <u>free skin flap</u> as the primary procedure.]

Pre-service work includes obtaining and reviewing hospital admission imaging studies, including angiograms, and laboratory studies; communicating with other health care professionals; ordering preoperative antibiotics; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Other preoperative services include dressing, scrubbing, and waiting for surgery; supervision of positioning, prepping, and draping the patient, with special attention to padding bony prominences and applying warming devices; and ensuring that surgical instruments and supplies that are necessary are present and available in the operative suite.

Intra-service work: The skin flap is outlined on the posterolateral aspect of the thorax. The dissection is carried down to the fascial layer of the underlying muscles. The flap is then elevated, taking care to protect the vascular supply to the flap. Once the pedicle is identified, microdissection of the vascular pedicle is completed. The flap is then harvested, transferred to the recipient bed, and loosely sewn in place. The operating microscope is then used to perform the microanastomosis of one artery and one or two veins using 9-0 or 10-0 suture. Attention to detail is critical at this juncture of the procedure, as even micro-injury to the vessels will lead to failure of the flap. Drains are place beneath the flap and the insetting of the flap is then meticulously completed. The donor site wound is closed in layers over drains and dressed. A bulky dressing is applied to the recipient site and reinforced with a plaster splint.

Post-service work includes monitoring patient stabilization; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon This includes: ICU care; monitoring and care of wound and flap circulation; ordering and reviewing postoperative radiographs and laboratory studies; monitoring, care, and removal of all drains; monitoring for management of possible infection and/or wound dehiscence; monitoring for flap failure [this generally occurs during the first 72 hours during which time the primary surgeon is continuously on call]; and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures, dressing and cast/splint changes; monitoring of multiple operative sites; assessment of rehabilitation progress; evaluation of periodic imaging and laboratory reports, if needed; and antibiotic and pain medication and is sutures.

SURVEY DATA:

Specialty(s): American Society for Reconstructive Microsurgery

Survey n:	250		PRE	INTRA		POST					
Response:	42				Day 1	ICU (n	ot day 1)	Hosp (n	ot day 1)	Of	fice
Rate %:	17%	RVW	total min	total min	total min	total min	# visits	total min	# visits	total min	# visits
	low	22.50		180							
	25th%	33.00		300							
	med	36.25	90	360	60	50	2	100	7	100	6
	75th%	43.73		480					-		
	high	100.00		720							

Reference service data:

СРТ	Data Source	96rvw	PRE	INTRA	Post-HOSP	Post-OFF	Resp n	IWPUT (1)
15755	Harvard (PH4)	28.33	102*	433	130*	83*	12	0.0456
20955	RUC ('94)	37.58	100	480	170	75	43	0.0633
19368	RUC ('94)	31.15	60	420	90	90	24	0.0587

An asterisk indicates times were "predicted," not surveyed.

(1) IWPUT for 15755 represents Harvard Phase 3 final work values scaled to the 1996 MFS. IWPUT for 20955 was determined by HCFA (see text under "Additional Rationale" on the next page). IWPUT for 19368 is a calculation based on RUC survey data.

Reference service(s) cited most frequently by survey respondents:

<u>1996 RVW</u>	<u>Count</u>	<u>CPT</u>	Descriptor
37.58	20	20955	Bone graft with microvascular anastomosis; fibula
31.15	14	19368	Breast reconstruction with transverse rectus abdominis myocutaneous flap
			(TRAM), single pedicle, including closure of donor site; with microvascular
			anastomosis (supercharging)

KEY REFERENCE SERVICE(S):

<u>1996 RVW</u>	<u>Global</u>	<u>CPT</u>	Descriptor
37.58	090	20955	Bone graft with microvascular anastomosis; fibula

Relationship of code being reviewed to key reference service(s): Compare the pre-, intra-, and post-service time and the intensity of the service you are rating to the key reference services listed above.

New Code: N3 Free skin flap with microvascular anastomosis **Recommended RVW:** 36.25 (survey median) **IWPUT:** 0.0677

• The total work for N3 closely approximates the work of CPT 20955 [RVW = 37.58], with slightly less intraoperative work because the pedicle is more accessible than in a free fibula and no osteotomies or osteosynthesis are needed; and slightly more postoperative care because the scapular flap requires more diligent monitoring and minor wound problems are frequent with these flaps as opposed to the bone flap where the flap is buried and covered by a sutured wound.

The specialty's RVS advisory committee recommends the survey median RVW of 36.25



Additional rationale:

[The specialty's RVS advisory committee would like to emphasize that the primary rationale for the recommended RVW for this new code is it's clinical and work relationship *relative to existing key reference services* as discussed above. The IWPUT that is provided below is an approximation of the intra-service intensity.]

For a recommended RVW of 36.25, the IWPUT for N3 is *approximately* equal to 0.0677 RVUs per minute or 4.06 RVUs per hour, compared to Harvard Study IWPUT for 15755 of 0.0456 RVUs per minute or 2.74 RVUs per hour.

The following text presents HCFA's response to previous AMA/RUC recommendations for the free flap CPT codes 20955, 20969, 20970, 20972, and 20973 (Federal Register, 12/8/94). Although HCFA discusses its use of intraoperative intensity comparisons (in RVUs per hour), no discussion regarding the RVUs for pre- and post-service work is provided, making it difficult to determine how they arrived at the final total RVW:

"We used an intraoperative intensity of 3.80 RVUs per hour for CPT codes 20955 and 20969. For CPT code 20955, the intraoperative time estimate was 8 hours, resulting in 38.00 RVUs. We used the RUC survey times for CPT code 20969 except that we reduced the preoperative time to 100 minutes because we believed the pre-service work description of CPT code 20969 was identical to CPT codes 20955 and 20970, both surveyed at 100 minutes. We also compared CPT code 20969 to CPT code 20802. CPT code 20969 is more likely to be performed on an elective basis, has more preoperative time, and is more intense. The assigned RVUs of 42.55 reflect these differences."

"We believe that the intensity of CPT code 20970 is slightly higher because this code is more difficult and riskier than CPT code 20969, and, therefore, we used an intensity of 4.00 RVUs per hour to calculate the RVUs. Because the estimated time is 40 minutes shorter than CPT code 20969, we assigned 41.68 RVUs to CPT code 20970. We also used the same intensity level to assign 44.80 RVUs to CPT code 20973."

" Using an intensity of 4.30 RVUs per hour for CPT code 20972, we assigned 42.00 RVUs to this code. This value maintains the rank order of CPT codes 20969, 20970, and 20972 that exists in the RUC-recommended RVUs."

HCFA-determined intensities (rvu's per minute / rvu's per hour):

<u>'96 RVW</u>	<u>Intensity</u>	<u>Graft</u>
37.58	0.0633 / 3.80	20955 Microvascular bone graft, fibular
42.08	0.0633 / 3.80	20969 Microvascular osteocutaneous graft. other
41.22	0.0667 / 4.00	20970 Microvascular osteocutaneous graft, iliac crest
41.54	0.0717/4.30	20972 Microvascular osteocutaneous graft, metatarsal
44.31	0.0667 / 4.00	20973 Microvascular osteocutaneous graft, great toe with web space

FREQUENCY INFORMATION

How was this service previously reported?

15755 Free flap (microvascular transfer)

20999 Unlisted procedure, musculoskeletal system, general

How often do physicians in your specialty perform this service?

Frequently.

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

The frequency outside the Medicare population is difficult to determine because the indications for these procedures varies widely, and no database exists which accurately tracks their frequency. Free muscle flaps are used to reconstruct soft tissue defects caused by trauma or neoplasm everywhere on the body in all age groups.

1994 Medicare Part B Allowed Frequency								
15755	Free flap (microvascular transfer)	1,547						
20999	Unlisted procedure, musculoskeletal system, general	1.219						

Is this service performed by many physicians across the United States?

Many surgeons are familiar with this procedure. Physicians practicing reconstructive microsurgery would most likely perform this service. However, because reconstructive microsurgery is not a *Medicare specialty category*, physicians practicing under one of the following specialty designations may also reasonably be expected to perform this procedure: plastic and reconstructive surgery, hand surgery, orthopaedic surgery, otolaryngology, general surgery, vascular surgery, thoracic surgery, maxillofacial surgery, and surgical oncology. CPT Code: 1575D Tracking Number: N4 Global Period: 090 Record

090 **Recommended RVW:** 35.00

Descriptor: Free fascial flap with microvascular anastomosis

CLINICAL DESCRIPTION OF SERVICE:

Typical Patient: A 25-year-old male involved in a moving vehicle accident suffers a degloving injury of the dorsal aspect of the hand, with loss of the extensor tendons and exposure of the dorsal carpus. A free lateral arm flap with **microvascular anastomosis** is performed. Any necessary free osteocutaneous flap(s), bone graft(s), and/or tendon graft(s) are reported separately, using different CPT code(s). [In completing steps 1 through 5 below, consider only the work related with the <u>free fascial flap</u> as the primary procedure.]

Pre-service work includes obtaining and reviewing hospital admission imaging studies, including angiograms, and laboratory studies; communicating with other health care professionals; ordering preoperative antibiotics; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Other preoperative services include dressing, scrubbing, and waiting for surgery; supervision of positioning, prepping, and draping the patient, with special attention to padding bony prominences and applying warming devices; and ensuring that surgical instruments and supplies that are necessary are present and available in the operative suite.

Intra-service work: An incision is made along the lateral aspect of the arm and the subcutaneous tissue is carefully dissected down to the fascia. The fascia is then elevated off of the adjacent muscle down to the lateral intramuscular septum where the vessels are identified. Branches of the radial nerve are identified. The radial nerve is protected. The vascular pedicle is then carefully identified using microsurgical technique. Great care must be taken during the microvascular dissection so as to not injure the vessels. The flap is then harvested and transferred to the recipient bed and loosely sewn in position. Attention to detail is critical at this juncture of the procedure, as even micro-injury to the vessels will lead to failure of the flap. The microanastomoses using the operating microscope of one artery and one or two veins is then carried out using 9-0 or 10-0 suture. The insetting of the flap is then meticulously completed. The donor site wound is closed in layers over drains and sterile dressings are applied. A bulky dressing is applied to the recipient site and reinforced with a plaster splint.

Post-service work includes monitoring patient stabilization; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon This includes: ICU care; monitoring and care of wound and flap circulation; ordering and reviewing postoperative radiographs and laboratory studies; monitoring, care, and removal of all drains; monitoring for management of possible infection and/or wound dehiscence; monitoring for flap failure [this generally occurs during the first 72 hours during which time the primary surgeon is continuously on call]; and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures, dressing and cast/splint changes; monitoring of multiple operative sites; assessment of rehabilitation progress; evaluation of periodic imaging and laboratory reports, if needed; and antibiotic and pain medication and justments.





SURVEY DATA:

Specialty(s): American Society for Reconstructive Microsurgery

Survey n:	250		PRE	INTRA		POST					
Response:	41				Day 1	ICU (n	ot day 1)	Hosp (n	ot day 1)	Of	fice
Rate %:	16%	RVW	total min	total min	total min	total min	# visits	total min	# visits	total min	# visits
	low	22.00		200							
	25th%	30.00		250							
	med	35.00	90	360	60	48	2	100	6	100	6
	75th%	39.00		420							
	hıgh	64.46		600							

Reference service data:

CPT	Data Source	96rvw	PRE	INTRA	Post-HOSP	Post-OFF	Resp n	IWPUT (1)
15755	Harvard (PH4)	28.33	102*	433	130*	83*	12	0.0456
20955	RUC ('94)	37.58	100	480	170	75	43	0.0633
19368	RUC ('94)	31.15	60	420	90	90	24	0.0587

An asterisk indicates times were "predicted," not surveyed.

(1) IWPUT for 15755 represents Harvard Phase 3 final work values scaled to the 1996 MFS. IWPUT for 20955 was determined by HCFA (see text under "Additional Rationale" on the next page). IWPUT for 19368 is a calculation based on RUC survey data.

Reference service(s) cited most frequently by survey respondents:

<u>1996 RVW</u>	<u>Count</u>	<u>CPT</u>	<u>Descriptor</u>
37.58	20	20955	Bone graft with microvascular anastomosis; fibula
31.15	12	19368	Breast reconstruction with transverse rectus abdominis myocutaneous flap,
			(TRAM), single pedicle, including closure of donor site; with microvascular
			anastomosis (supercharging)

KEY REFERENCE SERVICE(S):

<u>1996 RVW</u>	<u>Global</u>	<u>CPT</u>	Descriptor
37.58	090	20955	Bone graft with microvascular anastomosis; fibula

Relationship of code being reviewed to key reference service(s): Compare the pre-, intra-, and post-service time and the intensity of the service you are rating to the key reference services listed above.

New Code: N4 Free fascial flap with microvascular anastomosis Recommended RVW: 35.00 (survey median) IWPUT: 0.0644

• The total work for N4 closely approximates the work of CPT 20955 [RVW = 37.58], with slightly less intraoperative work because the pedicle is more accessible than in a free fibula and no osteotomies or osteosynthesis are needed; and slightly more postoperative care because the fascial flap requires more diligent monitoring and minor wound problems are frequent with these flaps as opposed to the bone flap where the flap is buried and covered by a sutured wound.



The specialty's RVS advisory committee recommends the survey median RVW of 35.00

Additional rationale:

[The specialty's RVS advisory committee would like to emphasize that the primary rationale for the recommended RVW for this new code is it's clinical and work relationship *relative to existing key reference services* as discussed above. The IWPUT that is provided below is an approximation of the intra-service intensity.]

For a recommended RVW of 35.00, the IWPUT for N4 is *approximately* equal to 0.0644 RVUs per minute or 3.87 RVUs per hour, compared to Harvard Study IWPUT for 15755 of 0.0456 RVUs per minute or 2.74 RVUs per hour.

The following text presents HCFA's response to previous AMA/RUC recommendations for the free flap CPT codes 20955, 20969, 20970, 20972, and 20973 (Federal Register, 12/8/94). Although HCFA discusses its use of intraoperative intensity comparisons (in RVUs per hour), no discussion regarding the RVUs for pre- and post-service work is provided, making it difficult to determine how they arrived at the final total RVW:

"We used an intraoperative intensity of 3.80 RVUs per hour for CPT codes 20955 and 20969. For CPT code 20955, the intraoperative time estimate was 8 hours, resulting in 38.00 RVUs. We used the RUC survey times for CPT code 20969 except that we reduced the preoperative time to 100 minutes because we believed the pre-service work description of CPT code 20969 was identical to CPT codes 20955 and 20970, both surveyed at 100 minutes. We also compared CPT code 20969 to CPT code 20802: CPT code 20969 is more likely to be performed on an elective basis, has more preoperative time, and is more intense. The assigned RVUs of 42.55 reflect these differences."

"We believe that the intensity of CPT code 20970 is slightly higher because this code is more difficult and riskier than CPT code 20969, and, therefore, we used an intensity of 4.00 RVUs per hour to calculate the RVUs Because the estimated time is 40 minutes shorter than CPT code 20969, we assigned 41.68 RVUs to CPT code 20970. We also used the same intensity level to assign 44.80 RVUs to CPT code 20973."

" Using an intensity of 4.30 RVUs per hour for CPT code 20972, we assigned 42.00 RVUs to this code. This value maintains the rank order of CPT codes 20969, 20970, and 20972 that exists in the RUC-recommended RVUs."

HCFA-determined intensities (rvu's per minute / rvu's per hour):

<u>'96 RVW</u>	Intensity	<u>Graft</u>	
37.58	0.0633 / 3.80	20955	Microvascular bone graft, fibular
42.08	0.0633 / 3.80	20969	Microvascular osteocutaneous graft, other
41.22	0.0667 / 4.00	20970	Microvascular osteocutaneous graft, iliac crest
41.54	0.0717/4.30	20972	Microvascular osteocutaneous graft, metatarsal
44.31	0.0667 / 4.00	20973	Microvascular osteocutaneous graft, great toe with web space

FREQUENCY INFORMATION

How was this service previously reported?

15755 Free flap (microvascular transfer)

20999 Unlisted procedure, musculoskeletal system, general

How often do physicians in your specialty perform this service?

Sometimes

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

The frequency outside the Medicare population is difficult to determine because the indications for these procedures varies widely, and no database exists which accurately tracks their frequency. Free muscle flaps are used to reconstruct soft tissue defects caused by trauma or neoplasm everywhere on the body in all age groups.

<u>1994 Me</u>	edicare Part B Allowed Frequency	
15755	Free flap (microvascular transfer)	1,547
20999	Unlisted procedure, musculoskeletal system, general	1,219

Is this service performed by many physicians across the United States?

Many surgeons are familiar with this procedure. Physicians practicing reconstructive microsurgery would most likely perform this service. However, because reconstructive microsurgery is not a *Medicare specialty category*, physicians practicing under one of the following specialty designations may also reasonably be expected to perform this procedure: plastic and reconstructive surgery, hand surgery, orthopaedic surgery, otolaryngology, general surgery, vascular surgery, thoracic surgery, maxillofacial surgery, and surgical oncology. CPT Code: 2095A Tracking Number: N5 Global Period: 090 Recommended RVW: 37.58

Descriptor: Bone graft with microvascular anastomosis; iliac crest

CLINICAL DESCRIPTION OF SERVICE:

Typical Patient: A 30-year-old male suffers a gunshot wound to the right hand resulting in the loss of the first metacarpal. The soft tissue envelope is satisfactory, but the entire first metacarpal must be replaced. A vascularized iliac crest bone graft is used to replace the first metacarpal.

Pre-service work includes obtaining and reviewing hospital admission imaging studies, including angiograms, and laboratory studies; communicating with other health care professionals; ordering preoperative antibiotics; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Other preoperative services include dressing, scrubbing, and waiting for surgery; supervision of positioning, prepping, and draping the patient, with special attention to padding bony prominences and applying warming devices; and ensuring that surgical instruments and supplies that are necessary are present and available in the operative suite.

Intra-service work: An incision is made along the upper border of the inguinal ligament and iliac crest. The spermatic cord and round ligament are retracted out of the field. The lateral femoral cutaneous nerve of the thigh is protected. The iliacus muscle is incised below the deep circumflexed iliac artery. The osteotomy is completed and the vascular pedicle dissected and isolated using meticulous microsurgical technique, since any injury to the intima of these vessels will lead to the failure of the flap. The iliac crest bone graft is then harvested and fashioned to the appropriate size and shape to replace the first metacarpal. This is accomplished using various bone cutting devices, rongeurs and saws and involves the performance of exact osteotomies to match the prepared surfaces of the trapezium and proximal phalanx. Fixation consisting of a plate and screws or k-wires is used proximally and distally. The operating microscope is then used to perform the microanastomoses of one artery and one or two veins using 9-0 or 10-0 suture. Attention to detail is critical at this juncture of the procedure, as even micro-injury to the vessels will lead to failure of the flap. The soft tissue envelope is then re-approximated over the bone graft. After meticulous hemostasis has been completed, the donor site is closed in layers over a drain, taking care to reconstruct the abdominal wall so as to avoid postoperative herniation. Sterile dressings are applied.

Post-service work includes monitoring patient stabilization; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon This includes: ICU care; monitoring and care of wound and flap circulation; ordering and reviewing postoperative radiographs and laboratory studies; monitoring, care, and removal of all drains; monitoring for management of possible infection and/or wound dehiscence; monitoring for flap failure [this generally occurs during the first 72 hours during which time the primary surgeon is continuously on call]; and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures, dressing and cast/splint changes; monitoring of multiple operative sites; assessment of rehabilitation progress; evaluation of periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments.

CPT: N5 (2095A) Page 2

SURVEY DATA:

Specialty(s): American Society for Reconstructive Microsurgery

Survey n:	250		PRE	INTRA				POS	r		
Response:	40				Day I	ICU (n	ot day 1)	Hosp (n	ot day. F)	Of	fice
Rate %:	16%	RVW	total mın	total min	total min	total min	# visits	total min	# visits	total min	# visits
	low	30.00		240							
	25th%	37.58		300							
	med	40.00	90	400	60	55	3	105	7	120	7
	75th%	42.00		480			1				
	high	110.00		720							

Reference service data:

CPT	Data Source	96rvw	PRE	INTRA	Post-HOSP	Post-OFF	Resp n	IWPUT (1)
15755	Harvard (PH4)	28.33	102*	433	130*	83*	12	0.0456
20955	RUC ('94)	37.58	100	480	170	75	43	0.0633
20970	RUC ('94)	41.22	100	500	200	90	58	0.0667

An asterisk indicates times were "predicted," not surveyed.

(1) IWPUT for 15755 represents Harvard Phase 3 final work values scaled to the 1996 MFS. IWPUT for 20955 and 20970 were determined by HCFA (see text under "Additional Rationale" on the next page).

Reference ser	vice(s) cited	most freq	uently by survey respondents:	E
<u>1996 RVW</u>	Count	<u>CPT</u>	Descriptor	
37.58	21	20955	Bone graft with microvascular anastomosis; fibula	
41.22	20	20970	Free osteocutaneous flap with microvascular anastomosis; iliac crest	
KEY REFER	ENCE SER	VICE(S):		
<u>1996 RVW</u>	<u>Global</u>	<u>CPT</u>	Descriptor	
37.58	090	20955	Bone graft with microvascular anastomosis; fibula	
41.22	090	20970	Free osteocutaneous flap with microvascular anastomosis; iliac crest	

Relationship of code being reviewed to key reference service(s): Compare the pre-, intra-, and post-service time and the intensity of the service you are rating to the key reference services listed above.

New Code: N5 Bone graft with microvascular anastomosis; iliac crest Recommended RVW: 37.58 (survey 25th percentile) IWPUT: 0.0621

• The components of intra-operative work of N5 (microdissection of one artery_and two veins; excision, incision, and fixation of the bone graft; and complex repair) are slightly more complex than CPT 20955 *free fibula*. It is more difficult to dissect out the iliac graft than the fibula because of a variable vascular supply. Additionally, a free iliac crest is often used in face reconstruction, where the postoperative management is more difficult and time intensive. But overall, the total work of N5 is comparable to CPT 20955.

• The total work of N5 is similar to CPT 20970 minus a portion of the intra-operative work to elevate a fasciocutaneous flap. An iliac crest graft is slightly less difficult to harvest than an iliac osteocutaneous flap. When performing an osteocutaneous iliac free flap, the flap is outlined in the skin and elevated with the underlying bone. The fasciocutaneous segment of the flap is not dissected to the extent it would be if one were doing a non-microsurgical iliac fasciocutaneous flap. Therefore, the survey 25th percentile RVW for N5 (37.58), which is the same RVW as CPT 20955, is recommended.





Additional rationale:

[The specialty's RVS advisory committee would like to emphasize that the primary rationale for the recommended RVW for this new code is it's clinical and work relationship *relative to existing key reference services* as discussed above. The IWPUT that is provided below is an approximation of the intra-service intensity.]

For a recommended RVW of 37.58, the IWPUT for N5 is *approximately* equal to 0.0621 RVUs per minute or 3.72 RVUs per hour, compared to Harvard Study IWPUT for 15755 of 0.0456 RVUs per minute or 2.74 RVUs per hour.

The following text presents HCFA's response to previous AMA/RUC recommendations for the free flap CPT codes 20955, 20969, 20970, 20972, and 20973 (Federal Register, 12/8/94). Although HCFA discusses its use of intraoperative intensity comparisons (in RVUs per hour), no discussion regarding the RVUs for pre- and post-service work is provided, making it difficult to determine how they arrived at the final total RVW:

"We used an intraoperative intensity of 3.80 RVUs per hour for CPT codes 20955 and 20969. For CPT code 20955, the intraoperative time estimate was 8 hours, resulting in 38.00 RVUs. We used the RUC survey times for CPT code 20969 except that we reduced the preoperative time to 100 minutes because we believed the pre-service work description of CPT code 20969 was identical to CPT codes 20955 and 20970, both surveyed at 100 minutes. We also compared CPT code 20969 to CPT code 20802: CPT code 20969 is more likely to be performed on an elective basis, has more preoperative time, and is more intense. The assigned RVUs of 42.55 reflect these differences."

"We believe that the intensity of CPT code 20970 is slightly higher because this code is more difficult and riskier than CPT code 20969, and, therefore, we used an intensity of 4.00 RVUs per hour to calculate the RVUs. Because the estimated time is 40 minutes shorter than CPT code 20969, we assigned 41.68 RVUs to CPT code 20970. We also used the same intensity level to assign 44.80 RVUs to CPT code 20973."

" Using an intensity of 4.30 RVUs per hour for CPT code 20972, we assigned 42.00 RVUs to this code. This value maintains the rank order of CPT codes 20969, 20970, and 20972 that exists in the RUC-recommended RVUs "

HCFA-determined intensities (rvu's per minute / rvu's per hour):

<u>'96 RVW</u>	Intensity	<u>Graft</u>
37.58	0.0633 / 3.80	20955 Microvascular bone graft, fibular
42.08	0.0633 / 3.80	20969 Microvascular osteocutaneous graft, other
41.22	0.0667 / 4.00	20970 Microvascular osteocutaneous graft, iliac crest
41.54	0.0717/4.30	20972 Microvascular osteocutaneous graft, metatarsal
44.31	0.0667 / 4.00	20973 Microvascular osteocutaneous graft, great toc with web space

FREQUENCY INFORMATION

How was this service previously reported?

CPT 15755 Free flap (microvascular transfer)

CPT 20962 Bone graft with microvascular anastomosis; other bone graft (specify)

CPT 20999 Unlisted procedure, musculoskeletal system, general

How often do physicians in your specialty perform this service?

Sometimes

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

The frequency outside the Medicare population is difficult to determine because there is a wide variability in the incidence of the patients requiring this service. This reconstructive procedure is performed on patients with congenital abnormalities, on patients with carcinoma, or on post-trauma patients.

1994 Medicare Part B Allowed Frequency

-15755	Free flap (microvascular transfer)	1,547
20962	Bone graft with microvascular anastomosis; other bone graft (specify)	102
20999	Unlisted procedure, musculoskeletal system, general	1,219

The frequency outside the Medicare population is difficult to determine because there is a wide variability in the incidence of the patients requiring this service. This reconstructive procedure is performed on patients with congenital abnormalities, on patients with carcinoma, or on post-trauma patients.



Is this service performed by many physicians across the United States?

Many surgeons are familiar with this procedure. Physicians practicing reconstructive microsurgery would most likely perform this service. However, because reconstructive microsurgery is not a *Medicare specialty category*, physicians practicing under one of the following specialty designations may also reasonably be expected to perform this procedure: plastic and reconstructive surgery, hand surgery, orthopaedic surgery, otolaryngology, general surgery, vascular surgery, thoracic surgery, maxillofacial surgery, and surgical oncology.

CPT Code: 2095B Tracking Number: N6 Global Period: 090 Recommended RVW: 38.00

Descriptor: Bone graft with microvascular anastomosis; metatarsal

CLINICAL DESCRIPTION OF SERVICE:

Typical Patient: A 30-year-old male suffers a crush injury to the hand resulting in the destruction of the third metacarpal, leaving the MCP joint intact. The soft tissue envelope is adequate to allow bony reconstruction. The second metatarsal, its soft tissue envelope, one artery, and two veins are harvested and transferred to the hand defect where osteosynthesis is completed and the microanastomosis of the one artery and two veins is completed.

Pre-service work includes obtaining and reviewing imaging studies, including angiograms, and laboratory studies; communicating with other health care professionals; ordering preoperative antibiotics; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Other preoperative services include dressing, scrubbing, and waiting for surgery; supervision of positioning, prepping, and draping the patient, and applying warming devices; and ensuring that surgical instruments and supplies that are necessary are present and available in the operative suite.

Intra-service work: An incision is made over the second metatarsal and dorsal aspect of the foot. The dorsalis pedia artery and greater saphenous vein are identified. The deep peroneal nerve is also identified and protected. The second metatarsal is identified and a cuff of interosseous muscle is left attached to the metatarsal. The first dorsal metatarsal artery is maintained in this cuff of muscle. The second metatarsal is then disarticulated. Dissection is carried out extra-periosteally and proximally and the vascular pedicle is isolated using microsurgical technique. Careful attention to detail is required to protect the vessels, as injury to the donor vessels will lead to the failure of the flap. The pedicle is then transsected and the flap transferred to the recipient site. The metatarsal is osteotomized so as to allow osteosynthesis to the residual proximal phalanx and trapezium. Proximal and distal osteosynthesis is accomplished using screws and plates, or k-wires. The operating microscope is then used to perform the microanastomoses of one artery and one or two veins using 9-0 or 10-0 suture. Attention to detail is critical at this juncture of the procedure, as even micro-injury to the vessels will lead to failure of the flap. The soft tissue envelope is then approximately loosely so as not to compress the vascular anastomosis. The wound is approximated over a drain. The intermetatarsal ligament is repaired. The donor site is closed in layers over a drain after meticulous hemostasis is accomplished. Sterile dressings are applied and both the recipient site and donor site are both splinted.

Post-service work includes monitoring patient stabilization; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon This includes: ICU care; monitoring and care of wound and flap circulation; ordering and reviewing postoperative radiographs and laboratory studies; monitoring, care, and removal of all drains; monitoring for management of possible infection and/or wound dehiscence; monitoring for flap failure [this generally occurs during the first 72 hours during which time the primary surgeon is continuously on call]; and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures, dressing and cast/splint changes; monitoring of multiple operative sites; assessment of rehabilitation progress; evaluation of periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments.



SURVEY DATA:

Specialty(s): American Society for Reconstructive Microsurgery

Survey n:	250		PRE	INTRA				, POS	۲ آ		
Response:	37				Day 1	ICU (no	ot day 1)	Hosp (n	ot day 1)	Of	fice
Rate %:	15%	RVW	total min	total min	total min	total min	# visits	total min	# visits	total min	# visits
	low	20.22		200							
	25th%	38.00		300							
	med	41.22	90	420	60	55	3	105	7	130	8
	75th%	45.00		480							
	high	90.00		660							-

Reference service data:

CPT	Data Source	96rvw	PRE	INTRA	Post-HOSP	Post-OFF	Resp n	IWPUT (1)
15755	Harvard (PH4)	28.33	102*	433	130*	83*	12	0.0456
20955	RUC ('94)	37.58	100	480	170	75	43	0.0633
20970	RUC ('94)	41.22	100	500	200	90	58	0.0667
20972	RUC ('94)	41.54	90	500	190	90	42	0.0717
20973	RUC ('94)	44.31	120	540	200	90	57	0.0667

An asterisk indicates times were "predicted," not surveyed.

(1) IWPUT for 15755 represents Harvard Phase 3 final work values scaled to the 1996 MFS. 1WPUT for 20955-20973 were determined by HCFA (see text under "Additional Rationale" on the next page).

Reference service(s) cited most frequently by survey respondents:

<u>1996 RVW</u>	<u>Count</u>	<u>CPT</u>	Descriptor
44.31	18	20973	Free osteocutaneous flap with microvascular anastomosis; great toe with
			web space
37.58	15	20955	Bone graft with microvascular anastomosis; fibula
41.22	15	20970	Free osteocutaneous flap with microvascular anastomosis; iliac crest

KEY REFERENCE SERVICE(S):

<u>1996 RVW</u>	<u>Global</u>	<u>CPT</u>	Descriptor
41.54	090	20972	Free osteocutaneous flap with microvascular anastomosis; metatarsal
37.58	090	20955	Bone graft with microvascular anastomosis; fibula

Relationship of code being reviewed to key reference service(s): Compare the pre-, intra-, and post-service time and the intensity of the service you are rating to the key reference services listed above.

New Code: N6 Bone graft with microvascular anastomosis; metatarsal Recommended RVW: 38.00 (survey 25th percentile) IWPUT: 0.0595

The work of N6 is similar to CPT 20972 minus a portion of the intraoperative work to elevate a fasciocutaneous flap. The fasciocutaneous segment of the flap is not dissected to the extent it would be if one were doing a non-microsurgical iliac fasciocutaneous flap and does not contribute significantly to the overall work.

• The components of work of N6 (microdissection of one artery and two veins; excision, incision, and fixation of the bone graft; and complex repair) are slightly more work than CPT 20955 [RVW = 37.58].

Based on this discussion, the specialty RVS advisory committee recommends the survey's 25th percentile RVW of 38.00 instead of the survey median. This recommended RVW creates an RVW relationship between N5 (iliac crest) and N6 (metatarsal) [37.58:38.00] that is similar to the free osteocutaneous flap codes 20970 (iliac crest) and 20972 (metatarsal) [41.22:41.54], but less because skin is not elevated with the flap.

<u>RVW</u>	<u>CPT</u>	Descriptor
37.58	20955	Bone graft with microvascular anastomosis; fibula
<u>37.58</u>	<u>N5: 2095A</u>	iliac crest
<u>38.00</u>	<u>N6: 2095B</u>	metatarsal
0.00	20962	other than fibula, iliac crest, or metatarsal
		·
42.08	20969	Free osteocutaneous flap with microvascular anastomosis; other than iliac crest;
		metatarsal, or great toe
41.22	20970	iliac crest
41.54	20972	metatarsal
44.31	20973	great toe with web space

Additional rationale:

[The specialty's RVS advisory committee would like to emphasize that the primary rationale for the recommended RVW for this new code is it's clinical and work relationship *relative to existing key reference services* as discussed above. The IWPUT that is provided below is an approximation of the intra-service intensity.]

For a recommended RVW of 38.00, the IWPUT for N6 is *approximately* equal to 0.0595 RVUs per minute or 3.57 RVUs per hour, compared to Harvard Study IWPUT for 15755 of 0.0456 RVUs per minute or 2.74 RVUs per hour.

The following text presents HCFA's response to previous AMA/RUC recommendations for the free flap CPT codes 20955, 20969, 20970, 20972, and 20973 (Federal Register, 12/8/94). Although HCFA discusses its use of intraoperative intensity comparisons (in RVUs per hour), no discussion regarding the RVUs for pre- and post-service work is provided, making it difficult to determine how they arrived at the final total RVW:

"We used an intraoperative intensity of 3.80 RVUs per hour for CPT codes 20955 and 20969. For CPT code 20955, the intraoperative time estimate was 8 hours, resulting in 38.00 RVUs. We used the RUC survey times for CPT code 20969 except that we reduced the preoperative time to 100 minutes because we believed the pre-service work description of CPT code 20969 was identical to CPT codes 20955 and 20970, both surveyed at 100 minutes. We also compared CPT code 20969 to CPT code 20802: CPT code 20969 is more likely to be performed on an elective basis, has more preoperative time, and is more intense. The assigned RVUs of 42.55 reflect these differences."

"We believe that the intensity of CPT code 20970 is slightly higher because this code is more difficult and riskier than CPT code 20969, and, therefore, we used an intensity of 4.00 RVUs per hour to calculate the RVUs. Because the estimated time is 40 minutes shorter than CPT code 20969, we assigned 41.68 RVUs to CPT code 20970. We also used the same intensity level to assign 44.80 RVUs to CPT code 20973."

"Using an intensity of 4.30 RVUs per hour for CPT code 20972, we assigned 42.00 RVUs to this code. This value maintains the rank order of CPT codes 20969, 20970, and 20972 that exists in the RUC-recommended RVUs."

HCFA-determined intensities (rvu's per minute / rvu's per hour):

<u>'96 RVW</u>	Intensity	<u>Graft</u>
37.58	0.0633 / 3.80	20955 Microvascular bone graft, fibular
42.08	0.0633 / 3.80	20969 Microvascular osteocutaneous graft, other
41.22	0.0667 / 4.00	20970 Microvascular osteocutaneous graft, iliac crest
41.54	0.0717/4.30	20972 Microvascular osteocutaneous graft, metatarsal
44.31	0.0667 / 4.00	20973 Microvascular osteocutaneous graft, great toe with web space



FREQUENCY INFORMATION

How was this service previously reported?

CPT 15755 Free flap (microvascular transfer) CPT 20962 Bone graft with microvascular anastomosis; other bone graft (specify) CPT 20999 Unlisted procedure, musculoskeletal system, general

How often do physicians in your specialty perform this service? Rarely.

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

The frequency outside the Medicare population is difficult to determine because there is a wide variability in the incidence of the patients requiring this service. This reconstructive procedure is performed on patients with congenital abnormalities, on patients with carcinoma, or on post-trauma patients.

1994 Medicare Part B Allowed Frequency

15755	Free flap (microvascular transfer)	1,547
20962	Bone graft with microvascular anastomosis; other bone graft (specify)	102
20999	Unlisted procedure, musculoskeletal system, general	1,219

Is this service performed by many physicians across the United States?

Many surgeons are familiar with this procedure. Physicians practicing reconstructive microsurgery would most likely perform this service. However, because reconstructive microsurgery is not a *Medicare specialty category*, physicians practicing under one of the following specialty designations may also reasonably be expected to perform this procedure: plastic and reconstructive surgery, hand surgery, orthopaedic surgery, otolaryngology, general surgery, vascular surgery, thoracic surgery, maxillofacial surgery, and surgical oncology.



CPT Code: 2098A Tracking Number: N12 Global Period: 090 Recommended RVW: 48.00

Descriptor: Toe-to-hand transfer with microvascular anastomosis; great toe "wrap-around" with bone graft

CLINICAL DESCRIPTION OF SERVICE:

Typical Patient: A 25-year-old female, who suffered an amputation through the proximal phalanx of the thumb, presents for reconstruction of the thumb. This is accomplished using a non-vascularized iliac bone graft around which is wrapped a free flap consisting of the skin of the great toe and first web space, including the nail, a portion of the distal phalanx, arteries, veins, and nerves.

Pre-service work includes obtaining and reviewing imaging studies, including angiograms, and laboratory studies; communicating with other health care professionals; ordering preoperative antibiotics; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Other preoperative services include dressing, scrubbing, and waiting for surgery; supervision of positioning, prepping, and draping the patient, and applying warming devices; and ensuring that surgical instruments and supplies that are necessary are present and available in the operative suite.

Intra-service work: Non-vascularized iliac crest graft: The subcutaneous tissue is incised over the iliac crest and a portion of the iliac crest is harvested. This wound is then closed in layers over a drain after meticulous hemostasis is achieved. The iliac bone graft is fashioned using saws and rongeurs to restore the length of the thumb. The iliac bone graft is attached to the residual proximal phalanx using Kirschner wires or plate and screws. Toe flap: A dorsal incision is made including the fibular portion of the great toe and a portion of the nail. The dorsalis pedis artery is identified. The deep peroneal nerve is also identified and followed distally. The first dorsal metatarsal artery is carefully dissected and the pattern of this artery is evaluated. If the first dorsal metatarsal artery is inadequate, the flap is based on the plantar vessels. The dissection is carried down to the artery which is then followed out to its branches to the great and second toes. The plantar dissection is carried out to expose the fibular and tibial digital nerves of the great toe which are identified and isolated. Assuming the first dorsal metatarsal artery is able to carry the flap, the plantar vessels are ligated. The flap including a portion of the nail and the underlying distal phalanx and pulp of the great toe are then carefully dissected off the remaining bone. Using microsurgical technique, the dorsalis pedis artery and saphenous vein as well as the deep peroneal nerve and the plantar digital nerves are identified, isolated, and transsected and the flap is then transferred to the hand. Careful attention to detail is required to protect the vessels, as injury to the donor vessels will lead to the failure of the flap. The flap is loosely positioned around the iliac bone graft and held in position with Kirschner wires passing through the donor bone into the iliac crest bone. The operating microscope is then used to perform the microsurgical anastomosis of one artery and one or two veins, and three nerves is carried out. Attention to detail is critical at this juncture of the procedure, as even micro-injury to the vessels will lead to failure of the flap. The wound is then gently and loosely closed. The great toe donor site is closed over a drain. This requires shortening of the toe with excision of the residual distal and a portion of the proximal phalanges with rotation of the medially based skin flap. A split-thickness skin graft (coded separately), required for closure, is harvested from the thigh, and this donor site prepared for its dressing. A stent is applied to hold the graft in place. A bulky dressing and splint are applied to both the recipient and donor sites.

Post-service work includes monitoring patient stabilization; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon This includes: ICU care; monitoring and care of wound and flap circulation; ordering and reviewing postoperative radiographs and laboratory studies; monitoring, care, and removal of all drains; monitoring for management of possible infection and/or wound dehiscence; monitoring for flap failure [this generally occurs during the first 72 hours during which time the primary surgeon is continuously on call]; and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures, dressing and cast/splint changes; monitoring of multiple operative sites; assessment of rehabilitation progress; evaluation of periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments.

SURVEY DATA:

Specialty(s): American Society for Reconstructive Microsurgery

Survey n:	250	[]	PRE	INTRA		POST					
Response:	41				Day I	ICU (n	ot day 1)	Hosp (n	ot day 1)	Of	fice
Rate %:	16%	tol RVW m	total min	al total n min	total min	total min	# visits	total min	# visits	total min	# visits
	low	33.00		240							
	25th%	44.00		415							
	med	45.00	120	480	60	50	3	105	7	120	7
	75th%	48.00		600							
	high	100.00		720							

Reference service data:

СРТ	Data Source	96rvw	PRE	INTRA	Post-HOSP	Post-OFF	Resp n	IWPUT (1)
15755	Harvard (PH4)	28.33	102*	433	130*	83*	12	0.0456
20970	RUC ('94)	41.22	100	500	200	90	58	0.0667
20973	RUC ('94)	44.31	120	540	200	9()	57	0.0667

An asterisk indicates times were "predicted," not surveyed.

(1) IWPUT for 15755 represents Harvard Phase 3 final work values scaled to the 1996 MFS. IWPUT for 20970 and 20973 were determined by HCFA (see text under "Additional Rationale" on the next page).

Reference service(s) cited most frequently by survey respondents:

<u>1996 RVW</u>	<u>Count</u>	<u>CPT</u>	Descriptor
44.31	32	20973	Free osteocutaneous flap with microvascular anastomosis; great toe with
			web space
41.22	12	20970	Free osteocutaneous flap with microvascular anastomosis; iliac crest

KEY REFERENCE SERVICE(S):

<u>1996 RVW</u>	<u>Global</u>	<u>CPT</u>	Descriptor
44.31	090	20973	Free osteocutaneous flap with microvascular anastomosis; great toe with
			web space

Relationship of code being reviewed to key reference service(s): Compare the pre-, intra-, and post-service time and the intensity of the service you are rating to the key reference services listed above.

New Code: N12 Toe-to-hand transfer with microvascular anastomosis; great toe "wrap-around" with bone graft Recommended RVW: 48.00 (survey 75th percentile) IWPUT: 0.0725

• The <u>components</u> of work of N12 (microdissection of one artery and one or two veins and three nerves; dissection and repair of tendons; osteotomies and osteosynthesis; and complex repair of several wounds) approximates the work of CPT 20973. However, N12 also involves the additional work of harvesting of an iliac crest bone graft, as well as two levels of fixation of the iliac bone graft: one area of fixation to the wrap-around and another to the residual first metacarpal. The neurovascular repairs for N12 and CPT 20973 are similar.

Based on this discussion, the specialty RVS advisory committee recommends the survey's 75th percentile RVW of 48.00 instead of the survey median. This recommended RVW creates an appropriate RVW relationship between new code N12, existing code 20973, and recommendations for new codes N13, N14, and N15.



<u>RVW</u>	<u>CPT</u>	Descriptor
41.22	20970	Free osteocutaneous flap with microvascular anastomosis; iliac crest
41.54	20972	metatarsal
44.31	20973	great toe with web space
<u>48.00</u>	<u>N12: 2098A</u>	Toe-to-hand transfer with microvascular anastomosis; great toe "wrap-around"
<u>48.00</u>	<u>N12: 2098A</u>	<u>Toe-to-hand transfer with microvascular anastomosis; great toe "wrap-around"</u> with bone graft
<u>48.00</u> <u>44.31</u>	<u>N12: 2098A</u> N13: 2098B	<u>Toe-to-hand transfer with microvascular anastomosis; great toe "wrap-around"</u> with bone graft other than great toe, single
<u>48.00</u> <u>44.31</u> <u>50.00</u>	<u>N12: 2098A</u> <u>N13: 2098B</u> <u>N14: 2098C</u>	<u>Toe-to-hand transfer with microvascular anastomosis; great toe "wrap-around"</u> with bone graft other than great toe, single other than great toe, double

Additional rationale:

[The specialty's RVS advisory committee would like to emphasize that the primary rationale for the recommended RVW for this new code is it's clinical and work relationship *relative to existing key reference services* as discussed above. The IWPUT that is provided below is an approximation of the intra-service intensity.]

For a recommended RVW of 48.00, the IWPUT for N12 is *approximately* equal to 0.0725 RVUs per minute or 4.35 RVUs per hour, compared to Harvard Study IWPUT for 15755 of 0.0456 RVUs per minute or 2.74 RVUs per hour.

The following text presents HCFA's response to previous AMA/RUC recommendations for the free flap CPT codes 20955, 20969, 20970, 20972, and 20973 (Federal Register, 12/8/94). Although HCFA discusses its use of intraoperative intensity comparisons (in RVUs per hour), no discussion regarding the RVUs for pre- and post-service work is provided, making it difficult to determine how they arrived at the final total RVW:

"We used an intraoperative intensity of 3.80 RVUs per hour for CPT codes 20955 and 20969. For CPT code 20955, the intraoperative time estimate was 8 hours, resulting in 38.00 RVUs. We used the RUC survey times for CPT code 20969 except that we reduced the preoperative time to 100 minutes because we believed the pre-service work description of CPT code 20969 was identical to CPT codes 20955 and 20970, both surveyed at 100 minutes. We also compared CPT code 20969 to CPT code 20802: CPT code 20969 is more likely to be performed on an elective basis, has more preoperative time, and is more intense. The assigned RVUs of 42.55 reflect these differences."

"We believe that the intensity of CPT code 20970 is slightly higher because this code is more difficult and riskier than CPT code 20969, and, therefore, we used an intensity of 4.00 RVUs per hour to calculate the RVUs. Because the estimated time is 40 minutes shorter than CPT code 20969, we assigned 41.68 RVUs to CPT code 20970. We also used the same intensity level to assign 44.80 RVUs to CPT code 20973."

" Using an intensity of 4.30 RVUs per hour for CPT code 20972, we assigned 42.00 RVUs to this code. This value maintains the rank order of CPT codes 20969, 20970, and 20972 that exists in the RUC-recommended RVUs."

HCFA-determined intensities (rvu's per minute / rvu's per hour):

<u>'96 RVW</u>	Intensity	<u>Graft</u>	
37.58	0.0633 / 3.80	20955	Microvascular bone graft, fibular
42.08	0.0633 / 3.80	20969	Microvascular osteocutaneous graft, other
41.22	0.0667 / 4.00	20970	Microvascular osteocutaneous graft, iliac crest
41.54	0.0717/4.30	20972	Microvascular osteocutaneous graft, metatarsal
44.31	0.0667 / 4.00	20973	Microvascular osteocutaneous graft, great toe with web space

FREQUENCY INFORMATION

How was this service previously reported?

15755 Free flap (microvascular transfer)

20999 Unlisted procedure, musculoskeletal system, general

- 26552 Reconstruction thumb with toe
- 26557 Toe to finger transfer; first stage
- 26558 Toe to finger transfer; each delay
- 26559 Toe to finger transfer; second stage
- 26989 Unlisted procedure, hands or fingers

5

How often do physicians in your specialty perform this service? Sometimes.

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

The frequency outside the Medicare population is difficult to determine because there is a wide variability in the incidence of the patients requiring this service. This reconstructive procedure is performed most often on post-trauma patients or patients with congenital abnormalities.

1994 Medicare Part B Allowed Frequency

15755	Free flap (microvascular transfer)	1.547
20999	Unlisted procedure, musculoskeletal system, general	1.219
26552	Reconstruction thumb with toe	2
26557	Toe to finger transfer; first stage	2
26558	Toe to finger transfer; each delay	0
26559	Toe to finger transfer; second stage	0
26989	Unlisted procedure, hands or fingers	362

Is this service performed by many physicians across the United States?

Some surgeons are familiar with this procedure. Physicians practicing reconstructive microsurgery would most likely perform this service. However, because reconstructive microsurgery is not a *Medicare specialty category*, physicians practicing under one of the following specialty designations may also reasonably be expected to perform this procedure: plastic and reconstructive surgery, hand surgery, or orthopaedic surgery.



Descriptor: Toe-to-hand transfer with microvascular anastomosis; other than great toe, single

CLINICAL DESCRIPTION OF SERVICE:

Typical Patient: A 20-year-old male, who suffered an amputation of all of his fingers, except the thumb, presents for reconstruction. The second toe, along with its tendons, arterics, and nerves, are harvested and transferred to the fifth ray.

Pre-service work includes obtaining and reviewing imaging studies, including angiograms, and laboratory studies; communicating with other health care professionals; ordering preoperative antibiotics; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Other preoperative services include dressing, scrubbing, and waiting for surgery; supervision of positioning, prepping, and draping the patient, and applying warming devices; and ensuring that surgical instruments and supplies that are necessary are present and available in the operative suite.

Intra-service work: An incision is made and the dorsalis pedis artery and the deep peroneal nerve are identified. The venous supply to the flap is identified and isolated. The dorsalis pedis artery is evaluated and its arterial pattern determined. Assuming the first dorsal metatarsal artery is able to carry the flap, its branch to the great toe is ligated. The plantar dissection is then carried out. The digital nerves to the second toe are isolated and dissected away from the common digital nerve to the second and third web space. The plantar digital arteries are identified and isolated. Their branches to the adjacent toes are ligated. Vascular clamps are applied to these vessels to protect them in the event they need to be used at the time of transfer to the hand. The flexor tendons are transsected. The extensor tendon is transsected. The toe is then disarticulated at the metatarsal-phalangeal joint. The dorsalis pedis artery and the saphenous vein are then carefully dissected proximally to provide an appropriate length of pedicle. Careful attention to detail is required to protect the vessels, as injury to the donor vessels will lead to the failure of the flap. The pedicle is then transsected and the toe flap is transferred to the hand. Osteosynthesis is then carried out to the residual metacarpal. This is accomplished using Kirschner wires or screws and a plate. The two flexor tendons and extensor tendon are then repaired using a core stitch combined with an epitenon stitch. The operating microscope is then used to perform the microsurgical anastomosis of one artery and one or two veins, and three nerves using 9-0 or 10-0 nylon is carried out. Attention to detail is critical at this juncture of the procedure, as even micro-injury to the vessels will lead to failure of the flap. The branch of the deep peroneal nerve as well as the plantar nerves are anastomosed to the recipient nerves using microsurgical technique and 9-0 and 10-0 nylon. The flap is loosely sewn into place. Skin grafts are harvested from the thigh and applied to the recipient site to achieve a tensionless closure. The intermetatarsal ligament is repaired and the space between the great and third toe is closed. The foot donor site is closed in layers over a drain. The skin graft donor site is prepared for its dressing. Sterile dressings and splinting are applied to both donor and recipients sites.

Post-service work includes monitoring patient stabilization; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon This includes: ICU care; monitoring and care of wound and flap circulation; ordering and reviewing postoperative radiographs and laboratory studies; monitoring, care, and removal of all drains; monitoring for management of possible infection and/or wound dehiscence; monitoring for flap failure [this generally occurs during the first 72 hours during which time the primary surgeon is continuously on call]; and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures, dressing and cast/splint changes; monitoring of multiple operative sites; assessment of rehabilitation progress; evaluation of periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments.

SURVEY DATA:

Specialty(s): American Society for Reconstructive Microsurgery

Survey n:	250		PRE	INTRA		POST					
Response: 41				Day 1	ICU (not day 1)		Hosp (not day 1)		Office		
Rate %:	16%	RVW	total min	total min	total min	total min	# visits	total min	# visits	total min	# visits
	low	36.00		240							
	25th%	43.00		400						-	
	med	44.31	105	480	60	50	3	105	7	120	7
	75th%	48.31		600							
	high	100.00		720							

Reference service data:

СРТ	Data Source	96rvw	PRE	INTRA	Post-HOSP	Post-OFF	Resp n	IWPUT (1)
15755	Harvard (PH4)	28.33	102*	433	130*	83*	12	0.0456
20970	RUC ('94)	41.22	100	500	200	90	58	0.0667
20973	RUC ('94)	44.31	120	540	200	. 90	57	0.0667

An asterisk indicates times were "predicted," not surveyed.

(1) IWPUT for 15755 represents Harvard Phase 3 final work values scaled to the 1996 MFS. IWPUT for 20970 and 20973 were determined by HCFA (see text under "Additional Rationale" on the next page).

Reference service(s) cited most frequently by survey respondents:

<u>1996 RVW</u>	Count	<u>CPT</u>	Descriptor
44.31	32	20973	Free osteocutaneous flap with microvascular anastomosis; great toe with
41.22	12	20970	web space Free osteocutaneous flap with microvascular anastomosis; iliac crest

KEY REFERENCE SERVICE(S):

<u>1996 RVW</u>	<u>Global</u>	<u>CPT</u>	Descriptor
44.31	090	20973	Free osteocutaneous flap with microvascular anastomosis; great toe with
			web space

Relationship of code being reviewed to key reference service(s): Compare the pre-, intra-, and post-service time and the intensity of the service you are rating to the key reference services listed above.

New Code: N13 Toe-to-hand transfer with microvascular anastomosis; other than great toe, single **Recommended RVW**: 44.31 **IWPUT**: 0.0655

• The <u>components</u> of work of N13 (microdissection of two arteries and four veins; dissection and repair of three digital nerves; dissection and repair of tendons; osteotomies and osteosynthesis; and complex repair of wounds) closely approximates the total work of CPT 20973. The specialty RVS advisory committee recommends the survey median RVW of 44.31. This recommended RVW creates an appropriate RVW relationship between new code N13, existing code 20973, and recommendations for new codes N12, N14, and N15.





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RVW	<u>CPT</u>	<u>Descriptor</u>
41.22	20970	Free osteocutaneous flap with microvascular anastomosis; iliac crest
41.54	20972	metatarsal
44.31	20973	great toe with web space
<u>48.00</u>	<u>N12: 2098A</u>	Toe-to-hand transfer with microvascular anastomosis: great toe "wrap-around" with bone graft
<u>44.31</u>	<u>N13: 2098B</u>	other than great toe, single
<u>50.00</u>	<u>N14: 2098C</u>	other than great toe, double
<u>45.00</u>	<u>N15: 2098D</u>	Free toe joint transfer with microvascular anastomosis

Additional rationale:

[The specialty's RVS advisory committee would like to emphasize that the primary rationale for the recommended RVW for this new code is it's clinical and work relationship *relative to existing key reference services* as discussed above. The IWPUT that is provided below is an approximation of the intra-service intensity.]

For a recommended RVW of 44.31, the IWPUT for N13 is *approximately* equal to 0.0655 RVUs per minute or 3.93 RVUs per hour, compared to Harvard Study IWPUT for 15755 of 0.0456 RVUs per minute or 2.74 RVUs per hour.

The following text presents HCFA's response to previous AMA/RUC recommendations for the free flap CPT codes 20955. 20969, 20970, 20972, and 20973 (Federal Register, 12/8/94). Although HCFA discusses its use of intraoperative intensity comparisons (in RVUs per hour), no discussion regarding the RVUs for pre- and post-service work is provided, making it difficult to determine how they arrived at the final total RVW:

"We used an intraoperative intensity of 3.80 RVUs per hour for CPT codes 20955 and 20969. For CPT code 20955, the intraoperative time estimate was 8 hours, resulting in 38.00 RVUs. We used the RUC survey times for CPT code 20969 except that we reduced the preoperative tune to 100 minutes because we believed the pre-service work description of CPT code 20969 was identical to CPT codes 20955 and 20970, both surveyed at 100 minutes. We also compared CPT code 20969 to CPT code 20802: CPT code 20969 is more likely to be performed on an elective basis, has more preoperative time, and is more intense. The assigned RVUs of 42.55 reflect these differences."

"We believe that the intensity of CPT code 20970 is slightly higher because this code is more difficult and riskier than CPT code 20969, and, therefore, we used an intensity of 4.00 RVUs per hour to calculate the RVUs. Because the estimated time is 40 minutes shorter than CPT code 20969, we assigned 41.68 RVUs to CPT code 20970. We also used the same intensity level to assign 44.80 RVUs to CPT code 20973."

" Using an intensity of 4.30 RVUs per hour for CPT code 20972, we assigned 42.00 RVUs to this code This value maintains the rank order of CPT codes 20969, 20970, and 20972 that exists in the RUC-recommended RVUs."

HCFA-determined intensities (rvu's per minute / rvu's per hour):

<u>'96 RVW</u>	Intensity	<u>Graft</u>	
37.58	0.0633 / 3.80	20955 Microvascular bone graft, fibular	
42.08	0.0633 / 3.80	20969 Microvascular osteocutaneous graft, other	
41.22	0.0667 / 4.00	20970 Microvascular osteocutaneous graft, iliac crest	
41.54	0.0717/4.30	20972 Microvascular osteocutaneous graft, metatarsal	
44.31	0.0667 / 4.00	20973 Microvascular osteocutaneous graft, great toe with web space	

FREQUENCY INFORMATION

How was this service previously reported?

15755 Free flap (microvascular transfer)20999 Unlisted procedure, musculoskeletal system, general26989 Unlisted procedure, hands or fingers

How often do physicians in your specialty perform this service? Sometimes

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

The frequency outside the Medicare population is difficult to determine because there is a wide variability in the incidence of the patients requiring this service. This reconstructive procedure is performed most often on post-trauma patients or patients with congenital abnormalities.

1994 Medicare Part B Allowed Frequency

15755	Free flap (microvascular transfer)	1.547
20999	Unlisted procedure, musculoskeletal system, general	1,219
26989	Unlisted procedure, hands or fingers	362

Is this service performed by many physicians across the United States?

Many surgeons are familiar with this procedure. Physicians practicing reconstructive microsurgery would most likely perform this service. However, because reconstructive microsurgery is not a *Medicare specialty category*, physicians practicing under one of the following specialty designations may also reasonably be expected to perform this procedure: plastic and reconstructive surgery, hand surgery, or orthopaedic surgery.

CPT Code: 2098C Tracking Number: N14 Global Period: 090 Recommended RVW: 50.00

Descriptor: Toe-to-hand transfer with microvascular anastomosis; other than great toe, double

CLINICAL DESCRIPTION OF SERVICE:

Typical Patient: A 20-year-old male, who suffered an amputation of all his fingers, except the thumb, presents for reconstruction. The second and third toes, along with their tendons, arteries, and nerves, are harvested and transferred to the fourth and fifth rays.

Pre-service work includes obtaining and reviewing imaging studies. including angiograms, and laboratory studies; communicating with other health care professionals; ordering preoperative antibiotics; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Other preoperative services include dressing, scrubbing, and waiting for surgery; supervision of positioning, prepping, and draping the patient, and applying warming devices; and ensuring that surgical instruments and supplies that are necessary are present and available in the operative suite.

Intra-service work: An incision is made and the dorsalis pedis artery and the saphenous vein are exposed. Venous dissection is carried out to be sure to include branches to the second and third toes. The extensor mechanism is identified and the extensor tendons are transsected proximally. The vascular supply of the flap is identified. The arcuate artery as well as the first dorsal metatarsal artery are isolated and their contribution to the flap is verified. The plantar dissection is then carried out with isolation of four flexor tendons and the common digital nerve to the second and third toes as well as the lateral digital nerve of the third toe and medial digital nerve of the second toe. The plantar vessels are preserved with vascular clamps. The toes are then disarticulated at the metatarsophalangeal joints. The flap is then isolated on the dorsalis pedis artery and saphenous vein. This pedicle is carefully dissected. Careful attention to detail is required to protect the vessels, as injury to the donor vessels will lead to the failure of the flap. The flap is then transferred to the hand. The bases of the proximal toe phalanges are cleared of cartilage and subchondral bone. Osteotomies are made to allow good coaptation of the toe phalanges on the distal fourth and fifth metacarpals. Attachment of the phalanges to the residual metacarpals is achieved using plates and screws or Kirschner wires. The four flexor tendons and two extensor tendons are than repaired using a core stitch combined with an epitenon stitch. The operating microscope is then used to perform the microsurgical anastomosis of the dorsalis pedis artery and saphenous vein and four nerves to the recipient vessels and nerves using 9-0 or 10-0 nylon is then carried out. Attention to detail is critical at this juncture of the procedure, as even micro-injury to the vessels will lead to failure of the flap. The flap is loosely sewn into place. Skin grafts are harvested from the thigh and applied to the recipient site to achieve a tensionless closure. The intermetatarsal ligament is repaired and the space between the great toe and fourth toe is closed. The foot donor site is closed in layers over a drain. The skin graft donor site is prepared for its dressing. Sterile dressings and splints are applied to both donor and recipient sites.

Post-service work includes monitoring patient stabilization; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon This includes: ICU care; monitoring and care of wound and flap circulation; ordering and reviewing postoperative radiographs and laboratory studies; monitoring, care, and removal of all drains; monitoring for management of possible infection and/or wound dehiscence; monitoring for flap failure [this generally occurs during the first 72 hours during which time the primary surgeon is continuously on call]; and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures, dressing and cast/splint changes; monitoring of multiple operative sites; assessment of rehabilitation progress; evaluation of periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments.

SURVEY DATA:

Specialty(s): American Society for Reconstructive Microsurgery

Survey n:	250		PRE	INTRA				POST	ſ		
Response:	38				Day 1	ICU (no	ot day 1)	Hosp (n	ot day 1)	Of	fice
Rate %:	15%	RVW	total min	total min	total min	total min	# visits	total min	# visīts	total min	# visits
١	low	37.58		300							
	25th%	46.00		480							
	med	50.00	120	595	60	50	3	120	8	130	8
	75th%	56.00	-	705						-	
	high	140.00		900							

Reference service data:

СРТ	Data Source	96rvw	PRE	INTRA	Post-HOSP	Post-OFF	Resp n	IWPUT (1)
15755	Harvard (PH4)	28.33	102*	433	130*	83*	12	0.0456
20970	RUC ('94)	41.22	100	500	200	90	58	0.0667
20973	RUC ('94)	44.31	120	540	200	90	57	0.0667

An asterisk indicates times were "predicted," not surveyed.

(1) IWPUT for 15755 represents Harvard Phase 3 final work values scaled to the 1996 MFS. IWPUT for 20970 and 20973 were determined by HCFA (see text under "Additional Rationale" on the next page).

Reference service(s) cited most frequently by survey respondents:

<u>1996 RVW</u>	<u>Count</u>	<u>CPT</u>	Descriptor
44.31	33	20973	Free osteocutaneous flap with microvascular anastomosis; great toe with
			web space
41.22	11	20970	Free osteocutaneous flap with microvascular anastomosis; iliac crest

KEY REFERENCE SERVICE(S):

<u>1996 RVW</u>	<u>Global</u>	<u>CPT</u>	Descriptor	
44.31	090	20973	Free osteocutaneous flap with microvascular anastomosis; great	toe with
			web space	

Relationship of code being reviewed to key reference service(s): Compare the pre-, intra-, and post-service time and the intensity of the service you are rating to the key reference services listed above.

New Code: N14 Toe-to-hand transfer with microvascular anastomosis; other than great toe, double **Recommended RVW**: 50.00 **IWPUT**: 0.0606

• The <u>components</u> of work of N14 (microdissection of arteries and veins; microdissection and repair of digital nerves; dissection and repair of tendons; osteotomies and osteosynthesis; and complex repair of wounds) closely approximates the total work of CPT 20973, except that twice as many osteotomies, tendon repairs, and nerve repairs, along with additional microdissection, are required for the rarely performed "double" toe transfer.

Based on this discussion, the specialty RVS advisory committee recommends the survey median RVW of 50.00. This recommended RVW creates an appropriate RVW relationship between new code N14, existing code 20973, and recommendations for new codes N12, N13, and N15.



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<u>RVW</u> 41.22 41.54 44.31	<u>CPT</u> 20970 20972 20973	Descriptor Free osteocutaneous flap with microvascular anastomosis; iliac crest metatarsal great toe with web space	
<u>48.00</u>	<u>N12: 2098A</u>	Toe-to-hand transfer with microvascular anastomosis: great toe "wrap-around" with bone graft	
<u>44.31</u> <u>50.00</u>	<u>N13: 2098B</u> <u>N14: 2098C</u>	other than great toe, single other than great toe, double	
<u>45.00</u>	<u>N15: 2098D</u>	Free toe joint transfer with microvascular anastomosis	

Additional rationale:

[The specialty's RVS advisory committee would like to emphasize that the primary rationale for the recommended RVW for this new code is it's clinical and work relationship *relative to existing key reference services* as discussed above. The IWPUT that is provided below is an approximation of the intra-service intensity.]

For a recommended RVW of 50.00, the IWPUT for N14 is *approximately* equal to 0.0606 RVUs per minute or 3.64 RVUs per hour, compared to Harvard Study IWPUT for 15755 of 0.0456 RVUs per minute or 2.74 RVUs per hour.

The following text presents HCFA's response to previous AMA/RUC recommendations for the free flap CPT codes 20955. 20969, 20970, 20972, and 20973 (Federal Register, 12/8/94). Although HCFA discusses its use of intraoperative intensity comparisons (in RVUs per hour), no discussion regarding the RVUs for pre- and post-service work is provided, making it difficult to determine how they arrived at the final total RVW:

"We used an intraoperative intensity of 3.80 RVUs per hour for CPT codes 20955 and 20969. For CPT code 20955, the intraoperative time estimate was 8 hours, resulting in 38.00 RVUs. We used the RUC survey times for CPT code 20969 except that we reduced the preoperative time to 100 minutes because we believed the pre-service work description of CPT code 20969 was identical to CPT codes 20955 and 20970, both surveyed at 100 minutes. We also compared CPT code 20969 to CPT code 20802: CPT code 20969 is more likely to be performed on an elective basis, has more preoperative time, and is more intense. The assigned RVUs of 42.55 reflect these differences."

"We believe that the intensity of CPT code 20970 is slightly higher because this code is more difficult and riskier than CPT code 20969, and, therefore, we used an intensity of 4.00 RVUs per hour to calculate the RVUs. Because the estimated time is 40 minutes shorter than CPT code 20969, we assigned 41.68 RVUs to CPT code 20970. We also used the same intensity level to assign 44.80 RVUs to CPT code 20973."

" Using an intensity of 4.30 RVUs per hour for CPT code 20972, we assigned 42.00 RVUs to this code. This value maintains the rank order of CPT codes 20969, 20970, and 20972 that exists in the RUC-recommended RVUs."

HCFA-determined intensities (rvu's per minute / rvu's per hour):

<u>'96 RVW</u>	<u>Intensity</u>	<u>Graft</u>
37.58	0.0633 / 3.80	20955 Microvascular bone graft, fibular
42.08	0.0633 / 3.80	20969 Microvascular osteocutaneous graft, other
41.22	0.0667 / 4.00	- 20970 Microvascular osteocutaneous graft, iliac crest
41.54	0.0717/4.30	20972 Microvascular osteocutaneous graft, metatarsal
44.31	0.0667 / 4.00	20973 Microvascular osteocutaneous graft, great toe with web space

FREQUENCY INFORMATION

How was this service previously reported?

15755 Free flap (microvascular transfer)20999 Unlisted procedure, musculoskeletal system, general26989 Unlisted procedure, hands or fingers

How often do physicians in your specialty perform this service? Rarely.



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

The frequency outside the Medicare population is difficult to determine because there is a wide variability in the incidence of the patients requiring this service. This reconstructive procedure is performed most often on post-trauma patients or patients with congenital abnormalities.

<u>1994 M</u>	1994 Medicare Part B Allowed Frequency					
15755	Free flap (microvascular transfer)	1,547				
20999	Unlisted procedure, musculoskeletal system, general	1,219				
26989	Unlisted procedure, hands or fingers	362				

Is this service performed by many physicians across the United States?

Many surgeons are familiar with this procedure. Physicians practicing reconstructive microsurgery would most likely perform this service. However, because reconstructive microsurgery is not a *Medicare specialty category*, physicians practicing under one of the following specialty designations may also reasonably be expected to perform this procedure: plastic and reconstructive surgery, hand surgery, or orthopaedic surgery.



CPT Code: 2098D Tracking Number: N15 Global Period: 090 Recommen

90 Recommended RVW: 45.00

Descriptor: Free toe joint transfer with microvascular anastomosis

CLINICAL DESCRIPTION OF SERVICE:

Typical Patient: A 9-year-old child suffers a fracture dislocation of the long finger proximal interphalangeal joint with destruction of that joint and its adjacent physis. The child presents for reconstruction of the joint and restoration of growth potential of the third ray.

Pre-service work includes obtaining and reviewing imaging studies, including angiograms, and laboratory studies; communicating with other health care professionals; ordering preoperative antibiotics; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Other preoperative services include dressing, scrubbing, and waiting for surgery: supervision of positioning, prepping, and draping the patient, and applying warming devices; and ensuring that surgical instruments and supplies that are necessary are present and available in the operative suite.

Intra-service work: An incision is made and the dorsalis pedis artery and saphenous vein at the dorsal aspect of the foot is identified. The vascular pedicle is then carefully followed out to the dorsal aspect of the second toe. A paddle of skin is isolated over the proximal interphalangeal joint of the second toe. The first dorsal metatarsal artery is identified and followed out into the second toe. Its branch to the great toe is ligated. Care is taken to the preserve the venous outflow from the flap. The medial plantar artery and nerve are transsected and ligated proximally and distally. The dorsal medial artery is ligated at the distal end of the flap. The extensor mechanism is transsected and the osteotomy is carried out at the level of the proximal phalanx. The middle phalanx is disarticulated at the distal interphalangeal joint. The flap is then isolated on its vascular pedicle using microsurgical technique. Careful attention to detail is required to protect the vessels, as injury to the donor vessels will lead to the failure of the flap. The flap is then transferred to the hand. Any necessary fashioning of the bone is completed. Osteosynthesis is completed using Kirschner wires. The extensor mechanism is repaired paying special attention to the tension applied to the tendon. The three intrinsic tendons are also repaired. The operating microscope is then used to perform the microsurgical anastomosis of the dorsalis pedis artery and saphenous vein to the recipient vessels using 9-0 or 10-0 nylon is then carried out. Attention to detail is critical at this juncture of the procedure, as even micro-injury to the vessels will lead to failure of the flap. The flap is carefully sewn in position. An arthroplasty (coded separately) is completed at the level of the donor site and the wound is closed over a drain. Sterile dressings and any necessary splints are applied to both the donor and recipient sites.

Post-service work includes monitoring patient stabilization; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon This includes: ICU care; monitoring and care of wound and flap circulation; ordering and reviewing postoperative radiographs and laboratory studies; monitoring, care, and removal of all drains; monitoring for management of possible infection and/or wound dehiscence; monitoring for flap failure [this generally occurs during the first 72 hours during which time the primary surgeon is continuously on call]; and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures, dressing and cast/splint changes; monitoring of multiple operative sites; assessment of rehabilitation progress; evaluation of periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments.

SURVEY DATA:

Specialty(s): American Society for Reconstructive Microsurgery

Survey n:	250		PRE	INTRA				POST	<u>г</u>		
Response:	36				Day 1	ICU (no	ot day 1)	Hosp (n	ot day 1)	Of	fice
Rate %:	14%	RVW	total min	total min	total min	total min	# visits	total min	# visits	total min	# visits
	low	20.22		240							
	25th%	40.00		360							
	med	45.00	90	480	60	48	3	120	7	155	8
	75th%	50.00		600							
	high	80.00		720							

Reference service data:

CPT	Data Source	96rvw	PRE	INTRA	Post-HOSP	Post-OFF	Resp n	IWPUT (1)
15755	Harvard (PH4)	28.33	102*	433	130*	83*	12	0.0456
20970	RUC ('94)	41.22	100	500	200	90	58	0.0667
20973	RUC ('94)	44.31	120	540	_200	90	57	0.0667

An asterisk indicates times were "predicted," not surveyed.

(1) IWPUT for 15755 represents Harvard Phase 3 final work values scaled to the 1996 MFS. IWPUT for 20970 and 20973 were determined by HCFA (see text under "Additional Rationale" on the next page).

Reference service(s) cited most frequently by survey respondents:

mosis; great toe with
mosis; iliac crest
,

KEY REFERENCE SERVICE(S):

<u>1996 RVW</u>	<u>Global</u>	<u>CPT</u>	Descriptor
44.31	090	20973	Free osteocutaneous flap with microvascular anastomosis; great toe with
			web space

Relationship of code being reviewed to key reference service(s): Compare the pre-, intra-, and post-service time and the intensity of the service you are rating to the key reference services listed above.

New Code: N15 Free toe joint transfer with microvascular anastomosis **Recommended RVW**: 45.00 **IWPUT**: 0.065

• The components of work of N15 (microdissection of arteries and veins; microdissection and repair of digital nerves; dissection and repair of tendons; osteotomies and osteosynthesis; and complex repair of wounds) closely approximates the total work of CPT 20973.

• Compared to new code N13 Toe-to-hand transfer with microvascular anastomosis; other than great toe, single, N15 is requires two levels of osteosynthesis, both proximal and distal to the joint. N15 requires repair of three tendons, while N13 requires repair of two tendons. The microdissection of the joint (N15) is also more delicate than for N13, as the vascular supply to the remaining toe has to be left intact.





Based on this discussion, the specialty RVS advisory committee recommends the survey median RVW of 45.00. This recommended RVW creates an appropriate RVW relationship between new code N15, existing code 20973, and recommendations for new codes N12, N14, and N15.

<u>RVW</u>	<u>CPT</u>	Descriptor
41.22	20970	Free osteocutaneous flap with microvascular anastomosis; iliac crest
41.54	20972	metatarsal
44.31	20973	great toe with web space
<u>48.00</u>	<u>N12: 2098A</u>	Toe-to-hand transfer with microvascular anastomosis; great toe "wrap-around" with bone graft
<u>44.31</u>	<u>N13: 2098B</u>	other than great toe, single
50.00	N14: 2098C	other than great toe, double
<u>45.00</u>	<u>N15: 2098D</u>	Free toe joint transfer with microvascular anastomosis

Additional rationale:

[The specialty's RVS advisory committee would like to emphasize that the primary rationale for the recommended RVW for this new code is it's clinical and work relationship *relative to existing key reference services* as discussed above. The IWPUT that is provided below is an approximation of the intra-service intensity.]

For a recommended RVW of 45.00, the IWPUT for N15 is *approximately* equal to 0.0650 RVUs per minute or 3.90 RVUs per hour, compared to Harvard Study IWPUT for 15755 of 0.0456 RVUs per minute or 2.74 RVUs per hour.

The following text presents HCFA's response to previous AMA/RUC recommendations for the free flap CPT codes 20955, 20969, 20970, 20972, and 20973 (Federal Register, 12/8/94). Although HCFA discusses its use of intraoperative intensity comparisons (in RVUs per hour), no discussion regarding the RVUs for pre- and post-service work is provided, making it difficult to determine how they arrived at the final total RVW:

"We used an intraoperative intensity of 3.80 RVUs per hour for CPT codes 20955 and 20969. For CPT code 20955, the intraoperative time estimate was 8 hours, resulting in 38.00 RVUs. We used the RUC survey times for CPT code 20969 except that we reduced the preoperative tune to 100 minutes because we believed the pre-service work description of CPT code 20969 was identical to CPT codes 20955 and 20970, both surveyed at 100 minutes. We also compared CPT code 20969 to CPT code 20802: CPT code 20969 is more likely to be performed on an elective basis, has more preoperative time, and is more intense. The assigned RVUs of 42 55 reflect these differences."

"We believe that the intensity of CPT code 20970 is slightly higher because this code is more difficult and riskier than CPT code 20969, and, therefore, we used an intensity of 4.00 RVUs per hour to calculate the RVUs. Because the estimated time is 40 minutes shorter than CPT code 20969, we assigned 41.68 RVUs to CPT code 20970. We also used the same intensity level to assign 44.80 RVUs to CPT code 20973."

"Using an intensity of 4.30 RVUs per hour for CPT code 20972, we assigned 42.00 RVUs to this code. This value maintains the rank order of CPT codes 20969, 20970, and 20972 that exists in the RUC-recommended RVUs."

HCFA-determined intensities (rvu's per minute / rvu's per hour):

<u>'96 RVW</u>	Intensity	<u>Graft</u>
37.58	0.0633 / 3.80	20955 Microvascular bone graft, fibular
42.08	0.0633 / 3.80	20969 Microvascular osteocutaneous graft, other
41.22	0.0667 / 4.00	20970 Microvascular osteocutaneous graft, iliac crest
41.54	0.0717 / 4.30	20972 Microvascular osteocutaneous graft, metatarsal
44.31	0.0667 / 4.00	20973 Microvascular osteocutaneous graft, great toe with web space

FREQUENCY INFORMATION

How was this service previously reported? 15755 Free flap (microvascular transfer) 20999 Unlisted procedure, musculoskeletal system, general

26989 Unlisted procedure, hands or fingers

How often do physicians in your specialty perform this service? Sometimes

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

The frequency outside the Medicare population is difficult to determine because there is a wide variability in the incidence of the patients requiring this service. This reconstructive procedure is performed on patients most often on post-trauma patients.

<u>1994 M</u>	1994 Medicare Part B Allowed Frequency					
15755	Free flap (microvascular transfer)	1,547				
20999	Unlisted procedure, musculoskeletal system, general	1,219				
26989	Unlisted procedure, hands or fingers	362				

Is this service performed by many physicians across the United States?

Many surgeons are familiar with this procedure. Physicians practicing reconstructive microsurgery would most likely perform this service. However, because reconstructive microsurgery is not a Medicare specialty category, physicians practicing under one of the following specialty designations may also reasonably be expected to perform this procedure: plastic and reconstructive surgery, hand surgery, or orthopaedic surgery.



AMA/Specia Summary of	lty Society Recomme	Y RVS Update Process		CPT: N21 (4990A) Page 1
CPT Code:	4990A	Tracking Number: N21	Global Period: 090	Recommended RVW: 35.00
Descriptor:	Free om	ental flap with microvascular and	astomosis	
		······································	<u></u>	· · · · · · · · · · · · · · · · · · ·

CLINICAL DESCRIPTION OF SERVICE:

Typical Patient: An 8-year-old child presents with a hemifacial microsomia requiring reconstruction. A free omental transfer with microvascular anastomosis is performed.

Pre-service work includes obtaining and reviewing imaging studies, including angiograms, and laboratory studies; communicating with other health care professionals; ordering pre-operative antibiotics; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent, both for surgery and blood transfusion. Other pre-operative services include dressing, scrubbing, and waiting for surgery; supervision of positioning, prepping, and draping the patient; and ensuring that surgical instruments and supplies that are necessary are present and available in the operative suite.

Intra-service work: The abdomen is entered through an upper abdominal incision. The greater omentum is delivered from the abdominal cavity. The right and left gastroepiploic vessels are identified. The branches of the gastroepiploic arterial arch to the greater curvature of the stomach are ligated and divided. The omentum is then separated from the transverse colon. The left gastroepiploic vessels are then ligated and the omental flap is isolated on the right gastroepiploic vessels. Careful microdissection is carried out so as not to injure this branch during the harvesting, as injury to the donor vessels will lead to the failure of the flap. The vascular pedicle is transsected and the flap is then transferred to the recipient site. The flap is loosely sutured in place. The microsurgical anastomosis using 9-0 or 10-0 nylon of one artery and two veins is then carried out. Attention to detail is critical at this juncture of the procedure, as even micro-injury to the vessels will lead to failure of the flap. The insetting of the flap is completed and the wound is closed over a drain. The donor site abdominal closure is accomplished in a routine fashion. Sterile dressings are applied.

Post-service work includes monitoring patient stabilization; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon This includes: ICU care, including monitoring ventilation, hemodynamics, and fluid balance; monitoring wound and flap for possible infection, which is a common complication of aerodigestive tract surgery; monitoring for flap failure [this generally occurs during the first 72 hours during which time the primary surgeon is continuously on call]; ordering and reviewing postoperative radiographs and laboratory studies; monitoring, care, and removal of all drains; and antibiotic and pain medication management. It should be noted that monitoring of the flap for infection and/or failure is a difficult process because the flap is often completely buried. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures; evaluation of laboratory reports, if needed; and antibiotic and pain medication adjustments.



Summary of	Recomme	CPT: N20 (4349A)	Page 1				
CPT Code:	4349A	Tracking Number: N20	Global Period: 090	Recommended RVW:	38.50		
Descriptor: Free jejunum transfer with microvascular anastomosis							

CLINICAL DESCRIPTION OF SERVICE:

Typical Patient: A 60-year-old male presents with laryngeal/pharyngeal carcinoma requiring total laryngopharyngectomy. The cervical esophagus is reconstructed with a free jejunum transfer with microvascular anastomosis.

Pre-service work: The patient is usually admitted to the floor the day before surgery for placement of a central venous pressure line. This allows maximal hydration when the patient comes to the operating room the next day, which is important in free tissue transfer procedures, to maintain ambulatory levels of blood pressure and vascular space filling to optimize flow through microvascular anastomoses. Pre-service work also includes obtaining and reviewing imaging studies, including angiograms, and laboratory studies; communicating with other health care professionals (eg, radiation therapy or chemotherapy consults relating to neo-adjuvant or postoperative treatment; review of the reports from speech and swallowing therapists regarding postoperative management of the patient); ordering pre-operative antibiotics; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent, both for surgery and blood transfusion. Additionally, the patient is monitored in the ICU on the pre-operative night because of the recent CVP line insertion. Other pre-operative services include dressing, scrubbing, and waiting for surgery; supervision of positioning, prepping, and draping the patient; and ensuring that surgical instruments and supplies that are necessary are present and available in the operative suite.

Intra-service work: An upper midline abdominal incision is made. The abdomen is entered and the upper part of the small intestines is delivered into the wound. The duodenojejunal flexure is identified. The intestinal branches of the superior mesenteric vessels are carefully inspected and the second intestinal branch with its arcades and vasa recta is identified and evaluated. The appropriate length of jejunum is emptied manually. Intestinal clamps are applied and the jejunal segment is divided. The mesentery is separated between the vasa recta and the first, second, and third intestinal branches. The arcades beyond the jejunal segment are ligated. The free jejunal segment is then harvested on the second jejunal branch. Careful microdissection is carried out so as not to injure this branch during the harvesting, as injury to the donor vessels will lead to the failure of the flap. The flap is then transferred and inset. The microsurgical anastomosis using 9-0 or 10-0 nylon of one artery and two veins is then carried out. Attention to detail is critical at this juncture of the procedure, as even micro-injury to the vessels will lead to failure of the flap. The intestinal continuity is restored with an end-to-end jejunal anastomosis. The abdomen is closed in a routine fashion. Sterile dressings are applied.

Post-service work includes monitoring patient stabilization; communication with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon This includes: ICU care, including monitoring ventilation, hemodynamics, and fluid balance, with particular attention to monitoring calcium balance because whenever a total laryngopharyngectomy has been performed, a total thyroidectomy and parathyroidectomy is often performed, which intensifies postoperative patient monitoring and may involve consults with the endocrine service, monitoring wound and flap for possible infection, which is a common complication of aerodigestive tract surgery; monitoring for flap failure [this generally occurs during the first 72 hours during which time the primary surgeon is continuously on call]; ordering and reviewing postoperative radiographs and laboratory studies; monitoring, care, and removal of all drains; and antibiotic and pain medication management. It should be noted that monitoring of the flap for infection and/or failure is a difficult process because the flap is often completely buried. Therefore, frequent fiber-optic scoping of the patient is necessary. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures; evaluation of periodic imaging and laboratory reports, if needed; supervision of speech and swallowing rehabilitation; and antibiotic and pain medication adjustments. Occasionally, toward the end of the global period, in very aggressive cases, scans or biopsies may be necessary to rule out tumor ecurrence.



CPT: N20 (4349A) Page 2

SURVEY DATA:

Specialty(s): American Society for Reconstructive Microsurgery

Survey n:	250		PRE	INTRA				POS	Г		
Response:	26				Day 1	ICU (no	ot day 1)	Hosp (n	ot day 1)	Of	fice
Rate %:	10%	rvw	total min	total min	total min	total min	# visits	total min	# visits	total min	# visits
	low	23.00		240							
	25th%	38.50		338							
	med	42.00	90	410	60	60	3	120	7	120	6
	75th%	45.00		480							
	high	100.00		720							

Reference service data:

СРТ	Data Source	96rvw	PRE	INTRA	Post-HOSP	Post-OFF	Resp n	IWPUT (1)
15755	Harvard (PH4)	28.33	102*	433	130*	83*	12	0.0456
20955	RUC ('94)	37.58	100	480	170	75	43	0.0633
20970	RUC ('94)	41 22	100	500	200	90	58	0.0667
20973	RUC ('94)	44.31	120	540	200	90	57	0.0667
19368	RUC ('94)	31.15	60	420	90	90	24	0.0587 -
43 108·	RUC ('94)	32.64	90	360	240	45	45	0.0610

An asterisk indicates times were "predicted," not surveyed.

(1) IWPUT for 15755 represents Harvard Phase 3 final work value scaled to the 1996 MFS. IWPUT for 20955, 20970, and 20973 were determined by HCFA. IWPUT for 19368 and 43108 are calculations based on RUC survey data.

Reference service(s) cited most frequently by survey respondents:

<u>1996 RVW</u>	<u>Count</u>	<u>CPT</u>	Descriptor
41.22	14	20970	Free osteocutaneous flap with microvascular anastomosis; iliac crest
37.58	9	20955	Bone graft with microvascular anastomosis; fibula
44.31	8	20973	Bone graft with microvascular anastomosis; great toe with web space

KEY REFERENCE SERVICE(S):

<u>1996 RVW</u>	<u>Global</u>	<u>CPT</u>	Descriptor
31.15	090	19368	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single
			pedicle, including closure of donor site; with microvascular anastomosis (supercharging)
37.58	090	20955	Bone graft with microvascular anastomosis; fibula
32.64	090	43108	Total or near total esophagectomy, without thoracotomy; with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosus(es)

Relationship of code being reviewed to key reference service(s): Compare the pre-, intra-, and post-service time and the intensity of the service you are rating to the key reference services listed above.

New Code: N20 Free jejunum transfer with microvascular anastomosis Recommended RVW: 38.50 (survey 25th percentile) IWPUT: 0.0612

The <u>total</u> work (pre-, intra-, and post-operative time and intensity) of N20 is greater than a free tram flap (CPT 19368; RVW=31.15), but similar to a free fibular flap (CPT 20955; RVW=37.58).



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CPT: N20 (4349A) Page 3

• N20 compared to CPT 20955 free fibular transfer. With respect to harvesting the free fibular flap, the microvascular surgeon is dealing with critical peripheral nerves and vessels of the foot and lower limb. This is compared to harvesting a free jejunal flap, where unless a gross surgical error occurs resulting in interruption of the superior mesenteric vessels, there is less intensity due to risk. The free fibular flap inset nearly always involves osteotomies, which have to be very carefully performed to avoid damage to the pedicle, as well as a careful shaving and repeated remolding of the graft, in order to fit the recipient site in the mandible or the midface. However, the fact that failure of a free jejunal flap is critical to the patient's life would make the total work intensity greater than the free fibular transfer. Additionally, the postoperative monitoring of the free jejunal flap for infection and/or failure is a difficult process because the flap is often completely buried. Therefore, frequent fiber-optic scoping of the patient is necessary. Postoperative monitoring of rehabilitation is more difficult and more time consuming for a free jejunal transfer as discussed in the postoperative service description on page one of this summary recommendation form.

• N20 compared to CPT 19368 free TRAM flap with supercharging. The patient presenting for a single pedicle TRAM flap that necessitates supercharging is considered a high-risk patient because of a history of heavy smoking, previous abdominal incisions, obesity, and/or diabetes. This is compared with a patient requiring a free jejunal flap who has a history of cancer and possibly other comorbid diseases, and often presents with damaged tissue from previous irradiation. While CPT 19368 is performed electively as a cosmetic reconstructive procedure, N20 is often necessary for the survival of the patient, as emphasized by the fact that failure of a free jejunal flap is critical to the patient's life. Postoperative monitoring and supervision of rehabilitation is considerably more difficult and time consuming for N20 compare to CPT 19368.

• Compared to a free bone flap (CPT 20955) or a TRAM flap (CPT 19368), a free jejunal flap (N20) involves significantly increased intra-operative intensity due to the fact that the intestinal mucosa does not tolerate ischemia. Consequently, the time without bloodflow must be kept as short as possible.

• N20 is similar to the combined work of CPT 43108 *esophagectomy*, <u>plus</u> additional work for the microdissection and microvascular preparation, most often in and around tissue that has been previously irradiated. N20 requires a more intensive and time consuming critical monitoring for postoperative infection, common with aerodigestive tract surgery, and critical monitoring of postoperative ventilation, nutritional status, and hemodynamics (please see postoperative service description on page one of this summary recommendation form).

The survey's 25th percentile RVW (38.50) is recommended because it reflects the relative relationship of the <u>total work</u> of N20 to the <u>total work</u> of CPT codes 19368, 43108, and 20955.

Additional rationale:

[The specialty's RVS advisory committee would like to emphasize that the primary rationale for the recommended RVW for this new code is it's clinical and work relationship *relative to existing key reference services* as discussed above. The IWPUT that is provided below is an approximation of the intra-service intensity.]

For a recommended RVW of 38.50, the IWPUT for N20 is *approximately* equal to 0.0612 RVUs per minute or 3.67 RVUs per hour, compared to Harvard Study IWPUT for 15755 of 0.0456 RVUs per minute or 2.74 RVUs per hour.

FREQUENCY INFORMATION

How was this service previously reported? CPT 15755 Free flap (microvascular transfer)

How often do physicians in your specialty perform this service? Sometimes.
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Estimate the number of times this service might be provided nationally in a one-year period? The frequency outside the Medicare population is difficult to determine because there is a wide variability in the incidence of the patients requiring this free flap with microvascular anastomosis. This reconstructive procedure is most often performed on patients with carcinoma.

1994 Medicare Part B Data Allowed Frequency

15755 Free flap (microvascular transfer)

1,547

Is this service performed by many physicians across the United States?

Many surgeons are familiar with this procedure. Physicians practicing reconstructive microsurgery would most likely perform this service. However, because reconstructive microsurgery is not a *Medicare specialty category*, physicians practicing under one of the following specialty designations may also reasonably be expected to perform this procedure: plastic and reconstructive surgery, otolaryngology, general surgery, and surgical oncology.



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SURVEY DATA:

Specialty(s): American Society for Reconstructive Microsurgery

Survey n:	250		PRE	INTRA		· · · · · · · · · · · · · · · · · · ·		POST	[
Response:	26				Day 1	ICU (no	ot day 1)	Hosp (n	ot day 1)	Óf	fice
Rate %:	10%	RVW	total min	total min	total min	total min	# visits	total min	# visits	total min	# visits
	low	24.00		200							
	25th%	35.00		333							
	med	40.00	9 0	420	60	60	3	100	6	120	6
	75th%	44.50		480							
	high	90.00		720							

Reference service data:

СРТ	Data Source	96rvw	PRE	INTRA	Post-HOSP	Post-OFF	Resp n	IWPUT (1)
15755	Harvard (PH4)	28.33	102*	433	130*	83*	12	0.0456
20955	RUC ('94)	37.58	100	480	170	75	43	0 0633
20970	RUC ('94)	41.22	100	500	200	90	58	0.0667
19368	RUC ('94)	31.15	60	420	90	90	24	0.0587
49905	RUC ('92)	6.55	n/a	n/a	n/a	n/a	n/a	n/a

An asterisk indicates times were "predicted," not surveyed.

(1) IWPUT for 15755 represents Harvard Phase 3 final work value scaled to the 1996 MFS. IWPUT for 20955 and 20970 were determined by HCFA. IWPUT for 19368 calculation is based on RUC survey data.

Reference service(s) cited most frequently by survey respondents:

	· · ·		
<u>1996 RVW</u>	<u>Count</u>	<u>CPT</u>	Descriptor
41.22	11	20970	Free osteocutaneous flap with microvascular anastomosis, iliac crest
37.58	9	20955	Bone graft with microvascular anastomosis; fibula
31.15	8	19368	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single
			pedicle, including closure of donor site; with microvascular anastomosis (supercharging)

KEY REFERENCE SERVICE(S):

<u>1996 RVW</u>	<u>Global</u>	<u>CPT</u>	Descriptor
31.15	090	19368	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single
			pedicle, including closure of donor site; with microvascular anastomosis (supercharging)

Relationship of code being reviewed to key reference service(s): Compare the pre-, intra-, and post-service time and the intensity of the service you are rating to the key reference services listed above.

New Code: N21 Free omental flap with microvascular anastomosis Recommended RVW: 35.00 (survey 25th percentile) IWPUT: 0.0529

• The total work of N21 is greater than the combined work of CPT 19368 free TRAM flap with supercharging (RVW=31.15) and CPT 49000 exploratory laparotomy (RVW=8.99). The intra-operative intesity and post-operative monitoring and care of a patient requiring N21 is considerably more difficult.

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• The vignette for N21, involving reconstruction of hemifacial microsomia, is an important use of the free omental flap. However, this flap is also used for reconstruction of difficult orocutaneous fistulae for post-radiation, post-cancer resection cases. This is a more critical context because of the obvious potential for flap failure leading to carotid exposure, carotid blowout, and death. Also, this flap is used for reconstruction of scalp and cranial defects, where, again a more critical situation pertains because of exposed dura. Little or no risk of this type exists in its application to hemifacial microsomia. Because of the variability in intensity of application of N21, it is the society's RVS committee's opinion that the overall work of N21 is less work than N20, and, as such an RVW of 35.00 (survey 25th percentile) is recommended.

• For informational purposes only: CPT 49905 omental flap (eg, for reconstruction of sternal and chest wall defects) (list separately in addition to code for primary procedure) was introduced by STS before formal RUC summary forms were used. This ZZZ code does not include pre- or post-service work. Additionally, this is not a free tissue transfer procedure, and, as such is not comparable in terms of time and intensity. The following text, extracted from a letter from STS to the RUC, is presented for informational purposes only: "...Patients needing this procedure are seriously ill middle-aged to elderly and often will have had chest wall tumors or invasion of the chest wall with lung cancer. The majority have had infections of the chest wall, resulting in sternal dehiscence, or mediastinitis following surgery or trauma. The procedure requires a separate celiotomy and closure and takedown and manipulation of the flap to accomplish the repair."

Additional rationale:

[The specialty's RVS advisory committee would like to emphasize that the primary rationale for the recommended RVW for this new code is it's clinical and work relationship *relative to existing key reference services* as discussed above. The IWPUT that is provided below is an approximation of the intra-service intensity.]

For a recommended RVW of 35.00, the IWPUT for N21 is *approximately* equal to 0.0529 RVUs per minute or 3.14 RVUs per hour, compared to Harvard Study IWPUT for 15755 of 0.0456 RVUs per minute.

FREQUENCY INFORMATION

How was this service previously reported? CPT 15755 Free flap (microvascular transfer)

How often do physicians in your specialty perform this service? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? The frequency outside the Medicare population is difficult to determine because there is a wide variability in the incidence of the patients requiring this free flap with microvascular anastomosis.

<u>1994 Medicare Part B Data Allowed Frequency</u> 15755 Free flap (microvascular transfer)

1,547

Is this service performed by many physicians across the United States?

Many surgeons are familiar with this procedure. Physicians practicing reconstructive microsurgery would most likely perform this service. However, because reconstructive microsurgery is not a *Medicare specialty category*, physicians practicing under one of the following specialty designations may also reasonably be expected to perform this procedure: plastic and reconstructive surgery, otolaryngology, general surgery, thoracic surgery, maxillofacial surgery, and surgical oncology.





Nasopharyngeal Lesion Resection/Excision- Tab 25

The RUC accepted the recommendation presented for a new skull base surgery code, 61586 *Bicoronal, transzygomatic* and/or LeFort I osteotomy approach to anterior cranial fossa with or without internal fixation, without bone graft, based on the survey responses of more than 35 otolaryngologists. 61586 is very similar to 21433 Open treatment of craniofacial separation (Lefort III type); complicated (eg, comminuted or involving cranial nerve foramina), multiple surgical approaches (work rvu = 23.69) because of the multiple approaches [LeFort I with removal of the zygomatic arch (occasionally with part of the orbital wall and/or floor), degloving the maxilla, and medial maxillectomy). It requires careful planning of the bone cuts to preserve vision, the blood supply to the palate, and careful reapproximation of the bones with plating. 61586 is more complicated than 21433 because the osteotomies must avoid incision of the vascular tumor because a life threatening hemorrhage may occur. The preservice work of 61586 is more complex than 21433, however, the post-service work is similar.

CPT Code (• New)	Tracking Number	CPT Descriptor	Global Period	RVW Recom- menda- tion
●61586	Z1	Bicoronal, transzygomatic and/or LeFort I osteotomy approach to anterior cranial fossa with or without internal fixation, without bone graft (For juvenile fibroadenoma, see 61586 and 61600)	090	23.60

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CPT Code (• New)	Tracking Number	CPT Descriptor	Global Period	RVW Recom- menda- tion
42880	Z2	Excision nasopharyngeal lesion (eg, fibroma) (42880 has been deleted. For juvenile angiofibroma of the nasopharynx, see 61586 and 61600)	090	N/A
		(For resection or excision of neoplastic, vascular or infectious nasopharyngeal lesion by bicoronal and/or transzygomatic approach, see 61586)		

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

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CPT Code: <u>61586</u>	Tracking Number: Global Period: 090 32vs	Recommended Work RVU: 23.6
CPT Descriptor:	Bicoronal, transzygomatic and/or LeFort I osteoto without internal fixation, without bone graft.	omy approach to anterior cranial fossa with or

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 16-year old male presents with a 6-month history of nasal obstruction and purulent nasal. drainage. For the past 3 months, he has had unilateral epistaxis which is becoming more difficult to control and is becoming more profuse. He has also noted a fullness in the roof of his mouth. Others have noticed hyponasal speech and have asked him if he has a chronic cold or allergies. His family physician felt that the patient had a nasal polyp and he was referred to an otolaryngologist. The otolaryngologist noted a mass in the nasal cavity and nasopharynx, along with fullness in the soft palate. A contrast enhanced CT scan showed a vascular neoplasm with distortion of the bone in the posterior ethmoid sinuses, the sphenoid sinus, the pterygomaxillary space, nasopharynx and extending into the infratemporal fossa. Angiography reveals a vascular mass whose blood supply is predominantly from the internal maxillary and ascending pharyngcal branches of the external carotid artery as well as contribution from the ipsilateral anterior and posterior ethmoid arteries. A clinical diagnosis of juvenile nasopharyngeal angiofibroma is clinically. The patient is typed and cross matched for 8 units of blood and on the day prior to surgery has repeat angiogram with embolization of the external carotid feeding vessels. At surgery, the patient a LeFort osteotomy to allow visualization of the lesion in the nose, nasopharynx, and the sphenoid sinuses, as well as the pterygomaxillary space. However, it is impossible to reach the extent of the lesion in the infratemporal fossa, and therefore a coronal incision is required with the zygomatic arch and lateral orbital bone left attached to the temporallis muscle. This vignette is a description of the most common entity, that of juvenile nasopharyngeal angiofibroma, but other very rare lesions may also be resected using this code.

Description of Pre-Service Work: The pre-service work includes answering any remaining questions the family and/or patient may have, reviewing the CT scans, MRIs, and angiograms (including the embolization angiogram), positioning the patient, injecting local anesthetic with vasoconstrictors, marking the incision(s), and prepping the patient.

Description of Intra-Service Work: The intraservice work is dependent upon the extent of the lesion – i.e., whether it goes into the parapharyngeal space, is unilateral or contralateral, involves the sphenoid sinus as well as the ethnoid sinuses and the maxillary sinus, and whether or not the lesion extends to the area of the cavernous sinus. The most common lesion will require multiple approaches which include a placement of arch bars for possible intermaxillary fixation, a bicoronal incision, removal of the ipsilateral zygomatic arch, and a sublabial incision with a "degloving" approach to obtain access to the floor of the nose, the maxillary sinus, and the pterygomaxillary fossa. A LeForte I osteotomy is then performed to down fracture the maxilla, leaving it attached (often quite tenuously so), to the neurovascular pedicles in the region of the greater palatine arteries. Often it is also necessary to incorporate an external ethmoidectomy incision.

After the tumor has been resected the zygomatic arch is then repositioned and secured with mini-plates. The maxilla is also stabilized with mini-plates. If necessary elastic bands are placed. An anterior and posterior nasal pack is then placed and the procedure is terminated.

Risks include injury to the orbital contents, the ipsilateral optic nerve, internal carotid artery, and cavernous sinus, a cerebrospinal fluid leak, injury to the pterygoid muscles resulting in trismus, and devitalization of the maxilla and/or zygomatic arch, and external cosmetic deformities with any external incisions which might be necessary.

Description of Post-Service Work: the post-service work includes accompanying the patient to the Recovery Room or Intensive Care Unit, stabilizing the patient in regard to vital signs, writing post-operative orders, dictating a detailed operative report, contacting the referring physician(s), and talking to the family.

SURVEY DATA:

Specialty: Otolaryngology-Head and Neck Surgery					
Sample Size: <u>97</u> Response Rate (%)	37.11 Mcdian RV	/U: <u>23.6</u>			
25th Percentile RVU: <u>21.56</u> 75th Percen	tile RVU: <u>25</u> Low:	: <u>15.19</u> High: <u>45</u>			
Median Pre-Service Time: <u>120</u>	_ Median Intra-Service Tim	ac: <u>270</u>			
25th Percentile Intra-Svc Time: _240 75th P	ercentile Intra-Svc Time: <u>36</u>	0_ Low: <u>120</u> High: <u>500</u>			
Median Post-Service Time:	Total Time Number o	<u>f Visits</u>			
Day of Procedure:	_40				
ICU:		2			
Other Hospital:		5			
Office:		4			

KEY REFERENCE SERVICE(S):

	CPT Code	CPT Descriptor	Work RVU
1)	21433	Open treatment of craniofacial separation (Lefort III type)	23.69
		Complicated (e.g., comminuted or involving cranial	
		Nerve foramina), multiple surgical approaches.	
2)	31225	Maxillectomy; without orbital exenteration:	15.19
-,		, <u> </u>	
3)	61580	Craniofacial approach to anterior cranial	28.90
·		fossa; extradural, including lateral	
		rhinotomy, ethmoidectomy, sphenoidotomy,	
		without maxillectomy or orbital exeneration	
4)			

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

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

The code under consideration (61586) is very similar to reference code 21433 chosen by many of the respondents due to the multiple approaches (LeForte I plus removal of the zygomatic arch (occasionally with part of the orbital wall and/or floor), degloving of maxilla, and medial maxillectorny). It requires careful planning of the bone cuts to preserve vision, the blood supply to the palate, and careful reapproximation of the bones with plating. It is more complicated in some parts than the reference code because the osteotomics must avoid incision of the very vascular tumor (life threatening hemorrhage may occur if the cuts enter the tumor since one would not have control of the tumor if it is incised). The preservice work would be more complex than the reference code and the post service work would be similar.



Code 61586 is similar to 61580 but 61586 also includes removal of the zygoma, a LeForte I osteotomy, and plating of these bony cuts when the tumor is removed.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results, or other data besides the survey data are available, please explain any additional rationale for the RVUs.

The recommended RVUs are based upon the median value from the survey respondents. Even though 61586 is more work than 61580 we will not request revision of the value upwards since we do not have <u>current</u> survey data to support such a stand. 61586 is very similar to 21433 (RVU of 23.69) as the survey data confirm. Thus, we strongly recommend the median value of 23.60.

FREQUENCY INFORMATION

How was this service previously reported? <u>42880-99 or 42999</u>

How often do physicians in your specialty perform this service? ____ Commonly _X___ Sometimes ____ Rarely Note: The lesion is a rare lesion but our specialty would be the specialty that would most commonly perform the procedure.

Estimate the number of times this service might be provided nationally in a one-year period? <u>200-250</u> Note: This procedure is almost exclusively performed on <u>Non Medicare</u> patients since juvenile nasopharyngeal angiofibromas are neoplasms of adolescent males.

Is this service performed by many physicians across the United States? ____Yes ___X_No Note: The procedure would be predominately performed in tertiary care centers.



AMA SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATIONS APRIL 1996

Computerized Dynamic Posturography - Tab 26

The RUC did not accept the work relative value recommendation of 1.30 presented by the specialty for 92548 Computerized dynamic posturography. The RUC recommends that this service be assigned a relative value similar to 92585 Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system (work rvu = .50) because both services are tests that require physician interpretation, but for which an evaluation and management service may be separately reported.

CPT Code	Tracking	CPT Descriptor	Global	RVW
(• New)	Number		Period	Recommendation
●92548	GG1	Computerized dynamic posturography	XXX	.50

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: <u>925XX</u> Tracking Number: ___ Global Period: ___

Recommended Work RVU. 1.30



CPT Descriptor: Computerized Dynamic Posturography

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A forty-five (45) year old woman with constant disequilibrium and disturbance of gait ten (10) months following a closed head injury. Physical examination shows ataxia and instability on Rhomberg testing. ENG reveals hypoactive caloric responses on the right side. Posturography shows impaired vestibluar-visual coordination. On the basis of this finding, the patient is referred for outpatient vestibular rehabilitation.

Description of Pre-Service Work: the physician reviews the patient's history, physical examination, and the findings of tests other than posturography. The physician explains why the symptoms and findings lead to obtaining a posturography study. The physician explains the testing procedure, including necessity to stand on a platform wearing a harness to catch the patient in case of a fall, and the need to follow simple instructions, such as opening or closing the eyes. The anticipated use of information obtained from posturography in planning future therapy is discussed.

Description of Intra-Service Work: The physician is available to assist in performing the study should difficulties be encountered during the test. Unusual or inconsistent findings are reviewed by the physician before completion of the study so that testing can be repeated fully or in part.

Description of Post-Service Work: The physician reviews all the data obtained from the posturography and prepares a written report summarizing and interpreting the findings. The results of posturography are explained to the patient by the physician. Recommendations for treatment are made based on the posturography results and these recommendations are discussed with the patient by the physician.

SURVEY DATA:

Specialty: Otolaryngology-Head and Neck Sur	Reiv
Sample Size: <u>93</u> Response Rate (%	6): <u>49.46</u> Mcdian RVU: <u>1.3</u>
25th Percentile RVU:91 75th Percenti	le RVU: <u>2.23</u> Low: <u>.5</u> High: <u>4.5</u>
Median Pre-Service Time: <u>10</u>	Median Intra-Service Time:15
25th Percentile Intra-Svc Time: 10 75th Per	centile Intra-Svc Time: 20 Low: 0 High: 45
Median Post-Service Time:	Total Time Number of Visits
Day of Procedure:	
ICU:	
Other Hospital:	0
Offico:	2

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KEY REFERENCE SERVICE(S):

1)	<u>CPT Code</u> 99214	<u>CPT Descriptor</u> Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components; a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problems(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.	<u>Work RVU</u> 0.94
2)	99244	Office consultation for a new or established patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination 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. Physician's typically spend 60 minutes face-to-face with the patient and/or family.	2.23

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

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

The pre intra and post service work times for computerized dynamic platform posturography and for key reference service 99214 were comparable. The mental effort and psychological stress were rated similar to reference service 99244. The intensity rating reflects the level of skill needed to counsel patients about a complex disorder that is also often accompanied by significant impairment of daily activities and strong emotional reaction.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results, or other data besides the survey data are available, please explain any additional rationale for the RVUs.

The rationale for the recommended RVU is based on the survey data.

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FREQUENCY INFORMATION	
How was this service previously reported? 92599	
How often do physicians in your specialty perform this service? Commonly _X Sometimes Rarely	
Estimate the number of times this service might be provided nationally in a one-year period? 8.000	
Is this service performed by many physicians across the United States?Yes X No	

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AMA SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATIONS APRIL 1996

Vital Capacity Test - Tab 27

The RUC agrees with the CMD comment for the five-year review that 94150 Vital capacity, total (separate procedure) (1996 work rvu = .11) is overvalued and should be assigned the same work relative value as 94690 Oxygen uptake, expired gas analysis; rest, individual (separate procedure) (work rvu = .07). A survey conducted during the five-year review by the pulmonologists indicates an intraservice time of only 4 minutes and the technical skill for this service is minimal.

CPT Code (• New)	Tracking Number	CPT Descriptor	Global Period	RVW Recommendation
94150	001	Vital capacity, total (separate procedure)	XXX	.07
94160	002	Vital capacity screening tests: total capacity, with timed forced expiratory volume (state duration), and peak flow rate	XXX	N/A
		(94160 has been deleted. For vital capacity only, see 94150. For spirometry with timed expiratory volumes, see 94010)		

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



CPT Descriptor: Vital Capacity, total

Source and Summary of Comment to HCFA on this service: Carrier Medical Directors

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 60 year old man with a history of chronic obstructive pulmonary disease (COPD) with chronic cough and shortness of breath is being evaluated as a new patient.

A 30 year old woman with a history of intermittent wheezing is being evaluated because of symptoms of shortness of breath.

Description of Pre-Service Work:

- 1. Explanation of procedure to patient and sometimes to other family members.
- 2. Explanation of the indications for doing the procedure.
- 3. Explanation of potential complications.

Description of Intra-Service Work:

Performing and monitoring the procedure.

Description of Post-Service Work:

- 1. Review and interpret results of procedure.
- 2. Explain implication of results to patient and sometimes other family members.
- 3. Discuss follow-up treatment options with patient and sometimes other family members.

SURVEY DATA:

Specialty: <u>Pulmonary Medicine</u>

Sample Size: <u>30</u>	Response Rate (%): 49	Median RVW: _	.17
25th Percentile RVW:10	75th Percentile RVW:	Low: <u>.05</u>	High: <u>2.40</u>
Median Prc-Service Time: <u>4.5</u>	mins Median Intra-Se	ervice Time: _4.	0 mins
25th Percentile Intra-Svc Time: _2	2.0 75th Percentile Intra-Svc Tir	me: <u>10.0</u> Low:	0 High: <u>30</u>



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Median Post-Service Time:		Total Time	Number of Visits	
	Dzy of Procedure:	_3.0		
	ICU:		<u> </u>	
	Other Hospital:			
	Office:	3.0	1.0	

KEY REFERENCE SERVICE(S):

1)	<u>CPT Code</u> 44160	CPT Descriptor Vital Capacity Sciencing	<u>RVW</u> - 18
2)			
3)			
4)			

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above. There is really very little difference between this procedure and the vital capacity screening test. Both 94150 and 94160 include the measurement of vital capacity and pulmonary flows. In 94150 only the vital apacity is reported, although the same measurements are made in 94160.

RATIONALE

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

The ACCP and ATS recommend that the vital capacity test and vital capacity screening should be combined under one code. The rationale for this recommendation is that the actual worl involved in both 94150 and 94160 are similar. The code should be <u>94160</u>. Please refer to the 94160 summary sheet for the recommended RVW.



AMA SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATIONS APRIL 1996

Autonomic Testing - Tab 28

The RUC accepted the recommendations presented by the American Academy of Neurology and the American Association of Electrodiagnostic Medicine which are based on the survey median of nearly 50 respondents.

Autonomic testing requires similar time and intensity than 95860 *Needle electromyography, one extremity and related paraspinal area* (work rvu = 0.96). 95860 involves 40 minutes of total time compared to 35 minutes for 95921 and 95923 and 45 minutes for 95922. The RUC also clarified that the physician is performing these tests, as well as generating a report based on the findings of the test.

CPT Code (● New)	PT Code Tracking CPT Descriptor New) Number		Global Period	RVW Recommenda- tion	
 93660 Evaluation of cardiovascular function with tilt table evaluation, with continuous ECG monitoring and intermittent blood pressure monitoring, with or without pharmacological intervention (For testing of autonomic nervous system evaluation of cardiovascular function, see 959X1-959X3) 					
●95921	•95921 PP1 Testing of autonomic nervous system evaluation of cardiovascular function, see 9. or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio		XXX	.90	

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

CPT Code (• New)	Tracking Number	CPT Descriptor	Global Period	RVW Recommenda- tion
•95922	PP2	vasomotor adrenergic innervation (sympathetic adrenergic function) including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least five minutes of passive tilt	XXX	.96
•95923	РР3	sudomotor, including one or more of the follow- ing: quantitative sudomotor axon reflex test (- QSART), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin poten- tial	XXX	.90

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

CPT Code: <u>95XX1</u> Tracking Number: <u>PP1</u> Global Period: <u>XXX</u> Recommended Work RVU: <u>0.90</u>

CPT Descriptor:

Testing of autonomic nervous system function; cardiovagal innervation (ie. Parasympathetic function), including two or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 35-year old female patient has had insulin-dependent diabetes for 8 years. She develops numbress of her feet. She is planning a pregnancy but has concerns about her prognosis, since autonomic neuropathy worsens her prognosis. Tests of cardiovagal function demonstrated a heart rate response of 1 beat per minute, confirming the presence of severe cardiovagal impairment

Description of Pre-Service Work:

Pre-service work includes discussion with referring physician regarding the need for the test, preparing to see the patient and reviewing patient's records.

Description of Intra-Service Work:



Intra-service work involves electrocardiographic monitoring of heart rate derived from R-R interval displayed on a monitor and stored for analysis. Heart response to deep breathing is derived from an anaylsis of recordings with subject breathing at a rate of 5-6 breaths per minute. Valsalva ratio is determined by dividing the maximum heart rate by the lowest heart rate. The initial heart rate responses to standing consist of tachycardia at 3 and then 12-15 seconds followed by a bradycardia at 20 seconds. The initial cardioaccelaration is an exercise reflex, while the subsequent tachycardia and bradycardia are baroreflex-medicated. The 30:15 ratio (R-R interval at beat 30)/(R-R interval at beat 15) is used as index of cardiovagal function.

Description of Post-Service Work:

Post-service work includes generation of a report based on the findings of the tests and further discussion with the referring physician if appropriate.

SURVEY DATA:

Specialty: American Academy of Neurology & America	n Association of Electrodiagnostic Medicine
Sample Size:150 Response Rate (%):33%	(49) Median RVU:0.90
25th Percentile RVU: 75th Percentile RVU:	<u>1.18</u> Low: <u>0.34</u> High: <u>2.23</u>
Median Pre-Service Time: <u>10 min</u>	Median Intra-Service Time: <u>15 min</u>
25th Percentile Intra-Service Time: <u>10 min</u>	75th Percentile Intra-Service Time: <u>30 min</u>
Low Intra-Service Time: <u>0 min</u>	High Intra-Service Time: <u>50 min</u>
Median Post-Service Time: <u>10 min</u>	

KLI I				
1)	<u>CPT Code</u> 95860	<u>CPT Descriptor</u> Needle electromyography, one extremity and related paraspinal area	<u>Work RVU</u> 0.96	
2)	95904	Nerve conduction, amplitude and latency/velocity study, each nerve, any/all site(s) along the nerve; motor, without F-wave study	0.42	
3)	95937	Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any one method	0.60	
4)	99273	Confirmatory consultation for a new or established patient, which requires a detailed history, a detailed exam, and medical decision making of low complexity	1.19	

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

		Refere	nce Ser	vices	
Time Comparison (Medians)	<u>95XX1</u>	<u>95860</u>	<u>95904</u>	<u>95937</u>	<u>99273</u>
Pre-Service Intra -Service Post-Service	10 min 15 min 10 min	10 20 10	5 10 5	5 15 10	10 20 15
Intensity Comparison (Medians)					
Mental Effort & Judgment Technical Skill & Physical Effort Psychological Stress	3 3 2	3 4 3	2 2 3	3 3 1	3 3 3

The above comparison of time and intensity of physician work appears to support the rank order of 95XX1 and the recommended RVW of 0.90 for this new service. The single extremity EMG service (CPT 95860, RVW - 0.96) was overwhelmingly listed as the primary reference service for this survey.

The median time and intensity estimates for 95XX1 are slightly lower than those for CPT 95860 and CPT 99273 and higher than those estimates for CPT 95904 and CPT 95937.

ADDITIONAL RATIONALE

KEV REFERENCE SERVICE(S).

For example, if recommended RVUs are based on an alternataive method instead of the survey results, or other data besides the survey data are available, please explain any additional rationale.

N/A - Recommended RVU is based directly on survey data.

FREQUENCY INFORMATION

How was this service previously reported? <u>The closest available code is CPT 95925 (short-latency somatosensory evoked potential study</u>). Somatosensory evoked potentials are electrically stimulated and consists of the recording of an electrical potential. The cardiovagal test described above is evoked by a standardized procedure by the patient and the response is a quantitation of changes in heart rate derived from an RR detector.

How often do physicians in your specialty perform this service? ____ Common X_ Some ____ Rarely ____

Estimate the number of times this service might be provided nationally in a one-year period? 10,000

Is this service performed by many physicians across the United States? <u>Yes X</u> No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION



CPT Code: <u>95XX2</u> Tracking Number: <u>PP2</u> Global Period: <u>XXX</u> Recommended Work RVU: <u>0.96</u>

CPT Descriptor:

Testing of autonomic nervous system function; vasomotor adrenergic innervation (ie. sympathetic adrenergic function) including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least five minutes of passive tilt

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Male, age 45, has frequent syncopal episodes, necessitating his medical retirement from his work as a building supervisor. Prolonged tilt study confirmed sycope and diagnosis of neurocardiogenic syncope was made. Treatment with β -antagonist worsened his orthostatic symptoms and frequency of syncope. He underwent tests of adrenergic function. His beat-to-beat blood pressure response to the Valsalva maneuver demonstrated an exaggerated early phase II, a loss of late phase II, and absent phase IV while a five-minute tilt demonstrated orthostatic hypotension. Sympathetic adrenergic denervation was diagnosed and he was treated with an α -agonist.

Description of Pre-Service Work:

Pre-service work includes discussion with referring physician regarding the need for the test, preparing to see the patient and reviewing patient's records.

Description of Intra-Service Work:

Intra-service work includes continuous beat-to-beat recording of blood pressure and heart rate in response to the Valsalva maneuver and at least five minutes of passive tilt-up and tilt-back. A series of Valsalva maneuvers are performed until reproducible arterial responses are obtained. Review/analysis and interpretation of the information is then performed by the physician.

Description of Post-Service Work:

Post-service work includes generation of a report based on the findings of the test and further discussion with the referring physician if appropriate.

SURVEY DATA:

Specialty: <u>American Academy of Neurology & American Association of Electrodiagnostic Medicine</u>

Sample Size: 150	_ Response Rate (%):	31% (46)	Median RVU:	0.96
25th Percentile RVU: <u>0.</u>	66 75th Percentile RV	'U: <u>1.53</u>	Low: <u>0.40</u>	High: <u>2.57</u>
Median Pre-Service Time:	<u>10 min</u>	Media	an Intra-Service T	Time: <u>25 min</u>
25th Percentile Intra-Servi	ce Time: <u>15 min</u>	75th F	Percentile Intra-S	ervice Time: <u>30 min</u>
Low Intra-Service Time: _	<u>0 min</u>	High	Intra-Service Tim	ne: <u>60 min</u>
Median Post-Service Time	: <u>10 min</u>			

KEY REFERENCE SERVICE(S):

1)	<u>CPT Code</u> 95860	<u>CPT Descriptor</u> Needle electromyography, one extremity and related paraspinal area	<u>Work RVU</u> 0.96	
2)	95861	Needle electromyography, two extremities and related paraspinal area	1.54	
3)	99243	Office consultation for a new or established patient, which requires a detailed history, a detailed exam and medical decision making of low complexity	1.47	
4)	93880	Duplex scan of extracranial arteries, complete bilateral study	0.60	

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

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

	-	Ketere	Reference Services				
Time Comparison (Medians)	<u>95XX2</u>	<u>95860</u>	<u>95861</u>	<u>99243</u>	<u>93880</u>		
Pre-Service Intra -Service Post-Service	10 min 25 min 10 min	10 20 10	10 30 10	5 35 10	5 15 10		
Intensity Comparison (Medians)							
Mental Effort & Judgment Technical Skill & Physical Effort Psychological Stress	4 3 · 3	3 4 3	4 4 3	4 3 4	3 3 2		C

The above comparison of time and intensity of physician work appears to support the rank order of 95XX2 and the recommended RVW of 0.96 for this new service. The single extremity EMG service (CPT 95860, RVW - 0.96) was overwhelmingly listed as the primary reference service for this survey.

The median time and intensity estimates for 95XX2 are nearly identical to those for CPT 95860. Respondents estimated intra-service time and the mental effort and judgment to be slightly greater for CPT 95XX1 than for CPT 95860 and the technical skill and physical effort to be slightly less. Time and intensity for CPT 95861 and 99243 were rated higher than that for 95XX1 and lower for CPT 93880.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternataive method instead of the survey results, or other data besides the survey data are available, please explain any additional rationale.

N/A - Recommended RVU is based directly on survey data.

FREQUENCY INFORMATION

How was this service previously reported? <u>CPT 93660 (evaluation of cardiovascular function with tilt table evaluation, with continuous ECG monitoring and intermittent blood pressure monitoring with or without pharmacological intervention) represents the best option. This code is appropriate for 40 minutes of passive tilt. The new code contains a shorter tilt component which is noninvasive, does not utilize pharmacologic agents and has different end-points. There is currently no code for recording of beat-to-beat blood pressure during the Valsalva maneuver.</u>

How often do physicians in your specialty perform this service? ____ Common X Some ___ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 10,000

Is this service performed by many physicians across the United States? ____Yes X__No

CPT Code: <u>95XX3</u> Tracking Number: <u>PP3</u> Global Period: <u>XXX</u> Recommended Work RVU: <u>0.90</u>

CPT Descriptor:

Testing of autonomic nervous system function; sudomotor including one of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A man age 52 years, develops severe burning sensation affecting his toes and proximal foot. Standard laboratory tests have excluded diabetes, avitaminosis B12, heavy metal poisoning and metabolic causes of neuropathy. There is no compelling sensory loss and normal reflexes. The electromyogram and nerve conduction studies are within normal limits. QSART distribution shows an absent response over the foot and a graded response proximal to that, definitively demonstrating the presence of distal small fiber (postganglionic sympathetic) involvement.

Description of Pre-Service Work:

Pre-service work includes discussion with referring physician regarding the need for the test, preparing to see the patient and reviewing patient's records.

Description of Intra-Service Work:



Intra-service work involves the stimulation of sympathetic nerve fibers to the sweat glands at standard sites by the iontophoresis of acetylcholine and measuring the evoked sweat response by sudrometers. Optimally, the test is performed on one forearm site and three lower extremity sites in order to determine the severity and distribution of the sympathetic deficit. Review/analysis and interpretation of the information is then performed by the physician.

(Silastic sweat imprint differs from QSART in that the recording is an imprint of the sweat droplets appearing as indentations on silastic material. Thermoregulatory sweat test is a test of sympathetic nerves that supply the skin involving dusting the skin with an indicator powder which changes color when the patient sweats in response to raising patient's temperature in a heat cabinet. Sympathetic skin potentials are evoked through electrical stimulation of the skin and recordings are made over the palm and soles of the feet. The skin potential change is carried by autonomic nerve fibers and determines if these fibers are working normally.

Description of Post-Service Work:

Post-service work includes generation of a report based on the findings of the test and further discussion with the referring physician if appropriate.

SURVEY DATA:

Specialty: <u>American Academy of Neurology & American Association of Electrodiagnostic Medicine</u>							
Sample Size: <u>150</u> Response Rate (%):	30% (45) Median RVU: 0.87						
25th Percentile RVU: <u>0.49</u> 75th Percentile I	RVU: <u>1.20</u> Low: <u>0.35</u> High: <u>3.00</u>						
Median Pre-Service Time: <u>10 min</u>	Median Intra-Service Time: <u>15 min</u>						
25th Percentile Intra-Service Time: <u>10 min</u>	75th Percentile Intra-Service Time: <u>30 min</u>						
Low Intra-Service Time: <u>0 min</u>	High Intra-Service Time: <u>70 min</u>						
Median Post-Service Time: 10 min							

			CPT Code:	95XX3	~	-
KEY	REFERENCE	SERVICE(S):				
1)	<u>CPT Code</u> 95860	<u>CPT Descriptor</u> Needle electromyography, one extremity and related paraspinal area		<u>Work RV</u> 0.96	<u>/U</u>	
2)	95861	Needle electromyography, two extremities and related paraspinal area		1.54		
3)	95900	Nerve conduction, amplitude and latency/velocity study, each nerve, any/all site(s) along the nerve; without F-wave study	y motor,	0.42		
4)	99214	Office or other outpatient visit for an established p which requires at least two of these three compone detailed history, a detailed exam, and medical dec making of moderate complexity	oatient ents: a ision	0.94		

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

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

		INCICIC.		VICCO		
Time Comparison (Medians)	<u>95XX3</u>	<u>95860</u>	<u>95861</u>	<u>95900</u>	<u>99214</u>	
Pre-Service Intra -Service Post-Service Intensity Comparison (Medians)	10 min 15 min 10 min	10 20 10	10 35 10	8 10 5	2 25 10	
Mental Effort & Judgment Technical Skill & Physical Effort Psychological Stress	3 3 2	3 3 3	4 4 4	3 2 2	4 3 3	

The above comparison of time and intensity of physician work appears to support the rank order of 95XX3 and the recommended RVW of 0.90 for this new service. The single extremity EMG service (CPT 95860, RVW - 0.96) was overwhelmingly listed as the primary reference service for this survey.

The median time and intensity estimates for 95XX3 are only slightly lower than those for CPT 95860 and CPT 99214 (RVW - 0.94) and are greater than estimates for motor nerve conduction CPT 95900.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternataive method instead of the survey results, or other data besides the survey data are available, please explain any additional rationale.

The median RVW for CPT 95XX3 is 0.87 as compared to a median value of 0.90 for CPT 95XX1. The time and intensity estimates of physician work for these two codes, however, are identical. Physicians who perform these tests agree that the amount and complexity of work associated with these two new codes is similar and therefore an identical value of 0.90 has been recommended for 95XX3.

FREQUENCY INFORMATION

How was this service previously reported? <u>There are currently no codes available for this service.</u> The closest available codes are CPT 97033 (iontophoresis, each 15 minutes) and CPT 89360 (sweat collection by iontophoresis). These codes do not accurately reflect the intent, procedure and equipment associated with the autonomic function test(s) as described in the above CPT descriptor.

How often do physicians in your specialty perform this service? ____ Common _X_ Some ____ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 10,000

Is this service performed by many physicians across the United States? ____Yes X__No





AMA SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATIONS APRIL 1996

Drainage of Abscess - Tab 29

The RUC reviewed 49020 Drainage of peritoneal abscess of localized peritonitis, exclusive of appendiceal abscess, transabdominal (work rvu = 9.06) during the five-year review and determined that the code should be split into two codes, one describing an open procedure and another describing percutaneous drainage.

The RUC agrees that code 49020, now clarified as an open procedure, is undervalued and recommends an increase to 14.25 based on the 25th percentile of the survey responses of 50 general surgeons. Only the most complex patients with extensive non-localized peritonitis require surgical drainage rather than percutaneous drainage. The intra-operative work involves draining the abscesses, as well as meticulously dissecting numerous adhesions. These patients usually are admitted to the ICU following the operation, are difficult to manage postoperatively, and require a great deal of care and attention by the surgeon.

In addition, the survey of 50 general surgeons conducted for the five-year indicates a dramatic increase in length of hospital stay for 49020. The Harvard data includes a length of stay of 7 days, with no ICU time. The RUC survey length of stay is 14 days, with 2 ICU visits by the surgeon.

The RUC is unable to develop a recommendation for 49021 *Drainage of peritoneal abscess of localized peritonitis, percutaneous* at this time. The Society of Cardiovascular and Interventional Radiology will be seeking reconsideration of CPT changes for percutaneous abscess drainage and will survey these codes for a future RUC meeting.

CPT Code (● New)	Tracking Number	CPT Descriptor	Global Period	RVW Recommendation
49020	U9	Drainage of peritoneal abscess of localized peritonitis, exclusive of appendiceal abscess; open transabdominal	090	14.25
•49021	U10	percutaneous	090	No Recommendation at this time

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

CPT Code: 49020 Global Period: 090 1995 RVW: 9.06 Recommended RVW: 16.50



CPT Descriptor: Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess, transabdominal

Source and Summary of Comment to HCFA on this service: A Technical Consulting Panel of 14 general surgeons, with the assistance of Abt Associates, Inc., designed a study that included a survey instrument to effectively measure all aspects of physician work for commonly performed general surgery services. The results of this study found code 49020 to be undervalued at the present time.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 58-year-old male presented a month ago with a history of severe abdominal pain and intraperitoneal free air. He was taken to the operating room and underwent a Hartmann procedure for perforated sigmoid diverticulum with gross intraperitoneal contamination and soilage. He did well in the immediate postoperative period, but subsequently he began to run low- and then high-grade fevers. CT scan showed multiple intraperitoneal abscesses throughout the entire range of the mesentery, with three separate obvious collections of pus, as well as a subhepatic collection on the right side and subphrenic collection on the left side. Because of the extensive nature of the disease and the lack of accessibility to drain these abscesses with a catheter percutaneously, he was taken to the operating room and underwent full abdominal re-exploration with interruption of all of the abscessed cavities, irrigation with saline, and subsequent antibiotic solution and closure. Postoperatively, the patient did fairly well and slowly got better. He was discharged from the hospital on the fourteenth postoperative day from this procedure.

Description of Pre-Service Work: Pre-service work begins after the decision to operate is made, from the day before the operation until the time of the procedure. This activity includes obtaining and reviewing the previous work-up, with special attention to cardiopulmonary, gastrointestinal, and hematologic status; reviewing previous CT scans and ultrasounds, pathology and laboratory studies; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or the patient's family) to explain the operative risks and benefits and to obtain informed consent. Other preoperative services include dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite.

Description of Intra-Service Work: The abdomen is incised, with dissection carried through the abdominal wall and into the peritoneal cavity. The peritoneum is explored for the presence of abscess, debris, or other abnormalities. There are multiple adhesions between loops of bowel, each requiring meticulous dissection and hemostasis. The subphrenic spaces also are explored, with drainage of pus. Cultures for aerobes and anaerobes are obtained for the various collections of drained pus. Fibrinous material, along with blood clots and necrotic material, is debrided and removed from the abdomen and pelvis. Lavage of the abscess cavities is performed, and drains are inserted, as necessary. The abdominal wall is closed in layers, including packing the skin open with gauze.

Description of Post-Service Work: Post-service work begins after skin closure in the operating room and includes the application of sterile dressings. Post-service work also includes monitoring the patient's stability in the recovery room; writing orders; communicating with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including ICU care and ventilator management, as necessary; careful monitoring of cardiopulmonary status; ordering and reviewing postoperative radiographs and laboratory studies; monitoring and care of the incision; monitoring, maintenance, and removal of all tubes and drains; and antibiotic and pain medication management. Discharge management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure including removal of sutures; ordering and evaluating periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments.



SURVEY DATA:

Specialty: American College of Surgeons

Sample Size: 175

Response Rate (%): 47 (27%)



1. ---

	Me	dian	Low	25th pctl	75th pctl	High
RVW:	16	.50	11.90	14.25	19.50	24.00
PRE-Service	6	0	1			
INTRA-Service	125		60	120	160	270
POST-Service:						
Day of procedure - total time	30]			
ICU - total time / # of visits	30	2	1			
Other hosp total time / # of visits	180	13]			
Office - total time / # of visits	60	4	1			

KEY REFERENCE SERVICE(S):

1995			
<u>RVW</u>	<u>Global</u>	<u>CPT</u>	Descriptor
12.52	090	44005	Enterolysis (freeing of intestinal adhesion) (separate procedure)
18.10	09 0	43631	Gastrectomy, partial, distal; with gastroduodenostomy
3.64	xxx	99291	Critical care, first hour
1.84	xxx	99292	Critical care, additional 30 minutes
0.51	xxx	99231	Subsequent hospital care
0.88	XXX	99232	Subsequent hospital care
1.25	xxx	99233	Subsequent hospital care
1.06	xxx	99238	Hospital discharge day
0.38	xxx	99212	Office/outpatient visit, established

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill and physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The intra-operative work of 49020 involves more work than 44005 due to the fact that, in addition to the abscesses, there are many adhesions that have to be meticulously dissected. The intra-operative work of 49020 is less than 43631 in that no resection or anastomosis is performed.

The work of 49020 relates to the following E/M services: preoperative care after the decision to operate is made (99232; RVW=0.88); intra-operative work (99291; RVW=3.64 plus 2x99292; RVW=3.68); subsequent same day hospital care (99232; RVW=0.88); ICU care (2x99233; RVW=2.50); subsequent hospital care (3x99232; RVW=2.64 plus 8x99231; RVW=4.08); discharge day management (99238; RVW=1.06); and post-discharge office visits (4x99212; RVW=1.52). These E/M codes equate to an RVW of 20.88. This calculation is based the building block methodology previously accepted and used by the RUC and demonstrates that this code is undervalued.

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

The recommended increase in the RVW (from 9.06 to 16.50) is based on two factors: CPT coding changes and inaccurate time data from the Harvard project.

1. Code 49020 does not accurately describe the surgical management of intra-abdominal abscesses. Due to advances in interventional radiological treatment, these abscesses frequently are drained percutaneously. Only the most complex patients with extensive non-localized peritonitis require surgical drainage. At the present time, the only code that is available to describe the surgical management of these patients is 49020.

When code 49020 was first introduced to the CPT system, it applied to an open surgical procedure. CPT coding changes from 1991 to 1992 led to the deletion of code 75990, which was used for percutaneous drainage [Radiological guidance for percutaneous drainage of abscess, or specimen collection (i.e., fluoroscopy, ultrasound or computer tomography), with or without placement of indwelling catheter; complete procedure]. A review of Medicare frequency data confirms that, since 1992, code 49020 is being used for percutaneous drainage, a substantially lesser procedure that previously was reported using 75990. It also should be noted that patients requiring percutaneous drainage seldom are seen again during the 90-day global period, as compared with the surgical patients who are followed postoperatively for at least 90 days. According to Medicare frequency data for this code, the specialty mix is as follows: 46.1 percent are radiologists, 3.3 percent are interventional radiologists, and 39.9 percent are general surgeons. At least in terms of the Medicare program, more radiologists and interventional radiologists are using this code than general surgeons. It would seem clear that code 75990 should be reinstituted in the CPT coding system.

CPT	Specialty	1991 Medicare Frequency	1992 Medicare Frequency
49020	All specialties	8,920	13,784
	General surgery	6,025	6,335
	Diagnostic radiology	964	5,285
75990	All specialties	. 14,472	8
	General surgery	47	0
	Diagnostic radiology	12,701	8

2. Code 49020 was included in the Harvard project, and a work value of 10.73 was recommended. This value is higher than the current value for this code. Moreover, the Harvard value is based on pre-service, intra-service, post-service hospital, and post-service office times that are less than those obtained in the five-year review survey. In addition, the Harvard data included no ICU time for these patients, while the 5-year review survey documented the need for 2 ICU visits by the surgeon. The length of stay for this procedure in the Harvard project was 7 days, compared with 14 days in the five-year review survey. The patients who require surgical treatment are not suitable for percutaneous drainage due to the multiple abscesses and are much sicker patients than those that are reflected in the Harvard data.

СРТ	Study	LOS	Pre-Service Time	Intra-Service Time	Post-Service Hospital Time	Post-Service Office Time
49020	Harvard	7 days	57	76	98	40
	5-Year Survey Review	14 days	60	125	240	60







AMA SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATIONS APRIL 1996

Nasolacrimal Duct Probe - Tab 30

The codes (68800-68830) for dilation of lacrimal punctum and probing of a nasolacrimal duct have been deleted and replaced with new codes (68801 - 68815) to indicate that these codes should be used to report unilateral procedures. Bilateral procedures will be reported using the code with the -50 modifier.

The RUC accepted the relative value recommendations presented by ophthalmology and optometry which were based on budget neutral calculations assuming that 50% of 68801 *Dilation of lacrimal punctum, with or without irrigation* and 31% of 68810 *Probing of nasolacrimal duct, with or without irrigation* are performed bilaterally and would be subject to the multiple surgery reduction.

The RUC also accepted the American Academy of Ophthalmology's request to increase the relative value for 68811 *Probing* of nasolacrimal duct, with or without irrigation; requiring general anesthesia from 1.53 to 2.25. Sixty-two percent of these procedures are performed unilaterally. The pre, intra, and post-service work of this service are also comparable to 67345 *Chemodenervation of extraocular muscle* (work rvu = 2.91).

68812 Probing of nasolacrimal duct, with or without irrigation; with insertion of tube or stent is performed when 68811 has failed. The RUC agreed that the relative value for this service should be increased from 2.12 to 3.00 to maintain relativity with 68810 and 68811. This increase is justified by: the degree of pre-, intra-, and post-service work involved in this procedure; the complications of intra-nasal bleeding; the possibility of aspirating blood intra- or post-operatively; and the morbidity associated with drawing metallic probes through the nasolacrimal system.

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

CPT Code (• New)	Tracking Number	CPT Descriptor	Global Period	RVW Recommendation
68800*	C1	Dilation of lacrimal punctum, with or without irrigation	010	N/A
		(68800 has been deleted. To report, 68801)		
•68801*	C2	Dilation of lacrimal punctum, with or without irrigation	010	.89
		(To report a bilateral procedure, use 68801 with modifier -50 or 09950)		
● 68810*	C3	Probing of nasolacrimal duct, with or without irrigation;	010	1.27
68820*	C4	Probing of nasolacrimal duct, with or without irrigation, unilateral or bilateral;	010	N/A
•68811	C5	requiring general anesthesia	010	2.25
68825	C6	requiring general anesthesia	010	N/A
•68815	C7	with insertion of tube or stent	010	3.00
68830	C8	with insertion of tube or stent	010	N/A
		(To report a bilateral procedure, use 68810, 68811 or 68815 with modifier -50 or 09950) (68820, 68825, 68830 have been deleted. To report, see 688- 10, 68811 or 68815).		

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: <u>688x1</u> Tracking Number: $\underline{\mathcal{L}}_{\underline{\mathcal{L}}}$ Global Period: <u>10</u> Recommended Work RVU: <u>0.89</u>

CPT Descriptor: Dilation of lacrimal punctum, with or without irrigation (To report a bilateral procedures 688X1 with Modifier -50 or 09950)

Note: The AAO withdrew its original recommendations for this procedure which were to be presented at the February RUC meeting. Since then the AAO and the AOA have surveyed members regarding the frequency with which this procedure is performed bilaterally. Since this procedure will be eligible for bilateral billing when the coding change takes effect, we now recommend a revenue neutral reduction in the RVWs for this procedure from 1.11 to 0.89.

CLINICAL DESCRIPTION OF SERVICE:

<u>Vignette:</u> 65 year old patient presents with chronic tearing. Examination reveals stenotic lacrimal punctae. Topical anesthesia is administered. the interior and superior puncta are dilated with a punctal dilator.

<u>Description of Pre-Service Work:</u> This procedure is typically performed on adults in the office under local and/or topical anesthesia. It is performed in an attempt to open a stenotic lacrimal punctae in patients complaining of epiphora (i.e., tearing).

Justification for this procedure is first determined by an appropriate examination typically paid under a separate E/M code. A nasal examination is also performed. Dye disappearance tests are performed to determine the possible position of the blockage, even though the punctae may appear physically stentotic. These involve placing fluorescein dye in the inferior conjunctival cul-de-sac and waiting 5-15 minutes for the dye to disappear from the surface of the eye.

If the dye remains, retrieval of the dye from the nose using a cotton tip applicator before and after irrigating the lacrimal system is performed. Topical and/or local anesthesia are usually given around the punctae and lacrimal sac areas.

<u>Description of Intra-Service Work:</u> Topical and/or local anesthesia are usually given around the punctae and lacrimal sac areas. Typically, commercially available lacrimal dilators of various sizes are pushed into each puncta. This procedure is performed in both the upper and lower punctae. The lacrimal system can be irrigated to insure its patency.

<u>Description of Post-Service Work:</u> Postoperative evaluations are typically once or twice during the first week after procedure (e.g., one day and/or one week postop). If the epiphora has resolved, then further follow-up is not necessary after this point. In cases where a chronic infection is a result of the nasolacrimal duct obstruction, continued follow-up may be required until problem is resolved.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 688x1 Tracking Number: ____ Global P

Global Period: 10 Recommended W

Recommended Work RVU: 1.50

CPT Descriptor: Dilation of lacrimal punctum, with or without irrigation (To report a bilateral procedures 688X1 with Modifier -50 or 09950)

CLINICAL DESCRIPTION OF SERVICE:

<u>Vignette Used in Survey</u>: A 65 year old patient presents with chronic tearing. Examination reveals stenotic lacrimal punctae. Topical anesthesia is administered. the interior and superior puncta are dilated with a punctal dilator.

<u>Description of Pre-Service Work</u>: This procedure is typically performed on adults in the office under local and/or topical anesthesia. It is performed in an attempt to open a stenotic lacrimal punctae in patients complaining of epiphora (i.e., tearing).

Justification for this procedure is first determined by an appropriate examination typically paid under a separate E/M code. A nasal examination is also performed. Dye disappearance tests are performed to determine the possible position of the blockage, even though the punctae may appear physically stentotic. These involve placing fluorescein dye in the inferior conjunctival cul-de-sac and waiting 5-15 minutes for the dye to disappear from the surface of the eye.

If the dye remains, retrieval of the dye from the nose using a cotton tip applicator before and after irrigating the lacrimal system is performed. Topical and/or local anesthesia are usually given around the punctae and lacrimal sac areas.

<u>Description of Intra-Service Work:</u> Topical and/or local anesthesia are usually given around the punctae and lacrimal sac areas. Typically. commercially available lacrimal dilators of various sizes are pushed into each puncta. This procedure is performed in both the upper and lower punctae. The lacrimal system can be irrigated to insure its patency.

<u>Description of Post-Service Work:</u> Postoperative evaluations are typically once or twice during the first week after procedure (e.g., one day and/or one week postop). If the epiphora has resolved, then further follow-up is not necessary after this point. In cases where a chronic infection is a result of the nasolacrimal duct obstruction, continued follow-up may be required until problem is resolved.

SURVEY DATA:

Specialty: American Academy of Ophthalmology

Sample Size: <u>117</u> Response Rate (%): <u>10</u> Median RVU: <u>1.5</u>

25th Percentile RVU: 0.86 75th Percentile RVU: 2.00 Low: 0.30 High: 2.80

Median Pre-Service Time: <u>17.5</u> Median Intra-Service Time: <u>11</u>

25th Percentile Intra-Svc Time: 7.50 75th Percentile Intra-Svc Time: 13.75 Low: 5 High: 30

Median Post-Service Time:	Total Time	Number of Visits
Day of Procedure:	10	
ICU:		
Other Hospital:	· · · · · · · · · · · · · · · · · · ·	
Office:		2.0

CPT Code: <u>688x1</u>

KEY REFERENCE SERVICE(S):

	CPT Code	CPT Descriptor	Work RVU
1)	20670	Removal of implant; superficial	1.69
2)	11622	Excision, malignant lesion, scalp,. neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm	2.29

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

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

Reference codes 20670 and 11622 involve less pre-service work than 688x1 since there is virtually no preparation other than the initial examination prior to these actual procedures. The 688x1 is commonly preceded by dye disappearance tests. Intra-service work is less work-intensive than either 20670 or 11642. The work time is less.

Post-service work is less than 11622 since sutures must be removed and a longer term follow-up exam is usually performed. In 20670, follow-up wound care must be performed However, in cases where a chronic infection is a result of the punctal stenosis, continued follow-up may be similar until problem is resolved.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results, or other data besides the survey data are available, please explain any additional rationale for the RVUs.

FREQUENCY INFORMATION

How was this service previously reported? <u>68800</u>

How often do physicians in your specialty perform this service? X Commonly Sometimes Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 33,000 in <u>Medicare (1994)</u>.

Is this service performed by many physicians across the United States? X Yes No





SURVEY DATA:

Specialty Societies: American Academy of Ophthalmology & American Optometric Association

The American Academy of Ophthalmology (AAO) surveyed 50 general ophthalmologists and asked them how frequently they perform this procedure and how frequently they perform it unilaterally and bilaterally. A copy of that questionnaire is attached. Thirty responded (a 60 percent response rate). The weighted mean of thes responses shows that 46 percent of these procedures perfromed by ophthalmolgists are done bilaterally.

The American Optometric Association (AOA) surveyed 50 optometrists and got 24 responses (a 48 percent response rate). The weighted mean of the responses shows that optometrists perform these procedures bilaterally 81 percent of the time.

To arrive at a revenue neutral recommended reduction in RVWs, we weighted the data to account for the fact that ophthalmolgist do 88 percent of these procedures (BESS - 1994). We also assumed that this procedure, when performed bilaterally, would be subject to HCFA's multiple surgery reduction policy.

Here is the math:

<u>Ophthalmolgists</u>	<u>Optometrists</u>		
46%	81%		
<u>x88%</u>	<u>x12%</u>		
40%	+ 10% =	50%	performed bilaterally

1.11 Current RVW / (1 + (50% bilateral X 50%)) = .89 Revenue Neutral RVW

Medicare data would not have been helpful in making this analysis because physician do not currently use the bilateral modifiers for this procedure.

KEY REFERENCE SERVICE(S):

	CPT Code	CPT Descriptor	Work RVU
1)	20670	Removal of implant; superficial	1.69
2)	11622	Excision, malignant lesion, scalp,. neck, hands, feet, genitalia; 2.29 lesion diameter 1.1 to 2.0 cm	

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

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

Reference codes 20670 and 11622 involve less pre-service work than 688x1 since there is virtually no preparation other than the initial examination prior to these actual procedures. The 688x1 is commonly preceded by dye disappearance tests. Intra-service work is less work-intensive than either 20670 or 11642. The work time is less.

Post-service work is less than 11622 since sutures must be removed and a longer term follow-up exam is usually performed. In 20670, follow-up wound care must be performed However, in cases where a chronic infection is a result of the punctal stenosis, continued follow-up may be similar until problem is resolved.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results, or other data besides the survey data are available, please explain any additional rationale for the RVUs.

FREQUENCY INFORMATION

How was this service previously reported? <u>68800</u>

How often do physicians in your specialty perform this service? X Commonly Sometimes Rarely

Estimate the number of times this service might be provided nationally in a one-year period? <u>33,000 in</u> <u>Medicare (1994).</u>

Is this service performed by many physicians across the United States? X Yes No
CPT Code:688x2Tracking Number: (23 Global Period:10Recommended Work RVU:1.27CPT Descriptor:Probing of nasolacrimal duct, with or without irrigation;

Note: The AAO withdrew its original recommendations for this procedure which were to be presented at the February RUC meeting. We have since surveyed members regarding the frequency with which this procedure is performed bilaterally. Since this procedure will be eligible for bilateral billing when the coding change takes effect, we now recommend a revenue neutral reduction in the RVWs for this procedure from 1.47 RVWs to 1.27 RVWs.

CLINICAL DESCRIPTION OF SERVICE:

<u>Vignette Used in Survey:</u> A 48 year old patient presents with chronic tearing and crusting. Topical anesthesia is administered. The superior and inferior puncta are dilated with a lacrimal dilator. A lacrimal probe is introduced into a punctum, passed through the canaliculus, through the lacrimal sac, through the nasolacrimal duct and into the nasopharynx. The probe is withdrawn. A lacrimal canula is placed in the nasolacrimal duct and fluorescein containing saline is irrigated through the duct into the nasal pharynx, where the dye is retrieved.

<u>Description of Pre-Service Work:</u> This procedure is typically performed on adults in the office under local and/or topical anesthesia. It is performed in an attempt to open a mechanically blocked nasolacrimal passage in patients complaining of epiphora (i.e., tearing).

Justification for this procedure is first determined by an appropriate examination typically paid under a separate E/M code. A nasal examination is also performed. Dye disappearance tests are performed to determine the possible position of the blockage. These involve placing fluorescein dye in the inferior conjunctival cul-de-sac and waiting 5-15 minutes for the dye to disappear from the surface of the eye.

If the dye remains, retrieval of the dye from the nose using a cotton tip applicator before and after irrigating the lacrimal system is performed. The lacrimal punctae are dilated (billed as a separate procedure). Topical and/or local anesthesia are usually given around the punctae and lacrimal sac areas.

<u>Description of Intra-Service Work:</u> Typically, commercially available lacrimal probes of various diameters are passed through the dilated puncta, canaliculus, nasolacrimal sac and nasolacrimal duct into the nose under the inferior tubinate. The end of the metal rod is pushed into the nose which, typically, penetrates a blockage in the nasolacrimal duct. This procedure is performed in both the upper and lower canalicular systems. The lacrimal system is usually irrigated to insure its patency.

<u>Description of Post-Service Work:</u> Postoperative evaluations are typically once or twice during the first week after procedure (e.g.. one day and/or one week postop). If the epiphora has resolved, then further follow-up is not necessary after this point. In cases where a chronic infection is a result of the nasolacrimal duct obstruction, continued follow-up may be required until problem is resolved.

CPT Code: <u>688x2</u> Tracking Number: ____ Global Period: <u>10</u> Recommended Work RVU: <u>2.00</u>

CPT Descriptor: Probing of nasolacrimal duct, with or without irrigation;

CLINICAL DESCRIPTION OF SERVICE:

<u>Vignette Used in Survey:</u> A 48 year old patient presents with chronic tearing and crusting. Topical anesthesia is administered. The superior and inferior puncta are dilated with a lacrimal dilator. A lacrimal probe is introduced into a punctum, passed through the canaliculus, through the lacrimal sac, through the nasolacrimal duct and into the nasopharynx. The probe is withdrawn. A lacrimal canula is placed in the nasolacrimal duct and fluorescein containing saline is irrigated through the duct into the nasal pharynx, where the dye is retrieved.

<u>Description of Pre-Service Work:</u> This procedure is typically performed on adults in the office under local and/or topical anesthesia. It is performed in an attempt to open a mechanically blocked nasolacrimal passage in patients complaining of epiphora (i.e., tearing).

Justification for this procedure is first determined by an appropriate examination typically paid under a separate E/M code. A nasal examination is also performed. Dye disappearance tests are performed to determine the possible position of the blockage. These involve placing fluorescein dye in the inferior conjunctival cul-de-sac and waiting 5-15 minutes for the dye to disappear from the surface of the eye.

If the dye remains, retrieval of the dye from the nose using a cotton tip applicator before and after irrigating the lacrimal system is performed. The lacrimal punctae are dilated (billed as a separate procedure). Topical and/or local anesthesia are usually given around the punctae and lacrimal sac areas.

<u>Description of Intra-Service Work</u>: Typically, commercially available lacrimal probes of various diameters are passed through the dilated puncta, canaliculus, nasolacrimal sac and nasolacrimal duct into the nose under the inferior tubinate. The end of the metal rod is pushed into the nose which, typically, penetrates a blockage in the nasolacrimal duct. This procedure is performed in both the upper and lower canalicular systems. The lacrimal system is usually irrigated to insure its patency.

<u>Description of Post-Service Work</u>: Postoperative evaluations are typically once or twice during the first week after procedure (e.g., one day and/or one week postop). If the epiphora has resolved, then further follow-up is not necessary after this point. In cases where a chronic infection is a result of the nasolacrimal duct obstruction, continued follow-up may be required until problem is resolved.

SURVEY DATA:

Specialty: American A	cademy of Ophthalmology		
Sample Size: <u>117</u>	Response Rate (%): <u>11</u> Median RVU: <u>2.125</u>		
25th Percentile RVU:	<u>0.96</u> 75th Percentile RVU: <u>2.8</u> Low: <u>0.30</u>	High: <u>3.50</u>	1
Median Pre-Service Til	me: <u>20</u> Median Intra-Service Time: <u>15</u>		

25th Percentile Intra-Svc Time: 10	75th Percentile Intra-Svc Time:	<u>30</u> Low: <u>5</u> High: <u>45</u>
Median Post-Service Time:	Total Time	Number of Visits
Day of Procedure:	15	
ICU:		
Other Hospital:	10	2
Office:	45	2



From: American Acad. of Ophthalmology To: Sandra ShermarDate: 1/23/95 Time: 09:26:00

CPT Code: <u>688x2</u>

KEY REFERENCE SERVICE(S):

	CPT Code	CPT Descriptor Work	<u>c RVU</u>
1)	66821	YAG laser posterior capsulotomy	2.78
2)	11642	Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0cm	2.88

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

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

Code 66821 (YAG laser posterior capsulotomy) and 11622 (Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0cm) These codes involve less pre-service work that 688x2 since there is virtually no preparation other than the initial examination prior to these actual procedures. The 688x2 requires some nasal preparation and is usually preceded by dye disappearance tests. Intra-service work is slightly more work-intensive since familiarity with two organ systems (e.g., eye and nose) is required. Excision of skin lesion is straight forward with all work visible at all times. YAG laser capsulotomy can be as difficult with a thick posterior capsule that does not split open when the laser pulse strikes it.

Intranasal work can be difficult is many cases with various nasal anatomies and more difficult in children with small nasal passages making visibility very difficult at times. These difficulties can increase mental and physical efforts as well as psychological stress of this procedure which is non-existent in the 11642. In 66821, the "pitting or tracking" of the intraocular lens (IOL) can increase the psychological stress when the capsule is touching the IOL surface.

Post-service work is slightly greater in 11642 since sutures must be removed and a longer term follow-up exam is usually performed. Likewise, after a YAG laser capsulotomy, the potential increase in intraocular pressure must be addressed and more frequent follow-up examinations are required. However, in cases where a chronic infection is a result of the nasolacrimal duct obstruction, continued follow-up may be similar to these other two codes until problem is resolved.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternataive method instead of the survey results, or other data besides the survey data are available, please explain any additional rationale for the RVUs.

FREQUENCY INFORMATION

How was this service previously reported? _____68820

How often do physicians in your specialty perform this service? X Commonly _ Sometimes _Rarely

Estimate the number of times this service might be provided nationally in a one-year period? <u>24,677</u> <u>Nationally in Medicare (1994)</u>.

Is this service performed by many physicians across the United States? X Yes No





SURVEY DATA:

Specialty Society: American Academy of Ophthalmology

The American Academy of Ophthalmology (AAO) surveyed 50 general ophthalmologists and asked them how frequently they perform this procedure and how frequently they perform it unilaterally and bilaterally. A copy of that questionnaire is attached. Thirty responded (a 60 percent response rate). The weighted mean of thes responses shows that 31 percent of these procedures performed by ophthalmolgists are done bilaterally.

We assumed that this procedure, when performed bilaterally, would be subject to HCFA's multiple surgery reduction policy. Here is the math:

1.47 current RVW / (1 + (31% Bilateral X 50%)) = 1.27 revenue neutral RVW

Medicare data would not have been helpful in making this analysis because physician do not currently use the bilateral modifiers for this procedure.

KEY REFERENCE SERVICE(S):

. <u> </u>	CPT Code	CPT Descriptor Work	<u>RVU</u>
1)	66821	YAG laser posterior capsulotomy	2.78
2)	11642	Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0cm	2.88

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

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

Code 66821 (YAG laser posterior capsulotomy) and 11622 (Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0cm) These codes involve less pre-service work that 688x2 since there is virtually no preparation other than the initial examination prior to these actual procedures. The 688x2 requires some nasal preparation and is usually preceded by dye disappearance tests. Intra-service work is slightly more work-intensive since familiarity with two organ systems (e.g., eye and nose) is required. Excision of skin lesion is straight forward with all work visible at all times. YAG laser capsulotomy can be as difficult with a thick posterior capsule that does not split open when the laser pulse strikes it.

Intranasal work can be difficult is many cases with various nasal anatomies and more difficult in children with small nasal passages making visibility very difficult at times. These difficulties can increase mental and physical efforts as well as psychological stress of this procedure which is non-existent in the 11642. In 66821, the "pitting or tracking" of the intraocular lens (IOL) can increase the psychological stress when the capsule is touching the IOL surface.

Post-service work is slightly greater in 11642 since sutures must be removed and a longer term follow-up exam is usually performed. Likewise, after a YAG laser capsulotomy, the potential increase in intraocular pressure must be addressed and more frequent follow-up examinations are required. However, in cases where a chronic infection is a result of the nasolacrimal duct obstruction, continued follow-up may be similar to these other two codes until problem is resolved.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results, or other data besides the survey data are available, please explain any additional rationale for the RVUs.

FREQUENCY INFORMATION

How was this service previously reported? _____68820

How often do physicians in your specialty perform this service? X Commonly _ Sometimes _Rarely

Estimate the number of times this service might be provided nationally in a one-year period? <u>24,677</u> <u>nationally in Medicare (1994)</u>.

Is this service performed by many physicians across the United States? X Yes No

68811

CPT Code: <u>688x3</u> Tracking Number: <u>5</u> Global Period: <u>10</u> Recommended Work RVU: <u>2.25</u>

CPT Descriptor: Probing of nasolacrimal duct, with or without irrigation; requiring general anesthesia

CLINICAL DESCRIPTION OF SERVICE:

<u>Vignette Used in Survey</u>: A 4 year old presents with a 3 year history of crusting, tearing and frequent episodes of conjunctivitis. The patient is taken to the operating room where general anesthesia is begun. The superior and inferior puncta are dilated with a lacrimal dilator. A lacrimal probe is introduced into a punctum, passed through the canaliculus, through the lacrimal sac, through the nasolacrimal duct and into the nasal pharynx. The probe is withdrawn. A lacrimal canula is placed in the nasolacrimal duct and saline is irrigated through the duct into the nasopharynx.

<u>Description of Pre-Service Work</u>: This procedure is rarely performed on an adult. The vignette describes a child under general anesthesia. It is performed in an attempt to open a mechanically blocked nasolacrimal passage in patients complaining of tearing/mattering or a suspected congenital nasolacrimal duct obstruction.

A nasal examination is also performed, when possible. Decongestion of the nasal mucosa with or without anesthetic (e.g., neosynephrine or cocaine) is performed.

<u>Description of Intra-Service Work:</u> The lacrimal punctac are dilated. Typically, commercially available lacrimal probes of various diameters are passed through the dilated puncta, canaliculus, nasolacrimal sac mid nasolacrimal duct into the nose under the inferior tubinate. The end of the metal rod is pushed into the nose which, typically, penetrates a mucosal membrane covering the ostium at the end of the nasolacrimal duct. An externally placed probe is passed via the nostril and used to establish patency of the system by metal-on-metal contact with the indwelling probe. This procedure is performed in both the upper and lower canalicular systems.

A syringe with colored saline (e.g., tinged with a fluorescein dye) is irrigated through the lacrimal system and retrieved in the nose via nasal suction catheter. This is to insure patency of the lacrimal system.

<u>Description of Post-Service Work:</u> Postoperative evaluations are typically once or twice during the first week after procedure (e.g., one day and/or one week postop). If the epiphora has resolved, then further follow-up is not necessary after this point. In cases where a chronic infection is a result of the nasolacrimal duct obstruction, continued follow-up may be required until problem is resolved.

		CPT Code: <u>688x3</u>
SURVEY DATA: Specialty: <u>American Academy of Ophr</u>	thalmology	
Sample Size: <u>100</u> Response Rate	(%): <u>42</u> Median	RVU: <u>3.00</u>
25th Percentile RVU: <u>2.28</u> 75th I	Percentile RVU: <u>3.75</u>	Low: <u>1.53</u> High: <u>6.67</u>
Median Pre-Service Time: <u>30</u>	Median Intra-Ser	vice Time: <u>23</u>
25th Percentile Intra-Svc Time: <u>20</u> 75	oth Percentile Intra-Svo	Time: <u>30</u> Low: <u>10</u> High: <u>75</u>
Median Post-Service Time:	Total Time	Number of Visits
Day of Procedure:	20	
ICU:		
Other Hospital:		
Office:	20	2

XEY REFERENCE SERVICE(S):

	CPT Code	CPT Descriptor	Work RVU
1)	67345	Chemodenervation of extraocular muscle.	2.91
2)	49580	Repair umbilical hernia, under age 5 years; reducible	3.24

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

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

Code 67345 requires less pre-service work than 688X3 because the procedure requires no use of general anesthetic, the formulation of a history and physical or any of the other work required for hospital procedures. The median intraservice time for 67345 is less than 10 minutes in most cases; the median intra-service time for 688X3 is 23 minutes. The intra-service work for 688X3 is slightly more labor intensive than 67345 since it requires familiarity with 2 organ systems; example, eye and nose, maintenance of hemostasis, multiple insertion of probes and irrigating cannulas. The intra-service work for 688X3 is less than the intra-service time and work for 49580 (unilateral repair of inguinal hernia).

Intra-nasal work can be difficult in many cases with various nasal anatomies and more difficult in children with small passages making visibility very difficult at times. These difficulties can increase mental and physical efforts as well as psychological stress of this procedure. The overall stress of 688X3 is greater than 67345 and probably less than 9580.

CŚ

Post-service work for 688X3 is greater than 67345. This usually does require the application of fluorescein dye to the patient's eye to see if there is any pooling of fluorescein. 67345 requires only an ocular motility exam to determine the effectiveness of the chemodenervation procedure. The post-service time for 688X3 is equal to that of 49580.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results, or other data besides the survey data are available, please explain any additional rationale for the RVUs.

We feel that the RVW value of 2.25 is commensurate with pre-, intra-, and post-service work of this procedure particularly when compared with 67345 which has an RVW of 2.91 and 49580 which has an RVW of 3.24. Sixty-two percent of procedures 68825 were done unilaterally. We request an upgrade from 1996 RVW of 1.53 to 2.25 to reflect the increased work, psychological stress, and complication rate associated with this procedure.

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FREQUENCY INFORMATION

How was this service previously reported? _____68825_____

How often do physicians in your specialty perform this service? Commonly Sometimes X Rarely

Estimate the number of times this service might be provided nationally in a one-year period? <u>676 in Medicare</u> (1994).

Is this service performed by many physicians across the United States? ___Yes X No





CPT Code: 688x3_Tracking Number: ____ Global Period: 10__ Recommended Work RVU: 2.80

CPT Descriptor: Probing of nasolacrimal duct, with or without irrigation; requiring general anesthesia

CLINICAL DESCRIPTION OF SERVICE:

<u>Vignette Used in Survey</u>: A 4 year old presents with a 3 year history of crusting, tearing and frequent episodes of conjunctivitis. The patient is taken to the operating room where general anesthesia is begun. The superior and inferior puncta are dilated with a lacrimal dilator. A lacrimal probe is introduced into a punctum, passed through the canaliculus, through the lacrimal sac, through the nasolacrimal duct and into the nasal pharynx. The probe is withdrawn. A lacrimal canula is placed in the nasolacrimal duct and saline is irrigated through the duct into the nasopharynx.

<u>Description of Pre-Service Work:</u> This procedure is rarely performed on an adult. The vignette describes a child under general anesthesia. It is performed in an attempt to open a mechanically blocked nasolacrimal passage in patients complaining of chronic epiphora (i.e., tearing) or a suspected congenital nasolacrimal duct obstruction.

Justification for this procedure is first determined by an appropriate examination typically paid under a separate E/M code. A nasal examination is also performed, when possible. Decongestion of the nasal mucosa with or without anesthetic (e.g., neosynephrine or cocaine) is performed. The lacrimal punctae are dilated (billed as a separate procedure).

<u>Description of Intra-Service Work:</u> Typically, commercially available lacrimal probes of various diameters are passed through the dilated puncta, canaliculus, nasolacrimal sac mid nasolacrimal duct into the nose under the inferior tubinate. The end of the metal rod is pushed into the nose which, typically, penetrates a mucosal membrane covering the ostium at the end of the nasolacrimal duct. This procedure is performed in both the upper and lower canalicular systems.

When retrieval of the probe is difficult the inferior turbinate in the nose is sometimes infractured with a Freer elevator to give better exposure of the tip of the probe. A syringe with colored saline (e.g., tinged with a fluorescein dye) is irrigated through the lacrimal system and retrieved in the nose via nasal suction catheter. This is to insure patency of the lacrimal system.

<u>Description of Post-Service Work</u>: Postoperative evaluations are typically once or twice during the first week after procedure (e.g., one day and/or one week postop). If the epiphora has resolved, then further follow-up is not necessary after this point. In cases where a chronic infection is a result of the nasolacrimal duct obstruction, continued follow-up may be required until problem is resolved.



From: American Acad. of	Ophthalmology	To:	Sandra ShermarDate: 1/23/96	Time: 09:29:13 .
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CPT Code: ____688x3

Sample Size: <u>117</u> Response Ra	ate (%): <u>11</u> Media	n RVU: <u>2.80</u>
25th Percentile RVU: <u>2.10</u> 75t	h Percentile RVU: <u>-3.</u>	25 Low: <u>2.00</u> High: <u>6.65</u>
Median Pre-Service Time: 30	Median Intra-S	Service Time: <u>30</u>
25th Percentile Intra-Svc Time: 20	75th Percentile Intra-Svo	: Time: <u>30</u> Low: <u>10</u> High: <u>40</u>
Median Post-Service Time:	Total Time	Number of Visits
Day of Procedure:	15	
ICU:	·	
Other Hospital:	10	2
Office:	28	2

	CPT Code	CPT Descriptor	Work RVU
1)	66821	YAG laser posterior capsulotomy	2.78
2)	11622	Excision of malignant lesion, trunk arms, of legs;	2.29

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Code 66821 (YAG laser posterior capsulotomy) and 11622 (Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0cm) These codes involve less pre-service work that 688x3 since there is virtually no preparation other than the initial examination prior to these actual procedures. The 688x3 requires some nasal preparation. Intra-service work is slightly more work-intensive since familiarity with two organ systems (e.g. eye and nose) is required. Excision of skin lesion is straight forward with all work visible at all times. YAG laser capsulotomy can be as difficult with a thick posterior capsule that does not split open when the laser pulse strikes it.

Intranasal work can be difficult is many cases with various nasal anatomies and more difficult in children with small nasal passages making visibility very difficult at times. These difficulties can increase mental and physical efforts as well as psychological stress of this procedure which is non-existent in the 11642. In 66821, the "pitting or tracking" of the intraocular lens (IOL) can increase the psychological stress when the capsule is touching the IOL surface.



CPT Code: <u>688x3</u>

Post-service work is slightly greater in 11642 since sutures must be removed and a longer term follow-up exam is usually performed. Likewise, after a YAG laser capsulotomy, the potential increase in intraocular pressure must be addressed and more frequent follow-up examinations are required. However, in cases where a chronic infection is a result of the nasolacrimal duct obstruction, continued follow-up may be similar to these other two codes until problem is resolved.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results, or other data besides the survey data are available, please explain any additional rationale for the RVUs.

FREQUENCY INFORMATION

How was this service previously reported? _____68825_____

How often do physicians in your specialty perform this service? Commonly Sometimes X Rarely

Estimate the number of times this service might be provided nationally in a one-year period? <u>676 in</u> <u>Medicare (1994)</u>

Is this service performed by many physicians across the United States? ____ Yes X No

C7

CPT Code: <u>688x4</u> Tracking Number: <u>67</u> Global Period: <u>10</u> Recommended Work RVU: <u>3.00</u>

CPT Descriptor: Probing of nasolacrimal duct, with or without irrigation; with insertion of tube or stent

CLINICAL DESCRIPTION OF SERVICE:

<u>Vignette Used in Survey:</u> A 4 year old presents with a 3 year history of crusting, tearing and frequent episodes of conjunctivitis. The p⁻ tient is taken to the operating room, where general anesthesia is begun. The superior and inferior puncta are dilated with a lacrimal dilator. A lacrimal probe is introduced into a punctum, passed through the canaliculus, through the lacrimal sac, through the nasolacrimal duct and into the nasal pharynx. The probe is withdrawn, a lacrimal canula is placed in the nasolacrimal duct and saline is irrigated through the duct into the nasopharynx. A second probe with silicone tubing is passed through the inferior canaliculus and through lacrimal drainage system and retrieved from the nasopharynx. The other end of the tube is passed through the superior canaliculus to the nasopharynx. The tubes are tied together.

<u>Description of Pre-Service Work:</u> Although the vignette describes a child under general anesthesia, this procedure is commonly used in conjunction with other lacrimal and/or cyclid reconstructive procedures in adults under local anesthesia or monitored anesthetic care. The insertion of a tube or stent in the lacrimal system is to maintain patency of the system during the healing process of the surrounding diseased or reconstructed tissues.

Iustification for this procedure is first determined by an appropriate examination typically paid under a separate E/M code. A nasal examination is also performed. The tubing or stent must be available at the time of the procedure. If not, it must be ordered. Decongestion of the nasal mucosa with or without anesthetic (e.g., neosynephrine or cocaine) is performed prior to the insertion of tube or stent. Prior to the insertion of the tube or stent, the lacrimal punctae are dilated. If not done under general anesthesia, topical and local anesthesia are given around The punctae and lacrimal sac areas.

<u>Description of Intra-Service Work:</u> Typically, a commercially available silicone tubing with metal rods attached to either end is passed through the dilated puncta, canaliculus, nasolacrimal sac and nasolacrimal duct into the nose under the inferior tubinate. The end of the metal rod is retrieved in the nose and a length of tubing withdrawn. This procedure is performed in both the upper and lower canalicular systems. The tubing is knotted inside the nostril. The knotted ends are sometimes sutured to the inside of the alae of the nose for easy retrieval at a later date.

<u>Description of Post-Service Work:</u> Postoperative evaluations are typically once or twice during the first week after procedure (e.g., one day and/or one week postop). The next postoperative visit is a predetermined time when the tube or stent is scheduled to be removed. If the tube or stent is left in for three months or more, then periodic visits are required to make sure that the tubing is not cheese wiring the punctae.

CPT Code: <u>688x4</u> Tracking Number: <u>Global Period</u>: <u>10</u> Recommended Work RVU: <u>4.54</u>

CPT Descriptor: Probing of nasolacrimal duct, with or without irrigation; with insertion of tube or stent

CLINICAL DESCRIPTION OF SERVICE:

<u>Vignette Used in Survey:</u> A 4 year old presents with a 3 year history of crusting, tearing and frequent episodes of conjunctivitis. The patient is taken to the operating room, where general anesthesia is begun. The superior and inferior puncta are dilated with a lacrimal dilator. A lacrimal probe is introduced into a punctum, passed through the canaliculus, through the lacrimal sac, through the nasolacrimal duct and into the nasal pharynx. The probe is withdrawn. a lacrimal canula is placed in the nasolacrimal duct and saline is irrigated through the duct into the nasopharynx. A second probe with silicone tubing is passed through the inferior canaliculus and through lacrimal drainage system and retrieved from the nasopharynx. The other end of the tube is passed through the superior canaliculus to the nasopharynx. The tubes are tied together.

<u>Description of Pre-Service Work:</u> Although the vignette describes a child under general anesthesia, this procedure is commonly used in conjunction with other lacrimal and/or eyelid reconstructive procedures in adults under local anesthesia or monitored anesthetic care. The insertion of a tube or stent in the lacrimal system is to maintain patency of the system during the healing process of the surrounding diseased or reconstructed tissues.

Justification for this procedure is first determined by an appropriate examination typically paid under a separate E/M code. A nasal examination is also performed. The tubing or stent must be available at the time of the procedure. If not, it must be ordered. Decongestion of the nasal mucosa with or without anesthetic (e.g., neosynephrine or cocaine) is performed prior to the insertion of tube or stent. Prior to the insertion of the tube or stent, the lacrimal punctae are dilated (billed as a separate procedure). If not done under general anesthesia, topical and local anesthesia are given around The punctae and lacrimal sac areas.

<u>Description of Intra-Service Work:</u> Typically, a commercially available silicone tubing with metal rods attached to either end is passed through the dilated puncta, canaliculus, nasolacrimal sac and nasolacrimal duct into the nose under the inferior tubinate. The end of the metal rod is retrieved in the nose and a length of tubing withdrawn. This procedure is performed in both the upper and lower canalicular systems. The tubing is knotted inside the nostril. The knotted ends are sometimes sutured to the inside of the alae of the nose for easy retrieval at a later date.

When retrieval of the tubing is difficult, the inferior turbinate in the nose is sometimes infractured with a Freer elevator to give better exposure of the tip of the metal rod with the tubing attached.

<u>Description of Post-Service Work:</u> Postoperative evaluations are typically once or twice during the first week after procedure (e.g., one day and/or one week postop). The next postoperative visit is a predetermined time when the tube or stent is scheduled to be removed. If the tube or stent is left in for three months or more, then periodic visits are required to make sure that the tubing is not cheese wiring the punctae.

CPT Code: <u>688x4</u>

Tubing removal involves placing a topical anesthetic on the surface of the eye. The knotted ends of the tubing are retrieved from the nose and secured with a clamp (e.g., hemostat) and held by, an assistant. The exposed loop of tubing between the upper and lower punctae is cut with a scissors and the tubing removed. Irrigation of the system is usually performed to demonstrate patency of the system. Follow-up is not necessary after this point.

In a pediatric patient. the child will have to be restrained (e.g., papoosed or mummified with a sheet). This requires one or two assistants. The procedure is the same.

SURVEY DATA: Specialty: <u>American Academy of Ophthalmology</u>				
Sample Size: <u>117</u> Response Rate (%	6): <u>11</u> Median R	VU: <u>4.50</u>		
25th Percentile RVU: <u>3.00</u> 75th Percent	ile RVU: <u>5.75</u> La	ow: <u>2.70</u> High: <u>6.85</u>		
Median Pre-Service Time: <u>30</u> Med	lian Intra-Service Tim	e: <u>45</u>		
25th Percentile Intra-Svc Time: 30 75th Percentile Intra-Svc Time: 60 Low: 20 High: 60				
Median Post-Service Time:	Total Time	Number of Visits		
Day of Procedure:	_20			
ICU:				
Other Hospital:		· · ·		
Office:	30	3		





07

Page 4 of 4

CPT Code: ____688x4___

KEY	REFERENCI	E SERVICE(S):	
	CPT Code	CPT Descriptor	Work RVU
1)	11642	Excision, malignant lesion, face, ears, eyelids, lips; lesion diameter 1.1 to 2.0 cm	2.88

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

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

Code 11642 (Excision, malignant lesion, face, ears, eyelids, lips; lesion diameter 1.1 to 2.0 cm) involves a little less pre-service work than 688x4 since there is virtually no preparation other than the initial examination prior to the actual procedure. The 688x4 requires some nasal preparation and availability of tube or stent. Intra-service work is slightly more work-intensive since familiarity with two organ systems (e.g., eye and nose) is required. Excision of skin lesion is straight forward with all work visible at all times. Intranasal work can be difficult is many cases with various nasal anatomies and more difficult in children with small nasal passages making visibility very difficult at times. These difficulties can increase mental and physical efforts as well as psychological stress of this procedure which is non-existent in The 11642. Post-service work is relatively similar except that tubing removal is much more difficult than skin suture removal.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results, or other data besides the survey data are available, please explain any additional rationale for the RVUs.

FREQUENCY INFORMATION

How was this service previously reported? _____68830__

How often do physicians in your specialty perform this service? ____ Commonly X Sometimes ____ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? <u>4771</u> <u>Nationally in Medicare (1994)</u>.

Is this service performed by many physicians across the United States? X Yes ___ No





		Ć7	CPT Code: <u>688x4</u>
Tubing removal involves placing a t are retrieved from the nose and secu- loop of tubing between the upper an of the system is usually performed to	opical anesthetic on the survey with a clamp (e.g., he do not be survey of the survey	urface of the eye. The kn emostat) and held by, an th a scissors and the tubi the system.	notted ends of the tubing assistant. The exposed ng removed. Irrigation
SURVEY DATA: Specialty: <u>American Academy of</u>	Ophthalmology	_	
Sample Size: <u>100</u> Response	Rate (%): <u>38</u> Media	n RVU: <u>4.50</u>	
25th Percentile RVU: <u>3.55</u> 75th	Percentile RVU: <u>5.05</u>	Low: <u>2.12</u> High	:10.00
Median Pre-Service Time: <u>40</u>	Median Intra-Service '	Time: <u>40</u>	
25th Percentile Intra-Svc Time: 30	75th Percentile Intra-Svc	Time: <u>50</u> Low: <u>17</u>	7.5 High: <u>80</u>
Median Post-Service Time:		Number of Visits	
Day of Procedure:	20		
ICU:			
Other Hospital:			
Office:	30	2	

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CPT Code: <u>688x4</u>

KEY REFERENCE SERVICE(S):

	CPT Code	CPT Descriptor	Work RVU	
1)	67345	Chemodenervation of extraocular muscle	2.91	· _
2)	49580	Repair umbilical hernia under age 5 years; reduciable	3.24	

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

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

Code 67345 (Chemodenervation of extraocular muscle) involves significantly less pre-service time than 688X4. Intra-service work for 688X4 has an intra-service time of 30 minutes (actual survey data shows 40 minutes). There is frequently intra-operative bleeding, difficulty in retrieving the probes connected to silicone tube and frequent breakage of the silicone tube during passage through the nasolacrimal duct. The psychological stress associated with this procedure is equal to or greater than 49850 primarily because of the variability in the nasal anatomy and the difficulty retrieving the silicone tube through the nasopharynx. The pre-, intra-, and post- service work for 688X4 is far greater than 67345 and equal to or greater than 49580. Post-service work for 688X4 is approximately equal to that of 49580 but more involved than 67345.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results, or other data besides the survey data are available. please explain any additional rationale for the RVUs.

This procedure is generally performed on patients for whom 688x3 has failed. The median surveyed intraservice time for 688X4 (unilateral probing with placement of silicone tubes) is 40 minutes. We feel that the surveyed intra-service time may be slightly higher than the average amount of time by approximately 10 minutes. The median RVW value from the surveyed data is 4.50. We are requesting an upgrade from the current value of 2.12 to 3.0 We feel that this is a fair request considering the degree of pre-, intra-, and postservice work involving this procedure and particularly the complications of intra-nasal bleeding, the possibility of aspirating blood intra or post-operatively, and the morbidity associated with drawing metallic probes through the nasolacrimal system.

FREQUENCY INFORMATION

How was this service previously reported? ____68830_

How often do physicians in your specialty perform this service? ____ Commonly _X Sometimes ____ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? <u>4771</u> Nationally in Medicare (1994).

Is this service performed by many physicians across the United States? X Yes ___ No

Apr. 196

Nasolacrimal Duct Probe (Tab 30), Tracking Numbers: C1 - C8

Codes 68800-68830 for *dilation of lacrimal punctum* and *probing of a nasolacrimal duct* have been deleted and replaced with new codes 68801 - 68815 to indicate that these codes should be used to report unilateral procedures. Bilateral procedures will be reported using the code with the -50 modifier. The RUC accepted the relative value recommendations presented by ophthalmology and optometry which were based on budget neutral calculations assuming that 50% of 68801 *Dilation of lacrimal punctum, with or without irrigation* and 31% of 68810 *Probing of nasolacrimal duct, with or without irrigation* are performed bilaterally and would be subject to the multiple surgery reduction.

The RUC also accepted the specialty recommendation to increase the relative value for 68811*Probing of nasolacrimal duct, with or without irrigation; requiring general anesthesia* from 1.53 to 2.25. Sixty-two percent of these procedures are performed unilaterally. The pre-, intra-, and post-service work of this service are also comparable to 67345 *Chemodenervation of extraocular muscle* (work rvu = 2.91).

68812 Probing of nasolacrimal duct, with or without irrigation; with insertion of tube or stent is performed when 68811 has failed. The RUC agreed that the relative value for this service should be increased from 2.12 to 3.00 to maintain relativity with 68810 and 68811. This is increase is merited by degree of pre-, intra-, and post-service work involved in this procedure; complications of intra-nasal bleeding; the possibility of aspirating blood intra- or post-operatively; and the morbidity associated with drawing metallic probes through the nasolacrimal system.

Other Issues

Pediatric Echocardiography (Tab 20)

The American Academy of Pediatrics and the American College of Cardiology have requested that this issue be tabled until after further consideration by the CPT Editorial Panel and a resurvey. The responses from the initial survey were inadequate to provide recommendations to the RUC. Many respondents were confused regarding the language of the new CPT codes.

Echocardiography (Tab 21)

The American College of Cardiology has requested that this issue be tabled until after further consideration by the CPT Editorial Panel.

Nuclear Cardiology (Tab 23)

The RUC recommends that the current work relative values be maintained for these nuclear cardiology codes and notes the American College of Nuclear Physicians and the Society of Nuclear Medicine will be requesting the CPT Editorial Panel to reconsider this issue.



RUC HCPAC REVIEW BOARD RECOMMENDATIONS

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CPT 1997 RUC HCPAC Review Board Recommendations

19-Jun-96

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CPT Code	Global Period	CPT Action	CPT Meeting	CPT Tab	RUC Issue	Track No.	HCPAC Meeting	НСРАС ТАВ	SS Rec	HCPAC REC	Same Value as 1996?	Code in MFS?	Other Comments
11700	000	Deleted	Feb 96	L	Debridement of Nails	Ml	April 96	Е				Yes	
11701	ZZZ	Deleted	Feb 96	L	Debridement of Nails	M2	April 96	E				Yes	
11710	000	Deleted	Feb 96	L	Debridement of Nails	M3	April 96	E				Yes	
11711	ZZZ	Deleted	Feb 96	L	Debridement of Nails	M4	April 96	E				Yes	
11720	000	New	Feb 96	L	Debridement of Nails	M5	April 96	E	0.4	5 0.45		Yes	
11721	000	New	Feb 96	L	Debridement of Nails	M6	April 96	Е	0.6	0 0.60		Yes	
90875	xxx	New	Feb 96	22	Biofeedback	FF10	April 96	F	1.3	0 1.11		Yes	Interim - Referred back to
90876	xxx	New	Feb 96	22	Biofeedback	FF11	April 96	F	2.0	3 1.73		Yes	Interim - Referred back to
90900	000	Deleted	Feb 96	22	Biofeedback	FF2	April 96	F				Yes	
90901	000	New	Feb 96	22	Biofeedback	FF1	April 96	F	0.4	5 0.45		Yes	
90902	000	Deleted	Feb 96	22	Biofeedback	FF3	April 96	F				Yes	
90904	000	Deleted	Feb 96	22	Biofeedback	FF4	April 96	F				Yes	
90906	000	Deleted	Feb 96	22	Biofeedback	FF5	April 96	F				Yes	
90908	000	Deleted	Feb 96	22	Biofeedback	FF6	April 96	F				Yes	
90910	000	Deleted	Feb 96	22	Biofeedback	FF7	April 96	F				Yes	

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

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CPT Code	Global Period	CPT Action	CPT Meeting	CPT Tab	RUC Issue	Track No.	HCPAC Meeting	HCPAC TAB	SS Rec	HCPAC REC	Same Value as 1996?	Code in MFS?	Other Comments
90915	000	Deleted	Feb 96	22	Biofeedback	FF8	April 96	5 F				Yes	
97500	xxx	Deleted	Feb 96	23	Orthotics and Prosthetic Training	QQ2	April 96	5 G				Yes	
97501	xxx	Deleted	Feb 96	23	Orthotics and Prosthetic Training	QQ3	April 96	5 G				Yes	
97504	xxx	New	Feb 96	23	Orthotics and Prosthetic Training	QQ1	April 96	6 G	0.4	5 0.45		Yes	
97520	xxx	Revised	Feb 96	23	Orthotics and Prosthetic Training	QQ4	April 96	G G	0.4	5 0.45		Yes	
97521	XXX	Deleted	Feb 96	23	Orthotics and Prosthetic Training	QQ5	April 96	5 G				Yes	
98940	000	New	Feb 96	D	Chiropractic Manipulative Treatment	RR1	April 96	5 D	0.4	8 0.45		Yes	
98941	000	New	Feb 96	D	Chiropractic Manipulative Treatment	RR2	April 96	5 D	0.6	5 0.65		Yes	
98942	000	New	Feb 96	D	Chiropractic Manipulative Treatment	RR3	April 96	5 D	0.9	2 0.87		Yes	
98943	000	New	Feb 96	D	Chiropractic Manipulative Treatment	RR4	April 96	5 D	0.4	0 0.40		Yes	

RUC HCPAC REVIEW BOARD RECOMMENDATIONS APRIL 1996

Chiropractic Manipulative Treatment

Chiropractic manipulation has been reimbursed by Medicare since the early 1970s and reported using the HCPCs Level II code, A2000 *Manipulation of spine by physician*. The work relative value (.45) was established by HCFA and is not based on any survey data or with consultation with the chiropractic community, which provides 94% of all spinal manipulation in the United States. The American Chiropractic Association submitted a comment during the five-year review that the physician work in CMT is equivalent to the existing Osteopathic Manipulative Treatment (CPT Codes 98925-98927) relative values.

The RUC HCPAC Review Board reviewed data based on survey responses of 106 chiropractors and a previous study performed by Lewin-VHI. The Review Board agreed that the work relative values for the CMT should be equivalent to the established relative values for Osteopathic Manipulative Treatment (OMT) codes as follows:

New	Existing	Work
CMT Code	OMT Code	<u>RVU</u>
98940 CMT; spinal, one to two regions	98925 OMT; one to two body regions	.45
98941 spinal, three to four regions	98926 three to four body regions	.65
98942 spinal, five	98927 five to six body regions	.87

CPT Code 98943 Chiropractic manipulative treatment (CMT); extraspinal, one or more regions is estimated to be reported 50% of the time as a stand-alone procedure and 50% of the time as an add-on procedure to codes 98940-98942. The global period assigned to this code is 000 and the Review Board assumes that when the service is reported as an add-on, it will be reduced by 50%. The Review Board recommends a work RVU of .40 for this procedure, when performed independently, which is based on the prior work of Lewin-VHI that resulted in a work RVU of .40 for CMT of one body region. The ACA reported that the vast majority of all extraspinal manipulation described with this code would be to one body region.



The Review Board also discussed agreed that a Manual Manipulative Technique Workgroup comprised of CPT and RUC representatives from the American Osteopathic Association, American Physical Therapy Association, American Academy of Physical Medicine and Rehabilitation, American Chiropractice Association, and other interested or appropriate parties, be formed to review current CPT descriptors and work RVUs for OMT, CMT, and Physical Medicine and Rehabilitation Manual Technique codes.

CPT Code (● New)	Tracking Number	CPT Descriptor	Global Period	RVW Recom- mendation				
Chiropractic manipulative treatment (CMT) is a form of manual treatment to influence joint and neurophysiological function. This treatment may be accomplished using a variety of techniques.								
The chiropractic manipulative treatment codes include a pre-manipulation patient assessment. Additional evaluation and management services may be reported separately using the modifier -25, if and only if 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. For purposes of CMT, the five spinal regions referred to are: cervical region (includes atlanto-occipital joint); thoracic region (includes costovertebral and costotransverse joints); lumbar region; sacral region; and pelvic (sacro-iliac joint) region. The five extraspinal regions referred to are: head (including temporomandibular joint, excluding atlanto-occipital)								
98940	RR1	Chiropractic manipulative treatment (CMT); spinal, one to two regions	000	.45				
98941	RR2	spinal, three to four regions	000	.65				
98942	RR3	spinal, five regions	000	.87				
98943	RR4	extraspinal, one or more regions	000	.40				

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CPT Code: <u>9892X1</u> Tracking Number: <u>RR1</u> Global Period: <u>XXX</u> Recommended Work RVU: <u>.48</u>

CPT Descriptor: Chiropractic manipulative treatment (CMT); spinal 1-2 regions:

CLINICAL DESCRIPTION OF SERVICE:

This clinical vignette describes CMT service on two (2) spinal body regions of an established patient previously scheduled for this service. The previous initial examination of the patient revealed a 32-year-old female with mid-back pain, stiffness, and persistent low back pain of two weeks duration (2 body regions—thoracic and lumbar).

Description of Pre-Service Work:

A brief evaluation of the patient, including a review of symptoms and a focused examination of the problem and related reason reveals that chiropractic spinal manipulative treatment is clinically indicated in 2 regions: the thoracic (T5) region and the lumbar (L4) region.

Description of Intra-Service Work:

Diversified Manipulation to T5

Following the pre-manipulation assessment and preparation, with the patient positioned prone on the treatment table, the physician applies brief myofascial treatment to existing trigger points in the thoracic paravertebral musculature. The appropriate segmental level is identified in the adjusting position (T5). The physician makes a pisiform contact on the left transverse process of T5. Breathing instructions are given to the patient. The physician pre-stresses the periarticular soft tissues. An articular (osseous) adjustive procedure is applied to the determined manipulatable spinal lesion at T5 utilizing a short lever, low amplitude high velocity thrust in a posterior to anterior direction. Post-adjustment procedures and interactive reassessments are made.

Diversified Manipulation to L4

A supportive cushion (half-Dutchman's roll) is then placed under the patient's pelvis at the appropriate position. The patient's ankles are cuffed, the locking levers of the table are released, and the table is gently extended (axial distraction). A palmar contact is made on the spinous process of L4 with the physician's cephalad hand. With the other hand the physician grasps the table or appropriate handle at the caudal end of the table. The patient is advised to take in a deep breath and let it out. A slow, controlled flexion maneuver is applied within patient tolerance and safety to the caudal portion of the table with multiple (5-8) repetitions. This process is repeated through 3 cycles. Following this treatment the locking levers are secured; the caudal end of the table is returned; the patient's ankles are un-cuffed and the cushion is removed. Post-adjustment procedures and interactive reassessments are made.

The patient is then turned onto his/her side, positioned for a side-posture manipulation/adjustment. A brief stretch is applied to the lumbo-pelvic musculature and a long lever, low amplitude, high velocity thrust is applied to the L4/L5 joint complex. Post-adjustment procedures and interactive reassessments are made. The patient is then returned to a comfortable position for a brief rest.

Description of Post-Service Work:

Chart entry and documentation, including documentation of appropriate subjective and objective assessments as well as the procedural components of this patient visit, are completed.

SURVEY DATA:

Specialty: American Chiropractic Association					
Sample Size: <u>233</u> Response Rate (%): <u>55.4%</u> Median RVU: <u>.50</u>					
25th Percentile RVU: <u>.45</u> 75th Percentile RVU: <u>.62</u> Low: <u>.19</u> High: <u>1.50</u>					
Median Pre-Service Time: 2.0 Median Intra-Service Time: 7.0					
25th Percentile Intra-Svc Time: <u>5.0</u> 75th Percentile Intra-Svc Time: <u>10.0</u> Low: <u>2.0</u> High: <u>60.0</u>					
Median Post-Service Time: <u>3.0</u>					

KEY REFERENCE SERVICE(S):

	CPT Code	<u>CPT Descriptor</u>	<u>Work RVU</u>
1)	A2000	Manipulation of spine by physician	0.45
2)	97265	Joint mobilization, one or more areas (peripheral or spinal)	0.45
3)	98925	Osteopathic manipulative treatment (OMT); one or two body regions involved	0.45
4)	98926	Osteopathic manipulative treatment (OMT); three to four body regions involved	0.65

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

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

<u>98925, 98926</u>

9892X1 is most comparable in work to the existing OMT code for 1-2 body regions (98925), with a proposed value that is slightly higher than the 0.45 value of the 98925 code. Survey respondents reported intra- (6 min) and post- (2 min) service times for 98925 that were slightly lower than those given for 9892X1. Pre-service time and intensity were the same for both codes. Code 9892X1 has a proposed work value that is significantly lower than the 0.65 value of the 98926 code (OMT for 3-4 body regions), as the proposed code represents fewer body regions. Also, survey respondents reported higher pre- (3 min) and intra- (8 min) service times, as well as increased intensity, for 98926 when compared to 9892X1.

<u>A2000</u>



The recommended value for CMT on 1-2 body regions, .48, is slightly higher than the A2000 work value 0.45. Survey respondants reported a post service time of 2 minutes for A2000, which is slightly lower than that given for 9892X1. Pre- and intra- service times, as well as intensity were the same for both codes. The code A2000 by definition does not encompass the patient encounter complexity inherent in the performance of manipulative treatment. More importantly, the A2000 coding work value was designated by HCFA but was not calculated in the original Harvard research. The value of the work of A2000 has never been documented.

<u>97265</u>

The code 97265 describes joint mobilization, one or more areas. The recommended work value of .48 for 9892X1 is slightly higher than the .45 work value of 97265. Survey respondents reported intra- (5 min) and post- (2 min) service times for 97265 that were slightly lower than those given for 9892X1. Pre-service time and intensity were the same for both codes.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results, or other data besides the survey data are available, please explain any additional rationale for the RVUs.

The AMA/RUC survey resulted in an estimated median value of .50 for the RVW of 9892X1 (RR1). However, the American Chiropractic Association's RVS Advisory Committee recognizes that the clinical vignette presented in the survey describes a patient receiving manipulative services on two body regions, which may have led to a higher estimation of the total work value, given that 9892X1 represents spinal manipulation for one or two body regions. For this reason, the Committee chose to conservatively recommend an RVW of .48. This recommendation is based upon 1) the prior work of an interdisciplinary consensus panel process conducted by Lewin-VHI that resulted in a work relative value of .40 for CMT on one body region and .50 for CMT on two body regions. (Note the consistency of the median RVW between the preliminary estimates made by the consensus panel and results of the AMA/RUC Survey for two body regions); 2) the estimates of the Committee, based upon clinical knowledge and experience, on the expected frequency (relative to each other) of patients requiring chiropractic spinal manipulation on one (20%) and two (80%) body areas.

Although the OMT codes have been used primarily by the osteopathic community, it is the opinion of the ACA's RVS Committee presenting this recommendation that the range of manual procedures and the clinical approach described by the OMT codes is similar to that of other physicians, including doctors of chiropractic, who use manual manipulation. The Committee believes that the total work in the services represented by 9892X1 (CMT) and 98925 (OMT) are similar. While the proposed value of 9892X1 is slightly higher, it is not considerably out of the range of the 0.45 value assigned to 98926.

FREQUENCY INFORMATION

How was this service previously reported? <u>A2000</u>

How often do physicians in your specialty perform this service? X Commonly _____Sometimes _____Rarely

Estimate the number of times this service might be provided nationally in a one-year period? _____2.898,546

As no actual utilization data exists for this new code, frequency estimates are based upon 1994 utilization of A2000 (12,077,274 total allowed services), 1994 BMAD data showing the percent of total Medicare charges by osteopaths for OMT codes, and the clinical knowledge, expertise and experience of a multi disciplinary consensus panel (CP) that was facilitated by Lewin-VHI. The CP, using the above-mentioned OMT data and a modified Delphi process, estimated that the frequency of this service would be approximately 24% of total allowed services if A2000 was replaced by the proposed three CMT codes.

Is this service performed by many physicians across the United States? X Yes No

CPT Code: <u>9892X2</u> Tracking Number: <u>RR2</u> Global Period: <u>XXX</u> Recommended Work RVU: <u>65</u>

CPT Descriptor: Chiropractic manipulative treatment (CMT); spinal 3-4 regions:

CLINICAL DESCRIPTION OF SERVICE:

This clinical vignette describes CMT service on four (4) spinal body regions of an established patient previously scheduled for this service. The previous initial examination of the patient revealed a 44-year-old man with complaints of a persistent tension-type headache noted daily for the last six months. Regular use of muscle relaxants decreased the pain temporarily, but he developed gastro-intestinal irritation from the medication and is seeking a different approach to treatment. Secondarily, he described low back pain that was noted intermittently for the past two years, but was most recently aggravated by a long bike ride. The ride aggravated his back pain to the point that he can no longer get a full night's rest due to his right-sided pelvic pain and lumbar aching. (4 body regions—cervical, head, lumbar, pelvic).

Description of Pre-Service Work:

A brief evaluation of the patient, including a review of symptoms and a focused examination of the problem and related areas reveals that chiropractic spinal manipulative treatment is clinically indicated in 4 regions: the head region (occiput), the upper cervical region (C2), the lumbar region (multiple lumbar segments), and the pelvic region (right innominate).

Description of Intra-Service Work:

Diversified Manipulation of C2

With the patient properly placed in the supine position during the pre-manipulation period, and with the premanipulative interactive assessments completed, an index contact with the right hand is taken at the predetermined manipulable segment in the right cervical region (C2). The left hand cradles the head, with appropriate support to the occiput and ear of the contralateral side. The head is laterally flexed to the right of the isolation prestress of the appropriate articulation. A specific thrust is made straight lateral at right angles to the mid-sagittal plane of the head within the appropriate paraphysiologic articular range to avoid iatrogenic/clinical risk. Post-adjustment procedures and interactive reassessments are made.

Diversified Craniovertebral Adjustment

From the concluding position of the previous procedure, the physician repositions the craniocervical region and completes a pre-manipulative interactive assessment in the new region. The physician then steps to the left of the table and cradles the head with the right hand using the appropriate supportive technique. The contact is made by taking a palmar position of the hand over the patient's ipsilateral mandible and cheek; thumb anterior to ear and fifth digit under the jaw. With the physician forearm low and parallel to the sternum, the patient's head is positioned with the manipulable lesion up and a bidirectional, one inch thrust is made with both hands straight cephalad. Post-adjustment procedures and interactive reassessments are made.

Diversified Innominate Adjustment

From the concluding position of the previous procedure, the patient is repositioned in a left recumbent sideposture, and the physician completes a pre-manipulative interactive assessment in the new region. The patient's lower shoulder is placed anterior with the hand under the head; upper shoulder is posterior with the forearm resting on the lateral thoracic wall; lower thigh and leg are straight; upper thigh and leg are flexed with the dorsum of the foot in the popliteal space of the lower knee; and the pelvis is vertical or slightly anterior on the upper side. The physician stands on the contralateral side facing cephalad with the cephalad foot on the floor. The caudal foot is off the floor with a thigh-to-thigh contact on the patient's upper thigh. The posterior ilium receives a pisiform contact with the physician's caudal hand, while the physician's cephalad hand makes a palmar contact on the anterior upper shoulder of the patient. With the appropriate articular prestress used, a manipulative thrust is delivered with the pisiform contact anterior and superior. Simultaneously, the physician makes a slight body drop downward with the thigh to open up the articulation. Post-adjustment procedures and interactive reassessments are made.

Multisegmental Gonstead Lumbar Adjustments

Using similar positioning as the previous procedure, a similar adjustment is made to the posterior L5 vertebra with a pisiform contact on the L5 transverse process. The patient is then positioned in a right recumbent sidelying position and a similar adjustment made to the L4 vertebra. A pre-manipulative interactive assessment is made prior to the application of the procedure, and post-adjustment interactive assessments are made following the procedure.

Description of Post-Service Work:

Chart entry and documentation, including documentation of appropriate subjective and objective assessments as well as the procedural components of this patient visit are completed. A brief telephone consultation or written summary with the patient's insurance company or referring provider to supply an update of patient progress is also conducted.

SURVEY DATA:

Specialty: American Chiropractic Association
Sample Size: 233 Response Rate (%): 55.4% Median RVU: .695
25th Percentile RVU: <u>.65</u> 75th Percentile RVU: <u>.88</u> Low: <u>.38</u> High: <u>2.25</u>
Median Pre-Service Time: <u>3.0</u> Median Intra-Service Time: <u>9.50</u>
25th Percentile Intra-Svc Time: <u>7.0</u> 75th Percentile Intra-Svc Time: <u>15.0</u> Low: <u>2.0</u> High: <u>90.0</u>
Median Post-Service Time: <u>4.0</u>

KEY REFERENCE SERVICE(S):

	CPT Code	<u>CPT Descriptor</u>	<u>Work RVU</u>
1)	97250	Myofascial release/soft tissue mobilization, one or more regions	0.45
2)	98925	Osteopathic manipulative treatment (OMT); one or two body regions involved	0.45
3)	98926	Osteopathic manipulative treatment (OMT); three to four body regions involved	0.65
4)	98927	Osteopathic manipulative treatment (OMT); five to six body regions involved	0.87

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

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

98925, 98926, 98927

The proposed value of code 9892X2 is most comparable in value to the existing OMT code for 3-4 body regions (0.65), 98926. Survey respondents reported intra- (8 min) and post- (3 min) service times for 98926 that were slightly lower than those given for 9892X2. Pre-service time and intensity were the same for both codes. Because a greater number of body regions are involved, the proposed value of 9892X2 is greater than the value of 98925. Survey respondents reported pre- (2 min), intra- (6 min) and post- (2 min) service times for 98925 that are lower than those given for 9892X2. Intensity for 98925 also recieved a lower rating. Subsequently, because fewer body regions are involved, the proposed work value for 9892X2 is lower than the 0.87 value of the OMT code for 5-6 body regions (98927). Survey respondents reported a slightly higher intraservice time (10 min) and somewhat greater intensity for 98927 than that given for 9892X2. Pre- and post-service time were the same for both codes.

<u>97250</u>

The code 97250 describes myofascial release or soft tissue mobilization, one or more regions. The recommended work value of .65 for 9892X2 is higher than the .45 work value of 97250. Survey respondents reported intra- (7.5 min), post- (3 min) service times, and intensity for 97250 that was lower than that given for 9892X1. Pre-service time was the same for both codes.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results, or other data besides the survey data are available, please explain any additional rationale for the RVUs.

The AMA/RUC survey resulted in an estimated median value of .695 for the RVW of 9892X2 (RR2). However, the American Chiropractic Association's RVS Advisory Committee recognizes that the clinical vignette presented in the survey describes a patient receiving manipulative services on four body regions, which may have led to a higher estimation of the total work value, given that 9892X2 represents spinal manipulation for three or four body regions. For this reason, the Committee chose to conservatively recommend an RVW of .65. This recommendation is based upon 1) the prior work of an interdisciplinary consensus panel process conducted by Lewin-VHI that resulted in a work relative value of .60 for CMT on three body region and .70 for CMT on four body regions. (Note the consistency of the median RVW between the preliminary estimates by the consensus panel and results of the AMA/RUC Survey for four body regions); 2) the estimates of the Committee, based upon clinical knowledge and experience, on the expected frequency (relative to each other) of patients requiring chiropractic spinal manipulation on three (50%) and four (50%) body areas.

Although the OMT codes have been used primarily by the ostseopathic community, it is the opinion of the ACA RVS Committee presenting this recommendation that the range of manual procedures and the clinical approach represented by the OMT codes is similar to that of other physicians, including doctors of chiropractic, who use manual manipulation. The Committee believes that the total <u>work</u> in the services represented by 9892X2 (CMT) and 98926 (OMT) are the same, and therefore recommends that 9892X2 have a value that is the same as the value of 98926.

CPT Code: 9892X2

FREQUENCY INFORMATION

How was this service previously reported? <u>A2000</u>

How often do physicians in your specialty perform this service? X Commonly ______ Sometimes _____ Rarely

As no actual utilization data exists for this new code, frequency estimates are based upon 1994 utilization of A2000 (12,077,274 total allowed services), 1994 BMAD data showing the percent of total Medicare charges by osteopaths for OMT codes, and the clinical knowledge, expertise and experience of a multidisciplinary consensus panel (CP) facilitated by Lewin-VHI. The CP, using the above-mentioned OMT data and a modified Delphi process, estimated that the frequency of this service would be approximately 63% of total allowed services if A2000 was replaced by the proposed three CMT codes.

Is this service	performed by	many physicians	across the United	States?	<u>X</u>	Yes	No
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CPT Code: <u>9892X3</u> Tracking Number: <u>RR3</u> Global Period: <u>XXX</u> Recommended Work RVU: <u>.92</u>

CPT Descriptor: Chiropractic manipulative treatment (CMT); spinal 5-7 regions

CLINICAL DESCRIPTION OF SERVICE:

This clinical vignette describes CMT on six (6) spinal body regions of an established patient previously scheduled for this service. The previous initial examination of the patient revealed a 38-year old male who sustained injuries to multiple body parts from a fall off an extension ladder. While trying to prevent the fall, he twisted and strained his upper and lower back and struck his head. He landed on his side on the collapsed ladder injuring his pelvis, hip and lower extremities. Complaints of 5-days duration include neck, mid and lower back pain and stiffness, headache and pelvic and hip pain and stiffness. He also suffered multiple contusions of various body regions including the head, shoulders, ribs, hip, buttocks, thigh, leg and ankle. (6 body regions— cervical, head, thoracic, lumbar, pelvic, and sacral)

Description of Pre-Service Work:

A brief evaluation of the patient, including a review of symptoms and a focused examination of the problem and related areas reveals that chiropractic spinal manipulative treatment is clinically indicated in 6 regions: the cervical region (C5), the head region (occiput), the thoracic region (T3, T6), the lumbar region (L5), the pelvic region (left innominate), and the sacral region (sacrum).

Description of Intra-Service Work:

Diversified Manipulation of C5

The patient is placed in a seated position during the pre-manipulation period, and the pre-manipulation interactive assessments are completed. With the physician standing on the left side of the patient, a middle finger contact with the right hand is taken at the predetermined manipulable segment in the left mid-cervical region (left C5). While the right middle finger is in contact with the segment described, the right hand simultaneously cradles the left laterally flexed head of the patient. A specific clockwise, very short amplitude, high velocity thrust is made, not exceeding the paraphysiologic range of motion to avoid iatrogenic/clinical risk. Post-adjustment procedures and interactive reassessments are made.

Diversified Occipital Adjustment

From the concluding position of the previous procedure, the physician repositions the patient supine and completes a pre-manipulation interactive assessment in the new region. The physician then steps to the right of the table and cradles the head with the left hand, while simultaneously taking a specific middle finger contact to the patient's lower left occiput. With the physician's right arm low and parallel to the patient's sternum in cephalad direction, and the palmar surface across the patient's right jaw for stabilization, a short amplitude, high velocity lift of the left occiput is administered by the physician's left hand/middle finger with the patient's head rotated 45 degrees, and the neck slightly flexed. Post-adjustment procedures and interactive reassessments are made.

Diversified Manipulation of T3 and T6

From the concluding position of the previous procedure, the physician repositions the patient prone with the

head in central position and completes a pre-manipulation interactive assessment in the new region. A contact is made at the right transverse process of T3 with the physician's left hand. The right hand takes a soft tissue traction by pushing slightly cephalad at the right occiput. The patient is then instructed to take a deep breath and exhale. At the point of full expiration, a straight arm body drop thrust is executed, with the line of drive slightly in the caudal direction. Next, a contact is made at the right transverse process of T6 with the physician's left hand. The right hand contacts the patient's left transverse process of T6. A soft tissue traction is taken, and the patient again is instructed to inhale and exhale fully. At the point of full expiration, a straight arm body drop thrust is executed with the line of drive at a 90 degree angle to the dorsal spine. Postadjustment procedures and interactive reassessments are made.

Gonstead Adjustment of L5

From the concluding position of the previous procedure, the patient is repositioned in right recumbent sideposture, and the physician completes a pre-manipulative interactive assessment of the new region. The patient's lower shoulder is placed anterior, with both hands interlocked. The upper shoulder is posterior, the lower thigh and leg are straight, and the upper thigh and leg are flexed with the dorsum of the foot in the popliteal fossa of the lower knee. The pelvis is vertical or slightly anterior on the upper side. The physician stands with feet slightly apart. The physician makes a pisiform contact on the left transverse process of the L5 with the caudal hand, a palmar contact on the upper anterior shoulder with the cephalad hand, and an upper thigh contact with one thigh. An appropriate articular prestress is used and a high velocity, low amplitude manipulative thrust is delivered from posterior to anterior using the pisiform contact combined with a slight downward thrust with the thigh contact. Post-adjustment procedures and interactive reassessments are then performed.

Diversified Innominate Adjustment

A pre-manipulative interactive assessment is performed. Using similar positioning as the previous procedure, a similar adjustment is executed on the left posterior innominate, directing the line of drive more cephalad in order to open the joint space of the sacro-iliac joint. A post-adjustment interactive assessment is completed following the procedure.

Diversified Manipulation of the Sacrum

The patient is repositioned from the concluding position of the previous procedure to the prone position, and a pre-manipulation assessment of the new region is performed. A contact is made at the base of the subluxated sacrum, with the physician's right hand placed just to the left of the median line and the physician's left hand placed just to the right of the median line. Soft tissue traction is taken by rotating both hands together clockwise, and a straight arm body drop is made with the line of drive posterior to anterior at 90 degrees to the sacrum. Post-adjustments procedures and interactive reassessments are performed. Post-adjustment procedures and interactive reassessments are made.

Description of Post-Service Work:

Chart entry and documentation including documentation of appropriate subjective and objective assessments as well as the procedural components of this patient visit are completed. A consultation will follow up with the patient's general internist to confirm patient progress and to confirm that there are no signs of closed head injury.

SURVEY DATA:

Specialty: American Chiropractic Association

Sample Size: <u>233</u> 25th Percentile RVU: <u>.87</u>	Response Rate (%): 55.4% 75th Percentile RVU: 1.19	Median RVU: <u>.915</u> Low: <u>.45</u> High: <u>3.50</u>
Median Pre-Service Time: _4.0	Median Intra-Sen	vice Time: <u>12.0</u>
25th Percentile Intra-Svc Time:_	9.0 75th Percentile Intra-Svc T	"ime: <u>18</u> Low: <u>4.0</u> High: <u>120.0</u>
Median Post-Service Time:	<u>5.0</u>	

KEY REFERENCE SERVICE(S):

	CPT Code	CPT Descriptor	<u>Work RVU</u>
l)	998926	Osteopathic manipulative treatment (OMT); three to four body regions involved	0.65
2)	98927	Osteopathic manipulative treatment (OMT); five to six body regions involved	0.87
3)	98928	Osteopathic manipulative treatment (OMT); seven to eight body regions involved	5 1.03
4)	98929	Osteopathic manipulative treatment (OMT); nine to ten body regions involved	1.19

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

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

<u>98926, 98927, 98928, 98929</u>

The proposed value of code 9892X3, at .92, is most comparable in value to the existing OMT code 98927 for 5-6 body regions (0.87). The proposed value of .92 is significantly higher than the 0.65 value of 98926, the OMT code for 3-4 body regions and somewhat higher than the 0.87 value of 98927, the OMT code for five to six body regions. The proposed value is significantly under the values of OMT Codes 98928 (1.03) and 98929 (1.19). Because a greater number of body regions are involved, the proposed value of 98926. Survey respondents reported pre- (3 min), intra- (8 min) and post- (3 min) service times for 98926 that are lower than those given for 9892X3. Reported intensity for 9892X3 was also greater than the intensity reported for 98926. Survey respondents reported pre- (3 min), intra- (10 min) and post-(4 min) service times for 9892X3. Pre (4.5 min for 98928 and 3.5 min for 98929) and intra (14 min for 98928 and 15 min for 98929) service times were reported. Post service time was the same for 98928, 98929 and 9892X3. Average intensity was similar for these same three codes.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results, or other data besides the survey data are available, please explain any additional rationale for the RVUs.

The AMA/RUC survey resulted in an estimated median value of .915 for the RVW of 9892X3 (RR3). Although the OMT codes have been used primarily by the osteopathic community, it is the opinion of the ACA RVS Committee presenting this recommendation that the range of manual procedures and the clinical approach represented by the OMT codes is similar to that of other physicians, including doctors of chiropractic, who use manual manipulation. The Committee believes that the total <u>work</u> in the services represented by 9892X3 (CMT) falls between the work involved in the services represented by OMT codes 98927 (five to six body regions) and 98928 (seven to eight body regions). Therefore, the Committee chose to conservatively recommend an RVW of .92 for 9892X3, based upon the survey estimate.

FREQUENCY INFORMATION

How was this service previously reported? <u>A2000</u>

How often do physicians in your specialty perform this service? X Commonly Sometimes Rarely

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

As no actual utilization data exists for this new code, frequency estimates are based upon 1994 utilization of A2000 (12,077,274 total allowed services), 1994 BMAD data showing the percent of total Medicare charges by osteopaths for OMT codes, and the clinical knowledge, expertise and experience of a multi-disciplinary consensus panel (CP) facilitated by Lewin-VHI. The CP, using the above-mentioned OMT data and a modified Delphi process, estimated that the frequency of this service would be approximately 13% of total allowed services if A2000 was replaced by the proposed three CMT codes.

Is this service performed by many physicians across the United States? X Yes No

CPT Code: <u>9892X4</u> Tracking Number: <u>RR4</u> Global Period: <u>XXX</u> Recommended Work RVU: <u>40</u>

CPT Descriptor: Chiropractic manipulative treatment (CMT); extraspinal 1 or more regions

CLINICAL DESCRIPTION OF SERVICE:

This clinical vignette describes CMT on two (2) extraspinal body regions as a portion of the manipulative treatment provided within a more complex chiropractic manipulative treatment service involving both spinal and extraspinal manipulation procedures on an established patient previously scheduled for this service. The previous initial examination revealed a 52-year-old patient who suffered a severe motor vehicle accident over seven years ago. She has since been diagnosed with fibromyalgia and mild clinical depression. Prior to the accident, she had been very active and now is only able to be employed in relatively sedentary positions. As a secretary, she has developed moderate right-sided carpal tunnel syndrome for which surgery was unsuccessful. Besides right hand weakness and numbness, she also complains of forearm and elbow pain which worsens as the day goes on. She complains of neck stiffness with associated "pressure type-headaches" on a regular basis. Moderate-low back pain and right buttock pain prevent her from sitting for more than 30 minutes before needing to change positions. She describes significant abdominal bloating after meals which does not seem to respond to medication. (2 regions—upper extremities and the abdomen)

Description of Pre-Service Work (for the extra-spinal portion of the service only):

A brief evaluation of the patient, including a review of symptoms and a focused examination of the problem and related areas reveals that a chiropractic extraspinal manipulation treatment is clinically 2 regions: the upper extremities (elbow and hand), and the abdominal region.

Description of Intra-Service Work:

Manipulation to the Elbow

The patient is positioned into a sitting posture, and the physician completes a pre-manipulation interactive reassessment of the region. The physician then stands behind the patient and extends the patient's arm out to the side at 90 degrees. The physician's outside hand grasps the patient's wrist from above while his/her inside hand makes a thumb and supported index contact on the posterior head of the radius. The patient's arm is placed into an extended position, and a high-velocity, low amplitude posterior to anterior thrust is delivered on the radial head. Post-adjustment procedures and interactive reassessments are made.

Manipulation to the Hand and Wrist

With the patient still in the sitting position, the physician now comes to the front of the patient and completes a pre-manipulative interactive assessment of the new region. The patient's hand is pronated, and the physician places both thumbs on the lunate of the patient's wrist. The patient's wrist is then placed into an extended position to the point of joint tension, and a high velocity, low amplitude thrust is delivered through both thumbs on the lunate in a dorsal to a palmar direction. Post-adjustment procedures and interactive reassessments are made.

Manipulation to the Abdomen

For complaints related to hiatal hernia, the patient is placed in a seated position. Pre-manipulative interactive assessments are completed. The physician sits behind the patient and places the fingers slightly below and to the left of the xyphoid, and then moves the fingers in deeply in an anterior to posterior direction. The patient is
asked to lean forward slightly to allow a greater penetration of the fingers which will allow the physician to feel the rectus abdominous relax. At maximum penetration, the physician's fingers will move superiorly and to the left. The patient is asked to take a full inspiration and expiration, after which the physician quickly releases pressure. The procedure is repeated, except that on the second pass, instead of moving the fingers superiorly and to the left, the physician moves the fingers anterioinferiorly. This relaxes the pressure of the gastroesophageal junction in the thorax.

Description of Post-Service Work:

Chart entry and documentation, including documentation of appropriate subjective and objective assessments as well as the procedural components of this patient visit are completed.

SURVEY DATA:

Specialty: American Chiropractic Association					
Sample Size: 233 Response Rate (%): 55.4% Median RVU: .50					
25th Percentile RVU: <u>.45</u> 75th Percentile RVU: <u>.83</u> Low: <u>.19</u> High: <u>2.00</u>					
Median Pre-Service Time: <u>3.0</u> Median Intra-Service Time: <u>8.0</u>					
25th Percentile Intra-Svc Time: 5.0 75th Percentile Intra-Svc Time: 11.0 Low: 1.0 High: 60.0					
Median Post-Service Time: <u>3.0</u>					

KEY REFERENCE SERVICE(S):

	CPT Code	CPT Descriptor	<u>Work RVU</u>
1)	97265	Joint mobilization, one or more areas (peripheral or spinal)	0.45
2)	98925	Osteopathic manipulative treatment (OMT); one to two body regions involved	0.45
3)	97250	Myofascial release/soft tissue mobilization, one or more regions	0.45
4)	99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family	0.38

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill and physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

<u>99212</u>

The code 99212 describes the decision-making processes that are inherent in responsibly and effectively providing chiropractic manipulative treatment but does not include spinal manipulation itself. The recommended work value of .40 for 9892X4, although slightly higher, is similar to the work value of .38 for 99212. Survey repondents reported an intra-service time of 8.5 minutes for 99212, while the intra-service time for 9892X4 was 8 minutes. Pre and post service times, as well as intensity were the same for both codes.

<u>98925</u>

The proposed value of code 9892X4 is somewhat comparable in value to the existing OMT code for 1-2 body regions (0.45). At .40, the value of the proposed code is slightly lower than the value of 98925. Survey respondents reported pre- (2 min), intra- (6 min) and post-service (2 min) times for 98925 that were lower than those given for 9892X4. Intensity was also slightly lower for 98925.

<u>97265</u>

The code 97265 describes joint mobilization, one or more areas. The recommended work value of .40 for [°] 9892X4 is lower than the .45 work value of 97265. Survey respondents reported pre (2 min), intra (5 min) and post- (2 min) service times for 97265 that were lower than those given for 9892X4. Intensity was also slighly lower for 989265.

<u>97250</u>

The code 97250 describes myofascial release or soft tissue mobilization, one or more regions. The recommended work value of .40 for 9892X4 is somewhat lower than the .45 work value of 97250. Survey respondents reported an intra-service time of 7.5 minutes for 97250, which is slightly lower than the intra-service time of 8 minutes that was reported for 9892X4. Pre and post service times were the same for both codes. Average intensity for both codes was also similar.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results, or other data besides the survey data are available, please explain any additional rationale for the RVUs.

The AMA/RUC survey resulted in an estimated median value of .50 for the RVW of 9892X4 (RR4). However, the American Chiropractic Association's RVS Advisory Committee recognizes that the clinical vignette presented in the survey describes a patient receiving manipulative services on two body regions, which may have led to a higher estimation of the total work value, given that 9892X4 represents extraspinal manipulation for one or two body regions. For this reason, the Committee chose to conservatively recommend an RVW of .40. This recommendation is based upon 1) the prior work of an interdisciplinary consensus panel process conducted by Lewin-VHI that resulted in a work relative value of .40 for CMT on one body region and .50 for CMT on two body regions. (Note the consistency of the median RVW between the preliminary estimates made by the consensus panel and results of the AMA/RUC Survey for two body regions); 2) the estimates of the Committee, based upon clinical knowledge and experience, on the expected frequency (relative to each other) of patients requiring chiropractic spinal manipulation on one and two body areas. The Committee felt that the vast majority of extraspinal manipulations described under this code would be to one body region.

FREQUENCY INFORMATION

How was this service previously reported? <u>Previously not reported</u>

How often do physicians in your specialty perform this service? _ Commonly X_ Sometimes __ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 5.600.000

As no actual utilization data exists for this new code, frequency estimates are based upon survey data which show an average number of 70 chiropractic patients per week, 50 weeks per year, an estimate that there are 40,000 chiropractors in full time clinical practice within the United States and 1995 Minnesota claims data from the American Chiropractic Network which shows a frequency of submitted claims for extra-spinal manipulation at .4%.

Is this service performed by many physicians across the United States? X Yes No



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RUC HCPAC REVIEW BOARD RECOMMENDATIONS APRIL 1996

Debridement of Nails

The RUC HCPAC Review Board accepted recommendations from the American Podiatric Medical Association which were based on survey medians and comparison to key reference services 11040 *Debridement, skin, partial thickness* (.50) and 11050 *Paring or curettement of benign hyperkeratotic skin lesion with or without chemical cauterization (such as verrucae or clavi) not extending through the stratum corneum (eg, callus or wart) with or without anesthesia; single lesion (.43).* The Harvard intra-service time for both of these reference services (11040 = 6 minutes and 11050 = 9 minutes) is similar to the APMA intra-service time median of 8 minutes for 11720. The existing codes for debridement of nails 11700 - 11711 were not previously surveyed.

The APMA also clarified in their presentation that these services should not be starred procedures. An evaluation and management service would only be reported if the patient's condition required a significant, separately identifiable E/M service above and beyond the usual pre-service and post-service work associated with the debridement of nails. In addition, if local anesthesia is utilized, the associated physician work is also included in this code.

CPT Code (● New)	Tracking Number	CPT Descriptor	Global Period	RVW Recom- mendation
11700*	M1	Debridement of nails, manual; five or less	000	N/A
11701	M2	each additional, five or less (11700, 11701 have been deleted. To report, use 117X1, 117X2)	ZZZ	N/A
11710*	M3	Debridement of nails, electric grinder; five or less	000	N/A

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

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CPT Code (• New)	Tracking Number	CPT Descriptor	Global Period	RVW Recom- mendation
11711	M4	each additional, five or less	ZZZ	N/A
		(11710, 11711 have been deleted. To report, use 117X1, 117X2)		
•11720	M5	Debridement of nail(s) by any method(s); one to five	000	.45
•11721	M6	six or more	000	.60

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: <u>117X1</u> Tracking Number: <u>M5</u> Global Period: <u>000</u> Recommended Work RVU: <u>0.45</u>

CPT Descriptor: Debridement of nail(s) by any method(s); one to five

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67 year-old female presents with four painful toenails. They began to develop 10 years ago and have progressively worsened so that these nails are thickened, dystrophic and painful. There is yellowish discoloration of each deformed nail plate with subungual debris. The patient has difficulty wearing normal shoes and difficulty walking.

Description of Pre-Service Work:

- review of medical records
- communicating with other professionals
- communicating with patient and/or family
- preparing patient and instruments

Description of Intra-Service Work:

• using a combination of surgical hand instruments and power rotating burr the nails are debrided to reduce the size and girth of the abnormal nail plates, short of avulsion

Description of Post-Service Work:

- application of appropriate topical medication and dressing as necessary
- appropriate prescriptions are written
- communicating with patient, family, and other professionals as appropriate
- medical record is completed

SURVEY DATA:

Specialty: Podiatric Medicine						
Sample Size: 42 Response Rate (%): 100 Median RVU: 0.45						
25th Percentile RVU: <u>0.40</u> 75	th Percentile RVU: 0.50	Low: <u>0.32</u> High: <u>0.80</u>				
Median Pre-Service Time: 5	Median Intra-S	Service Time: <u>8</u>				
25th Percentile Intra-Svc Time: <u>5</u>	75th Percentile Intra-Svc 7	Time: <u>10</u> Low: <u>1</u> High: <u>20</u>				
Median Post-Service Time:		Number of Visits				
Day of Procedure:	5	N/A				
ICU:	<u> </u>	X				
Other Hospital:	X	X				
Office:	<u> </u>	X				

KEY REFERENCE SERVICE(S):

1)	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Work RVU</u>
	11040	Debridement; skin, partial thickness	0.50
2)	11050	Paring or curettement of benign hyperkeratotic skin lesion with or without chemical cauterization (such as verrucae or clavi) not extending through the stratum corneum (e.g., callus or wart) with or without local anesthesia; single lesion	0.43

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

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

The pre-, intra-, and post-service times for the two reference procedures were identical to the surveyed times for 117X1. The intensity of the two reference procedures was slightly greater than 117X1. In particular, the mental effort and judgment, and psychological stress of both reference procedures were higher than 117X1. The technical skill and physical effort was identical for reference procedure 11050 and 117X1, but slightly lower for reference procedure 11040.



ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results, or other data besides the survey data are available, please explain any additional rationale for the RVUs.

The survey results provide a rationale to set the value of 117X1 at approximately 0.45 RVU. We believe that the value of the procedure that is described by this new code should be higher than the previous codes 11700 (Debridement of nails, manual; five or less) and 11710 (Debridement of nails, electric grinder; five or less) each valued at 0.32 RVU. We believe that additional work may now be provided in instances when the practitioner utilizes more than one type of instrument to perform the debridement. [Please note that codes 11700-11711 have never been formally surveyed.]

FREQUENCY INFORMATION

How was this service previously reported? <u>11700 or 11710</u>
How often do physicians in your specialty perform this service? <u>X</u> Commonly <u>Sometimes</u> Rarely
Estimate the number of times this service might be provided nationally in a one-year period? <u>5.45 million</u>
Is this service performed by many physicians across the United States? X Yes No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: <u>117X2</u> Tracking Number: <u>M6</u> Global Period: <u>000</u> Recommended Work RVU: <u>0.60</u>

CPT Descriptor: Debridement of nail(s) by any method(s); six or more

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67 year-old female presents with eight painful toenails. They began to develop 10 years ago and have progressively worsened so that these nails are thickened, dystrophic and painful. There is yellowish discoloration of each deformed nail plate with subungual debris. The patient has difficulty wearing normal shoes and difficulty walking.

Description of Pre-Service Work:

- review of medical records
- communicating with other professionals
- communicating with patient and/or family
- preparing patient and instruments

Description of Intra-Service Work:

• using a combination of surgical hand instruments and power rotating burr the nails are debrided to reduce the size and girth of the abnormal nail plates, short of avulsion

Description of Post-Service Work:

- application of appropriate topical medication and dressing as necessary
- appropriate prescriptions are written
- communicating with patient, family, and other professionals as appropriate
- medical record is completed

SURVEY DATA:

Specialty: <u>Podiatric Medicine</u>						
Sample Size: <u>41</u> Response Rate (%): <u>100</u> Median RVU: <u>0.60</u>						
25th Percentile RVU: <u>0.55</u> 75th Percenti	le RVU: <u>0,75</u>	Low: <u>0.35</u> High: <u>1.1</u>				
Median Pre-Service Time: 5	Median Intra-S	Service Time: <u>12</u>				
25th Percentile Intra-Svc Time: <u>10</u> 75th Perc	entile Intra-Svc	Time: <u>15</u> Low: <u>7</u> High: <u>30</u>				
Median Post-Service Time:	Median Post-Service Time: <u>Total Time</u> <u>Number of Visits</u>					
Day of Procedure:	5	<u> N/A </u>				
ICU:	X	X				
Other Hospital:	X	X				
Office:	<u> </u>	X				



KEY REFERENCE SERVICE(S):

1) 、	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Work RVU</u>
	11040	Debridement; skin, partial thickness	0.50
2)	11050	Paring or curettement of benign hyperkeratotic skin lesion with or without chemical cauterization (such as verrucae or clavi) not extending through the stratum corneum (e.g., callus or wart) with or without local anesthesia; single lesion	0.43

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

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

The pre-,and post-services times for the two reference procedures were identical to the surveyed time for 117X2; however, the intra-service time for 117X2 was 50% greater than both reference procedures. The intensity of 117X2 was comparable to the two key reference procedures. The mental effort and judgment were identical for all services. The technical skill and physical effort was the same for 11050 and 117X2, and only slightly lower for 11040. The psychological stress of the two reference procedures was only slightly more than 117X2.

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ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results, or other data besides the survey data are available, please explain any additional rationale for the RVUs.

The survey results provide a rationale to set the value of 117X2 at approximately 0.60 RVU. We believe that the value of the procedure described by this new code should be slightly higher than 0.55, the sum of the relative values for physician work for the codes 11700 (Debridement of nails, manual; five or less- 0.32 RVU) and 11701(each additional five or less- 0.23 RVU), and 11710(Debridement of nails, electric grinder; five or less- 0.32 RVU) and 11711(each additional five or less-0.23 RVU) that were previously used to report this same work. [Please note that codes 11700-11711 have never been formally surveyed.]

FREQUENCY INFORMATION

How was this service previously reported? <u>11700 and 11701 or 11710 and 11711</u>				
How often do physicians in your specialty perform this service? X Commonly Sometimes Rarely				
Estimate the number of times this service might be provided nationally in a one-year period? <u>4.9 million</u>				
Is this service performed by many physicians across the United States? X Yes No				



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RUC HCPAC REVIEW BOARD RECOMMENDATIONS APRIL 1996

Biofeedback

In the five-year review process, a comment was received from a Carrier Medical Director (CMD) that biofeedback (codes 90900-90915) were overvalued and suggested that the current work RVUs be reduced from .89 to .43. The American Psychological Association (APA) conducted a survey of these codes in the Spring and determined that psychologists are performing a more involved service than what is currently described in these codes (i.e., providing psychotherapy). The RUC recommended that a coding proposal be developed to adequately describe the services performed by psychologists and other mental health providers versus the biofeedback training referred to in the CMD comments. The CPT Editorial Panel accepted a proposal to replace the existing biofeedback codes with one code for biofeedback training by any modality (90901) and two codes for psychophysiological therapy with biofeedback (90875 and 90876).

The RUC HCPAC Review Board accepted a recommendation from the American Physical Therapy Association to reduce the current value for biofeedback to 0.45, which is similar to the work RVU proposed in the CMD comment. 90901 is similar in work to 97110 Therapeutic procedure; one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range or motion or flexibility (work RVU = .45).

The American Psychological Association (APA) presented recommendations for the two new codes, 90875 and 90876, based on the survey they conducted in the Spring. The HCPAC Review Board was concerned that the APA had not surveyed the codes based on the new CPT descriptors and referred the codes back to APA to resurvey for reconsideration at the September meeting. In the interim, the Review Board recommends that the work relative values be equivalent to 90842 *Individual medical psychotherapy by a physician, with continuing medical diagnostic evaluation, and drug management when indicated, including insight oriented, behavior modifying or supportive psychotherapy (face-to-face with the patient); 20-30 minutes (1.11) and 90844 Individual medical psychotherapy...;45 to 50 minutes (1.73).*

CPT Code (• New)	Tracking Number	CPT Descriptor	Global Period	RVW Recommendation
•90901	FF1	Biofeedback training by any modality	000	.45
90900	FF2	Biofeedback training; by electromyogram application (eg, in tension headache, muscle spasm)	000	N/A
90902	FF3	in conduction disorder (eg, arrhythmia)	000	N/A
90904	FF4	regulation of blood pressure (eg, in essential hypertension)	000	N/A
90906	FF5	regulation of skin temperature or peripheral blood flow	000	N/A
90908	FF6	by-electroencephalogram application (eg, in anxiety, insomnia)	000	N/A
90910	FF7	by electrooculogram application (eg, in blepharospasm) (90900,90902, 90904, 90906, 90908, 90910 have been deleted. To report, see 9090X)	000	N/A
90911	FF8	Biofeedback training, anorectal including EMG and/or manome- try	000	N/A
90915	FF9	other (90915 has been deleted. To report, see 9090X)	000	N/A

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CPT Code (• New)	Tracking Number	CPT Descriptor	Global Period	RVW Recommendation		
PSYCHIAT OTHER PS	PSYCHIATRIC THERAPEUTIC PROCEDURES OTHER PSYCHIATRIC THERAPY					
●90875 ·	FF10	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient) (eg, insight oriented, behavior modifying or supportive psychothera- py); approximately 20-30 minutes	XXX	1.11 (Interim)		
●90876	FF11	approximately 45-50 minutes	XXX	1.73 (Interim)		

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 9090X Tracking Number: FF1 Global Period: XXX Recommended Work RVU: 0.45

CPT Descriptor: Biofeedback training by any modality

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 47-year-old man has a chronic history of muscle spasms in the neck and shoulders, and tension-type diagnosed headaches. He has not responded well to a prior history of treatment with anti-anxiety medication and physical therapy.

Patient is monitored with surface EMG-electrodes placed bilaterally on the trapezius, frontalis, and sternocleidomastoid muscle areas, given specific instruction as to how to interact with biofeedback information (visual and/or auditory signals meaningfully related to amplitude of EMG) and provided with directions of appropriate reduction of tension in the targeted muscle group. Possible factors precipitating tension-type headaches discussed. Pain levels reviewed from charts supplied by patient; session changes reviewed with patient and recommendations made for follow-up training during the week plus additional recommendations for monitoring. 45-60 minutes session length, with one-on-one interaction with treating therapist. A brief session could be 30 minutes.

The sample note may be a computerized printout of changes in EMG values over time, plus comments of treating practitioner, patient's responses, compendium pain values as well as recording of medication type and usage during the interval since last session.

Description of Pre-Service Work: Pre-service work includes reviewing history/chart and preparing equipment to be used.

Description of Intra-Service Work: Intra-service work includes placement of electrodes, the reading of responses (including galvanic skin responses), and working with the patient to monitor and control/change muscle responses.

Description of Post-Scrvice Work: Post-service work includes disposal or cleaning of electrodes, and documentation of services and results.

SURVEY DATA:

Specialty:American Physical Therapy Association						
Sample Size: 20/119 Response Rate (%):7% Median RVU:						
25th Percentile RVU: 0.45 75th Percentile RVU: 1.73 Low: 0.25 High: 2.2						
Median Pre-Service Time: <u>5 min</u>	Median Intra-Service Time: <u>45 min</u>					
25th Percentile Intra-Svc Time: 30 75	5th Percentile Intra-Svc Time: 45 Low: 30 High: 60					
Median Post-Service Time:	Total Time Number of Visits					
Day of Procedure:						
ICU:	n/a					
Other Hospital:	<u>n/a</u> <u>n/a</u>					
Office:	1					

CPT Code: <u>9090X</u>

KEY REFERENCE SERVICE(S):

<u>CPT</u>	Code <u>CPT Descriptor</u>	Work RVU
1) 97110	Therapeutic procedure; one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	0.45
2) 97530	Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional peformance, each 15 minutes	0.44
3) 97250	Myofascial release/soft tissue mobilization, one or more regions	0.45
4) 90843	Individua, medical psychotherapy by a physician, with continuing medical diagnostic evaluation, and drug management when indicated, including insight oriented, behavior modifying or supportive psychotherapy (face-to-face with the patient); time bespecified	1.11

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

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



The responses indicate that pre- and post-service times for reviewed code 9090X are very similar (within only a few minutes) to the key reference services 97110 and 97530. The intra-service time for reviewed code 9090X is shown to be more similar to key reference service 97110 than to key reference service 97530. Intensity, measured by "mental effort and judgment" and "technical skill and physical effort" is judged to be high (scale 4-5) for both the reviewed code 9090X and its key reference services. "Psychological stress" is shown to be moderate to low (scale 2-3), with the reviewed code 9090X only slightly lower than its key reference services.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results, or other data besides the survey data are available, please explain any additional rationale for the RVUs.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: <u>9080X</u> Tracking Number: <u>FF10</u> Global Period: ____ Recommended RVW: <u>1.30</u>

CPT Descriptor: Individual psychophysiological therapy incorporating biofeedback training by any modality (face-toface with the patient) eg, insight oriented, behavior modifying or supportive psychotherapy): approximately 20-30 minutes______

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 35-year-old woman has a history of migraine headache, low back pain, irritable bowel syndrome, and cervical strain. She has been referred by her neurologist for biofeedback, with the statement that "primary diagnosis for treatment is unclear."

Description of Pre-Service Work:

Preparing to see patient, preparation of biofeedback equipment, and review of records.

Description of Intra-Service Work:



Patient may be monitored with a variety of different biofeedback monitoring equipment which might possibly vary from one session to another in light of the complex presenting symptomatology. Such might include temperature sensor placement on the hands or feet, placement of EMG sensors on the trapezius or neck muscle area, placement of EMG sensors at appropriate placement sites over relevant back musculature. Patient would be given specific instructions as to how to interact with biofeedback information meaningfully related to the physiological function being monitored and provided with directions for appropriate physiological control for the targeted biological function. Possible factors precipitating physical symptoms discussed. Pain levels reviewed from charts supplied by patient; session changes reviewed with patient and recommendations made for follow-up training during week plus additional recommendations for monitoring. 20-30 minutes session length, with one-on-one interaction with treating therapist.

Description of Post-Service Work:

Arranging next visit. Dictating report. Cleaning equipment and supplies. Whatever contact is necessary with insurer for continuation of coverage for services. Periodic telephonic consultation with referring physician, other professionals, and family for continuity of care. Review of new medical or lab studies when relevant.

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SURVEY DATA:

Specialty: American Psychological Association					
Sample Size:	Response Rate (%):	Median RVW:			
25th Percentile RVW:	75th Percentile RVW:	Low:	High:		
Median Pre-Service Time:	Median Intra-S	Service Time: _			
25th Percentile Intra-Svc Time	: 75th Percentile Intra-Sv	c Time:	Low: High:		

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	RVW
1)			
2)			
			•

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

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

ADDITIONAL RATIONALE

9080X represents a briefer, 20-30 minute session, of 9081X, Individual Psychophysiological Therapy, 45-50 min. The survey of 9081X found a Median RVW of 2.03 and a Median Intra-Service Time of 50 minutes. The Individual Psychophysiological therapy codes 9081X and 9080X parallel the time intervals for Individual Medical Psychotherapy, 90844 (45-50 min), and 90843 (20-30 minutes), and there is overlap in their patient groups and techniques. The ratio of the work value of 90843 to 90844 is 0.64. 64% of the surveyed median work value of 9081X (2.03) results in a value of 1.30 for 9080X, the 20-30 minute code. The briefer service has a work value greater than 50% of the 45-50 minute service as the pre- and post-service time for both procedures is identical, as is also the case with the Individual medical psychotherapy codes.

FREQUENCY INFORMATION

How was this service previously reported? 90900, 90915

How often do physicians in your specialty perform this service? XXX Commonly

Estimate the number of times this service might be provided nationally in a one-year period. As HCFA reimbursement for biofeedback services has been limited to specific rehabilitative and neuromuscular re-educational applications, and the pre-existing codes did not adequately describe this service, the actual incidence of this service is unknown.

Is this service performed by many physicians across the United States? XXX Yes No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS-SUMMARY OF RECOMMENDATION

CPT Code: <u>9081X</u> Tracking Number: <u>FF11</u> Global Period: <u>Recommended RVW: 2.03</u>

CPT Descriptor: Individual psychophysiological therapy incorporating biofeedback training by any modality (face-toface with the patient) eg, insight oriented, behavior modifying or supportive psychotherapy): approximately 45-50 minutes

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 35-year-old woman has a history of migraine headache, low back pain, irritable bowel syndrome, and cervical strain. She has been referred by her neurologist for biofeedback, with the statement that "primary diagnosis for treatment is unclear."

Description of Pre-Service Work:

Preparing to see patient, preparation of biofeedback equipment, and review of records.

Description of Intra-Service Work:

Patient may be monitored with a variety of different biofeedback monitoring equipment which might possibly vary from one session to another in light of the complex presenting symptomatology. Such might include temperature sensor placement on the hands or feet, placement of EMG sensors on the trapezius or neck muscle area, placement of EMG sensors at appropriate placement sites over relevant back musculature. Patient would be given specific instructions as to how to interact with biofeedback information meaningfully related to the physiological function being monitored and provided with directions for appropriate physiological control for the targeted biological function. Possible factors precipitating physical symptoms discussed. Pain levels reviewed from charts supplied by patient; session changes reviewed with patient and recommendations made for follow-up training during week plus additional recommendations for monitoring. 45-50 minutes session length, with one-on-one interaction with treating therapist.

Description of Post-Service Work:

Arranging next visit. Dictating report. Cleaning equipment and supplies. Whatever contact is necessary with insurer for continuation of coverage for services. Periodic telephonic consultation with referring physician, other professionals, and family for continuity of care. Review of new medical or lab studies when relevant.

SURVEY DATA:

Specialty: American Psychological Association				
Sample Size: 200 ¹ Response Rate (%): 15%(30) Median RVW: 2.03				
25th Percentile RVW: <u>1.80</u> 75th Percentile RVW: <u>2.29</u> Low: <u>1.00</u> High: <u>3.95</u>				
Median Pre-Service Time: <u>8 Min.</u> Median Intra-Service Time: <u>50 Min.</u>				
25th Percentile Intra-Svc Time: <u>45 Min.</u> 75th Percentile Intra-Svc Time: <u>60 Min.</u> Low: <u>30</u> High: <u>90</u>				

Median Post-Service Time:	Total Time
Documentation of service provided	8.5
Arranging for further services	5
Reviewing results of studies	5
Communication further with patient, family, and other professionals including reports	10
Providing written or telephone reports to Medicare or other third party payors	9.5

KEY REFERENCE SERVICE(S):

	CPT Code	<u>CPT Descriptor</u>	RVW
1)	99204	Office visit, moderate to high severity (45 minutes)	1.71
2)	99404	Preventive medicine counseling to an individual (approx 60 min)	1.95

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

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

	Pre	Intra	Post	Mental Te Ph	chnical Skill and aysical Effort	Psychological Stress	
9081X	8	50	38	4	4	3	
99204	5	45	17	3	3	3	
99404	5	50	20.5	2	3	2	

ADDITIONAL RATIONALE

FREQUENCY INFORMATION

How was this service previously reported? 90900, 90915

How often do physicians in your specialty perform this service? XXX Commonly

Estimate the number of times this service might be provided nationally in a one-year period. As HCFA reimbursement for biofeedback services has been limited to specific rehabilitative and neuromuscular re-educational applications and the pre-existing codes did not adequately describe this service, the actual incidence of this service is unknown.

Is this service performed by many physicians across the United States? XXX Yes No

RUC HCPAC REVIEW BOARD RECOMMENDATIONS APRIL 1996

Orthotics and Prosthetics Training

The RUC HCPAC Review Board accepted recommendations presented by the American Physical Therapy Association (APTA) and the American Occupational Therapy Association (AOTA) which were based on survey medians and comparison to existing relative values for physical medicine therapeutic services. For example, 97110 *Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility* (work RVU = .45).

These services are infrequently performed and had never been surveyed, in either the Harvard study or the earlier APTA/AOTA survey of the physical medicine and rehabilitation section. Therapists would normally be expected to report orthotic or prosthetic training for the first few initial visits, and minor adjustments to the patient's bracing or splinting during other therapeutic services would not be reported separately.

CPT Code (• New)	Tracking Number	CPT Descriptor	Global Period	RVW Recommendation
97500	QQ2	Orthotics training (dynamic bracing, splinting), upper and/or lower extremities; initial 30 minutes, each visit	XXX	N/A
97501	QQ3	each additional 15 minutes (97500-97501 have been deleted. To report, see 9750X)	XXX	N/A

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CPT Code (• New)	Tracking Number	CPT Descriptor	Global Period	RVW Recommendation
●97504 ·	QQ1	Orthotics fitting and training, upper and/or lower extremities, each 15 minutes		.45
		<u>29000-29590)</u> Codes <u>97500, 97501</u> <u>9750X</u> should not be reported with 97116)		
97520	QQ4	Prosthetic training, initial 30 minutes, each visit upper and/or lower extremities; each 15 minutes	XXX	.45
97521	QQ5	each additional 15 minutes	xxx	N/A
		(97541 has been deleted. To report, see 97520)		

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SUMMARY OF RECOMMENDATION

CPT Code: 975XX Tracking Number: <u>OO1</u> Global Period: <u>XXX</u> Recommended Work RVU: <u>0.45</u>

Orthotics fitting and training, upper and/or lower extremities; each 15 minutes CPT Descriptor:

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Patient with 6 week old median & ulnar nerve injury is referred for splinting to improve hand use. Through a combination of gross impairment assessment and clinical reasoning, the therapist designs a splint that stabilizes the thumb for 3 jaw chuck prehension and facilitates the finger. extension required to place the hand around large objects. During the fitting process, the patient is instructed in split application, uses and frequency of wear, how to check for pressure areas and care of the splint.

Description of Pre-Service Work:

Includes:

reviewing history/chart discussion with other team members gathering/preparing materials to be used in procedure

Description of Intra-Service Work:

Direct patient time may include:

assessing splint for proper fit and function (optimal components/position) making necessary modification to splint training patient in use of splint, wearing schedule, care & precautions, tolerance issues, adjustments having patient practice functional activities while wearing splint

Description of Post-Scrvice Work:

Includes:

writing notes/documentation, charting communicating with other team members communicating with patient/family

SURVEY DATA:

Specialty: <u>AOTA & APTA</u>		
Sample Size: <u>39</u> Re	esponse Rate (%): <u>13.4</u>	Median RVU: 0.45
25th Percentile RVU: 0.45	75th Percentile RVU: <u>0.85</u>	Low: <u>0.25</u> High: <u>1.32</u>
Mcdian Prc-Service Time: <u>10</u>	Mcdian Intra	a-Service Time: 40
25th Percentile Intra-Sve Time: 20.7	75_75th Percentile Intra-Svc	Time: <u>6()</u> Low: <u>12</u> High: <u>60</u>
Mcdian Post-Service Time:	Total Time	Number of Visits
Day of Procedure:		
ICU:		<u> </u>
Other Hospital:		
Office:	·	

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KEY REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	Work RVU
97530	Therapeutic activities, direct (one on one) patient contact	0.44
	by the provider (use of dynamic activities to improve functional	l
	performance), each 15 minutes	
97110	Therapeutic procedure, one or more areas, each 15 minutes;	0.45
	therapeutic exercises to develop strength and endurance, range	
	of motion and flexibility	
97112	Therapeutic procedure, one or more areas, each 15 minutes;	0.45
	neuromuscular reeducation of movement, balance, coordination	•
	kinesthetic sense, posture, and proprioception	
	<u>CPT Code</u> 97530 97110 97112	CPT CodeCPT Descriptor97530Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes97110Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility97112Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination kinesthetic sense, posture, and proprioception

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

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

Respondents indicated that overall mental effort/judgement and technical skill/physical effort factors were in the medium to high (3-5) range of the intensity scale and were generally higher than the reference services. Psychological stress was rated lower overall (1-3) when compared to the above factors, but was rated higher than the reference services.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternataive method instead of the survey results, or other data besides the survey data are available, please explain any additional rationale for the RVUs.

FREQUENCY INFORMATION

How was this service previously reported? ______97500, 97501______ How often do physicians in your specialty perform this service? _X_ Commonly ____ Sometimes ____ Rarcly

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

1995 Carrier data show above services performed 15,585 times. Survey respondents indicate service is performed thousands of times yearly.

Is this service performed by many physicians across the United States? X Yes No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 975XX Tracking Number: 004 Global Period: XXX Recommended Work RVU: 0.45

CPT Descriptor: Prosthetic training, upper and/or lower extremities; each 15 minutes

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Upper Extremity Vignette: Patient with a below elbow amputation is referred for training in the use of a body powered B/E prosthesis which has both a Dorrance hook and functional hand terminal devices (TDs). After determining that the patient understands how to activate the muscles used to power TDs, control training begins with practice opening and closing the TDs and performing graded, repetitive tasks. Treatment culminates in training the patient to use the prosthesis as a functional assist.

Lower Extremity Vignette: Patient with a below knee amputation is referred for training in the use and care of a below knee prosthesis with molded socket and SACH foot. Following instruction in the purpose and use of the various components of the device itself, the patient is trained in the following: 1) Application and removal of prosthetic device. 2) Proper alignment and fit of prosthetic device with observation of related changes in skin condition during stance and gait activities.

Description of Pre-Service Work:

Includes:

reviewing chart

communicating with other team members on patient status/progress gathering/preparing materials to be used in procedure

ADTA

Description of Intra-Service Work:

Direct patient time may include:

checking prosthetic fit and componentry of prosthetic instructing patient in care of prosthetic, prosthetic characteristics, precautions and wear assessing level of function while wearing prosthetic instructing home program based on training techniques learned in clinic

Description of Post-Service Work:

Direct patient time may include: writing documentation/chart

communicating with other team members

SURVEY DATA:

Specialty: <u>AOTA & APTA</u>		
Sample Size: 35 Respon	use Rate (%): <u>12.1</u>	Median RVU: 0.45
25th Percentile RVU: 0.45 75th	Percentile RVU: <u>0.50</u>	Low: <u>0.35</u> High: <u>1.50</u>
Median Pre-Service Time: <u>10</u>	Median Intr	a-Service Time: _45
25th Percentile Intra-Svc Time: <u>30</u>	75th Percentile Intra-Svc	Time: <u>60</u> Low: <u>3</u> High: <u>99</u>
Mcdian Post-Scrvice Time:	Total Time	Number of Visits
Day of Procedure: ICU: Other Hospital: Office:		

KEY REFERENCE SERVICE(S):

	CPT Code	CPT Descriptor	Work RVU
1)	97530	Therapeutic activities, direct (one on one) patient contact	0.44
		by the provider (use of dynamic activities to improve function performance), each 15 minutes	al
2)	97110	Therapeutic procedure, one or more areas, each 15 minutes;	0.45
		therapcutic exercises to develop strength and endurance, range of motion and flexibility	:
3)	97112	Therapeutic procedure, one or more areas, each 15 minutes;	0.45
	•	neuromuscular reeducation of movement, balance, coordination	۵,
		kinesthetic sense, posture, and proprioception	
4)	97116	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)	0.40

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

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

The mental effort/judgement intensity factor was generally rated in the medium to high range of the scale and equal to the reference services. The technical skill/physical effort factor also was rated medium to high, but overall was higher than references. Psychological stress ranged across the scale, but was overall lower than other factors and higher than reference services.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternataive method instead of the survey results, or other data besides the survey data are available, please explain any additional rationale for the RVUs.

FREQUENCY INFORMATION

How was this service previously reported? 97520, 97521

How often do physicians in your specialty perform this service? X Commonly Sometimes Rarely

Is this service performed by many physicians across the United States? X Yes ____ No

RUC HCPAC REVIEW BOARD RECOMMENDATION Physical Medicine and Rehabilitation

In response to HCFA's comments in the December 8, 1995 Rule regarding physical medicine and rehabilitaiton services, a workgroup was formed to assist in developing a response by the American Physical Therapy Association and the American Occupational Therapy Association. The workgroup was chaired by Doctor Richard Whitten, an AMA representative, and included members of the RUC HCPAC Review Board and members of the RUC representing orthopaedic surgery, physiatry, and osteopathic medicine. The workgroup met in February and April to finalize the attached report which was then approved by the RUC HCPAC Review Board at their April meeting.

CPT Code	Descriptor	Global Period	1996 Work RVU	HPAC Rec. Work RVU
97010	Application of a modality to one or more areas; hot or cold packs	xxx	0.11	0.11
97012	Application of a modality to one or more areas; traction, mechanical	XXX	0.25	0.25
97014	Application of a modality to one or more areas; electrical stimulation (unattended)	XXX	0.18	0.18
97016	Application of a modality to one or more areas; vasopneumatic devices	XXX	0.18	0.18
97018	Application of a modality to one or more areas; paraffin bath	XXX	0.11	0.11
97020	Application of a modality to one or more areas; microwave	XXX	0.11	0.11
97022	Application of a modality to one or more areas; whirlpool	XXX	0.25	0.25
97024	Application of a modality to one or more areas; diathermy	XXX	0.11	0.11
97026	Application of a modality to one or more areas; infrared	XXX	0.11	0.11
97028	Application of a modality to one or more areas; ultraviolet	XXX	0.20	0.20
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes	XXX	0.25	0.25
97033	Application of a modality to one or more areas; iontophoresis, each 15 minutes	XXX	0.26	0.26
97034	Application of a modality to one or more areas; contrast baths, each 15 minutes	XXX	0.21	0.21
97035	Application of a modality to one or more areas; ultrasound, each 15 minutes	XXX	0.21	0.21
97036	Application of a modality to one or more areas; Hubbard tank, each 15 minutes	XXX	0.38	0.28
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CPT Code	Descriptor	Global Period	1996 Work RVU	HPAC Rec. Work RVU
97039	Unlisted modality (specify type and time if constant attendance)	xxx	0.29	0.20
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	XXX	0.45	0.45
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception	XXX	0.45	0.45
97113	Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises	XXX	0.44	0.44
97116	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)	XXX	0.40	0.40
97122	Therapeutic procedure, one or more areas, each 15 minutes; traction, manual	XXX	0.45	0.45
97124	Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	XXX	0.35	0.35
97139	Therapeutic procedure, one or more areas, each 15 minutes; unlisted therapeutic procedure (specify)	XXX	0.21	0.35
97150	Therapeutic procedure(s), group (2 or more individuals)	XXX	0.27	0.27
97250	Myofascial release/soft tissue mobilization, one or more regions	000	0.45	0.45
97265	Joint mobilization, one or more areas (peripheral or spinal)	XXX	0.45	0.45
97504	Orthotics fitting and traning, upper and/or lower extremities, each 15 minutes	XXX		0.45
97520	Prosthetic training, upper and/or lower extremities, each 15 minutes	XXX	0.37	0.45
97530	Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	XXX	0.44	0.44
97535	Self care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment) direct one on one contact by provider, each 15 minutes	XXX	, 0.33	0.45

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CPT Code	Descriptor	Global Period	1996 Work RVU	HPAC Rec. Work RVU
97537	Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis), direct one on one contact by provider, each 15 minutes	XXX	0.33	0.45
97542	Wheelchair management/propulsion training, each 15 minutes	XXX	0.25	0.45
97545	Work hardening/conditioning; initial 2 hours	XXX		
97546	Work hardening/conditioning; each additional hour	XXX		
97703	Checkout for orthotic/prosthetic use, established patient, each 15 minutes	XXX	0.25	0.45
97750	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes	XXX	0.45	0.45
97770	Development of cognitive skills to improve attention, memory, problem solving, includes compensatory training and/or sensory integrative activities, direct (one on one) patient contact by the provider, each 15 minutes	XXX	0.44	0.44
97799	Unlisted physical medicine/rehabilitation service or procedure	XXX		

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Review of Physical Medicine and Rehabilitation Codes April 1996

1. <u>BACKGROUND</u>

In the Federal Register of December 8, 1995 (p. 63167) HCFA notes that while reviewing codes to be implemented in 1996, they experienced some concerns regarding other physical medicine codes. "While we agree that these new services appropriately are compared to other therapeutic procedures, our review of the new services causes us to believe that the interim RVUs we assigned to the therapeutic procedures services may have been too high relative to other services on the fee schedule, for example, evaluation and management services." Consequently, while maintaining the values for 1996, and acknowledging that they accepted last year's recommendations, they "...now plan to refer these codes back to the RUC Health Care Professionals Advisory Committee Review Board for reconsideration, and will notify RUC of our concerns". Subsequent to these statements, HCFA valued the new 1996 codes at a level significantly below the previous levels established for physical medicine and Rehabilitation (PM&R)codes.

In the *Federal Register* there is some confusion as to whether just the "procedures" (typically those codes beginning with 971) or all "other physical medicine codes" are included in the requested "reconsideration." After further discussion at the RUC meeting in February and clarification from HCFA it was indicated that it would be appropriate to include all codes in the physical medicine section

As previously mentioned, the Dec. 8 *Federal Register* describes HCFA's rationale in assigning values to the new 1996 physical medicine codes. A discussion of this rationale is included in this outline.

2. MODALITIES

Modalities are those services within the CPT PM&R section that begin with 970. Prior to the changes that were made for 1995, a frequent criticism of these codes was that they were valued inconsistently as compared with the other codes in the 97000 series. The changes made for 1995 generally moved the values for the modalities into a more appropriate rank order with the remaining codes.

After the HCFA review, one modality, 97036 (Hubbard tank), was increased in work beyond the HCPAC RUC recommendation. This increase (from 0.28 to 0.38) appears too high relative to the therapeutic procedures and no additional evidence has been

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submitted to support this increase. It is therefore our recommendation that the relative work value for 97036, Hubbard tank, be reduced to the previously recommended value of 0.28.

3. MODALITIES VERSUS PROCEDURES

For the most part, the modality codes are appropriately valued less than procedure codes. The one exception is 97039, which describes an unlisted modality in comparison to 97139, which describes an unlisted procedure. These codes were not surveyed in the 1994 survey of physical medicine codes because, by definition, there is no standard description for either of the services. After the HCPAC RUC process, these codes were assigned values in the Federal Register that do not appear appropriate.

The Federal Register reported a work value of 0.29 for the unlisted modality (total value=0.56) and a work value of 0.21 for the unlisted procedure (total value=0.39). There is some thought that perhaps the values were erroneously reversed, but even with the reversal, the value of the modality appears too high. High values encourage the unnecessary use of these codes and discourage the highly efficient and cost-effective computerization of claims processing (claims submitted with these non-specific codes should be and generally are manually reviewed). Therefore, we recommend that the relative work value for 97039, Unlisted modality, be reduced to 0.20 which approximates the other work values in the 9703X series of codes and that the relative work value for 97139, Unlisted procedure, be increased to 0.35, equal to the lowest value for any of the therapeutic procedures.

4. PROCEDURE VALUATIONS

The physical medicine procedure codes were part of the 10% of CPT codes that were left unsurveyed by the Hsaio/Harvard study. In spring 1994, the APTA and AOTA conducted a survey of these codes in order to bring the relative values of this family of codes in line with previously surveyed codes.

Before the codes could be surveyed for a relative value, appropriate reference codes and values had to be selected. This was a particularly difficult task as the codes to be used as reference codes needed to be both stable and include a pre-survey value that reflected some accurate measure of the work involved. The reference codes that were selected were primarily those that reflected recent HCFA approved values as other values were often distorted: for example, an ice pack (97010) was valued almost as high as 30 minutes of hands-on exercises (97110) with the patient (0.23 vs. 0.27). This overvalued the application of an ice pack while undervaluing the intense hands on skilled treatment that involves therapist judgement and decision making and typically produces patient functional progress.

Approximately 80 to 100 responses were received for each code that was surveyed. The results were presented by APTA and AOTA to the RUC HCPAC Review Board in May 1994 for their approval. With little modification, the codes were approved by the HCPAC Review Board and presented to HCFA.

The survey process established by the RUC was rigorously followed. After a lengthy HCPAC Review Board deliberation and negotiation, accolades were received from several HCPAC and RUC members and staff regarding the completeness and professionalism of the survey and presentation.

We believe a fair and rigorous process was followed and appropriate values for the surveyed codes were established.

5. <u>COMPARISON OF THE PROCEDURE CODES</u>

Many of the procedure codes in the 97000 series have relative values in the range of 0.40 to 0.45. These codes are:

Code	Short Title	Work Value
97110	Therapeutic Exercise	0.45
97112	Neuromusc Re-ed	0.45
97113	Aquatic Therapy	0.44
97116	Gait Training	0.40
97122	Manual Traction	0.45
97124	Massage	0.35
97250	Soft Tissue Mobil/MFR	0.45
97530	Therapeutic Activities	0.44
97750	Phys Performance Test	0.45
97770	Cognitive Skills	0.44

With the exception of Massage (97124), all of these codes fall into the 0.40 to 0.45 range. The code for Massage is valued lower based on a lesser intensity of work required in providing this service and received that value from the HCPAC Review Board.

For the purposes of this discussion, this collective group of procedures will be represented by the Therapeutic Exercise code, 97110. It would be awkward to list all of the codes each time the group is discussed, and as 97110 shares the highest value of the codes under discussion, arguments made for it should be able to apply to any of these highly related set of codes.

There are three comparisons that will be made: first, the codes will be compared to Multispecialty Points of Comparison (MPC) a compilation of approximately 350 stable

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codes that have received broad consensus as appropriately valued codes; second, the Therapeutic Exercise code as a representative of the Physical Medicine procedures will be compared to Evaluation and Management codes as suggested by HCFA in the *Federal Register*; and finally, the code will be compared to other codes that are valued at approximately the same value as Therapeutic Exercise.

Multispecialty Points of Comparison (MPC)

Over the course of more than a year, RUC worked to develop a "multispecialty points of comparison" listing of stable codes whose value was recognized by a consensus of reviewers. A "cross specialty reference sub-committee" was also created to insure that codes relative to all specialties were included in the MPC. The MPC provides a "reasonableness check" by which any new code may be measured, and consequently is one of the first places to check when questioning the value of a given code. Therapeutic Exercise was accepted by the committee to be added to the MPC.

Comparison to Evaluation and Management Codes

Attachment II is an outline of several codes that have, as part of their descriptors, a time element. This includes several families of Evaluation and Management codes (these are specifically mentioned in the *Federal Register* as a comparison basis for the 97000 series)

We believe that therapeutic procedures, which are performed after an initial therapist evaluation, most closely approximate established patient evaluations (99211 - 99215). Although physical and occupational therapy treatment is provided in nursing homes and other facilities, therapists' services paid under the Medicare Fee Schedule are, by definition, performed in the therapist's office or patient's home.

The level of service for the E&M codes is defined by seven components, of which the three key elements are history, examination, and complexity of decision making. The additional component of time, although not the best descriptor, also must be considered, since time is a defined component of the PM&R services.

While assigning an intensity level to a procedure cannot be directly compared to an evaluation, the E&M documentation guidelines provide some direction. Generally, a therapist must address two history areas, past and social history, in order to ensure an appropriate therapeutic intervention. Often, attention must be paid to multiple systems and/or the interaction of multiple body areas. Therefore, we believe a comparison can be made to the "problem-focused" or "expanded problem-focused" history and examination levels. Patients often present with multiple, sometimes chronic, problems. Additionally, in many instances, therapists must consider cognitive, as well as physical factors, which may complicate treatment. Overall, we believe that this comparison equates either to a straightforward or low level of complexity.

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While the E&M code most closely related in time to the PM&R codes is 99213, we recognize that time may not be the best element of comparison. Additionally, a point could be made that the intensity of the typical service delivered during an office visit described by 99213 exceeds that of a typical Therapeutic Exercise session. Therefore, based on the above analysis, we believe that 99212, which describes a visit where there is a problem focused examination (limited examination of the affected body area), a problem focused history (brief history of present illness), and a straight-forward decision making process (minimal number of diagnoses/management options, minimal or no complexity of data to review, minimal risk of complications and/or morbidity or mortality) is the better description of the typical Therapeutic Exercise encounter. The time increment associated with 99212 is 10 minutes and the current RUC recommended work value for this code is 0.50. This also compares very favorably to the 0.45 work value for Therapeutic Exercise.

Comparison to other codes of approximately the same value (0.45)

Included as Table One is a listing of codes that are similar in value to Therapeutic exercise. Also included are several codes that are valued at approximately the same value as two units (or thirty minutes) of Therapeutic exercise. For comparison purposes, the time associated with each of the codes is included. Some of these time increments are intra service times and others are times that are used in the code descriptors. It is also recognized that "time" is not always the best determinate of work value. The inclusion of the time crement is meant only to bring clarity to the comparison.

The number of codes that could be used for comparison purposes is probably limited by only time and energy. The use of several codes seems sufficient to show that Therapeutic exercise is appropriately valued when compared to other codes of similar value. Because the appropriate rank order as demonstrated by Table One shows Therapeutic Exercise to be appropriately valued relative to codes of similar value, it is recommended that the current work values for the Physical Medicine and Rehabilitation <u>procedure codes</u> (97110 thru 97799) remain as initially recommended by the HCPAC Review Board and established by HCFA as interim values for 1995.

6. VALUES FOR THE 1996 CODES

Four new codes were established for 1996. In the December 8, 1995 Federal Register, the work value of the codes was reduced from the HCPAC recommended 0.45 to 0.33 for two of the codes and to 0.25 for the remaining two.

HCFA based the reduction to 0.33 for both 97535 (Self care/home management) and 97537 (Community/work integration) on the 1995 value for code 97540 (ADL training). However, the work value for the 97540 code was without basis. This code was not addressed by the Hsaio study, nor had it been surveyed in the APTA/AOTA effort during the Spring of 94. The value had no basis relative to any surveyed code. In addition, this code (97540)

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was deleted by the CPT Editorial Panel when 97535 and 97537 were approved: therefore, because 97540 was an "unstable" code it should not have been used by HCFA as a reference code on which to base work values for newly defined codes.

The additional codes (97542 - Wheelchair management/propulsion training and 97703 - Checkout for orthotics/prosthetics) that were reduced to 0.25 are procedure codes which involve the active and direct hands-on skilled care of the provider, working interactively with the patient. The reference value used by HCFA as a basis to reduce the HCPAC Review Board's RVW recommendations for these procedures is a modality. Equating the work involved in the direct application of a therapeutic procedure to that of a modality is inappropriate. For example, the following vignette for Wheelchair management/propulsion was used for the Spring 1994 survey.

A 29 year old C4 quadriplegic with complete right shoulder disarticulation and left above knee amputation has been fitted with a powered wheelchair and custom seating system. After an assessment of the seating system in conjunction with his functional goals, the therapist determines that the system must provide stabilization, support and balance as well as pressure management. To achieve these goals, the therapist trains the patient in the safe operation and management of the wheelchair in order to achieve independent mobility in his home and community environment.

This vignette reflects significantly more work than 15 minutes of manual electrical stimulation, the code to which it has been equated. The vignette for the manual electrical stimulation describes a 52 year old male with patellar femoral dysfunction. The provider works with the patient for proper electrode placement and stimulus parameter adjustment and uses probe stimulation to find motor points to obtain good muscle contraction.

A more appropriate comparison for Wheelchair management might be 97116, gait training. The vignette used for the original survey describes a 18 year post ACL arthroscopic repair presenting for gait training to eliminate gait deviations affecting normal swing and stance phase, i.e., stride length and cadence symmetry. An alternate clinical scenario for gait training would be a post CVA patient with left hemiparesis. The therapist works directly with the patient in facilitating trunk and pelvic stabilization, inhibiting excessive tone, and assisting with mobility and weight transfer to normalize the gait pattern.

Gait training has a relative value of 0.40. Considering the difference in work intensity described in the two procedures versus the modality, there is ample justification for the wheelchair management code to be valued at a level that is no less than gait training. This same comparison can be made for 97703, the other code that was valued based on a comparison to manual electrical stimulation. Additionally, we believe this analysis demonstrates the validity of the current work value of gait training in the rank order of the PM&R procedures.

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To further illustrate the work involved in the other 1996 codes in question, following are the vignettes that were used when these codes were approved for CPT and surveyed.

Self Care/Home Management Training (97535)

The patient is a 65 year old woman recently discharged from the hospital with a diagnosis of CVA resulting in a right hemiparesis. The patient lives alone and wants to be able to remain in her home. The initial evaluation has revealed performance deficits in bathroom activities and meal preparation. At the home site, the therapist recommends and sets up proper adaptive equipment in the bathroom, so that the patient can safely transfer to toilet and bathtub using compensatory techniques. In the kitchen, the therapists teaches and observes meal preparation using one-handed techniques and special adaptive equipment. Therapist must assure that patient's functional level is sufficient to perform necessary self care and home management activities within safe limits (e.g., picking items off floor, lifting pots from stove, reaching items in cupboards, opening drawers)

Community/Work Reintegration Training (97537)

A 35 year old computer programmer with a diagnosis of Guillain-Barre syndrome is being treated in an outpatient department for residual weakness which is limiting his ability to return to community and work activities. After evaluation, the therapist identifies transportation and work environment as two barriers to his ability to return to former functional level. The therapist determines the type of driving adaptation needed, trains him in the use of the equipment (including on-road practice), and trains on car transfer techniques.

(Same patient) With the patient, the therapist analyzes the essential job functions. At the work site the therapist analyzes the work environment to identify any factors with potential negative impact on balance/stability, posture and safe extremity function. The therapist reports all findings to the patient and, if necessary, the employer, recommends necessary changes in routine (e.g. stretching periods) or assistive technology (e.g. ergonomic seating, computer access) and provides equipment purchasing information to the patient and/or employer.

Checkout for orthotic/prosthetic use, established patient (97703)

Orthotic: A 56 year old female with a diagnosis of rheumatoid arthritis is seen for a follow-up checkout subsequent to a metacarpal phalangeal flexible implant arthroplasty. The therapist has previously fitted the patient with a dorsal dynamic orthosis that provides correction of residual deformity and permits metacarpal flexion and extension in desired plane and range. The patient's edema has decreased and she complains of pressure on the ulnar styloid. The therapist re-assesses the fit and makes adjustments to the orthosis.

Prosthetic: A forty year old man with a left below knee amputation is seen two months after being fitted for a prosthesis consisting of a conventional socket with supra condylar suspension and sach foot. The therapist reassesses the patient's need for additional modifications to the socket of the prosthesis following a stump revision. The therapist documents the fit of the prosthesis and checks the patient's comfort and safety during gait and standing activities.

Additional discussion of the inappropriateness of the 1996 values is found in both the APTA response to HCFA of February 1 and the AOTA response of January 22, both of which are attached.

Since, for 97535 and 97537, the comparison code was inappropriate, and because for 97542 and 97703 it can be demonstrated that significantly more work is involved than with the manual electric stimulation modality, it is recommended that the relative work values for these codes be returned to the values that were originally recommended by the HCPAC Review Board for 1996.

7. VOLUME OF PHYSICAL MEDICINE SERVICES IN 1995

It is apparent that there was concern that the changes in time increments that took place in the physical medicine section would result in an inappropriate gross annual reimbursement level for these codes. The concern was that there would be a significant increase in the frequencies of utilization of some codes. The available information from HCFA is included as attachment II and shows that in fact the number of services rendered actually <u>decreased in 1995</u> after increasing at more than 20% for each of the five previous years.

These statistics do not include all of the 1996 runoff of claims (those services that are rendered in 1995 but received by HCFA in 1996) or those that are submitted using a modifier. They are however the most recent available and even significant increases due to the runoff would still represent an impressive change that was generated by the new coding structure.

8. <u>SUMMARY</u>

We believe that a rigorous and statistically defendable process has been established through the RUC and HCPAC RUC process for the development of relative work values for CPT codes. This system successfully incorporates the input of practitioners who actually deliver the services and provides for a democratic method to present all views and opinions. While it can never be a perfect process, it is by far the most successful effort yet established for creating equitable and consistent values.



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16:10 MAY 02, 1996 ID: (301) 652-7711

In this response, we have considered the request of HCFA to reconsider the values that were assigned to the Physical Medicine and Rehabilitation codes for 1995. We recommend the following:

- 1. The current work values for the Physical Medicine and Rehabilitation procedure codes should remain as initially recommended by the HCPAC Review Board and established by HCFA as interim values for 1995.
- 2. The work values for the new 1996 codes (97535, 97537, 97542, 97703) should be adjusted to reflect the values that were originally recommended by the HCPAC Review Board.
- 3. The work value for 97036, Hubbard tank, be reduced to the value of 0.28, as previously recommended by the HCPAC Review Board.
- 4. To correct the rank order anomaly of the two "unlisted" code values, the work value for 97039, Unlisted modality, should be reduced to 0.20, which approximates the other work values in the 9703X series of codes and the work value for 97139, Unlisted procedure, be increased to 0.35, which equals the lowest value for any of the therapeutic procedures.

We appreciate the opportunity to present this additional information regarding PM&R services. Since our initial proposal to better define and value this family of codes, we have attempted to follow closely the AMA and HCFA processes to assure a valid outcome. We recognize the need to clarify and review services that are not familiar to all participants and believe that this discussion supports the original recommendations of the HCPAC Review Board. If additional questions remain, please contact us to arrange a meeting for response.
Table One

		RUC**	
Code	Descriptor	<u>Valuc</u>	<u>Time</u> *
9254	1 Spontaneous nystagmus test	0.40	13 min*
9892	5 Osteopathic manipulation, 1-2 regions	0.45	13 min*
9711) Therapeutic exercise	0.45	15 min
9940	Preventive medicine counseling	0.48	15 min
99212	2 Outpatient, established visit	0.50	10 min*
99 31	Subsequent nursing facility care	0.54	15 min
9921	B Outpatient, established patient	0.80	15 min
9586	Muscle test, head or neck	0.79	23 min*
9892	Osteopathic manipulation, 5-6 regions	0.87	25 min*
	2 units of Therapeutic exercise (97110)	0.90	30 min
95860) Muscle test, one limb	0.96	34 min*
98928	Osteopathic manipulation, 7-8 regions	1.03	30 min*

* The * indicates that the "time" is an "intraservice" time. All other "times" are in the descriptor of the code itself.

** This is the current or the most recently recommended work value by RUC.

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			<u> </u>	<u> </u>		Percent		Diff
Cude		1989	1994	1995	diff 94-95	Change	1995+8%	94-(95+8%)
97010	hi/ed pac	1,211,275	2.688.348	2,101,343	(587,005)	-21.84%	2,269,450	(418,898)
97012	2 trac, mech	130,209	197,974	173.579	(24.395)	-12.32%	187,465	(10,509)
97014	t c-stini unait	392,132	1,044,482	825,144	(218,338)	-20.90%	892,236	(152,246)
97016	ร์ พลรอ	18,377	74,784	64,586	(10,198)	-13.64%	69,753	(5,031)
97018	B paraffin	61.023	177,320	126,820	(50,500)	-28.48%	136,966	(40,354)
97020	micro	12,232	8,302	7,865	(437)	-5.26%	8,494	192
97022	2 whiel	416,721	579,724	407,037	(172,687)	-29,79%	439,600	(140,124)
97024	l dia	159,750	173,662	164_353	(905,9)	-5.36%	177,501	3,839
97026	infru	17,268	52,766	35,971	(16,795)	-31.83%	38,849	(13,917)
97028	3 ultra	23,549	16,200	14,178	(2,022)	-12.48%	15,312	(888)
97032	c-stin man			312,991	312,991		338,030	338.030
97033	lionto			75,394	75,194		81.42G	81,426
97034	contrst ba		,	4.844	4,844		5,232	5,232
97035	5 ultra			1,410,385	1,410,385		1,523,216	1,523,2]6
97036	hub taak			9,319	9,319		10,065	10,065
97039	unlisted	160,442	48,364	\$2,538	4,174	8.63%	56,741	8,377
97110	ther ex	1,029,837	2,015,418	2,346,270	330,852	16.42%	2,533,972	518,554
97112	neuro muse	59,138	250,896	229,081	(21,815)	-8.69%	247,407	(3,489)
97113	aquatic			142.142	142,142		153,513	153,513
97114	old fime act	\$8,377	180,422	18,363	(162,059)	-89.82%	19.832	(160,590)
97116	gait Img	82,745	162,354	143.038	(19,316)	-11.90%	154,483	(7.873)
97118	old c-stim man	238,852	536,058	53,998	(482,060)	-89.93%	58,318	(477,740)
97120	old ionto	35,697	100,380	10,574	(19,806)	-89.47%	11,420	(88,960)
97122	trac, man	26,697	101,644	76,785	(24,859)	-24.46%	82,928	(18,716)
97124	massage	384,754	1.094.440	914,962	(179,478)	-16.40%	988,159	(106,281)
97126	old contrst bath	3.454	6,4KD	608	(5,872)	-90.62%	657	(5.823)
97128	old ultra	1.100.111	2.035.916	210,804	(1.825,112)	-89,65%	227.668	(1.808.248)
97139	unisted	99.251	131.354	115.740	(15,614)	-11.89%	124,999	(6.355)
97145	add 15 min	315,798	723,430	74.433	(618,997)	-89.71%	80.388	(643.042)
97150	group		·	(9,387	19.387		20,938	20,938
97220	old hub mk	5.287	4,276	651	(3,625)	-84.78%	703	(3,573)
97221	old add 15	621	328	39	(289)	-88,11%	42	(286)
97240	old pool ther	33,555	91,986	10,693	(81,293)	-88.38%	11,548	(80,438)
97241	old add 15	3,853	42,138	5,796	(36,342)	-86.25%	6,260	(35 878)
97250	nifr/sm		54 552	209.366	154,814	283.79%	226 115	171 563
97260	manin	221211	151,850	73,976	(77.874)	-51.28%	79,894	(71.956)
97261	add 15	110 877	68.018	24,719	(43,292)	-63.66%	26.697	(41.321)
97265	ioint mob			150,740	150,740		162,799	162,799
27500	orth trac	5.987	9 304	10,703	1.399	15.04%	11 559	2 215
97501	add 15	1 408	2.366	4.882	2.516	106.34%	5,273	2 907
27520		2 375	3 312	4.099	787	23.76%	4 477	1115
1520	ndd 15	312	1 556	1 934	378	74 79%	7 020	533
07520	ther (kin) year	706 654	764 604	701 07	27 334	3 474	844 703	90 620
97330	add 15	200,034	175 774		Let 12	-17 5/4/	21 (20	(152 042)
9/33	nud 15	21,224	113,124	41,000	(133,630)	0/ +C, / 0-	23,039	(132,083)
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9/341		3,/43	13,042		116,0	40,447		,,ada
97542	wheelchr mgt		· ·	17/			-	-
97343	wk nrdn/cnd			<u>٥</u> ٢	134		145	143
97546	add i br					2 222		
97700	ov chk out	31.079	70,692	09,086	(1.000)	-2.2/%	/4,61.5	3,921
97701	21 DDB	7,163	21,714	22,308		2.14%	24.093	<u>۷/ د ب</u>
97703	orth/pros chkout							-
97720	old extra tatg	57.075	100,470	8,379	(92,091)	-91.66%	9,049	(91,421)
97721	old add 15	9,817	16,610	1,481	(15,129)	-91.08%	1,599	(15,011)
97750	phys perf tst	<u> </u>		76,570	76,570		82,696	82.696
97752	old muse tsig	8,660	15.270	2,672	(12,598)	-82.50%	2,886	(12,384)
97770	cog skills			4,062	4,062		4,387	4,387
97799	unlisted			2,298	2,298		2,482	2,482
								•
	Total	6,799,492	14,279,846	11,767,672	(2.512,174)	-17.59%	12,709,086	(1.570.760)
			l	% chg	-0.175924446		% chg	-0.109998402

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	CODE	LINGTORY	EXAM	DECISION	TIME MIND	TUUT	PLIC PUNUI	
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urpanen	L new pane	n	DROD	ICT E	10	0.30	0.20	
	99201	PROB	PROB	51-1	10	0.38	0.39	
	99202	EXP	EXP	151-F	20	0./5	0.79	
	99203	DET	DET	LOW	30	1.14	1.20	
	99204	COMP	COMP	MOD	45	1.71	1.80	-
	99205	COMP	COMP	HIGH	60	2.28	2.41	
			· "					
utpatien	t, establishe	d patient						
	99211	· · · · · · · · · · · · · · · · · · ·	Minima	1		0,17	0.25	
	99212	PROB	PROB	ST-F	10	0.38	0.54	 · ,
•	99213	EXP	FXP	ti ow	15	0.55	0.80	
	99214	DET	DET	MOD		0.94	1 27	
<u> </u>	00216	COLUB	COMP	UTCH		1 51	····· 1.00	
	99215	COMP	COMP	mon	40		1.90	
	1	<u> </u>		ļ				<u> </u>
urparient		SUICUION	0000		···			
	99241	PROB	PROB	51-1	15	0.54	0.63	
	99242	EXP	EXP	ST-F	30	1.11	1.25	
	99243	DET	DET	LOW	40	1.47	1.90	
	99244	COMP	COMP	MOD	60	2.23	2.50	
	99245	COMP	COMP	HIGH	80	2.96	3.21	
	1			·				
bsequer	nt Nursing F	acility Care	·	······			···	
· · · · · · ·	99311	PROB	PROB	ST-F/MOD	15	0.54	0.54	··· · · ·
	00312	TYP	FYP	MOD		0.29	0.34	
	00312		DET	MODATCH		1.10	1.10	
	C1566	DEI	DEI	MODINIGH		1.19	1.19	
ome Serv	99351	PROB	it PROB	ST-F/MOD	·	0.83	0.83	•
	99352	EXP	EXP	MOD		1.12	1.12	
	99353	DET	DET	MOD/HIGH		1.48	1.48	
						I.		
	SELECTE	D DEFINI	TIONS					•
		1						
	EXAMIN	ATION						
	PROB	Problem Fo	cused - a li	mited examinati	on of the affecte	d body are	a or orean system	
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		Lybunded L	CODICILL L'U	m and other	untomatic or rol	and among	sustem/w	
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	DET	Detailed - a	n extended	examination of	the affected bod	y arca(s) at	nd other	•
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	DET HISTORY PROB EXP DECISIO ST-F	Detailed - a Problem Fo Expanded P N MAKING Straight for	n extended symptoma cused - a b roblem Foo pertinent o	examination of ic or related org rief history of pr cused - a brief h f systems Minimal numbe	the affected bod an system(s) csent illness istory of present r of diagnoses of	y arcs(s) an illness and r managem	ad other	
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	DET HISTORY PROB EXP DECISIO ST-F	Detailed - a Problem Fo Expanded P N MAKING Straight for Low comple	n extended symptomat cused - a b roblem Foo pertinent o	examination of ic or related org rief history of pr cused - a brief h f systems Minimal number Minimal or no a Minimal risk of Limited number	the affected bod an system(s) csent illness istory of present r of diagnoses of mount and/or co complications at of diagnoses or and/or complex	y arca(s) an y arca(s) an illness and r managem mplexity of nanagement ity of data	a problem ent options of data to be revier idity or mortality ent options to be reviewed	wcd



January 22, 1996

Health Care Financing Administration Department of Health and Human Services Attention: BPD-827-FC P.O. Box 7519 Baltimore, MD 21207-0519.

Dear Sir/Madam:

The American Occupational Therapy Association, Inc. (AOTA), representing over 54,000 occupational therapy practitioners, is responding to the December 8, 1995 Federal Register (60 FR 63124) notice concerning the 1996 RBRVS Fee Schedule. We appreciate the policy discussions related to the elimination of the HCPCS codes H5300 and M0005 - M0008 which clarify the use of CPT by occupational therapy practitioners. However, we strongly object to the arbitrary assignment of work values to the new or revised 1996 physical medicine codes. HCFA "believes the recommended...RVUs are too high", to be a valid basis for taking this extreme action and we urge that this decision be reconsidered.

Our specific comments on these codes follow.

- 97535; 97537: HCFA is assigning RVUs on the present erroneous charge-based values. If there was any evidence that these charge-based values validly represented the work intensity of these codes, there would have been no reason to survey for work values.
- 97542; 97703: To state that "these services are comparable to attended modality services such as manual electrical stimulation (CPT code 97032)" is patently absurd. The work intensity involved in performing these procedures cannot be compared in any way to that of 97032.

Equally disturbing is the decision to refer the entire physical medicine section back to the HCPAC. The Federal Register states that "the interim RVUs ...may have been too high relative to other services... for example, evaluation and management services". There is no logical basis for comparing rehabilitation procedures to E&M codes. Additionally, if HCFA plans to revisit the entire Physical Medicine section, we believe the RUC recommendations these codes should stand as interim values until such time as the issues involving the dire section are resolved.

4720 Montgomery Lane PO BOX 31220 Bethesda, MD 20824-1220
 301-652-AOTA (2682)

 301-652-7711

 FAX

 1-800-377-8555



Health Care Financing Administration Attention: BPD-827-FC January 22, 1996 Page 2

From the initial discussions concerning the Physical Medicine codes, the AOTA and the APTA advisors asserted that the work intensity of rehabilitation procedures is far greater than required for modalities and the RVWs should reflect that professional judgement. The goal of restructuring and valuing these codes was not to arbitrarily raise the codes, but to accurately place rehabilitation services into the fee schedule and to indicate the correct relationship among the family of services. We believe that to HCFA's "after-the-fact" adjustments of these codes based on the belief that they are too high relative to the E&M codes (which are not even available to OTs and PTs) arbitrary. If adjustments to this family of codes are required for budget or other purposes, we urge HCFA to consider the clinical experience and professional analysis of the therapists who perform these services, and make the necessary reductions in the highly utilized modalities. This would not only be a more credible approach, but would be of greater value to the Medicare budget.

Thank you for your consideration of our comments.

Sincerely,

Judy Thomas Director, Reimbursement Policy Program Government Relations Department

JT/dm

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HYSICAL THEATY 16 SCIENTIFIC MEETING & EXPOSITION June 14-16, 1996 Minimanala, Minimara February 1, 1996

ADTA

Health Care Financing Administration Department of Health and Human Services Attention: BPD-827-FC P.O. Box 7519 Baltimore, MD 21207-0519

RE: File Code BPD-827-FC Final Rule - Revisions to Payment Policies and Adjustments to RVUs Under the Physician Fee Schedule for CY 1996 (Federal Register, Vol. 60, No. 236)

To Whom It May Concern:

The American Physical Therapy Association (APTA) welcomes the opportunity to comment on the final rule published in the Federal Register on December 8, 1995, regarding adjustments to the relative value units (RVUs) under the physician fee schedule.

The APTA represents over 69,000 physical therapists, physical therapist assistants and students of physical therapy throughout the United States. Many of our members bill under the physician fee schedule as physical therapists in independent practice (PTIPs), or are otherwise affected by the reimbursement rates established by the Medicare program under the resource-based relative value system (RBRVS).

According to the final rule, the Health Care Financing Administration (HCFA) believes that the values assigned to several therapeutic procedure codes may be "too high relative to other services on the fee schedule, for example, evaluation and management services." As a result, the values requested for new CPT codes for 1996 (97535 and 97537) were arbitrarily reduced from 0.45 to 0.33. The formula used to arrive at a work value of 0.33 is flawed, insofar as it is based on the work value of a 30 minute code (CPT code 97540) that was never surveyed and, therefore, never accurately reflected the actual work that went into providing the service. Thus, there is no reason to assume that this is a proper reference point for establishing the work values of the new CPT codes. Equally distressing is the specious reasoning behind reducing the RVUs for new CPT codes 97542 and 97703 from the recommended value of 0.45 to 0.25. According to the rule, HCFA believes that wheelchair management training (97542) and prosthetic checkout (97703) are comparable to attended modulity services. The level of work that goes into furnishing procedures designed to effect change through the application of clinical skills or services that attempt to improve function and that require direct one-on-one patient contact is inherently higher than the work involved in the application of a modality. The recommended values for the new CPT codes should be retained. Summarily dismissing the recommended values and replacing those values with arbitrarily established RVUs for these new codes invalidates the rigorous process that the RUC has been perfecting over the last five years.

Further, notwithstanding the fact that HCFA accepted the Health Care Professional Advisory Committee (HCPAC) Review Board's recommendation to assign a work value of 0.45 to CPT code 97110 (as well as several other therapeutic procedures), HCFA now intends to refer these codes back to the Review Board for reconsideration. The APTA strongly encourages HCFA to retain the values recommended by the RUC HCPAC for the new 1996 CPT codes, as well as the interim RVUs assigned to the therapeutic procedures codes, pending review of the evaluation and HCFA I February 1996 Page two

management (E&M) codes. This approach is entirely reasonable, particularly in light of the fact that the 97000 series codes were surveyed in 1994 to establish, for the first time, RVUs that reflect the actual work involved in furnishing the services. The RUC HCPAC adhered to this extremely rigorous process, which included providing justification for the recommended values. The RVUs established and authenticated by this process should be retained.

As part of the five-year review, the RUC intends to revisit the work values of the E&M codes at its February 1996 meeting. As a result of this review process, the values assigned to the E&M codes are subject to change. Given that the E&M codes are currently unstable in terms of the assigned work values, they should not be used as a reference point or benchmark for the valuation of other codes at this time. Because changes to the E&M codes are likely, it would be premature and ineffectual to use these codes as a basis to revalue the therapeutic procedures codes. If HCFA intends to use the E&M codes as a reference point in assessing the values of other codes, re-evaluation of the therapeutic procedures codes should be held in abeyance until such time as the E&M codes have been assigned proper work values.

On another matter related to this rule, it has been brought to our attention that some Part B carriers have erroneously advised physical therapists that they can no longer use Q0103 and Q0104 for evaluations and re-evaluations, respectively. The carriers may be confusing the "Q" codes with the unspecified bundled "M" codes, the latter having been eliminated as of January 1, 1996. It would be useful for HCFA to issue an affirmative statement that physical therapists in independent practice can bill Medicare for evaluations and re-evaluations utilizing Q0103 and Q0104.

Thank you for the opportunity to comment on these matters. If further information is needed, please contact the undersigned at (703) 706-8549.

Sincerely,

Kathryn D. McCann, Esq. Assistant Director, Regulatory Affairs

enclosures (3 copies)

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Color Antipy
 Sociation
 1111 North Fairfax Street
 Mexandria VA 22314-1488
 703/684-2782
 703/684-7343 Jax

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James A Boll NA P1 Samuel M. Brewn, PT Patricia McAdoo, PT, MEd Rodney 4, Mixasako, MA, PT Patricia C. Montgomery, PhD, PT

Roger M. Nelson, PhD. PT.

Jan K. Richardson, PT, PhD, OCS

Jayne L. Snyder, MA, PI

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PHYSICAL THERAPY 96 SCIENTIFIC MEETING & EVPOSITION (C1C (4413) (100) (C1C (4413) (100) 23 April 1996

Grant Bagley, M.D. Room C4-02-06 Bureau of Policy Development Health Care Financing Administration 7500 Security Boulevard Baltimore, MD 21244-1850

RE: Practice Expense Relative Value Units

Dear Dr. Bagley:

As part of our comprehensive review of the physical medicine and rehabilitation CPT codes, the American Physical Therapy Association (APTA) would like to comment at this time on the practice expense (PE) relative values of certain codes within the physical medicine and rehabilitation section of the CPT. As we have previously conveyed, it is the APTA's position that the PE relative value units (RVUs) for the supervised modalities (970XX) are excessive in relation to the remaining 97000 series, particularly in relation to therapeutic procedures.

The current PE RVUs for the supervised modalities do not accurately reflect the actual practice expenses and resources used in furnishing these services, as is required pursuant to the methodology described in the physician fee schedule legislation. The practice expenses incurred in furnishing therapeutic procedures are generally appreciably higher than those incurred in furnishing supervised modalities. A comparison of the PE RVUs for CPT code 97010 - hot/cold packs (0.21) vis a vis those for CPT code 97110 therapeutic exercises (0.13) is illustrative of this gross distortion. Intervention with therapeutic exercises (97110) frequently involves the use of sophisticated, costly equipment. Conversely, a cold pack (97010) is often simply a bag of ice or some other basic means of producing cryotherapeutic benefits. Considering the work values exclusively for therapeutic exercises (97110) and hot/cold packs (97010), there is about a 4:1 relationship between the two codes (0.45 and 0.11, respectively). This relationship is statistically sound based on the survey results and, more importantly, it is sound based on common sense. However, once the PE values and malpractice expense value are added, the relationship deteriorates to less than 2:1 (0.60 vis a vis 0.34). Given that the malpractice value for both codes is 0.02, the factor that skews the relationship is the practice values. Placing such an inordinately high valuation on the practice expense for hot/cold packs (97010) disturbs the proper "rank order" of the physical medicine codes. The distortion also exists between the supervised modalities and the constant attendance modalities (9703X). For CY 1995, the average Medicare allowed charge for 97010 (application of a hot or cold pack) was \$13.19. The work value for this supervised modality is 0.11 and the PE value is almost twice as high at 0.21. With one exception, this exceeds the practice expense values associated with the constant attendance modalities.

While we appreciate and welcome the opportunity to participate in the Clinical Practice Expert Panel (CPEP) process and believe that it may eventually produce accurate PE

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Grant Bagley, M.D. HCFA/BPD 23 April 1996 Page two

values, we further believe that a reduction in the PE RVUs for supervised modalities warrants immediate attention, given the distortion created by the current values. In addition to the statutorily mandated five year review of the relative values, the statute confers upon the Secretary of Health and Human Services broad authority to adjust the relative value units to account for changes in medical practice, coding changes, new data on relative value components, or the addition of new procedures. It is our position that the PE values of the supervised modalities can, and should, be reduced at this time.

We propose that the distortion be remedied by reducing the PE RVUs for all modalities (970XX) to 0.10. In our presentation to the HCPAC Review Board, we also recommended: (1) that the work value for CPT code 97036 (Hubbard tank) be reduced to 0.28, as originally recommended by the HCPAC Review Board; and (2) that the work value for CPT code 97039 (unlisted modality) be reduced to 0.20, which is approximately the work value of the other codes in the 9703X series. As you will note from Attachment II, these changes would result in a savings to the Medicare program of more than \$17,300,000.

Moreover, one assumption made by the Health Care Financing Administration (HCFA) in assigning practice expense values for CY 1995 was that there would be an increase in the frequency of services of approximately 69% due to the coding changes. This assumption is unsupported by the latest figures from HCFA, as shown on Attachment I. Given this actuality and the skewed rank order of the codes (noted above), we strongly support the reinstatement of the pre-1995 practice expense values for the procedure codes (97110-97799) in the physical medicine and rehabilitation section.

The overvaluation of the supervised modalities diminishes the proper relativity between the modalities and the therapeutic procedures and reduces the effectiveness of the Resource Based Relative Value System (RBRVS) overall. The reduction of the PE values for the supervised modalities is a necessary step in the accurate valuation of these codes and advances the goal of establishing a proper relationship among the 97000 series codes, based on actual resource utilization.

We appreciate your serious consideration of these recommendations. If further information is needed in your deliberation of these proposals, please contact the undersigned at (703) 706-3175.

Sincerely. Jim Nugent/

Director, Reimbursement Department

Attachment

6 **%**

						Percent		Diff
Code		1989	1994	1995	diff 94-95	change	1995+8%	94-(95+8%)
97010	ht/cd pac	1,211,275	2,688,348	2,101,343	(587,005)	(21.84)	2,269,450	(418,898)
97012	trac, mech	130,209	197,974	173,579	(24,395)	(12.32)	187,465	(10,509)
97014	e-stim unatt	392,132	1,044,482	826,144	(218,338)	(20.90)	892,236	(152,246)
97016	vaso	18,377	/4,/84	64,586	(10,198)	(13.64)	69,753	(5,031)
9/018	parattin	61,023	177,320	126,820	(50,500)	(28.48)	136,966	(40,354)
97020	micro	12,232	8,302	7,865	(437)	(5.26)	8,494	192
97022	Whiri	416,721	5/9,/24	407,037	(1/2,687)	(29.79)	439,600	(140,124)
97024		159,750	1/3,662	104,353	(9,309)	(0.30)	177,501	3,839
9/020	intra	17,208	52,700	35,971	(10,795)	(31.03)	38,849	(13,917)
97028	ultra	23,549	10,200	212 001	(2,022)	(12.40)	10,312	(888)
97032	e-sum man			75 304	75 304		81 426	91 426
97033	contret ha			4 844	4 844		5 232	5 232
97035	ultra			1 410 385	1 410 385		1 523 216	1 523 216
97036	hub tank			9,319	9.319		10.065	10.065
97039	unisted	160.442	48.364	52.538	4.174	8.63	56.741	8.377
97110	ther ex	1,029,837	2,015,418	2,346.270	330,852	16.42	2,533.972	518,554
97112	neuro musc	59,138	250,896	229,081	(21,815)	(8.69)	247,407	(3,489)
97113	aquatic			142,142	142,142	······	153,513	153,513
97114	old func actv	58,377	180,422	18,363	(162,059)	(89.82)	19,832	(160,590)
97116	gait trng	82,745	162,354	143,038	(19,316)	(11 90)	154,481	(7,873)
97118	old e-stim man	238,852	536,058	53,998	(482,060)	(89.93)	58,318	(477,740)
97120	old ionto	35,697	100,380	10,574	(89,806)	(89.47)	11,420	(88,960)
97122	trac, man	26,697	101,644	76,785	(24,859)	(24.46)	82,928	(18,716)
97124	massage	384,754	1,094,440	914,962	(179,478)	(16.40)	988,159	(106,281)
97126	old contst bath	3,454	6,480	608	(5,872)	(90.62)	657	(5,823)
97128	old ultra	1,100,111	2,035,916	210,804	(1,825,112)	(89.65)	227,668	(1,808,248)
97139	unisted	99,251	131,354	115,740	(15,614)	(11.89)	124,999	(6,355)
9/145	add 15 min	315,798	/23,430	/4,433	(648,997)	(89.71)	80,388	(643,042)
9/150	group	<u> </u>	4.070	19,387	19,387		20,938	20,938
9/220		5,287	4,276	651	(3,625)	(84.78)	703	(3,573)
9/221		621	328	39	(289)	(88.11)	42	(286)
97240	old pool ther	33,555	91,986	10,693	(81,293)		11,548	(80,438)
97241		3,603	42,130	200,266	(30,342)	(00.20)	0,200	
97250	min/sun manin	221 211		209,300	(77.974)	203.79	220,113	(71.056)
97200	add 15	110 877	68 018	24 719	(12,200)	(63.66)	79,094	(71,900)
97265	ioint mob	10,077	00,010	150 740	150 740	(00.00)	162 700	162 700
97500	orth trng	5 987	9 304	10 703	1 300	15.04	11 550	2 255
97501	add 15	1 408	2 366	4 882	2 516	106.34	5 273	2,200
97520	pros trng	2 325	3 312	4 099	787	23.76	4 427	1 115
97521	add 15	312	1,556	1,000	378	24.29	2 089	533
97530	Ther (kin) actv	206.654	764.604	791,938	27.334	3.57	855,293	90.689
97531	add 15	27.224	175.724	21.888	(153.836)	(87.54)	23,639	(152.085)
97535	self cr/hm mat				0		0	0
97537	comm/wrk re				0		0	0
97540	trng in adl	24,952	271,316	106,347	(164,969)	(60.80)	114,855	(156,461)
97541	add 15	3,743	13,042	19,359	6,317	48.44	20,908	7,866
97542	wheelchr mgt				0		0	0
97545	wk hrdn/cnd			134	134		145	145
94546	add 1 hr			20	· 20		22	22
97700	ov chk out	31,079	70,692	69,086	(1,606)	(2.27)	74,613	3,921
97701	add 15	7,163	21,714	22,308	594	2.74	24,093	2,379

97703	orth/pr chkout				0		0	0
97720	old extrm tstg	57,075	100,470	8,379	(92,091)	(91.66)	9,049	(91,421)
97721	old add 15	9,817	16,610	1,481	(15,129)	(91.08)	1,599	(15,011)
97750	phys perf tst			76,570	76,570	ERR	82,696	82,696
97752	old musc tstg	8,660	15,270	2,672	(12,598)	(82 50)	2,886	(12,384)
97770	cog skills			4,062	4,062		4,387	4,387
97799	unlisted			2,298	2,298		2,482	2,482
								0
	Total	6,799,492	14,279,846	11,767,672	(2,512,174)	(17.59)	12,709,086	(1,570,760)
				%chg	-0.1759244		%chg	-0.1099984
				•				

	ł			1995	1995	proposed	total	total	
Coc	le		1995	avg cost	total rvu	total rvu	1995 cost	cost using	SAVINGS
								new rvus	e to marchael e la
97	010 ht/co	d pac	2,101,343	13.19	0.34	0.23	27716714 17	18749541 94	8967172 23
97	012 trac,	mech	173,579	15.8	0.46	0.37	2742548.2	2205962 68	536585 52
97	014 e-sti	m unatt	826,144	14.92	0.4	0.3	12326068.48	9244551 36	3081517 12
97	016 vasc)	64,586	15.69	0.45	0.3	1013354.34	675569.56	337784.78
97	018 para	ffin	126,820	15.07	0.38	0.24	.1911177.4	1207059 41	7.04117.99
97	020 micr	0	7,865	13.02	0.33	0.23	102402.3	71371.30	31.031.00
97	022 whir		407,037	15.6	0.46	0.37	6349777.2	5107429 49	1242347 71
97	024 dia		164,353	13.54	0.34	0.23	2225339.62	1505376.80	7,19962 82
97	026 infra		35,971	12.86	0.32	0.23	462587.06	332484.45	130102.61
97	028 ultra		14,178	14.63	0.4	0.31	207424.14	160753.71	46670'43
97	032 e-sti	m man	312,991	14.47	0.4	0.36	4528979.77	4076081.79	452897 98
97	033 ionto)	75,394	14.65	0.42	0.38	1104522.1	999329.52	105192 58
97	034 cont	rst ba	4,844	12.96	0.32	0.32	62778.24	62778.24	O OC
97	035 ultra		1,410,385	12.49	0.33	. 0.32	17615708.65	17081899.30	.533809.35
97	036 hub	tank	9,319	15.71	0.61	0: 4	• 146401.49	96000.98	50400.51
97	039 unist	ted	52,538	18.46	0.56	0.33	969851.48	571519 62	398 331 86
									\$17,337,924.49

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