RUC Recommendations For CPT 2001

RUC Meetings:

February 2000 and April 2000

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS RECOMMENATIONS

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AMA SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
October 2000

Transesophageal Echocardiography (TEE)

Work Relative Value Recommendations

The RUC reviewed new CPT code 93318 *Echocardiography, transesophageal (TEE) for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis* and compared this service to code 93312 *Echocardiography, transesophageal, real time with image documentation (2D) (with or without m-mode recording); including probe placement, image acquisition, interpretation and report* (work RVU = 2.20). Unlike 93312, 93318 does not require a written report. However, code 93318 includes a wider range of diagnostic possibilities and more imaging is required over a longer period of time. The RUC agreed that code 93318 requires significantly more work than 93313 *Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); placement of transesophageal probe only)* (work RVU = 0.95) as 93318 requires manipulating the probe many times and requires complex image acquisition.

The RUC recommends a work relative value of 2.20 for CPT code 93318.

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●93318	CC1	Echocardiography, transesophageal (TEE) for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis	XXX	2.20

AMA SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
October 2000

Anesthesia Services

Work Relative Value Recommendations

00537 (BBI)
The RUC agreed that the ASA base unit recommendation of 8 for CPT code 00537 *Anesthesia for cardiac electrophysiologic procedures including radiofrequency ablation* is appropriate. The RUC agreed that this service is more intense than compared to existing CPT code 00534 *Anesthesia for transvenous insertion or replacement of cardioverter/defibrillator* (base unit = 7).

The RUC recommends a base unit of 8 for CPT code 00537.

00550 (BB2)
The RUC reviewed the ASA base unit recommendation of 12 for code 00550 *Anesthesia for sternal debridement* and was concerned that this recommendation was too high. The RUC noted that the vignette might not have reflected the typical patient. The vignette refers to a trauma patient; however, the typical patient is usually one with an infection. The RUC agreed that code 00550 is more comparable to code 00472 *Anesthesia for partial rib resection; thoracoplasty (any type)* (base unit = 10) and 00350 *Anesthesia for procedures on major vessels of neck; not otherwise specified* (base unit = 10). In addition, the RUC agreed that 00550 is similar in intensity to code 00540 *Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); not otherwise specified* (base unit = 10).

The RUC recommends a base unit of 10 for CPT code 00550.

00563 (BB3)
The RUC reviewed the ASA recommendation of 25 base units for code 00563 *Anesthesia for procedures on heart, pericardium, and great vessels of chest; with pump oxygenator with hypothermic circulatory arrest*. This service, whose typical patient is a newborn, is more work than 00562 *Anesthesia for procedures on heart, pericardium, and great vessels of chest; with pump oxygenator* (base unit = 20), especially due to the high psychological stress.

The RUC recommends a base unit of 25 for CPT code 00563.

00566

The RUC agreed with the ASA recommendation of 25 base units for code 00566 *Anesthesia for direct coronary artery bypass grafting without pump oxygenator* and agreed that this service is as intense as 00563 *Anesthesia for procedures on heart, pericardium, and great vessels of chest; with pump oxygenator with hypothermic circulatory arrest.*

The RUC recommends a base unit of 25 for CPT code 00566.

00635 (BB4)

The RUC reviewed the ASA recommendation of 5 base units for CPT code 00635 *Anesthesia for procedures in lumbar region; diagnostic or therapeutic lumbar puncture* agreed that it was too high. The RUC agreed that this service is more comparable to the following CPT codes:

00104 *Anesthesia for electroconvulsive therapy* (base unit = 4)

00148 *Anesthesia for procedures on eye; ophthalmosocpy* (base unit = 4)

00522 *Anesthesia for closed chest procedures (including bronchoscopy); needle biopsy of pleura* (base unit = 4)

The RUC recommends a base unit of 4 for CPT code 00635.

01112 (BB5)

The RUC reviewed CPT code 01112 *Anesthesia for bone marrow aspiration and/or biopsy, anterior or posterior iliac crest* and expressed concern that two different services are described within this single code. The RUC agreed that the ASA recommendation of 6 base units may be appropriate for bone marrow harvesting, but as the code is currently described, the more typical patient will require diagnostic biopsy. The RUC, therefore, recommended that a base unit of 5 is more appropriate and suggested that ASA submit a code proposal to describe anesthesia for harvesting of bone marrow.

The RUC recommends a base unit of 5 for CPT code 01112.

01215 (BB6)
01214 (BB7)

The RUC reviewed 01215 *Anesthesia for open procedures involving hip joint; revision of total hip arthroplasty* and 01214 *Anesthesia for open procedures involving hip joint; total hip replacement* as a group. These codes are the result of separating the revision of total hip arthroplasty and total hip replacement, as previously both services were combined into one code. Since the current HCFA published value for the more difficult procedure involving revision of total hip arthroplasty is 10 base units, the RUC agreed that such a value was appropriate for the work involved. Additionally, the RUC agreed that the median survey base unit value of 8 for the revised code 01214 pertaining to total hip replacement was appropriate since it was a more benign procedure and also created a proper rank order.

The RUC recommends a base unit of 10 for CPT code 01215.
The RUC recommends a base unit of 8 for CPT code 01214.

01951(BB8), 01952 (BB9), 01953 (BB10)

The RUC reviewed these three codes as a group. The ASA recommended 3 base units for code 01951 *Anesthesia for second and third degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; less than one percent total body surface area.* The ASA recommended 5 base units for code 01952 *Anesthesia for second and third degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; one percent to nine percent total body surface area.* The ASA recommended 1 base unit for code 01953 *Anesthesia for second and third degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; each additional nine percent total body surface area or part thereof (List separately in addition to code for primary procedure).*

The RUC examined the increasing amounts of work involved with increasing areas of burned body surfaces and made the following recommendations. The RUC agreed that the existing ranges were inappropriate and different ranges should be used for these three codes to be consistent with other CPT codes, such as the local treatment of burn codes (16000-16035). However, since the code descriptors cannot be changed for 2001, the RUC agreed to value the codes given the current CPT code descriptors. The RUC agreed with the recommended base units for codes 01951 and 01953 and felt these were appropriate values. However, the RUC recommended 3 base units for code 01952, as the family of codes would then be in proper rank order. The RUC also recommended that these codes should be referred back to CPT, so the total body surface area ranges can be based on the rule of 9's, with revised body surface areas for each code.

However, the RUC agreed to value these three CPT codes using CPT's current code descriptors, with the understanding that if the code descriptors are revised, the RUC will review these three codes based on new descriptors.

The RUC recommends the following base units:

3 base units for 01951;
3 base units for 01952; and
1 base unit for 01953.

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Base Unit Recommendation
▲00145(e)		Anesthesia for procedures on eye; ~~vitrectomy~~ vitreoretinal surgery	XXX	6 (no change)
▲00190 (e)		Anesthesia for procedures of facial bones or skull; not otherwise specified	XXX	5 (no change)
▲00215 (e)		Anesthesia for intracranial procedures; cranioplasty or elevation of depressed skull fracture, extradural (simple or compound)	XXX	9 (no change)
▲00530 (e)		Anesthesia for permanent transvenous pacemaker insertion	XXX	4 (no change)

●00537	BB1	Anesthesia for cardiac electrophysiologic procedures including radio frequency ablation	XXX	8
▲00534 (e)		Anesthesia for transvenous insertion or replacement of pacing cardioverter/defibrillator	XXX	7 (no change)
●00550	BB2	Anesthesia for sternal debridement	XXX	10
●00563	BB3	Anesthesia for procedures on heart, pericardium, and great vessels of chest; with pump oxygenator with hypothermic circulatory arrest	XXX	25
●00566		Anesthesia for direct coronary artery bypass grafting without pump oxygenator	XXX	25
▲00604(e)		Anesthesia for procedures on cervical spine and cord; ~~posterior cervical laminectomy~~ procedures with patient in the sitting position	XXX	13 (no change)
●00635	BB4	Anesthesia for procedures in lumbar region; diagnostic or therapeutic lumbar puncture	XXX	4
▲00670(e)		Anesthesia for extensive spine and spinal cord procedures (eg, ~~Harrington rod technique~~ spinal instrumentation or vascular procedures)	XXX	13 (no change)
▲00792(e)		Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; partial hepatectomy or management of major liver hemorrhage (excluding liver biopsy)	XXX	13 (no change)

~~00900~~		~~Anesthesia for procedures on perineal integumentary system (including biopsy of male genital system); not otherwise specified~~ (00900 has been deleted. To report, see 00300, 00400)	XXX	N/A
▲00920(e)		Anesthesia for procedures on male ~~external~~ genitalia (including open urethral procedures); not otherwise specified	XXX	3 (no change)
▲00942(e)		Anesthesia for vaginal procedure (including biopsy of labia, vagina, cervix or endometrium); colpotomy, colpectomy, colporraphy, and open uretheral procedures	XXX	4 (no change)
●01112	BB5	Anesthesia for bone marrow aspiration and/or biopsy, anterior or posterior iliac crest	XXX	5
●01215	BB6	Anesthesia for open procedures involving hip joint; revision of total hip arthroplasty	XXX	10
▲01214	BB7	total hip replacement ~~or revision~~	XXX	8
▲01482 (e)		Anesthesia for open procedures on bones of lower leg, ankle, and foot; radical resection (including below knee amputation)	XXX	4 (no change)
~~01784~~		~~Anesthesia for repair of arterio-venous (A-V) fistula, congenital or acquired~~ 01784 has been deleted. To report, see 01770, 01780)	XXX	N/A
●01951	BB8	Burn Excisions or Debridement Anesthesia for second and third degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; less than 1% TBS	XXX	3

●01952	BB9	one percent to nine percent total body surface area	XXX	3
●01953	BB10	each additional nine percent total body surface area or part thereof (List separately in addition to code for primary procedure) (Use 0202X in conjunction with code 0201X)	XXX	1

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: ~~00570~~ 93318 Tracking Number: CC1 Global Period: XXX **Recommended RVW:** ~~2.5~~ 2.20 RUC

CPT Descriptor: : Echocardiography, transesophageal (TEE) for monitoring purposes; including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient under general anesthesia for a surgical operation or other intervention that is expected to produce or actually produces hemodynamic disturbances has a TEE probe inserted orally and advanced into the esophagus (essentially the same as for gastroscopy.

Description of Pre-Service Work: The anesthesiologist checks the TEE console and probe for proper functioning.

Description of Intra-Service Work: The probe is connected to a TEE console and 2-dimensional images of the heart, pericardium, great vessels, and other organs are projected onto a video screen. For purposes of monitoring and immediate therapeutic intervention, the most important information includes heart chamber configuration and filling volume, atrial and ventricular contraction sequence and degree of contractility, cardiac valvular function ventricular wall motion and thickening, external compression of the heart (e.g., tamponade), and guidance to positioning of intravascular cannulae (e.g., pulmonary artery catheter) and other devices (e.g., intra aortic balloon pump). With the availability of this type of information, the physician is able to make immediate decisions about the need for altering intravascular volume (e.g., administer a venodilator drug reduce venous return and intracardiac blood volume; infuse fluids to increase ventricular filling), the need particular type of drug administration (e.g., inotrope, vasodilator, coronary artery dilator). In contrast to central venous and pulmonary artery occlusion pressure monitoring with thermodilution cardiac output measurements which provide indirect and global assessment of cardiac function, the TEE images provide direct evaluation of cardiac performance. This level of monitoring can be performed continuously throughout the surgical operation or other intervention. In contrast to the traditional echocardiography examination which focuses on a description of anatomic structure and cardiac function under more or less stable conditions at one point in time, the use of TEE for dynamic monitoring of cardiac function is not intended to provide specific anatomic details, pathologic diagnosis, or assessment of the efficacy of the surgical correction (e.g., anatomic and functional integrity of a prosthetic cardiac valve).

Description of Post-Service Work: Cleaning of console and probe.

SURVEY DATA:

Presenter(s): Karl E. Becker, Jr., M.D.

Specialty(s): Anesthesiology

Sample Size: 24 Response Rate: (%): 50% Median RVW: 2.50

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: Our sample population needed to be larger. Many anesthesiologists do not perform this procedure.

25th Percentile RVW: 1.79 75th Percentile RVW: 2.86 Low: 0.30 High: 8.93

Median Pre-Service Time: 5 Median Intra-Service Time: 60

25th Percentile Intra-Svc Time: 16.25 75th Percentile Intra-Svc Time: 105 Low: 10 High: 360

Median Post-Service Time: 5

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	10	
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.11	3.10
Intra-Service intensity/complexity	4.14	4.09
Post-Service intensity/complexity	2.89	2.84

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The ASA reached our final recommendation after consideration of this procedure by the ASA Committee on Economics (COE) and evaluation of the results of this survey by the ASA RVS committee, a subcommittee of the ASA COE, which has editorial responsibility for the ASA RVG.

FREQUENCY INFORMATION

How was this service previously reported? 99312

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

Specialty Anesthesiology ____Commonly x Sometimes ____Rarely

Specialty _____ ____Commonly ____Sometimes ____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology Frequency 5200

Specialty _____ Frequency _____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Anesthesiology Frequency 3400

Specialty _____ Frequency _____

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 00537 Tracking Number: BB1 Global Period: XXX **Recommended RVU_{Anes}:** 8

CPT Descriptor: Anesthesia for electrophysiologic procedures including radio frequency ablation.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 32-year-old male, in good general health, complains of palpitations an occasional shortness of breath, not associated with activity. Evaluation included an electrocardiogram, which revealed findings consistent with the Wolff-Parkinson-White Syndrome (WPW). Given that patients with WPW are at increased risk for fatal rhythm disturbances, his is scheduled for cardiac electrophysiologic studies and possible ablation of the aberrant pathways.

Description of Pre-Service Work: The patient will be seen by an anesthesiologist for a pre-anesthesia evaluation. At that time, the patient's medical history will be reviewed, including current medications, drug allergies, previous operations and anesthetics, and family history of problems with anesthetics. Physical examination will include evaluation for airway problems and the ease of obtaining intravenous access. Laboratory studies, the EKG, and any imaging studies will be reviewed. The anesthetic technique to be used, given the nature of the procedure, the requirements of the physician performing the procedure as well of those of the patient will be discussed with the patient, and informed consent will be obtained. The anesthesiologist also sets up anesthetic and cardiovascular drugs in preparation for the anesthetic, and checks anesthesia equipment, supplies and monitors

Description of Intra-Service Work: Either a general anesthetic with the patient's trachea being intubated, or a technique including infiltration of local anesthetic by the "operator" combined with the intravenous administration of narcotics, benzodiazepines, and perhaps an hypnotic agent (commonly referred to as Monitored Anesthesia Care – MAC) will be used. Monitoring of the patient will include blood pressure, either by cuff or perhaps also with an intra-arterial catheter, multi-lead EKG, pulse oximetry, and end-tidal carbon dioxide analysis. A central venous catheter may also be utilized, and if the clinical situation dictates, a pulmonary artery catheter may be inserted.

During the course of the procedure, attempts will be made to identify the aberrant pathways. Stimulation of these pathways will initiate rhythm problems that, if not recognized and the stimulus aborted or the rhythm disturbance otherwise stopped may result in an undesirable outcome. Thus, continuous and diligent vigilance in monitoring of the patient, an understanding of treatment options, and readiness to treat and initiate other resuscitation efforts are required for anesthesiologists and cardiologists involved in cases such as these. At the end of the procedure, the anesthesiologist will transfer the patient to a monitored bed, usually in the Coronary Care Unit. When the patient is stable, the anesthesiologist will hand over care of the patient to the critical care unit nurses. He will to continue to evaluate the patient as needed regarding pain control and nausea.

Description of Post-Service Work: The anesthesiologist with visit and evaluate the patient post-operatively within 24 hours. He/she will continue to participate in management of post-operative pain and nausea as needed.

SURVEY DATA:

Presenter(s) Karl E. Becker, Jr., M.D.

Specialty(s): Anesthesiology

Sample Size: 28 Response Rate: (%): 58% Median RVW: 8

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: Our panel size (48) was not quite large enough for this procedure code.

25th Percentile RVW: 7 75th Percentile RVW: 10 Low: 4 High: 15

Median Pre-Service Time: 15.00 Median Intra-Service Time: 120.00

25th Percentile Intra-Svc Time: 28.13 75th Percentile Intra-Svc Time: 180.00 Low: 10.00 High: 280.00

Median Post-Service Time: 15.00

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	15	Post-op care and visit included in code
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

CPT Code: 00537

KEY REFERENCE SERVICE:

CPT Code	Descriptor	RVU_{Anes}
00534	Anesthesia for transvenous insertion or replacement	7

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

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

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	15	15
Median Intra-Time	120	90
Median Immediate Post-service Time	15	15
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.63	3.48
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.7	3.7
Urgency of medical decision making	4.185	3.81

Technical Skill/Physical Effort (Mean)

Technical skill required	3.444	3.444
Physical effort required	3.296	3.19

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.15	4.0
Outcome depends on the skill and judgement of physician	3.93	3.741
Estimated risk of malpractice suit with poor outcome	3.815	3.41

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.37	3.52
Intra-Service intensity/complexity	4	3.7
Post-Service intensity/complexity	3.26	3.3

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The ASA reached our final recommendation after consideration of this procedure by the ASA Committee on Economics (COE) and evaluation of the results of this survey by the ASA RVS committee, a subcommittee of the ASA COE, which has editorial responsibility for the ASA RVG.

FREQUENCY INFORMATION

How was this service previously reported? 00560,01920

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

Specialty Anesthesiology ____Commonly ____Sometimes x Rarely

Specialty _____ ____Commonly ____Sometimes ____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology Frequency 760

Specialty _____ Frequency _____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Anesthesiology Frequency 76

Specialty _____ Frequency _____

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

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 00550 Tracking Number: BB2 Global Period: XXX **Recommended RVU_{Anes}:** ~~12~~ 10 RUC

CPT Descriptor: Anesthesia for sternal debridement (separate procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 34 year old male suffered penetrating trauma of the thorax with a resultant cardiac injury that required a median sternotomy for surgical repair. On postoperative day six, dehiscence of the sternal wound was noted. The patient is to return to the operating room for wound debridement.

Description of Pre-Service Work: The preanesthetic care of the patient includes a history and physical examination noting the method and course of the previous anesthetic and determining the presence of any cardiovascular instability secondary to the initial injury or subsequent infection. Anesthetic goals include maintenance of hemodynamic stability while providing the optimum surgical condition. The anesthesiologist also sets up anesthetic and cardiovascular drugs in preparation for the anesthetic, and checks anesthesia equipment, supplies and monitors.

Description of Intra-Service Work: After reviewing the information, the patient is premedicated for the surgery as appropriate. Upon arrival to the operating room, monitors are applied and venous access is obtained. General anesthesia is induced and maintained, the trachea is intubated, and positive pressure ventilation is initiated and maintained. The patient may be given a neuromuscular blocking agent to facilitate muscle relaxation during the procedure. The patient's hemodynamics are maintained throughout the procedure, with vasoactive therapeutic agents given as necessary. At the end of surgery depending on the patient's condition, the patient will either be awakened from anesthesia and the trachea extubated in the operating room or the patient will be transported to the intensive care unit and ventilated as necessary. The patient is observed for recovery and the need for pain therapy. When stable, his care is transferred SICU personnel with further evaluation and treatment by the anesthesiologist as required.

Description of Post-Service Work: Within 24 hours, the anesthesiologist will make a post-operative visit to evaluate the patient's analgesic requirements and post-operative course. The anesthesiologist will continue to participate in evaluation and management of the patient while he/she is in the SICU regarding pain control, nausea and cardiorespiratory instability.

SURVEY DATA:

Presenter(s) Karl E. Becker, Jr., M.D.

Specialty(s): Anesthesiology

Sample Size: 30 Response Rate: (%): 63% Median RVU_{Anes}: 12

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVW: 10 75th Percentile RVW: 15 Low: 6.5 High: 20

Median Pre-Service Time: 12.50 Median Intra-Service Time: 90.00

25th Percentile Intra-Svc Time: 30.00 75th Percentile Intra-Svc Time: 120.00 Low: 15.00 High: 180.00

Median Post-Service Time: 20.00

Level of Service by CPT Code

	Total Time	(List CPT Code & # of Visits)
Immediate Post Service Time:	20	Post-op care and visit included in code
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVU_{Anes}
00540	Anesthesia for thoracotomy prcedures involving the lungs, pleura, diaphragm and mediastinum	13

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	12.5	12.5
Median Intra-Time	90	120
Median Immediate Post-service Time	20	20
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.48	3.87
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4	3.87
Urgency of medical decision making	3.667	3.77

Technical Skill/Physical Effort (Mean)

Technical skill required	3.73	4.23
Physical effort required	3.655	3.86

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.9	3.967
Outcome depends on the skill and judgement of physician	3.73	3.967

Estimated risk of malpractice suit with poor outcome	3.767	3.83

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.57	3.5
Intra-Service intensity/complexity	3.77	4.17
Post-Service intensity/complexity	3.53	3.73

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The ASA reached our final recommendation after consideration of this procedure by the ASA Committee on Economics (COE) and evaluation of the results of this survey by the ASA RVS committee, a subcommittee of the ASA COE, which has editorial responsibility of the ASA RVG.

FREQUENCY INFORMATION

How was this service previously reported? 00540

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

Specialty Anesthesiology ____Commonly x Sometimes _____Rarely

Specialty _____ _____Commonly _____Sometimes _____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology Frequency 7545

Specialty _____ Frequency _____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Anesthesiology Frequency 4980

Specialty _____ Frequency _____

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

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 00563 Tracking Number: BB3 Global Period: XXX **Recommended RVU_{Anes}:** 25

CPT Descriptor: Anesthesia for procedures on heart, pericardium, and great vessels of chest; with pump oxygenator with hypothermic circulatory arrest.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A three-day old newborn female with transposition of the great arteries with ventricular defect is prepared for a Jatene type operation. Based upon the anatomy of this congenital heart defect, cardiac surgery with pump oxygenator using deep hypothermic circulatory arrest is selected for the surgical procedure.

Description of Pre-Service Work: Preoperative assessment by the anesthesiologist includes a thorough physical examination and a history taken from the family specific to co-morbidity in the patient, and any family history of anesthetic difficulty. In addition, there is a complete discussion with the patient's family outlining the procedures to be performed by the anesthesiologist pre- and post-induction of general anesthesia including the placement of arterial and central lines, and the certainty of blood product administration. Included in the discussion are the risks of these procedures, the risks of the anesthetic and a description of the child's expected postoperative course. The anesthesiologist conducts a careful evaluation of the patient, his cardiovascular status, his concomitant diseases and his physical condition and pertinent laboratory values. The anesthesiologist also sets up a wide array of anesthetic and cardiovascular drugs in preparation for the anesthetic, and checks anesthesia equipment, supplies and monitors. He consults with other physicians when needed.

Description of Intra-Service Work: Anesthetic goals include sufficient anesthetic depth to protect the brain, heart and other organ systems during deep hypothermic circulatory arrest as well as the avoidance of significant hemodynamic instability after CPB, which exacerbates ischemia and bleeding tendencies. The manipulation of blood gas management during cooling, topical head cooling, and the use of vasoactive substances is common before CPB. The introduction of air into the left and right heart due to cardiac surgical incision on the left side of the heart as well as the aortic and venous cannulae promotes the opportunity for air emboli. Meticulous monitoring and removal of air is required prior to the reinstitution of CPB and re-warming. Additional brain monitoring such as transcranial Doppler or the use of transesophogeal echocardiography may be indicated to treat the suspicion of air emboli. Episodes of hemodynamic instability after re-warming and the cessation of CPB are common due to mild cardiac ischemia, a direct result of the use of deep hypothermic circulatory arrest. Hemodynamic instability and low cardiac output can further aggravate any organ system dysfunction due to circulatory arrest and must be treated urgently and aggressively. Often this requires the careful titration of anesthetic drugs as well as the use of several inotropes or vasodilators. The anesthesiologist administers drugs so as to promote hemodynamic stability and to increase cardiac output. The use of deep hypothermic circulatory arrest also disrupts liver metabolism and the level of procoagulants, often resulting in excessive bleeding. This requires the anesthesiologist to more aggressively monitor the activated clotting time and platelet function, and often requires multiple blood component therapy. Once the bleeding issues have been controlled and the child's hemodynamics are stabilized, the chest is closed and the child is transferred to the pediatric intensive care unit for further management. The anesthesiologist accompanies the patient to the PICU and is responsible for patient care until directly transferred to the ICU attending physician.

Description of Post-Service Work: On the first and/or the second postoperative day, the anesthesiologist visits the child in the PICU specifically to assess the postoperative progress of the child and to inquire about complications that may be related to the anesthetic. In the child post deep hypothermic circulatory arrest, central nervous system events are the most worrisome; seizures, the most common.

SURVEY DATA:

Presenter(s) Karl E. Becker, Jr., M.D.

Specialty(s): Anesthesiology

Sample Size: 61 Response Rate: (%): 25% Median RVU_{Anes}: 25

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVU_{Anes}: 25 75th Percentile RVU_{Anes}: 26.5 Low: 25 High: 30

Median Pre-Service Time: 60 Median Intra-Service Time: 300

25th Percentile Intra-Svc Time: 270 75th Percentile Intra-Svc Time: 480 Low: 210 High: 720

Median Post-Service Time: 30

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	30	Post-op care and visit included in code
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

CPT Code: 00563

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVU_{Anes}
00564	Anesthesia for direct coronary artery grafting without pump oxygenator	25

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	60	50
Median Intra-Time	300	300
Median Immediate Post-service Time	30	30
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.53	4.23
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.6	4.23
Urgency of medical decision making	4.6	4.38

Technical Skill/Physical Effort (Mean)

Technical skill required	4.8	4.46
Physical effort required	4.66	4.15

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.86	4.38
Outcome depends on the skill and judgement of physician	4.8	4.61
Estimated risk of malpractice suit with poor outcome	4.33	4

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.4	4.23
Intra-Service intensity/complexity	4.93	4.46
Post-Service intensity/complexity	4.46	4.38

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The ASA reached our final recommendation after consideration of this procedure by the ASA Committee on Economics (COE) and after evaluation of the results of this survey by the ASA RVS committee, a subcommittee of the ASA COE, which has editorial responsibility for the ASA RVG.

FREQUENCY INFORMATION

How was this service previously reported? 00562

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

Specialty Anesthesiology ____Commonly x Sometimes ____Rarely

Specialty _____ ____Commonly ____Sometimes ____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology Frequency 3500-5000

Specialty _____ Frequency _____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Anesthesiology Frequency 200-500

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? ____Yes x No

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 00635 Tracking Number: BB4 Global Period: XXX **Recommended RVU_{Anes}:** ~~5~~ 4 RUC

CPT Descriptor: Anesthesia for procedures in lumbar region; diagnostic or therapeutic lumbar puncture.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A four year-old patient with Down's syndrome was diagnosed with acute lymphoblastic leukemia after presenting with fatigue, fever and weight loss. Significant history includes surgical repair of a ventricular septal defect at two years of age. The patient is extremely anxious and the parents request the child be anesthetized for cerebral spinal fluid testing and administration of intrathecal methotrexate.

Description of Pre-Service Work: Anesthetic services for this patient include a pertinent history with emphasis on the present illness and significant past history specifically reviewing cardiac function and other systemic involvement from Trisomy 21. Previous anesthesia records are reviewed, and a physical examination is performed. An anesthetic plan is formed and discussed with the parents for approval. The anesthesiologist also sets up anesthetic and cardiovascular drugs in preparation for the anesthetic, and checks anesthesia equipment, supplies and monitors.

Description of Intra-Service Work: Premedication with agents used to decrease anxiety is used as needed. Monitors are placed and anesthesia is induced through the use of systemic medications or inhaled anesthetics alone or in combination. The patient is turned to allow access to the lumbar region after the airway is appropriately secured. General anesthesia is maintained and the patient's hemodynamics are maintained throughout the procedure, with vasoactive therapeutic agents given as necessary. At the end of the procedure anesthesia is discontinued and the patient is awakened. The patient is transported when stable to the postanesthesia care unit. When the patient has been observed to be adequately recovered from the anesthetic, the anesthetist will treansfer the care of the patient to the post-operative care unit personnel who he will continue to supervise in the care of this patient.

Description of Post-Service Work: The anesthesiologist will also be responsible for maintaining a stable patient during the early recovery period in the post anesthesia care unit as well as managing pain relief and controlling nausea during this period . The anesthesiologist will conduct a post-operative visit within 24 hours and further evaluate the post-operative progress of the patient.

SURVEY DATA:

Presenter(s) Karl E. Becker, Jr., M.D.

Specialty(s): Anesthesiology

Sample Size: 28 Response Rate: (%): 58% Median RVU_{Anes}: 5

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: The panel should have been larger since this procedure is not commonly performed by all members of the panel.

25th Percentile RVW: 5 75th Percentile RVW: 8 Low: 3 High: 12

Median Pre-Service Time: 15.00 Median Intra-Service Time: 20.00

25th Percentile Intra-Svc Time: 13.75 75th Percentile Intra-Svc Time: 41.25 Low: 10.00 High: 60.00

Median Post-Service Time: 15.00

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	15	Post-op visit and care included in procedure
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

CPT Code: 00635

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVU_{Anes}
00630	Anesthesia for procedures in the lumbar region; NOS	8

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

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

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	15	12.5
Median Intra-Time	20	42.5
Median Immediate Post-service Time	15	15
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.28	2.74
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.36	2.67
Urgency of medical decision making	3.18	2.85

Technical Skill/Physical Effort (Mean)

Technical skill required	3.5	2.81
Physical effort required	3.269	2.85

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.22	2.778
Outcome depends on the skill and judgement of physician	3.52	3.037
Estimated risk of malpractice suit with poor outcome	3.444	3.11

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.18	2.71
Intra-Service intensity/complexity	3.25	2.79
Post-Service intensity/complexity	2.96	2.61

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The ASA reached our final recommendation after consideration of this procedure by the ASA Committee on Economics (COE) and evaluation of the results of this survey by the ASA RVS committee, a subcommittee of the ASA COE, which has editorial responsibility for the ASA RVG.

FREQUENCY INFORMATION

How was this service previously reported? ____00630_____

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

Specialty_____Anesthesiology_____ _____Commonly _____Sometimes ___x__Rarely

Specialty_____ _____Commonly _____Sometimes _____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty _____Anesthesiology_____ Frequency _5109_____

Specialty _____ Frequency_____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty _____ Frequency___2000_____

Specialty _____ Frequency_____

Do many physicians perform this service across the United States? ____Yes __x__No

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 01112 Tracking Number: BB5 Global Period: XXX **Recommended RVU_{Anes}:** ~~6~~ 5 RUC

CPT Descriptor: Anesthesia for bone marrow aspiration and/or biopsy, anterior or posterior iliac crest.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A four year-old child presents for bone marrow aspiration and possible marrow harvest for autologous transplantation. The child was diagnosed earlier with acute myelogenous leukemia. A multiple agent anti-neoplastic chemotherapy regimen including busulfan was administered. The patient is now suspected to be in remission. The patient has been noted to become short of breath with minimal physical exertion. Because of the question of pulmonary fibrosis secondary to chemotherapy and the requirement of significant volume of marrow aspirate and potential hemodynamic instability, general anesthesia is requested for the procedure.

Description of Pre-Service Work: The anesthetic care of this patient begins with a pertinent history and physical with particular attention paid to specific organ systems that may be involved secondary to anti-neoplastic chemotherapy. A review of previous anesthetics is made. After discussion with and the consent of the parents, an anesthesia plan is devised that might include a preprocedure medicant to relieve anxiety. The anesthesiologist also sets up anesthetic and cardiovascular drugs in preparation for the anesthetic, and checks anesthesia equipment, supplies and monitors.

Description of Intra-Service Work: Appropriate monitors are placed with special attention to any involved body systems. The goal of anesthesia is to provide a quiet and comfortable patient for the hematologist to safely aspirate the bone marrow as needed. This can be accomplished with intravenous anesthetics or inhaled agents alone or in combination. Inhalational agents, narcotics, muscle relaxants and reversal drugs are used to induce and maintain an adequate level of anesthesia. Vital signs are monitored at least every 3-5 minutes and adjustments made in depth of anesthesia and IV fluid administration rates to assure a stable anesthetic and stable vital signs and adequate respiratory and hemodynamic parameters. At the end of the procedure the anesthetics will be discontinued and the patient awakened as deemed appropriate. The patient will be transferred to the recovery room and, when stable, left in the immediate care of the post-operative care personnel.

Description of Post-Service Work:. The anesthesiologist will also be responsible for maintaining a stable patient during the early recovery period in the post anesthesia care unit as well as managing pain relief during this period. He/she will make a post-operative visit within 24 hours.

SURVEY DATA:

Presenter(s) Karl E. Becker, Jr., M.D.

Specialty(s): Anesthesiology

Sample Size 28 Response Rate: (%): 58% Median RVU_{Anes}: 6

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: This procedure was not performed by some of our panel. Our panel needed to be larger than 48.

25th Percentile RVW: 5.1 75th Percentile RVW: 8 Low: 2.86 High: 15

Median Pre-Service Time: 15.00 Median Intra-Service Time: 45.00

25th Percentile Intra-Svc Time: 15.00 75th Percentile Intra-Svc Time: 60.00 Low: 10.00 High: 120.00

Median Post-Service Time: 15.00

Level of Service by CPT Code

	Total Time	(List CPT Code & # of Visits)
Immediate Post Service Time:	15	Post-op care and visit included in code
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVU_{Anes}
01120	Anesthesia for procedures on bony pelvis	6

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	15	11.25
Median Intra-Time	45	52.5
Median Immediate Post-service Time	15	15
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.54	2.86
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.61	2.79
Urgency of medical decision making	3.357	2.82

Technical Skill/Physical Effort (Mean)

Technical skill required	3.519	2.93
Physical effort required	3.259	2.85

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.54	2.857
Outcome depends on the skill and judgement of physician	3.46	3.036
Estimated risk of malpractice suit with poor outcome	3.5	2.89

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.46	2.86
Intra-Service intensity/complexity	3.5	2.96
Post-Service intensity/complexity	3.18	2.82

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The ASA reached our final recommendation after consideration of this procedure by the ASA Committee on Economics (COE) and evaluation of the results of this survey by the ASA RVS committee, a subcommittee of the ASA COE, which has editorial responsibility for the ASA RVG.

FREQUENCY INFORMATION

How was this service previously reported? 01120

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

Specialty Anesthesiology ____Commonly __x__Sometimes _____Rarely

Specialty _____ _____Commonly _____Sometimes _____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology Frequency 1517

Specialty _____ Frequency _____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Anesthesiololgy Frequency 455

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? _____Yes __x__No

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 01215 Tracking Number: BB6 Global Period: XXX **Recommended RVU_{Anes}:** 10

CPT Descriptor: Anesthesia for open procedures involving hip joint; revision of total hip arthroplasty

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is a 72 year old woman who initially underwent left cemented total hip arthroplasty one year ago. After recovery from the first total hip replacement, the patient suffered two left hip dislocations. Radiographic studies revealed a loosening of the femoral component. The surgical plan includes removal and replacement of the femoral component and assessment and possible replacement of the acetabular components to prevent further dislocations

Description of Pre-Service Work: The service includes pre-anesthetic assessment of the patient; new and old chart review; development of an anesthetic plan; obtaining informed consent. Particular attention is paid to co-morbid diseases and cardiovascular status. The anesthesiologist also sets up anesthetic and cardiovascular drugs in preparation for the anesthetic, and checks anesthesia equipment, supplies and monitors.

Description of Intra-Service Work: Intra-service work includes assurance of adequate intravenous access; application and interpretation of non-invasive and indicated invasive monitoring; induction of anesthesia or initiation of a regional anesthetic; maintenance of anesthesia, ongoing intra-operative monitoring of vital signs, fluid balance, blood loss, and anesthetic depth; proper positioning of patient; and administration of IV fluids, including blood, as needed. The patient is transferred to recovery room and monitored until stable enough to be left in the care of the post-anesthesia care unit personnel. While in recovery room, the anesthesiologist further evaluates the patient's status and orders analgesics and fluids as required.

Description of Post-Service Work: The anesthesiologist is responsible for maintaining a stable patient during the early recovery period in the post anesthesia care unit and for providing control of pain and nausea during this period. Post-anesthesia care includes a post-op visit within 24 hours and further evaluation of the patient's fluid status and analgesic requirements if indicated.

SURVEY DATA:

Presenter(s) Karl E. Becker, Jr., M.D.

Specialty(s): Anesthesiology

Sample Size: 29 Response Rate: (%): 60% Median RVU_{Anes}: 10

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: Response rate was good but population sampled should have been slightly larger.

25th Percentile RVW: 10 75th Percentile RVW: 12 Low: 2.56 High: 14

Median Pre-Service Time: 15.00 Median Intra-Service Time: 150.00

25th Percentile Intra-Svc Time: 24.37 75th Percentile Intra-Svc Time: 230.00 Low: 10.00 High: 360.00

Median Post-Service Time: 20.00

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	15	Post-op visit included in the code
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

CPT Code: 01215

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVU_{Anes}
01212	Anesthesia for open procedures involving hip joint; hip disarticulation	12

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	15	15
Median Intra-Time	150	120
Median Immediate Post-service Time	20	15
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.37	3.28
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.33	3.31
Urgency of medical decision making	3.185	3.10

Technical Skill/Physical Effort (Mean)

Technical skill required	3.643	3.48
Physical effort required	3.821	3.45

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.86	3.655
Outcome depends on the skill and judgement of physician	3.89	3.655
Estimated risk of malpractice suit with poor outcome	3.5	3.41

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.21	3.10
Intra-Service intensity/complexity	3.90	3.66
Post-Service intensity/complexity	3.34	3.17

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The ASA reached our final recommendation after consideration of this procedure by the ASA Committee on Economics (COE) and evaluation of the results of this survey by the ASA RVS committee, a subcommittee of the ASA COE, which has editorial responsibility for the ASA RVG.

FREQUENCY INFORMATION

How was this service previously reported? 01212_____

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

Specialty___Anesthesiology_____ __x__Commonly _____Sometimes _____Rarely

Specialty_____ _____Commonly _____Sometimes _____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty ___Anesthesiology_____ Frequency __22,893____

Specialty _____ Frequency_____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty ___Anesthesiology_____ Frequency __17,200____

Specialty _____ Frequency_____

Do many physicians perform this service across the United States? __x__Yes _____No

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 01214 Tracking Number: BB7 Global Period: XXX **Recommended RVW_{Anes}:** 8

CPT Descriptor: Anesthesia for open procedures involving hip joint; total hip replacement

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is a 73 year old man with a long history of hip pain and degenerative joint disease in his left hip. Radiographic studies revealed severe degenerative arthritis of femoral head and acetabulum. The patient has controlled hypertension and mild adult-onset diabetes. The surgical plan is for a hip arthroplasty with acetabular and proximal prosthetic replacement (total hip replacement).

Description of Pre-Service Work: Pre-operative preparation of the patient for anesthesia includes a history, physical examination, review of the patient's new and old medical records, review of laboratory studies and ordering of additional studies as indicated. The anesthesiologist discusses anesthetic and monitoring options and associated risks with the patient and obtains informed consent. Anesthetic approaches typically employed include spinal, epidural or general anesthesia. In addition to patient and surgeon preference, considerations in anesthetic choice include duration of the planned procedure, anticipated blood loss, surgical requirements, post-operative analgesic requirements, and the patient's health status. The anesthesiologist also sets up anesthetic and cardiovascular drugs in preparation for the anesthetic, and checks anesthesia equipment, supplies and monitors.

Description of Intra-Service Work: After obtaining adequate intravenous access and monitoring the patient as indicated by the patient's underlying medical condition, the anesthesiologist will initiate the selected anesthetic. The operating room staff, surgeon, and anesthesiologist will carefully position the patient in the lateral position, taking care to avoid stretch or pressure upon the nerves in the arms, axillae and lower extremities. Other positioning considerations include achieving a neutral position of the head and neck and avoiding pressure upon or abrasions to the eyes and ears. After securing the patient in the desired position, the nurse will prepare the patient's skin with an antimicrobial solution and the surgical team will drape the operative site in a sterile fashion. The anesthesiologist will employ measures to achieve normothermia, which may include active or passive warming of the patient, administered intravenous fluids and/or inspired respiratory gases.

Intra-operatively, the anesthesiologist will monitor the patient's vital signs, surgical blood loss, and anesthetic depth or level of sedation. Based on these observations, the anesthesiologist may choose to administer fluids, blood products, and medications to achieve hemodynamic stability, adequate oxygen carrying capacity and acceptable anesthetic depth or level of sedation. In addition, the anesthesiologist may obtain certain laboratory studies to better evaluate changes in the patient's clinical status. Depending on the results, the anesthesiologist may make additional medical interventions. At the conclusion of the procedure, the anesthesiologist will allow the patient to emerge from the anesthetic or sedation and will transport the patient to the Post-Anesthesia Care Unit (PACU). The anesthesiologist will intervene as necessary to achieve an acceptable level of hemodynamic stability, level of consciousness, patency of the airway, and analgesia. The anesthesiologist will report to the PACU nurse pertinent aspects of the patient's medical condition and intra-operative anesthetic course before transferring care of the patient to the PACU personnel.

Description of Post-Service Work: The anesthesiologist is responsible for maintaining a stable patient during the early recovery period in the post anesthesia care unit and for providing control of pain and nausea during this period. When the patient is clinically stable and awake, the anesthesiologist with order the transfer of the patient to the surgical floor. Post-service work includes a post-op visit within 24 hours and further evaluation of the patient's fluid status and analgesic requirements if indicated.

SURVEY DATA:

Presenter(s) Karl E. Becker, Jr. M.D.

Specialty(s): Anesthesiology

Sample Size: 30 Response Rate: (%): 63% Median RVW: 8

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVW: 8 75th Percentile RVW: 10 Low: 3.57 High: 12

Median Pre-Service Time: 12.50 Median Intra-Service Time: 120.00

25th Percentile Intra-Svc Time: 30.00 75th Percentile Intra-Svc Time: 170.00 Low: 10.00 High: 250.00

Median Post-Service Time: 20.00

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	20	Post-op care and visits included in procedure
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

CPT Code: 01214

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVU_{Anes}
01210	Anesthesia for open procedures involving hip joint, NOS	6

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	12.5	12
Median Intra-Time	120	120
Median Immediate Post-service Time	20	15
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.47	3.27
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.43	3.27
Urgency of medical decision making	3.3	2.97

Technical Skill/Physical Effort (Mean)

Technical skill required	3.6	3.43
Physical effort required	3.433	3.23

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.77	3.517
Outcome depends on the skill and judgement of physician	3.73	3.550
Estimated risk of malpractice suit with poor outcome	3.367	3.20

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.2	3.07
Intra-Service intensity/complexity	3.57	3.4
Post-Service intensity/complexity	3.23	2.93

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The ASA reached our final recommendation after consideration of this procedure by the ASA Committee on Economics (COE) and evaluation of the results of this survey by the ASA RVS committee, a subcommittee of the ASA COE, which has editorial responsibility for the ASA RVG.

FREQUENCY INFORMATION

How was this service previously reported? 01210, 01214

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

Specialty Anesthesiology x Commonly ____ Sometimes ____ Rarely

Specialty _____ ____ Commonly ____ Sometimes ____ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology Frequency 116,000

Specialty _____ Frequency _____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Anesthesiology Frequency 81,000

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? x Yes ____ No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 01951 Tracking Number: BB8 Global Period: XXX **Recommended RVU_{Anes}:** 3

CPT Descriptor: Anesthesia for second or third degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; Less than 1% TBSA

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A thirty-four year-old female is burned by a cooking oil fire on the right hand. The patient is in extreme pain from her burned hand. The patient is brought to the operating room emergently for debridement and dressing of the burn wound under general anesthesia.

Description of Pre-Service Work: The service includes pre-anesthetic assessment of the patient; new and old chart review; development of an anesthetic plan; obtaining informed consent. Particular attention is paid to NPO status. The anesthesiologist also sets up anesthetic and cardiovascular drugs in preparation for the anesthetic, and checks anesthesia equipment, supplies and monitors.

Description of Intra-Service Work: Intra-service work includes assurance of adequate intravenous access; application and interpretation of non-invasive monitoring; induction of anesthesia or initiation of a regional anesthetic; maintenance of anesthesia, ongoing intra-operative monitoring of vital signs, fluid balance, blood loss and anesthetic depth; and administration of IV fluids as needed. The patient is transferred to recovery room and monitored until stable enough to be left in the care of the post-anesthesia care unit personnel. While in recovery room, the anesthesiologist further evaluates the patient's status and orders analgesics and fluids as required.

Description of Post-Service Work: The anesthesiologist is responsible for maintaining a stable patient during the early recovery period in the post anesthesia care unit and for providing control of pain and nausea during this period. Post-anesthesia care includes a post-op visit within 24 hours.

SURVEY DATA:

Presenter(s) Karl E. Becker, Jr., M.D.

Specialty(s): Anesthesiology

Sample Size: 26 Response Rate: (%): 54% Median RVU_{Anes}: 5

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: Population sample size should have been larger. Not all anesthesiologists work on burn patients.

25th Percentile RVW: 4 75th Percentile RVW: 7.75 Low: 2.14 High: 30

Median Pre-Service Time: 15.00 Median Intra-Service Time: 60.00

25th Percentile Intra-Svc Time: 30.00 75th Percentile Intra-Svc Time: 75.00 Low: 10.00 High: 120.00

Median Post-Service Time: 20.00

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	15	Post-op care and visit included in code
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

CPT Code: 01951

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVU_{Anes}
00300	Anesthesia for procedures on integumentary system, muscles and nerves of head, neck and posterior trunk	5

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

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

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	15	15
Median Intra-Time	60	60
Median Immediate Post-service Time	20	15
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.29	2.63
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.96	2.42
Urgency of medical decision making	3.5	2.63

Technical Skill/Physical Effort (Mean)

Technical skill required	3.521	2.71
Physical effort required	3.188	2.54

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.42	2.708
Outcome depends on the skill and judgement of physician	3.46	2.833
Estimated risk of malpractice suit with poor outcome	3.063	2.83

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.04	2.57
Intra-Service intensity/complexity	3.26	2.57
Post-Service intensity/complexity	3.09	2.48

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The ASA reached our final recommendation after consideration of this procedure by the ASA Committee on Economics (COE) and evaluation of the results of this survey by the ASA RVS committee, a subcommittee of the ASA COE, which has editorial responsibility for the ASA RVG. The Anesthesiology RVS committee believes that this coded should be valued at 3.0 ASA RVUs, since the surgery generally involves an extremity .

FREQUENCY INFORMATION

How was this service previously reported? 00400, 01810

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

Specialty Anesthesiology ____Commonly x Sometimes ____Rarely

Specialty ____ ____Commonly ____Sometimes ____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology Frequency 25,000 to 50,000

Specialty ____ Frequency____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Anesthesiology Frequency 6,000 to 12,000

Specialty ____ Frequency____

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 01952 Tracking Number: BB9 Global Period: XXX **Recommended RVU_{Anes}:** ~~5~~ 3 RUC

CPT Descriptor: Anesthesia for second or third degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; 1%-9% TBSA

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A thirty-four year-old female is burned by a cooking oil fire over the face, neck, anterior chest, forearms and hands. The patient is in extreme pain from her chest burns, but reports no pain on the face, neck, forearms or hands. There is obvious charred tissue over the anesthetic tissue in the face, neck, forearms and hands. The patient is brought to the operating room emergently for debridement and dressing of the wounds over face and neck under general anesthesia.

Description of Pre-Service Work: The patient is rapidly evaluated in the burn unit, especially for respiratory distress and airway patency. Initial IV fluid access is attained. Available history is reviewed and a physical exam performed. NPO status is evaluated. The patient may be intubated prior to the OR if airway is questionable. Laboratory studies including arterial blood gases, electrolytes, hemoglobin, and blood for X-matching are obtained. The patient is transferred to the OR with oxygen and monitoring. Anesthesia equipment and supplies are prepared, as are monitors for invasive monitoring.

Description of Intra-Service Work: On arrival in the OR, the patient is positioned on the OR table, monitors applied, oxygen continually administered, and anesthesia induced. If the patient is not already intubated, the anesthesiologist accomplishes this as rapidly as possible—either with an awake or with fiber-optic intubation. The anesthesiologist maintains an adequate depth of anesthesia with inhalational agents and intravenous drugs. He administers blood and intravenous fluids as required to maintain homeostasis. He monitors vital signs, including temperature, closely and treats as necessary. At the end of the procedure, the anesthesiologist transports the patient to the Burn Intensive Care Unit and places the patient on a ventilator. After determining that the patient has stable respiratory and circulatory parameters, the anesthesiologist transferred the patient to the care of the burn intensive care personnel. After attaining adequate sedation and pain control for the patient, the anesthesiologist returns to the OR to clean equipment and dispose of unused anesthesia drugs and supplies.

Description of Post-Service Work: : The anesthesiologist will continue to evaluate the patient while in the BICU regarding pain control, nausea and cardiorespiratory instability. The anesthesiologist will visit the patient post-op within 24 hours of surgery, often several times. He will be involved in the post-operative care of the patient to varying degrees depending on the hospital milieu.

SURVEY DATA:

Presenter(s) Karl E. Becker, Jr., M.D.

Specialty(s): Anesthesiology

Sample Size: 26 Response Rate: (%): 54% Median RVU_{Anes}: 7

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: Sample population needed to be larger. Not all anesthesiologists treat burn patients.

25th Percentile RVW: 5.1 75th Percentile RVW: 10 Low: 5 High: 30

Median Pre-Service Time: 15.00 Median Intra-Service Time: 90.00

25th Percentile Intra-Svc Time: 39.37 75th Percentile Intra-Svc Time: 120.00 Low: 10.00 High: 300.00

Median Post-Service Time: 25.00

:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	25	Post-op care and visits included in code
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

CPT Code: 01952

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVU_{Anes}
00300	Anesthesia for procedures on integumentary system, muscles and nerves of head, neck and posterior trunk	5

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

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

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	15	10
Median Intra-Time	90	75
Median Immediate Post-service Time	25	15
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.52	2.6
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.12	2.52
Urgency of medical decision making	4.04	2.64

Technical Skill/Physical Effort (Mean)

Technical skill required	3.88	2.76
Physical effort required	3.68	2.76

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.0	2.8
Outcome depends on the skill and judgement of physician	4.0	2.84
Estimated risk of malpractice suit with poor outcome	3.28	2.80

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.62	2.73
Intra-Service intensity/complexity	3.88	2.69
Post-Service intensity/complexity	3.73	2.65

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The ASA reached our final recommendation after consideration of this procedure by the ASA Committee on Economics (COE) and evaluation of the results of this survey by the ASA RVS committee, a subcommittee of the ASA COE which has editorial responsibility of the ASA RVG. The ASA RVS committee believes that this code should be valued at 5.0 ASA RVUs since the majority of burns of this type do not involve more than 10% of TBSA.

FREQUENCY INFORMATION

How was this service previously reported? 00300,00400

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

Specialty Anesthesiology ____Commonly x Sometimes ____Rarely

Specialty ____ ____Commonly ____Sometimes ____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology Frequency ~20,000
Specialty ____ Frequency ____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Anesthesiology Frequency ~4,000

Specialty ____ Frequency ____

Do many physicians perform this service across the United States? ____Yes x No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 01953 Tracking Number BB10 Global Period: XXX **Recommended RVU_{Anes}:** 1

CPT Descriptor: Anesthesia for second or third degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; Each additional 9% TBSA or part thereof.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A thirty-four year-old female is burned by a cooking oil fire over the face, neck, anterior chest, forearms and hands. The patient is in extreme pain from her chest burns, but reports no pain on the face, neck, forearms or hands. There is obvious charred tissue over the anesthetic tissue in the face, neck, forearms and hands. The patient is brought to the operating room emergently for debridement and dressing of the wounds under general anesthesia. Second and third degree burns cover about 50% of TBSA.

Description of Pre-Service Work: The patient is rapidly evaluated in the burn unit, especially for respiratory distress and airway patency. Initial IV fluid access is attained. Available history is reviewed and a physical exam performed. NPO status is evaluated. The patient may be intubated prior to the OR if airway is questionable. Laboratory studies including arterial blood gases, electrolytes, hemoglobin, and blood for X-matching are obtained. The patient is transferred to the OR with oxygen and monitoring. Anesthesia equipment and supplies are prepared, as are monitors for invasive monitoring.

Description of Intra-Service Work: On arrival in the OR, the patient is positioned on the OR table, monitors applied oxygen continually administered, and anesthesia induced. If the patient is not already intubated, the anesthesiologist accomplishes this as rapidly as possible—either with an awake or with fiber-optic intubation. The anesthesiologist maintains an adequate depth of anesthesia with inhalational agents and intravenous drugs. He administers blood and intravenous fluids as required to maintain homeostasis. He/she monitors vital signs, including temperature, closely and treats as necessary. At the end of the procedure, the anesthesiologist transports the patient to the Burn Intensive Care Unit and places the patient on a ventilator. After determining that the patient has stable respiratory and circulatory parameters, the anesthesiologist transferred the patient to the care of the burn intensive care personnel. After attaining adequate sedation and pain control for the patient, the anesthesiologist returns to the OR to clean equipment and dispose of unused anesthesia drugs and supplies.

Description of Post-Service Work: : The anesthesiologist will continue to evaluate the patient while in the BICU regarding pain control, nausea and cardiorespiratory instability. The anesthesiologist will visit the patient post-op within 24 hours of surgery, often several times. He/she will be involved in the post-operative care of the patient to varying degrees depending on the hospital milieu.

SURVEY DATA:

Presenter(s) Karl E. Becker, Jr., M.D.

Specialty(s): Anesthesiology

Sample Size: 26 Response Rate: (%): 54% Median RVU_{Anes}: 10

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: Population sample size was not sufficient since these procedures are not commonly performed by most anesthesiologists.

25th Percentile RVU: 7 75th Percentile RVU: 13 Low: 13 High: 202

Median Pre-Service Time: 20 Median Intra-Service Time: 120

25th Percentile Intra-Svc Time: 27.5 75th Percentile Intra-Svc Time: 97.5 Low: 10 High: 330

Median Post-Service Time: 30

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:		Post-op care and visits included in code
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

CPT Code: 01953

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVU_{Anes}
00300	Anesthesia for procedures on integumentary system, muscles and nerves of head, neck and posterior trunk	5

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

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

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	20	15
Median Intra-Time	120	75
Median Immediate Post-service Time	30	15
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.15	2.81
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.76	2.64
Urgency of medical decision making	4.577	2.85

Technical Skill/Physical Effort (Mean)

Technical skill required	4.5	3
Physical effort required	4.231	2.81

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.62	2.962
Outcome depends on the skill and judgement of physician	4.54	3.0
Estimated risk of malpractice suit with poor outcome	3.423	2.88

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.21	2.74
Intra-Service intensity/complexity	4.5	2.87
Post-Service intensity/complexity	4.21	2.7

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The ASA reached our final recommendation after consideration of this procedure by the ASA Committee on Economics (COE) and evaluation of the results of this survey by the ASA RVS committee, a subcommittee of the ASA COE which has editorial responsibility of the ASA RVG. The ASA RVS committee believes that this code was misinterpreted by survey panel since they were not familiar with add-on codes. For this vignette, we think the ASA RVU for this code should be 1 to 2.

FREQUENCY INFORMATION

How was this service previously reported? 00300,00400,01810

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

Specialty Anesthesiology ____Commonly x Sometimes ____Rarely

Specialty _____ ____Commonly ____Sometimes ____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology Frequency 15,000 to 25,000

Specialty _____ Frequency _____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Anesthesiology Frequency 3,000 to 5,000

Specialty _____ Frequency _____

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

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American Medical Association
Physicians dedicated to the health of America

James G. Hoehn, MD
Chairman
AMA/Specialty Society RVS
Update Committee

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Chicago, Illinois 60610

312 464-5604
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May 31, 2000

Robert Berenson, MD
Director, Center for Health Plans and Providers
Health Care Financing Administration
7500 Security Boulevard, C5-26-25
Baltimore, Maryland 21244

Dear Doctor Berenson.

It is with pleasure that I submit to the Health Care Financing Administration (HCFA), on behalf of the American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC), work relative value and direct practice expense inputs for new and revised codes for CPT 2001. In addition, we are submitting recommendations on refinements to the direct practice expense inputs for existing CPT codes. These recommendations are the result of tremendous effort, and commitment of the members of the RUC, the Practice Expense Advisory Committee (PEAC), and representatives from more than eighty medical specialty societies to improving the Resource-Based Relative Value System (RBRVS).

Recommendations for New and Revised Codes

Enclosed are two binders of RUC recommendations, the first represents the recommendations for new and revised codes. The total number of coding changes for CPT 2001 is 434, including 209 additions, 191 revisions, and 34 deletions. 149 of these coding changes are not payable on the RBRVS (eg, laboratory services), and accordingly, the RUC does not submit any information on these codes Of the remaining 270 new and revised codes, the RUC submits 224 recommendations at this time.

A summary table included in the recommendations, specifically identifies a number of "interim" work relative value recommendations. The RUC has requested the specialty societies to re-present data on these services at a future RUC meeting, and we will send any new information to HCFA at that time. In addition, the CPT Editorial Panel approved new codes at its May 2000 meeting and the RUC has not yet had the opportunity to review these issues. These codes are also noted on the summary table. Any recommendations for these services will be submitted to HCFA after the RUC has had the opportunity to review the new codes.

Finally, the RUC's recommendations on direct practice expense inputs for new and revised codes should be considered "interim" recommendations. The RUC and PEAC continue to review the overall ground rules and potential standardization of these direct

inputs, and would like the opportunity to re-address these codes in the future, if necessary.

Practice Expense Refinement Recommendations

The second binder includes the RUC's recommendations for refinements to one or more of the direct practice expense input categories (clinical staff, supplies, and equipment) for more than 600 existing CPT codes. The PEAC, the advisory group to the RUC, has made significant progress this spring in refining the practice expense inputs for office visits and consultations. These evaluation and management recommendations reflect consensus amongst the medical community, developed through a special workgroup, the PEAC, and the RUC over the course of the past year. These refinements will play an important role in the PEAC's future review of services with global periods.

In addition, the PEAC and RUC approved standardized medical supply packages for post-operative visits in the global period for ophthalmology, neurosurgery, and obstetrics/gynecology

- The ophthalmology standards may be applied to the post-operative visits for all codes with a 010 and 090 day global period in the code range 65091 – 67999.

- The RUC recommended standards for neurosurgical post-operative visits are grouped into four categories: craniotomy, spine, peripheral nerve, and general. The specialty will forward a list of codes to be applied to each category and we will forward this list to HCFA in June.

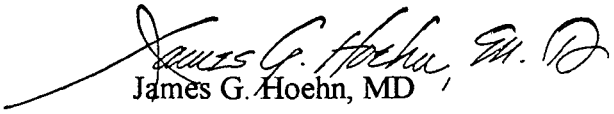
- The specific codes to which the obstetrics/gynecology codes apply are included in the attached binder, and we expect to receive further recommendations from the specialty on other applicable codes at a future PEAC meeting.

The RUC Health Care Professionals Advisory Committee (HCPAC) Review Board will convene a meeting in June to consider three issues: Development of Cognitive Reasoning, Medical Nutrition Therapy, and Active Wound Care Management. The HCPAC will forward their recommendations to HCFA following this meeting.

As you know, the RUC is embarking on a process to review 875 codes from public comments that you shared with us for the Five-Year Review of the RBRVS. The RUC will convene meetings in August and October of this year and will submit our recommendations to you by October 31, 2000. We invite HCFA, as we do for every

RUC meeting, to send observers to these meetings. The RUC appreciates HCFA's participation in our meetings and your effort to ensure a fair review of the RUC recommendations.

Sincerely,



James G. Hoehn, MD

cc: Terry Kay
Paul Rudolf, MD
Carolyn Mullen
Rick Ensor
Sherry Smith
Patrick Gallagher

American Medical Association
Physicians dedicated to the health of America

James G. Hoehn, MD
Chairman
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May 31, 2000

Robert Berenson, MD
Director, Center for Health Plans and Providers
Health Care Financing Administration
7500 Security Boulevard, C5-26-25
Baltimore, Maryland 21244

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Recommendations for New and Revised Codes

Enclosed are two binders of RUC recommendations, the first represents the recommendations for new and revised codes. The total number of coding changes for CPT 2001 is 434, including 209 additions, 191 revisions, and 34 deletions. 149 of these coding changes are not payable on the RBRVS (eg, laboratory services), and accordingly, the RUC does not submit any information on these codes. Of the remaining 270 new and revised codes, the RUC submits 224 recommendations at this time.

A summary table included in the recommendations, specifically identifies a number of "interim" work relative value recommendations. The RUC has requested the specialty societies to re-present data on these services at a future RUC meeting, and we will send any new information to HCFA at that time. In addition, the CPT Editorial Panel approved new codes at its May 2000 meeting and the RUC has not yet had the opportunity to review these issues. These codes are also noted on the summary table. Any recommendations for these services will be submitted to HCFA after the RUC has had the opportunity to review the new codes.

Finally, the RUC's recommendations on direct practice expense inputs for new and revised codes should be considered "interim" recommendations. The RUC and PEAC continue to review the overall ground rules and potential standardization of these direct

inputs, and would like the opportunity to re-address these codes in the future, if necessary.

Practice Expense Refinement Recommendations

The second binder includes the RUC's recommendations for refinements to one or more of the direct practice expense input categories (clinical staff, supplies, and equipment) for more than 600 existing CPT codes. The PEAC, the advisory group to the RUC, has made significant progress this spring in refining the practice expense inputs for office visits and consultations. These evaluation and management recommendations reflect consensus amongst the medical community, developed through a special workgroup, the PEAC, and the RUC over the course of the past year. These refinements will play an important role in the PEAC's future review of services with global periods.

In addition, the PEAC and RUC approved standardized medical supply packages for post-operative visits in the global period for ophthalmology, neurosurgery, and obstetrics/gynecology.

- The ophthalmology standards may be applied to the post-operative visits for all codes with a 010 and 090 day global period in the code range 65091 – 67999.

- The RUC recommended standards for neurosurgical post-operative visits are grouped into four categories: craniotomy, spine, peripheral nerve, and general. The specialty will forward a list of codes to be applied to each category and we will forward this list to HCFA in June.

- The specific codes to which the obstetrics/gynecology codes apply are included in the attached binder, and we expect to receive further recommendations from the specialty on other applicable codes at a future PEAC meeting.

The RUC Health Care Professionals Advisory Committee (HCPAC) Review Board will convene a meeting in June to consider three issues. Development of Cognitive Reasoning, Medical Nutrition Therapy, and Active Wound Care Management The HCPAC will forward their recommendations to HCFA following this meeting.

As you know, the RUC is embarking on a process to review 875 codes from public comments that you shared with us for the Five-Year Review of the RBRVS. The RUC will convene meetings in August and October of this year and will submit our recommendations to you by October 31, 2000. We invite HCFA, as we do for every

RUC meeting, to send observers to these meetings. The RUC appreciates HCFA's participation in our meetings and your effort to ensure a fair review of the RUC recommendations.

Sincerely,

James G. Hoehn, MD

cc: Terry Kay
Paul Rudolf, MD
Carolyn Mullen
Rick Ensor
Sherry Smith
Patrick Gallagher

CPT 2001 RUC Recommendations

CPT Code	Global Period	Coding Change	CPT Date	Main Tab	Issue	Tracking Number	RUC Date	RUC Tab	Specialty Rec	RUC Rec	Same RVU as last yr?	MFS?	Comments
00145	XXX	R	Feb00	O	Anesthesia Services		Apr00	I	6 00	6 00	Yes	Yes	Interim - RUC review at Oct 2000 meeting
00190	XXX	R	Feb00	O	Anesthesia Services		Apr00	I	5 00	5 00	Yes	Yes	Interim - RUC review at Oct 2000 meeting
00215	XXX	R	Feb00	O	Anesthesia Services		Apr00	I	9 00	9 00	Yes	Yes	Interim - RUC review at Oct 2000 meeting
00530	XXX	R	Feb00	O	Anesthesia Services		Apr00	I	4.00	4 00	Yes	Yes	Interim - RUC review at Oct 2000 meeting
00534	XXX	R	Feb00	O	Anesthesia Services		Apr00	I	7 00	7.00	Yes	Yes	Interim - RUC review at Oct 2000 meeting
00537	XXX	N	Feb00	O	Anesthesia Services	BB1	Apr00	I	8 00	8 00		Yes	Interim - RUC review at Oct 2000 meeting
00550	XXX	N	Feb00	O	Anesthesia Services	BB2	Apr00	I	12 00	12 00		Yes	Interim - RUC review at Oct 2000 meeting
00563	XXX	N	Feb00	O	Anesthesia Services	BB3	Apr00	I	25 00	25 00		Yes	Interim - RUC review at Oct 2000 meeting
00566	XXX	N	Feb00	O	Anesthesia Services		Apr00	I	25 00	25 00		Yes	Interim - RUC review at Oct 2000 meeting
00570	XXX	N	Feb00	O	Echocardiography		Apr00	J	2 50			Yes	No RUC Rec at this time - RUC review in Oct 2000
00604	XXX	R	Feb00	O	Anesthesia Services		Apr00	I	13.00	13 00	Yes	Yes	Interim - RUC review at Oct 2000 meeting
00635	XXX	N	Feb00	O	Anesthesia Services	BB4	Apr00	I	5 00	5.00		Yes	Interim - RUC review at Oct 2000 meeting
00670	XXX	R	Feb00	O	Anesthesia Services		Apr00	I	13 00	13 00	Yes	Yes	Interim - RUC review at Oct 2000 meeting
00792	XXX	R	Feb00	O	Anesthesia Services		Apr00	I	13 00	13 00	Yes	Yes	Interim - RUC review at Oct 2000 meeting
00900	XXX	D	Feb00	O	Anesthesia Services		Apr00	I				Yes	
00902	XXX	R	Feb00	O	Anesthesia Services		Apr00	I	5.00	5 00	Yes	Yes	Interim - RUC review at Oct 2000 meeting
00920	XXX	R	Feb00	O	Anesthesia Services		Apr00	I	3.00	3 00	Yes	Yes	Interim - RUC review at Oct 2000 meeting
00942	XXX	R	Feb00	O	Anesthesia Services		Apr00	I	4.00	4 00	Yes	Yes	Interim - RUC review at Oct 2000 meeting
01112	XXX	N	Feb00	O	Anesthesia Services	BB5	Apr00	I	6 00	6 00		Yes	Interim - RUC review at Oct 2000 meeting
01214	XXX	R	Feb00	O	Anesthesia Services	BB7	Apr00	I	8 00	8 00		Yes	Interim - RUC review at Oct 2000 meeting
01215	XXX	N	Feb00	O	Anesthesia Services	BB6	Apr00	I	10 00	10 00		Yes	Interim - RUC review at Oct 2000 meeting

CPT Code	Global Period	Coding Change	CPT Main Date	Tab	Issue	Tracking Number	RUC Date	RUC Tab	Specialty Rec	RUC Rec	Same RVU as last yr?	MFS?	Comments
01482	XXX	R	Feb00	O	Anesthesia Services		Apr00	I	4.00	4 00	Yes	Yes	Interim - RUC review at Oct 2000 meeting
01784	XXX	D	Feb00	O	Anesthesia Services		Apr00	I				Yes	Interim - RUC review at Oct 2000 meeting
01951	XXX	N	Feb00	O	Anesthesia Services	BB8	Apr00	I	3 00	3 00		Yes	Interim - RUC review at Oct 2000 meeting
01952	XXX	N	Feb00	O	Anesthesia Services	BB9	Apr00	I	5 00	5 00		Yes	Interim - RUC review at Oct 2000 meeting
01953	ZZZ	N	Feb00	O	Anesthesia Services	BB1	Apr00	I	1 00	1 00		Yes	Interim - RUC review at Oct. 2000 meeting
11980	XXX	N	Nov98	14	Hormone Pellet Implantation	I1	Apr00	10	1.48	1.48	Yes	Yes	
15342	090	N	Feb00	3	Bioengineered Tissue Grafts	M1	Apr00	12	1.50	1.50		Yes	Interim - RUC review in February 2001
15343	ZZZ	N	Feb00	3	Bioengineered Tissue Grafts	M2	Apr00	12	0.38	0 38		Yes	Interim - RUC review in February 2001
15842	090	R	May00	Q	Graft for facial nerve paralysis		Editorial		37.96	37.96	Yes	Yes	
16035	000	R	Aug99	K	Escharotomy	A1	Apr00	13	3 75	3 75		Yes	
16036	ZZZ	N	Aug99	K	Escharotomy	A2	Apr00	13	1 50	1 50		Yes	
19100	000	R	Feb00	E	Breast Biopsy		Apr00	14	1 27	1 27	Yes	Yes	
19101	010	R	Feb00	E	Breast Biopsy		Apr00	14	3 18	3 18	Yes	Yes	
19102	000	N	Feb00	E	Breast Biopsy	X1	Apr00	14	2 00	2 00		Yes	
19103	000	N	Feb00	E	Breast Biopsy	X2	Apr00	14	2 37	2 37		Yes	
19120	090	R	Feb00	E	Breast Biopsy		Apr00	14	5.56	5.56	Yes	Yes	
19125	090	R	Feb00	E	Breast Biopsy		Apr00	14	6 06	6.06	Yes	Yes	
19126	ZZZ	R	Feb00	E	Breast Biopsy		Apr00	14	2.93	2 93	Yes	Yes	
19295	ZZZ	N	Feb00	P	Insertion of Breast Markers	DD1	Apr00	15	0.00	0.00		Yes	No Physician Work
21199	090	N	Feb00	S	Mandibular Osteotomy and Genioglossus Advancement	FF1	Apr00	17	16 00	16.00		Yes	
22520	010	N	Feb00	T	Percutaneous Vertebroplasty	GG1	Apr00	25	10 00	8.91		Yes	
22521	010	N	Feb00	T	Percutaneous Vertebroplasty	GG2	Apr00	25	9.43	8 34		Yes	

CPT Code	Global Period	Coding Change	CPT Main Date	Tab	Issue	Tracking Number	RUC Date	RUC Tab	Specialty Rec	RUC Rec	Same RVU as last yr?	MFS?	Comments
22522	ZZZ	N	Feb00	T	Percutaneous Vertebroplasty	GG3	Apr00	25	4 41	4 31		Yes	
27236	090	R	May00	G	Fracture Treatment		Editorial		15 60	15 60	Yes	Yes	
30465	090	N	Feb00	U	Nose Repair	HH1	Apr00	18	11 64	11 64		Yes	
33140	090	R	Feb00	5	Transmyocardial Laser Revascularization		Apr00	21	20 00	20 00	Yes	Yes	
33141	ZZZ	N	Feb00	5	Transmyocardial Laser Revascularization	N1	Apr00	21	9 00	4 84		Yes	
33533	090	R	Aug99	X	Harvest of Upper Extremity Artery for CABG	B2	Feb00	8	25.83	25 83	Yes	Yes	
33534	090	R	Aug99	X	Harvest of Upper Extremity Artery for CABG	B3	Feb00	8	28.82	28 82	Yes	Yes	
33535	090	R	Aug99	X	Harvest of Upper Extremity Artery for CABG	B4	Feb00	8	31.81	31 81	Yes	Yes	
33536	090	R	Aug99	X	Harvest of Upper Extremity Artery for CABG	B5	Feb00	8	34 79	34 79	Yes	Yes	
34800	090	N	Feb00	10	Endovascular Graft for Abdominal Aortic Aneurysm	QQ1	Apr00	26	20 75	20 75		Yes	
34802	090	N	Feb00	10	Endovascular Graft for Abdominal Aortic Aneurysm	QQ2	Apr00	26	23 00	23 00		Yes	
34804	090	N	Feb00	10	Endovascular Graft for Abdominal Aortic Aneurysm	QQ3	Apr00	26	23 00	23 00		Yes	
34808	ZZZ	N	Feb00	10	Endovascular Graft for Abdominal Aortic Aneurysm	QQ4	Apr00	26	8 95	4 13		Yes	
34812	000	N	Feb00	10	Endovascular Graft for Abdominal Aortic Aneurysm	QQ5	Apr00	26	9 55	6.75		Yes	
34813	ZZZ	N	Feb00	10	Endovascular Graft for Abdominal Aortic Aneurysm	QQ6	Apr00	26	4 80	4 80		Yes	
34820	000	N	Feb00	10	Endovascular Graft for Abdominal Aortic Aneurysm	QQ7	Apr00	26	14 25	9 75		Yes	
34825	090	N	Feb00	10	Endovascular Graft for Abdominal Aortic Aneurysm	QQ8	Apr00	26	12.00	12 00		Yes	

CPT Code	Global Period	Coding Change	CPT Main Date	Tab	Issue	Tracking Number	RUC Date	RUC Tab	Specialty Rec	RUC Rec	Same RVU as last yr?	MFS?	Comments
34826	ZZZ	N	Feb00	10	Endovascular Graft for Abdominal Aortic Aneurysm	QQ9	Apr00	26	4 13	4 13		Yes	
34830	090	N	Feb00	10	Endovascular Graft for Abdominal Aortic Aneurysm	QQ1	Apr00	26	32 59	32 59		Yes	
34831	090	N	Feb00	10	Endovascular Graft for Abdominal Aortic Aneurysm	QQ1	Apr00	26	36 46	35 34		Yes	
34832	090	N	Feb00	10	Endovascular Graft for Abdominal Aortic Aneurysm	QQ1	Apr00	26	37 10	35 34		Yes	
35600	ZZZ	N	Aug99	X	Harvest of Upper Extremity Artery for CABG	B1	Feb00	8	9 50	4 95		Yes	
36540	XXX	N	Feb00	V	Venous Access for Specimen Collection Implantable Venous Access Port	II1	Apr00	C	0 00	0 00		Yes	No Physician Work
36831	090	R	Feb00	W	Percutaneous Management of Dialysis Graft/Fistula		Apr00	27	8 00	8 00	Yes	Yes	
36832	090	R	Feb00	W	Percutaneous Management of Dialysis Graft/Fistula		Apr00	27	10 50	10 50	Yes	Yes	
36870	090	N	Feb00	W	Percutaneous Management of Dialysis Graft/Fistula	JJ1	Apr00	27	6 85	5 16		Yes	
38500	010	R	Aug99	Y	Lymph Node Biopsy	C1	Apr00	M	2 88	2 88	Yes	Yes	
38505	000	R	May00	12	Lymph Node Biopsy		Editorial		1 14	1 14	Yes	Yes	
38510	090	R	May00	12	Lymph Node Biopsy		Editorial		4 14	4 14	Yes	Yes	
38520	090	R	May00	12	Lymph Node Biopsy		Editorial		5 12	5 12	Yes	Yes	
38525	090	R	May00	12	Lymph Node Biopsy		Editorial		4 66	4 66	Yes	Yes	
38530	090	R	Aug99	Y	Lymph Node Biopsy	C2	Apr00	M	6 13	6 13	Yes	Yes	
43231	000	N	Feb00	G	GI Endoscopy Procedures	Y1	Apr00	29	5 96	4 09		Yes	Interim - RUC to Review at Feb 2001 meeting
43232	000	N	Feb00	G	GI Endoscopy Procedures	Y2	Apr00	29	8 00	4 71		Yes	Interim - RUC to Review at Feb 2001 meeting
43240	000	N	Feb00	G	GI Endoscopy Procedures	Y4	Apr00	29	10 50	7 39		Yes	Interim - RUC to Review at Feb 2001 meeting
43241	000	R	Feb00	G	GI Endoscopy Procedures		Apr00	29	2.59	2 59	Yes	Yes	

CPT Code	Global Period	Coding Change	CPT Main Date	Tab	Issue	Tracking Number	RUC Date	RUC Tab	Specialty Rec	RUC Rec	Same RVU as last yr?	MFS?	Comments
43242	000	N	Feb00	G	GI Endoscopy Procedures	Y3	Apr00	29	9 53	5 51		Yes	Interim - RUC to Review at Feb 2001 meeting
43256	000	N	May00	EC	Endoscopic Enteral Stenting		Apr00	30				Yes	No RUC Rec at this time - Review at Feb 2001 mtg
43752	000	N	Feb00	12	Naso- or Oro-gastric tube placement	RR1	Apr00	28	0.75			Yes	No RUC Rec at this time - Review at Feb 2001 mtg
44132	YYY	N	Aug99	1	Small Bowel Transplantation	D1	Apr00	M				Yes	Carrier Price in 2000 - RUC to Review in Feb 2001
44133	YYY	N	Aug99	1	Small Bowel Transplantation	D2	Apr00	M				Yes	Carrier Price in 2000 - RUC to Review in Feb 2001
44135	YYY	N	Aug99	1	Small Bowel Transplantation	D3	Apr00	M				Yes	Carrier Price in 2000 - RUC to Review in Feb 2001
44136	YYY	N	Aug99	1	Small Bowel Transplantation	D4	Apr00	M				Yes	Carrier Price in 2000 - RUC to Review in Feb 2001
44370	000	N	May00	EC	Endoscopic Enteral Stenting		Apr00	30				Yes	No RUC Rec at this time - Review at Feb 2001 mtg
44379	000	N	May00	EC	Endoscopic Enteral Stenting		Apr00	30				Yes	No RUC Rec at this time - Review at Feb 2001 mtg
44383	000	N	May00	16	Endoscopic Enteral Stenting		Apr00	30				Yes	No RUC Rec at this time - Review at Feb 2001 mtg
44397	000	N	Feb00	Y	Endoscopic Enteral Stenting	KK1	Apr00	30	7 53	4 78		Yes	Interim - RUC to Review at Feb 2001 meeting
44500	000	R	May00	EC	Naso- or Oro-gastric tube placement		Apr00	28	0 49	0 49	Yes	Yes	
45327	000	N	Feb00	Y	Endoscopic Enteral Stenting	KK2	Apr00	30	7.20	2.66		Yes	Interim - RUC to Review at Feb 2001 meeting
45341	000	N	Feb00	G	GI Endoscopy Procedures	Y5	Apr00	29	5.00	3.46		Yes	Interim - RUC to Review at Feb 2001 meeting
45342	000	N	Feb00	G	GI Endoscopy Procedures	Y6	Apr00	29	6.20	4 08		Yes	Interim - RUC to Review at Feb 2001 meeting
45345	000	N	Feb00	Y	Endoscopic Enteral Stenting	KK3	Apr00	30	6 65	2 92		Yes	Interim - RUC to Review at Feb 2001 meeting
45387	000	N	Feb00	Y	Endoscopic Enteral Stenting	KK4	Apr00	30	8 05	5 66		Yes	Interim - RUC to Review at Feb 2001 meeting
47379	YYY	N	Feb00	H	Unlisted Laparoscopic Procedure, Liver							Yes	Carrier Price
49320	010	R	Nov99	7	Laparoscopic Abdominal Procedures		Editorial		5.10	5 10	Yes	Yes	
49321	010	R	Nov99	7	Laparoscopic Abdominal Procedures		Editorial		5 40	5 40	Yes	Yes	
50545	090	N	Nov99	R	Laparosocpic Radical Nephrectomy	P1	Feb00	11	24 00	24 00		Yes	
50546	090	R	Nov99	R	Laparosocpic Radical Nephrectomy	P2	Feb00	11	20 48	20 48	Yes	Yes	

CPT Code	Global Period	Coding Change	CPT Date	Main Tab	Issue	Tracking Number	RUC Date	RUC Tab	Specialty Rec	RUC Rec	Same RVU as last yr?	MFS?	Comments
50548	090	R	Nov99	R	Laparosocpic Radical Nephrectomy	P3	Feb00	11	24 40	24 40	Yes	Yes	
50947	090	N	Nov99	T	Laparoscopic Ureterneocystostomy	Q1	Feb00	12	24 50	24 50		Yes	
50948	090	N	Nov99	T	Laparoscopic Ureterneocystostomy	Q2	Feb00	12	22 50	22 50		Yes	
50949	YYY	N	Nov99	T	Laparoscopic Ureterneocystostomy		Feb00	12				Yes	Carrier Price
52335	000	D	Nov99	U	Endoscopic Urinary System Procedures		Feb00	13				Yes	
52336	000	D	Nov99	U	Endoscopic Urinary System Procedures		Feb00	13				Yes	
52337	000	D	Nov99	U	Endoscopic Urinary System Procedures		Feb00	13				Yes	
52338	000	D	Nov99	U	Endoscopic Urinary System Procedures		Feb00	13				Yes	
52339	000	D	Nov99	U	Endoscopic Urinary System Procedures		Feb00	13				Yes	
52340	000	D	Nov99	U	Endoscopic Urinary System Procedures		Feb00	13				Yes	
52341	000	N	Nov99	U	Endoscopic Urinary System Procedures	R1	Feb00	13	6 00	6 00		Yes	
52342	000	N	Nov99	U	Endoscopic Urinary System Procedures	R2	Feb00	13	6 50	6 50		Yes	
52343	000	N	Nov99	U	Endoscopic Urinary System Procedures	R3	Feb00	13	7 20	7 20		Yes	
52344	000	N	Nov99	U	Endoscopic Urinary System Procedures	R4	Feb00	13	7 70	7 70		Yes	
52345	000	N	Nov99	U	Endoscopic Urinary System Procedures	R5	Feb00	13	8 20	8 20		Yes	
52346	000	N	Nov99	U	Endoscopic Urinary System Procedures	R6	Feb00	13	9 23	9 23		Yes	
52351	000	N	Nov99	U	Endoscopic Urinary System Procedures	R7	Feb00	13	5 86	5 86		Yes	
52352	000	N	Nov99	U	Endoscopic Urinary System Procedures	R8	Feb00	13	6.88	6 88		Yes	
52353	000	N	Nov99	U	Endoscopic Urinary System Procedures	R9	Feb00	13	7 97	7 97		Yes	
52354	000	N	Nov99	U	Endoscopic Urinary System Procedures	R10	Feb00	13	7 34	7 34		Yes	
52355	000	N	Nov99	U	Endoscopic Urinary System Procedures	R11	Feb00	13	8 82	8 82		Yes	
52400	090	N	Nov99	U	Endoscopic Urinary System Procedures	R12	Feb00	13	9 68	9 68		Yes	

CPT Code	Global Period	Coding Change	CPT Main Date	Tab	Issue	Tracking Number	RUC Date	RUC Tab	Specialty Rec	RUC Rec	Same RVU as last yr?	MFS?	Comments
54512	090	N	Nov99	V	Partial Orchiectomy	S1	Feb00	14	8 58	8 58		Yes	
54522	090	N	Nov99	V	Partial Orchiectomy	S2	Feb00	14	9 50	9.50		Yes	
55873	090	N	Feb00	7	Cryosurgical Ablation of the Prostate	O1	Apr00	6	26 50	17 80		Yes	
57022	010	N	Feb00	2	Incision and Drainage of Vaginal Hematoma	LL1	Apr00	9	2 56	2 56		Yes	
57023	010	N	May00	2	Incision and Drainage of Vaginal Hematoma		Apr00	9				Yes	No RUC Rec at this time - Review at Feb 2001 mtg
57287	090	N	Nov99	Z	Reversal of Sling Operation for Stess Incontinence	T1	Apr00	7	12 25	10 71		Yes	
58353	010	N	Aug99	L	Endometrial Ablation	E1	Apr00	8	3 56	3 56		Yes	
58943	090	R	Feb00	2	Gynecological Oncology Procedures		Editorial		18 43	18 43	Yes	Yes	
58950	090	R	Feb00	2	Gynecological Oncology Procedures		Editorial		15 27	15 27	Yes	Yes	
58951	090	R	Feb00	2	Gynecological Oncology Procedures		Editorial		21 81	21 81	Yes	Yes	
58952	090	R	Feb00	2	Gynecological Oncology Procedures		Editorial		25 01	25 01	Yes	Yes	
58960	090	R	Feb00	2	Gynecological Oncology Procedures		Editorial		14 65	14 65	Yes	Yes	
61697	090	N	Feb00	5	Repair of Intracranial Aneurysm	NN1	Apr00	22	50 52	50 52		Yes	Interim RUC Rec - RUC review after freq Available
61698	090	N	Feb00	5	Repair of Intracranial Aneurysm	NN2	Apr00	22	48 41	48 41		Yes	Interim RUC Rec - RUC review after freq Available
61700	090	R	Feb00	5	Repair of Intracranial Aneurysm	NN3	Apr00	22	50.52	50 52	Yes	Yes	Interim RUC Rec - RUC review after freq Available
61702	090	R	Feb00	5	Repair of Intracranial Aneurysm	NN4	Apr00	22	48 41	48 41	Yes	Yes	Interim RUC Rec - RUC review after freq Available
61770	090	R	Feb00	6	Stereotactic Localization Insertion of Catheters/Probes/Radiation Source		Editorial		21 44	21.44	Yes	Yes	
62252	XXX	N	Feb00	3C	Reprogramming of Programable CSF Shunt	J1	Apr00	23	0 92	0.74		Yes	
62350	090	R	Feb00	8	Implantation Tunneled Intrathecal/Epidural Catheter		Editorial		6.87	6 87	Yes	Yes	
63040	090	R	Feb00	9	Laminotomy Re-Exploration		Apr00	24				Yes	No RUC Rec at this time - Review at Feb 2001 mtg

CPT Code	Global Period	Coding Change	CPT Main Date	Tab	Issue	Tracking Number	RUC Date	RUC Tab	Specialty Rec	RUC Rec	Same RVU as last yr?	MFS?	Comments
63042	090	R	Feb00	9	Laminotomy Re-Exploration		Apr00	24				Yes	No RUC Rec at this time - Review at Feb 2001 mtg
63043	ZZZ	N	Feb00	9	Laminotomy Re-Exploration	YY1	Apr00	24				Yes	No RUC Rec at this time - Review at Feb 2001 mtg
63044	ZZZ	N	Feb00	9	Laminotomy Re-Exploration	YY2	Apr00	24				Yes	No RUC Rec at this time - Review at Feb 2001 mtg
64612	010	R	Aug99	J	Chemodenervation of muscles of the trunk and limbs	F1	Apr00	5	1 96	1 96	Yes	Yes	
64613	010	R	Aug99	J	Chemodenervation of muscles of the trunk and limbs	F2	Apr00	5	1 96	1 96	Yes	Yes	
64614	010	N	Aug99	J	Chemodenervation of muscles of the trunk and limbs	F3	Apr00	5	2 20	2 20		Yes	
66982	090	N	Nov99	3	Complex Cataract	U2	Feb00	10	13 50	13 50		Yes	
66984	090	R	Nov99	3	Complex Cataract	U1	Feb00	10	10 23	10 23		Yes	
67220	090	R	May00	EC	Occular Photodynamic Therapy		Editorial		13 13	13 13	Yes	Yes	
67221	?	N	May00	EC	Occular Photodynamic Therapy							Yes	No RUC Rec at this time - Review at Feb 2001 mtg
69714	090	N	Feb00	7	Implantation or Replacement of Osseointegrated Implan Temporal Bone	OO1	Apr00	19	14 00	14 00		Yes	
69715	090	N	Feb00	7	Implantation or Replacement of Osseointegrated Implan Temporal Bone	OO2	Apr00	19	18 25	18 25		Yes	
69717	090	N	Feb00	7	Implantation or Replacement of Osseointegrated Implan Temporal Bone	OO3	Apr00	19	14 98	14 98		Yes	
69718	090	N	Feb00	7	Implantation or Replacement of Osseointegrated Implan Temporal Bone	OO4	Apr00	19	18.50	18.50		Yes	
70336	XXX	R	Feb00	13	MRI, joints		Editorial		1 48	1 48	Yes	Yes	
70496	XXX	N	Feb00	12	Computed Tomographic Angiography	SS1	Apr00	D	1 75	1 75		Yes	
70498	XXX	N	Feb00	12	Computed Tomographic Angiography	SS2	Apr00	D	1.75	1.75		Yes	
70540	XXX	R	Feb00	12	Magnetic Resonance Imaging Procedures	TT1	Apr00	E	1.48	1 48	Yes	Yes	
70541	XXX	D	Feb00	9	Magnetic Resonance Angiography		Apr00	F				Yes	

CPT Code	Global Period	Coding Change	CPT Date	Main Tab	Issue	Tracking Number	RUC Date	RUC Tab	Specialty Rec	RUC Rec	Same RVU as last yr?	MFS?	Comments
70542	XXX	N	Feb00	12	Magnetic Resonance Imaging Procedures	TT2	Apr00	E	1 90	1 78		Yes	
70543	XXX	N	Feb00	12	Magnetic Resonance Imaging Procedures	TT3	Apr00	E	2 40	2 36		Yes	
70544	XXX	N	Feb00	9	Magnetic Resonance Angiography	PP1	Apr00	F	1 20	1 20		Yes	
70545	XXX	N	Feb00	9	Magnetic Resonance Angiography	PP2	Apr00	F	1 20	1 20		Yes	
70546	XXX	N	Feb00	9	Magnetic Resonance Angiography	PP3	Apr00	F	1 80	1 80		Yes	
70547	XXX	N	Feb00	9	Magnetic Resonance Angiography	PP4	Apr00	F	1 20	1 20		Yes	
70548	XXX	N	Feb00	9	Magnetic Resonance Angiography	PP5	Apr00	F	1 20	1 20		Yes	
70549	XXX	N	Feb00	9	Magnetic Resonance Angiography	PP6	Apr00	F	1 80	1 80		Yes	
71036	XXX	D	Feb00	12	Radiological Needle Placement Procedures							Yes	
71275	XXX	N	Feb00	12	Computed Tomographic Angiography	SS3	Apr00	D				Yes	No RUC Rec at this time- Review at Feb 2001 mtg
71550	XXX	R	Feb00	12	Magnetic Resonance Imaging	TT4	Apr00	E				Yes	No RUC Rec at this time- Review at Feb 2001 mtg
71551	XXX	N	Feb00	12	Magnetic Resonance Imaging	TT5	Apr00	E				Yes	No RUC Rec at this time- Review at Feb 2001 mtg
71552	XXX	N	Feb00	12	Magnetic Resonance Imaging	TT6	Apr00	E				Yes	No RUC Rec at this time- Review at Feb 2001 mtg
72040	XXX	R	Feb00	12	Radiological Examination		Editorial		0 22	0 22	Yes	Yes	
72070	XXX	R	Feb00	12	Radiological Examination		Editorial		0 22	0 22	Yes	Yes	
72072	XXX	R	Feb00	12	Radiological Examination		Editorial		0 22	0 22	Yes	Yes	
72074	XXX	R	Feb00	12	Radiological Examination		Editorial		0 22	0.22	Yes	Yes	
72080	XXX	R	Feb00	12	Radiological Examination		Editorial		0 22	0 22	Yes	Yes	
72100	XXX	R	Feb00	12	Radiological Examination		Editorial		0 22	0 22	Yes	Yes	
72110	XXX	R	Feb00	12	Radiological Examination		Editorial		0 31	0 31	Yes	Yes	
72170	XXX	R	Feb00	12	Radiological Examination		Editorial		0 17	0 17	Yes	Yes	

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72191	XXX	N	Feb00	12	Computed Tomographic Angiography	SS4	Apr00	D				Yes	No RUC Rec at this time-Review at Feb 2001 mtg
72195	XXX	N	Feb00	12	Magnetic Resonance Imaging	TT7	Apr00	E				Yes	No RUC Rec at this time-Review at Feb 2001 mtg
72196	XXX	R	Feb00	12	Magnetic Resonance Imaging	TT8	Apr00	E				Yes	No RUC Rec at this time-Review at Feb 2001 mtg
72197	XXX	N	Feb00	12	Magnetic Resonance Imaging	TT9	Apr00	E				Yes	No RUC Rec at this time-Review at Feb 2001 mtg
73070	XXX	R	Feb00	12	Radiological Examination		Editorial		0 15	0 15	Yes	Yes	
73090	XXX	R	Feb00	12	Radiological Examination		Editorial		0 16	0 16	Yes	Yes	
73100	XXX	R	Feb00	12	Radiological Examination		Editorial		0 16	0 16	Yes	Yes	
73206	XXX	N	Feb00	12	Computed Tomographic Angiography	SS5	Apr00	D				Yes	No RUC Rec at this time - Review at Feb 2001 mtg
73218	XXX	N	Feb00	12	Magnetic Resonance Imaging	TT10	Apr00	E				Yes	No RUC Rec at this time - Review at Feb 2001 mtg
73219	XXX	N	Feb00	12	Magnetic Resonance Imaging	TT11	Apr00	E				Yes	No RUC Rec at this time - Review at Feb 2001 mtg
73220	XXX	R	Feb00	12	Magnetic Resonance Imaging	TT12	Apr00	E				Yes	No RUC Rec at this time - Review at Feb 2001 mtg
73221	XXX	R	Feb00	12	Magnetic Resonance Imaging	TT13	Apr00	E				Yes	No RUC Rec at this time - Review at Feb 2001 mtg
73222	XXX	N	Feb00	12	Magnetic Resonance Imaging	TT14	Apr00	E				Yes	No RUC Rec at this time - Review at Feb 2001 mtg
73223	XXX	N	Feb00	12	Magnetic Resonance Imaging	TT15	Apr00	E				Yes	No RUC Rec at this time - Review at Feb 2001 mtg
73550	XXX	R	Feb00	12	Radiological Examination		Editorial		0 17	0 17	Yes	Yes	
73590	XXX	R	Feb00	12	Radiological Examination		Editorial		0 17	0 17	Yes	Yes	
73600	XXX	R	Feb00	12	Radiological Examination		Editorial		0 16	0 16	Yes	Yes	
73620	XXX	R	Feb00	12	Radiological Examination		Editorial		0.16	0 16	Yes	Yes	
73706	XXX	N	Feb00	12	Computed Tomographic Angiography	SS6	Apr00	D				Yes	No RUC Rec at this time - Review at Feb 2001 mtg
73718	XXX	N	Feb00	12	Magnetic Resonance Imaging	TT16	Apr00	E				Yes	No RUC Rec at this time - Review at Feb 2001 mtg
73719	XXX	N	Feb00	12	Magnetic Resonance Imaging	TT17	Apr00	E				Yes	No RUC Rec at this time - Review at Feb 2001 mtg
73720	XXX	R	Feb00	12	Magnetic Resonance Imaging	TT18	Apr00	E				Yes	No RUC Rec at this time - Review at Feb 2001 mtg

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73721	XXX	R	Feb00	12	Magnetic Resonance Imaging	TT19	Apr00	E				Yes	No RUC Rec at this time - Review at Feb 2001 mtg
73722	XXX	N	Feb00	12	Magnetic Resonance Imaging	TT20	Apr00	E				Yes	No RUC Rec at this time - Review at Feb 2001 mtg
73723	XXX	N	Feb00	12	Magnetic Resonance Imaging	TT21	Apr00	E				Yes	No RUC Rec at this time - Review at Feb 2001 mtg
74175	XXX	N	Feb00	12	Computed Tomographic Angiography	SS7	Apr00	D				Yes	No RUC Rec at this time- Review at Feb 2001 mtg
74181	XXX	R	Feb00	12	Magnetic Resonance Imaging	TT22	Apr00	E				Yes	No RUC Rec at this time- Review at Feb 2001 mtg
74182	XXX	N	Feb00	12	Magnetic Resonance Imaging	TT23	Apr00	E				Yes	No RUC Rec. at this time- Review at Feb 2001 mtg
74183	XXX	N	Feb00	12	Magnetic Resonance Imaging	TT24	Apr00	E				Yes	No RUC Rec. at this time- Review at Feb 2001 mtg
75635	XXX	N	Feb00	12	Computed Tomographic Angiography	SS8	Apr00	D				Yes	No RUC Rec at this time-Review at Feb 2001 mtg
75809	XXX	R	Feb00	13	Radiological Editorial Revisions		Editorial		0 47	0 47	Yes	Yes	
75952	XXX	N	Feb00	10	Endovascular Graft for Abdominal Aortic Aneurysm	QQ1	Apr00	26	4 50	4 00		Yes	Interim - RUC review at Feb 2001 meeting
75953	XXX	N	Feb00	10	Endovascular Graft for Abdominal Aortic Aneurysm	QQ1	Apr00	26	1 36	1 36		Yes	
75989	XXX	R	Feb00	13	Radiological Editorial Revisions		Editorial		1 19	1 19	Yes	Yes	
76003	XXX	R	Feb00	12	Radiological Needle Placement Procedures		Editorial		0 54	0 54	Yes	Yes	
76010	XXX	R	Feb00	13	Radiological Editorial Revisions		Editorial		0 18	0 18	Yes	Yes	
76012	XXX	N	Feb00	T	Percutaneous Vertebroplasty	GG4	Apr00	25	1 16	1 31		Yes	
76013	XXX	N	Feb00	T	Percutaneous Vertebroplasty	GG5	Apr00	25	1 22	1 38		Yes	
76095	XXX	R	Feb00	12	Radiological Needle Placement Procedures		Editorial		1 59	1 59	Yes	Yes	
76096	XXX	R	Feb00	12	Radiological Needle Placement Procedures		Editorial		0.56	0 56	Yes	Yes	
76360	XXX	R	Feb00	12	Radiological Needle Placement Procedures		Editorial		1.16	1 16	Yes	Yes	
76365	XXX	D	Feb00	12	Radiological Needle Placement Procedures							Yes	

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76393	XXX	N	Feb00	12	Magnetic Resonance Guidance Needle Placement	UU1	Apr00	G	1 50	1 50		Yes	
76818	XXX	R	Feb00	2	Fetal Biophysical Profile	MM1	Apr00	11	1 05	1 05		Yes	
76819	XXX	N	Feb00	2	Fetal Biophysical Profile	MM2	Apr00	11	0 77	0 77		Yes	
76930	XXX	R	Nov99	4	Ultrasound Editorial Revisions		Editorial		0 67	0 67		Yes	
76932	XXX	R	Nov99	4	Ultrasound Editorial Revisions		Editorial		0 67	0 67		Yes	
76934	XXX	D	Nov99	4	Ultrasound Editorial Revisions							Yes	
76938	XXX	D	Nov99	4	Ultrasound Editorial Revisions							Yes	
76941	XXX	R	Nov99	4	Ultrasound Editorial Revisions		Editorial		1 34	1 34	Yes	Yes	
76942	XXX	R	Nov99	4	Ultrasound Editorial Revisions		Editorial		0 67	0 67	Yes	Yes	
76945	XXX	R	Nov99	4	Ultrasound Editorial Revisions		Editorial		0 67	0 67	Yes	Yes	
76946	XXX	R	Nov99	4	Ultrasound Editorial Revisions		Editorial		0 38	0 38	Yes	Yes	
76948	XXX	R	Nov99	4	Ultrasound Editorial Revisions		Editorial		0.38	0 38	Yes	Yes	
76950	XXX	R	Nov99	4	Ultrasound Editorial Revisions		Editorial		0.58	0 58	Yes	Yes	
76960	XXX	D	Nov99	4	Ultrasound Editorial Revisions							Yes	
76975	XXX	R	Feb00	G	GI Endoscopy Procedures		Apr00	29	0 81	0 81	Yes	Yes	
76986	XXX	R	Nov99	4	Ultrasound Editorial Revisions		Editorial		1 20	1 20	Yes	Yes	
77470	XXX	R	Feb00	15	Radiation Oncology		Editorial		2 09	2.09	Yes	Yes	
77520	YYY	R	Aug99	I	Proton Beam Treatment Delivery		Apr00	M				Yes	Carrier Price
77522	YYY	N	Aug99	I	Proton Beam Treatment Delivery		Apr00	M				Yes	Carrier Price
77523	YYY	R	Aug99	I	Proton Beam Treatment Delivery		Apr00	M				Yes	Carrier Price
77525	YYY	N	Aug99	I	Proton Beam Treatment Delivery		Apr00	M				Yes	Carrier Price
77761	XXX	R	Feb00	15	Radiation Oncology		Editorial		3 81	3 81	Yes	Yes	

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77776	XXX	R	Feb00	15	Radiation Oncology			Editorial	4 66	4 66	Yes	Yes	
77789	XXX	R	Feb00	15	Radiation Oncology			Editorial	1 12	1 12	Yes	Yes	
77790	XXX	R	Feb00	15	Radiation Oncology			Editorial	1 05	1 05	Yes	Yes	
78805	XXX	R	Feb00	13	Radiological Editorial Revisions			Editorial	0 73	0 73	Yes	Yes	
78806	XXX	R	Feb00	13	Radiological Editorial Revisions			Editorial	0 86	0 86	Yes	Yes	
78807	XXX	R	Feb00	13	Radiological Editorial Revisions			Editorial	1 09	1 09	Yes	Yes	
80100	XXX	R	Nov99	6	Multiple Drug ClassTesting							No	
80101	XXX	R	Nov99	6	Multiple Drug ClassTesting							No	
80156	XXX	R	May00	K	Therapeutic Drug Assay							No	
80157	XXX	N	May00	K	Therapeutic Drug Assay							No	
80173	XXX	N	May00	K	Therapeutic Drug Assay							No	
81007	XXX	R	Aug99	U	Comprehensive Pathology and Laboratory Revisions							No	
82042	XXX	R	May00	K	Laboratory and Pathology Revisions							No	
82251	XXX	D	May00	K	Laboratory and Pathology Revisions							No	
82270	XXX	R	May00	K	Laboratory and Pathology Revisions							No	
82273	XXX	R	May00	K	Laboratory and Pathology Revisions							No	
82373	XXX	N	Feb00	24	Carbohydrate deficient transferrin							No	
82465	XXX	R	May00	K	Cholesterol (Finger Stick)							No	
82595	XXX	R	May00	K	Laboratory and Pathology Revisions							No	
82744	XXX	D	May00	K	Laboratory and Pathology Revisions							No	
82787	XXX	R	May00	K	Laboratory and Pathology Revisions							No	
82788	XXX	D	May00	K	Laboratory and Pathology Revisions							No	

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82945	XXX	N	Aug99	P	Glucose Testing							No	
82947	XXX	R	Aug99	P	Glucose Testing							No	
83013	XXX	R	Aug99	V	Helicobacter pylori (blood)							No	
83033	XXX	R	May00	K	Laboratory and Pathology Revisions							No	
83090	XXX	N	May00	K	Laboratory and Pathology Revisions							No	
83661	XXX	R	Aug99	Q	Fetal lung maturity assessment							No	
83662	XXX	R	Aug99	Q	Fetal lung maturity assessment							No	
83663	XXX	N	Aug99	Q	Fetal lung maturity assessment							No	
83664	XXX	N	Aug99	Q	Fetal lung maturity assessment							No	
83898	XXX	R	Feb00	10	PCR Amplification							No	
83918	XXX	R	May00	K	Laboratory and Pathology Revisions							No	
83921	XXX	N	May00	K	Laboratory and Pathology Revisions							No	
84152	XXX	N	Feb00	25	PSA							No	
84591	XXX	N	May00	K	Laboratory and Pathology Revisions							No	
85307	XXX	N	May00	K	Laboratory and Pathology Revisions							No	
85536	XXX	N	Feb00	19	Iron Stain							No	
86001	XXX	N	May00	K	Laboratory and Pathology Revisions							No	
86146	XXX	N	Nov99	5	Immunology Anti-Beta 2							No	
86147	XXX	R	May00	K	Laboaratory and Pathology Revisions							No	
86294	XXX	N	Nov99	G	Immunoassay for Tumor Antigens							No	
86300	XXX	N	Nov99	G	Immunoassay for Tumor Antigens							No	
86301	XXX	N	Nov99	G	Immunoassay for Tumor Antigens							No	

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86304	XXX	N	Nov99	G	Immunoassay for Tumor Antigens							No	
86316	XXX	R	Nov99	G	Immunoassay for Tumor Antigens							No	
86611	XXX	N	May00	K	Laboratory and Pathology Revisions							No	
86666	XXX	N	May00	K	Laboratory and Pathology Revisions							No	
86683	XXX	N	Feb00	23	Hemoglobin in Stool							No	
86696	XXX	N	Feb00	26	Herpes Simplex Type 2							No	
86704	XXX	R	May00	K	Laboratory and Pathology Revisions							No	
86708	XXX	R	May00	K	Laboratory and Pathology Revisions							No	
86757	XXX	N	May00	K	Laboratory and Pathology Revisions							No	
87015	XXX	R	Nov99	H	Microbiology Revisions							No	
87040	XXX	R	Nov99	H	Microbiology Revisions							No	
87045	XXX	R	Nov99	H	Microbiology Revisions							No	
87046	XXX	N	Nov99	H	Microbiology Revisions							No	
87060	XXX	D	Nov99	H	Microbiology Revisions							No	
87070	XXX	R	Nov99	H	Microbiology Revisions							No	
87071	XXX	N	Nov99	H	Microbiology Revisions							No	
87072	XXX	D	Nov99	H	Microbiology Revisions							No	
87073	XXX	N	Nov99	H	Microbiology Revisions							No	
87075	XXX	R	Nov99	H	Microbiology Revisions							No	
87076	XXX	R	Nov99	H	Microbiology Revisions							No	
87077	XXX	N	Nov99	H	Microbiology Revisions							No	
87081	XXX	R	Nov99	H	Microbiology Revisions							No	

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87082	XXX	D	Nov99	H	Microbiology Revisions							No	
87083	XXX	D	Nov99	H	Microbiology Revisions							No	
87084	XXX	D	Nov99	H	Microbiology Revisions							No	
87085	XXX	D	Nov99	H	Microbiology Revisions							No	
87086	XXX	R	Nov99	H	Microbiology Revisions							No	
87087	XXX	D	Nov99	H	Microbiology Revisions							No	
87088	XXX	R	Nov99	H	Microbiology Revisions							No	
87101	XXX	R	Nov99	H	Microbiology Revisions							No	
87102	XXX	R	Nov99	H	Microbiology Revisions							No	
87106	XXX	R	Nov99	H	Microbiology Revisions							No	
87107	XXX	N	Nov99	H	Microbiology Revisions							No	
87110	XXX	R	Nov99	H	Microbiology Revisions							No	
87116	XXX	R	Nov99	H	Microbiology Revisions							No	
87117	XXX	D	Nov99	H	Microbiology Revisions							No	
87118	XXX	R	Nov99	H	Microbiology Revisions							No	
87140	XXX	R	Nov99	H	Microbiology Revisions							No	
87143	XXX	R	Nov99	H	Microbiology Revisions							No	
87147	XXX	R	Nov99	H	Microbiology Revisions							No	
87149	XXX	N	Nov99	H	Microbiology Revisions							No	
87151	XXX	D	Nov99	H	Microbiology Revisions							No	
87152	XXX	N	Nov99	H	Microbiology Revisions							No	
87155	XXX	D	Nov99	H	Microbiology Revisions							No	

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87163	XXX	D	Nov99	H	Microbiology Revisions							No	
87168	XXX	N	Nov99	H	Microbiology Revisions							No	
87169	XXX	N	Nov99	H	Microbiology Revisions							No	
87172	XXX	N	Nov99	H	Microbiology Revisions							No	
87174	XXX	D	Nov99	H	Microbiology Revisions							No	
87175	XXX	D	Nov99	H	Microbiology Revisions							No	
87176	XXX	R	Nov99	H	Microbiology Revisions							No	
87181	XXX	R	May00	T	Laboratory and Pathology Revisions							No	
87184	XXX	R	Nov99	H	Microbiology Revisions							No	
87185	XXX	N	Nov99	H	Microbiology Revisions							No	
87186	XXX	R	Nov99	H	Microbiology Revisions							No	
87187	XXX	R	Nov99	H	Microbiology Revisions							No	
87188	XXX	R	Nov99	H	Microbiology Revisions							No	
87190	XXX	R	Nov99	H	Microbiology Revisions							No	
87192	XXX	D	Nov99	H	Microbiology Revisions							No	
87205	XXX	R	Nov99	H	Microbiology Revisions							No	
87206	XXX	R	Nov99	H	Microbiology Revisions							No	
87207	XXX	R	Nov99	H	Microbiology Revisions		Editorial		0 37	0 37	Yes	Yes	
87208	XXX	D	Nov99	H	Microbiology Revisions							No	
87210	XXX	R	Nov99	H	Microbiology Revisions							No	
87211	XXX	D	Nov99	H	Microbiology Revisions							No	
87220	XXX	R	Nov99	H	Microbiology Revisions							No	

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87250	XXX	R	Aug99	U	Comprehensive Pathology and Laboratory Revisions							No	
87252	XXX	R	Aug99	U	Comprehensive Pathology and Laboratory Revisions							No	
87253	XXX	R	May00	K	Laboratory and Pathology Revisions							No	
87254	XXX	N	May00	K	Laboratory and Pathology Revisions							No	
87260	XXX	R	Aug99	U	Comprehensive Pathology and Laboratory Revisions							No	
87273	XXX	N	Aug99	U	Comprehensive Pathology and Laboratory Revisions							No	
87274	XXX	R	Aug99	U	Comprehensive Pathology and Laboratory Revisions							No	
87275	XXX	N	Aug99	U	Comprehensive Pathology and Laboratory Revisions							No	
87277	XXX	N	Aug99	U	Comprehensive Pathology and Laboratory Revisions							No	
87279	XXX	N	Aug99	U	Comprehensive Pathology and Laboratory Revisions							No	
87281	XXX	N	Aug99	U	Comprehensive Pathology and Laboratory Revisions							No	
87283	XXX	N	Aug99	U	Comprehensive Pathology and Laboratory Revisions							No	
87299	XXX	R	Aug99	U	Comprehensive Pathology and Laboratory Revisions							No	
87300	XXX	N	Aug99	U	Comprehensive Pathology and Laboratory Revisions							No	
87324	XXX	R	Aug99	U	Comprehensive Pathology and Laboratory Revisions							No	
87327	XXX	N	Aug99	U	Comprehensive Pathology and Laboratory Revisions							No	

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87336	XXX	N	Aug99	U	Comprehensive Pathology and Laboratory Revisions							No	
87337	XXX	N	Aug99	U	Comprehensive Pathology and Laboratory Revisions							No	
87339	XXX	N	Aug99	U	Comprehensive Pathology and Laboratory Revisions							No	
87341	XXX	N	May00	K	Comprehensive Pathology and Laboratory Revisions							No	
87400	XXX	N	May00	K	Laboratory and Pathology Revisions							No	
87427	XXX	N	Aug99	U	Comprehensive Pathology and Laboratory Revisions							No	
87449	XXX	R	Aug99	U	Comprehensive Pathology and Laboratory Revisions							No	
87450	XXX	R	Aug99	U	Comprehensive Pathology and Laboratory Revisions							No	
87451	XXX	N	Aug99	U	Comprehensive Pathology and Laboratory Revisions							No	
87797	XXX	R	Aug99	U	Comprehensive Pathology and Laboratory Revisions							No	
87798	XXX	R	Aug99	U	Comprehensive Pathology and Laboratory Revisions							No	
87799	XXX	R	Aug99	U	Comprehensive Pathology and Laboratory Revisions							No	
87800	XXX	N	Aug99	U	Comprehensive Pathology and Laboratory Revisions							No	
87801	XXX	N	Aug99	U	Comprehensive Pathology and Laboratory Revisions							No	
87901	XXX	N	May00	K	Microbiology Revisions							No	
87902	XXX	N	May00	K	Microbiology Revisions							No	
87903	XXX	N	May00	K	Microbiology Revisions							No	

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87904	XXX	N	May00	K	Microbiology Revisions							No	
88170	XXX	R	Aug99	S	Fine Needle Aspiration		Editorial		1 27	1 27	Yes	Yes	
88171	XXX	R	Aug99	S	Fine Needle Aspiration		Editorial		1 27	1 27	Yes	Yes	
88172	XXX	R	Aug99	S	Fine Needle Aspiration		Editorial		0 60	0 60	Yes	Yes	
88173	XXX	R	Aug99	S	Fine Needle Aspiration		Editorial		1 39	1 39	Yes	Yes	
88180	XXX	R	May00	K	Laboratory and Pathology Revisions		Editorial		0 36	0 36	Yes	Yes	
88307	XXX	R	Aug99	T	Sentinel node biopsy		Editorial		1 59	1 59	Yes	Yes	
88331	XXX	R	Feb00	20	Path Consulation During Surgery		Editorial		1 19	1 19	Yes	Yes	
88400	XXX	N	Feb00	21	Bilirubin							No	
89125	XXX	R	Aug99	U	Comprehensive Pathology and Laboratory Revisions							No	
89321	XXX	N	May00	K	Laboratory and Pathology Revisions							No	
90378	XXX	R	May00	L	RSV Immune Globulin							No	
90669	XXX	R	May00	EC	Pneumococcal Vaccines							No	
90702	XXX	R	Feb00	K	Diphtheria and Tetanus Toxoids							No	
90718	XXX	R	Feb00	K	Diphtheria and Tetanus Toxoids							No	
90723	XXX	N	Nov99	8	Pentavalent Combination Vaccine							No	
90740	XXX	N	Nov99	7	Hepatitis B Vaccines							No	
90743	XXX	N	Nov99	7	Hepatitis B Vaccines							No	
90744	XXX	R	Nov99	7	Hepatitis B Vaccines							No	
90747	XXX	R	Nov99	7	Hepatitis B Vaccines							No	
90940	XXX	N	Aug99	H	Hemodialysis Flow Study	H1	Feb00	9	0 00	0 00		Yes	No Physician Work
91132	000	N	Feb00	30	Cutaneous Electrogastrography Provactive Testing	VV1	Apr00	31				Yes	Carrier Price- Spec to present to RUC in future

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91133	000	N	Feb00	30	Cutaneous Electrogastrography Provactive Testing	VV2	Apr00	31				Yes	Carrier Price- Spec to present to RUC in future
92585	XXX	R	Feb00	M	Auditory Evoked Potentials Services	Z1	Apr00	20	0 50	0 50	Yes	Yes	
92586	XXX	N	Feb00	M	Auditory Evoked Potentials Services	Z2	Apr00	20	0 50	0 00		Yes	No Physician Work
93662	ZZZ	N	Feb00	3B	Intracardiac Electrophysiological Procedures	WW	Apr00	K	2 80	2 80		Yes	
93668	XXX	N	Feb00	N	Peripheral Vascular Rehabilitation	AA1	Apr00	L	0 28	0 00		Yes	No Physician Work
96570	XXX	N	May00	EC	Photodynamic Therapy		Apr00	A	5 21	1 10		Yes	Interim - RUC Review at Feb 2001 mtg
96571	XXX	N	May00	EC	Photodynamic Therapy		Apr00	A	3 88	0 55		Yes	Interim - RUC Review at Feb 2001 mtg
97532	XXX	N	Feb00	3G	Development of Cognitive Reasoning	L1						Yes	HCPAC to Review in June 2000
97533	XXX	N	Feb00	3G	Development of Cognitive Reasoning	L2						Yes	HCPAC to Review in June 2000
97601	XXX	N	May00	M	Active Wound Care Management							Yes	HCPAC to Review in June 2000
97602	XXX	N	May00	M	Active Wound Care Management							Yes	HCPAC to Review in June 2000
97770	XXX	D	Feb00	3G	Development of Cognitive Reasoning							Yes	HCPAC to Review in June 2000
97802	XXX	N	May00	EC	Medical Nutrition Therapy	K1						Yes	HCPAC to Review in June 2000
97803	XXX	N	May00	EC	Medical Nutrition Therapy	K2						Yes	HCPAC to Review in June 2000
97806	XXX	N	May00	EC	Medical Nutrition Therapy	K3						Yes	HCPAC to Review in June 2000
99172	XXX	N	Nov99	13	Occular Function Screening	W1	Apr00	M	0 00	0 00		Yes	No Physician Work
99374	XXX	R	Nov99	14	Care Plan Oversight		Editorial		1 10	1 10	Yes	Yes	
99375	XXX	R	Nov99	14	Care Plan Oversight		Editorial		1 73	1 73	Yes	Yes	
99377	XXX	R	Nov99	14	Care Plan Oversight		Editorial		1 10	1 10	Yes	Yes	
99378	XXX	R	Nov99	14	Care Plan Oversight		Editorial		1 73	1 73	Yes	Yes	
99379	XXX	R	Nov99	14	Care Plan Oversight		Editorial		1 10	1.10	Yes	Yes	
99380	XXX	R	Nov99	14	Care Plan Oversight		Editorial		1 73	1.73	Yes	Yes	

AMA SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Anesthesia Services

Base Unit Recommendations
The RUC recommends the following base units be interim values until the RUC has the opportunity to review these services and will forward to HCFA final recommendations when the RUC has the opportunity to do so.

Practice Expense Recommendations
The Specialty Society presented that these services are performed in the facility setting and; therefore, would not have any direct practice expense recommendations. The RUC; therefore, recommends no direct practice expense inputs for these codes.

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Base Unit Recommendation
▲00145(e)		Anesthesia for procedures on eye; ~~vitrectomy~~ vitreoretinal surgery	XXX	6 (no change) (Interim)
▲00190 (e)		Anesthesia for procedures of facial bones or skull; not otherwise specified	XXX	5 (no change) (Interim)

▲00215 (e)		Anesthesia for intracranial procedures; cranioplasty or elevation of depressed skull fracture, extradural (simple or compound)	XXX	9 (no change) (Interim)
▲00530 (e)		Anesthesia for permanent transvenous pacemaker insertion	XXX	4 (no change) (Interim)
▲00534 (e)		Anesthesia for transvenous insertion or replacement of pacing cardioverter/defibrillator	XXX	7 (no change) (Interim)
●00537	BB1	Anesthesia for cardiac electrophysiologic procedures including radiofrequency ablation	XXX	8 (Interim)
●00550	BB2	Anesthesia for sternal debridement	XXX	12 (Interim)
●00563	BB3	Anesthesia for procedures on heart, pericardium, and great vessels of chest; with pump oxygenator with hypothermic circulatory arrest	XXX	25 (Interim)
●00566		Anesthesia for direct coronary artery bypass grafting without pump oxygenator	XXX	25 (Interim)
▲00604(e)		Anesthesia for procedures on cervical spine and cord; ~~posterior cervical laminectomy~~ procedures with patient in the sitting position	XXX	13 (no change) (Interim)

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●00635	BB4	Anesthesia for procedures in lumbar region; diagnostic or therapeutic lumbar puncture	XXX	5 (Interim)
▲00670(e)		Anesthesia for extensive spine and spinal cord procedures (eg, ~~Harrington rod technique~~ spinal instrumentation or vascular procedures)	XXX	13 (no change) (Interim)
▲00792(e)		Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; partial hepatectomy or management of major liver hemorrhage (excluding liver biopsy)	XXX	13 (no change) (Interim)
~~00900~~		~~Anesthesia for procedures on perineal integumentary system (including biopsy of male genital system); not otherwise specified~~ (00900 has been deleted. To report, see 00300, 00400)	XXX	**N/A**
▲00902		Anesthesia for; anorectal procedure (~~including endoscopy and/or biopsy~~)	XXX	5 (no change) (Interim)

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲00920(e)		Anesthesia for procedures on male ~~external~~ genitalia (including open urethral procedures); not otherwise specified	XXX	3 (no change) (Interim)
▲00942(e)		Anesthesia for vaginal procedure (including biopsy of labia, vagina, cervix or endometrium); colpotomy, colpectomy, colporraphy, and open urethral procedures	XXX	4 (no change) (Interim)
●01112	BB5	Anesthesia for bone marrow aspiration and/or biopsy, anterior or posterior iliac crest	XXX	6 (Interim)
▲01214	BB7	Anesthesia for open procedures involving hip joint; total hip replacement ~~or revision~~	XXX	8 (Interim)
●01215	BB6	Anesthesia for open procedures involving hip joint; revision of total hip arthroplasty	XXX	10 (Interim)
▲01482 (e)		Anesthesia for open procedures on bones of lower leg, ankle, and foot; radical resection (including below knee amputation)	XXX	4 (no change) (Interim)
~~01784~~		~~Anesthesia for repair of arterio-venous (A-V) fistula, congenital or acquired~~ 01784 has been deleted. To report, see 01770, 01780)	XXX	N/A

●01951	BB8	Burn Excisions or Debridement Anesthesia for second and third degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; less than 1% TBS	XXX	3 (Interim)
●01952	BB9	one percent to nine percent total body surface area	XXX	5 (Interim)
●01953	BB10	each additional nine percent total body surface area or part thereof (List separately in addition to code for primary procedure) (Use 02003 in conjunction with code 02002)	XXX	1 (Interim)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 0053x Tracking Number: BB1 Global Period: XXX **Recommended RVU_{Anes}:** 8

CPT Descriptor: Anesthesia for electrophysiologic procedures including radio frequency ablation.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 32-year-old male, in good general health, complains of palpitations an occasional shortness of breath, not associated with activity. Evaluation included an electrocardiogram, which revealed findings consistent with the Wolff-Parkinson-White Syndrome (WPW). Given that patients with WPW are at increased risk for fatal rhythm disturbances, his is scheduled for cardiac electrophysiologic studies and possible ablation of the aberrant pathways.

Description of Pre-Service Work: The patient will be seen by an anesthesiologist for a pre-anesthesia evaluation. At that time, the patient's medical history will be reviewed, including current medications, drug allergies, previous operations and anesthetics, and family history of problems with anesthetics. Physical examination will include evaluation for airway problems and the ease of obtaining intravenous access. Laboratory studies, the EKG, and any imaging studies will be reviewed. The anesthetic technique to be used, given the nature of the procedure, the requirements of the physician performing the procedure as well of those of the patient will be discussed with the patient, and informed consent will be obtained. The anesthesiologist also sets up anesthetic and cardiovascular drugs in preparation for the anesthetic, and checks anesthesia equipment, supplies and monitors

Description of Intra-Service Work: Either a general anesthetic with the patient's trachea being intubated, or a technique including infiltration of local anesthetic by the "operator" combined with the intravenous administration of narcotics, benzodiazepines, and perhaps an hypnotic agent (commonly referred to as Monitor Anesthesia Care – MAC) will be used. Monitoring of the patient will include blood pressure, either by cuff or perhaps also with an intra-arterial catheter, multi-lead EKG, pulse oximetry, and end-tidal carbon dioxide analysis. A central venous catheter may also be utilized, and if the clinical situation dictates, a pulmonary artery catheter may be inserted.

During the course of the procedure, attempts will be made to identify the aberrant pathways. Stimulation of these pathways will initiate rhythm problems that, if not recognized and the stimulus aborted or the rhythm disturbance otherwise stopped may result in an undesirable outcome. Thus, continuous and diligent vigilance in monitoring of the patient, an understanding of treatment options, and readiness to treat and initiate other resuscitation efforts are required for anesthesiologists and cardiologists involved in cases such as these. At the end of the procedure, the anesthesiologist will transfer the patient to a monitored bed, usually in the Coronary Care Unit. When the patient is stable, the anesthesiologist will hand over care of the patient to the critical care unit nurses. He will to continue to evaluate the patient as needed regarding pain control and nausea.

Description of Post-Service Work: The anesthesiologist with visit and evaluate the patient post-operatively within 24 hours. He/she will continue to participate in management of post-operative pain and nausea as needed.

SURVEY DATA:

Presenter(s) Karl E. Becker, Jr., M.D.

Specialty(s): Anesthesiology

Sample Size: 28 Response Rate: (%): 58% Median RVU_{Anes}: 8

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: Our panel size (48) was not quite large enough for this procedure code.

25th Percentile RVU: 7 75th Percentile RVU: 10 Low: 4 High: 15

Median Pre-Service Time: 15 Median Intra-Service Time: 90

25th Percentile Intra-Svc Time: 28.125 75th Percentile Intra-Svc Time: 150 Low: 10 High: 220

Median Post-Service Time: 15

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	15	Post-op care and visit included in code
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

CPT Code: 0053x

KEY REFERENCE SERVICE:

CPT Code	Descriptor	RVU_{Anes}
00534	Anesthesia for transvenous insertion or replacement	7

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	15	15
Median Intra-Time	120	90
Median Immediate Post-service Time	15	15
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.63	3.48
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.7	3.7
Urgency of medical decision making	4.185	3.81

Technical Skill/Physical Effort (Mean)

Technical skill required	3.444	3.444
Physical effort required	3.296	3.19

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.15	4.0
Outcome depends on the skill and judgement of physician	3.93	3.741
Estimated risk of malpractice suit with poor outcome	3.815	3.41

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.37	3.52
Intra-Service intensity/complexity	4	3.7
Post-Service intensity/complexity	3.26	3.3

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The ASA reached our final recommendation after consideration of this procedure by the ASA Committee on Economics (COE) and evaluation of the results of this survey by the ASA RVS committee, a subcommittee of the ASA COE, which has editorial responsibility for the ASA RVG.

FREQUENCY INFORMATION

How was this service previously reported? 00560,01920

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

Specialty Anesthesiology ____Commonly ____Sometimes x Rarely

Specialty _____ ____Commonly ____Sometimes ____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology Frequency 760

Specialty _____ Frequency _____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Anesthesiology Frequency 76

Specialty _____ Frequency _____

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

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 0055x Tracking Number: BB2 Global Period: XXX **Recommended RVU_{Anes}:** 12

CPT Descriptor: Anesthesia for sternal debridement (separate procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 34 year old male suffered penetrating trauma of the thorax with a resultant cardiac injury that required a median sternotomy for surgical repair. On postoperative day six, dehiscence of the sternal wound was noted. The patient is to return to the operating room for wound debridement.

Description of Pre-Service Work: The preanesthetic care of the patient includes a history and physical examination noting the method and course of the previous anesthetic and determining the presence of any cardiovascular instability secondary to the initial injury or subsequent infection. Anesthetic goals include maintenance of hemodynamic stability while providing the optimum surgical condition. The anesthesiologist also sets up anesthetic and cardiovascular drugs in preparation for the anesthetic, and checks anesthesia equipment, supplies and monitors.

Description of Intra-Service Work: After reviewing the information, the patient is premedicated for the surgery as appropriate. Upon arrival to the operating room, monitors are applied and venous access is obtained. General anesthesia is induced and maintained, the trachea is intubated, and positive pressure ventilation is initiated and maintained. The patient may be given a neuromuscular blocking agent to facilitate muscle relaxation during the procedure. The patient's hemodynamics are maintained throughout the procedure, with vasoactive therapeutic agents given as necessary. At the end of surgery depending on the patient's condition, the patient will eithe awakened from anesthesia and the trachea extubated in the operating room or the patient will be transported to intensive care unit and ventilated as necessary. The patient is observed for recovery and the need for pain therapy. When stable, his care is transferred SICU personnel with further evaluation and treatment by the anesthesiologist as required.

Description of Post-Service Work: Within 24 hours, the anesthesiologist will make a post-operative visit to evaluate the patient's analgesic requirements and post-operative course. The anesthesiologist will continue to participate in evaluation and management of the patient while he/she is in the SICU regarding pain control, nausea and cardiorespiratory instability.

SURVEY DATA:

Presenter(s) Karl E. Becker, Jr., M.D.

Specialty(s): Anesthesiology

Sample Size: 30 Response Rate: (%): 63% Median RVU_{Anes}: 12

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVU: 10 75th Percentile RVU: 15 Low: 6.5 High: 20

Median Pre-Service Time: 12.5 Median Intra-Service Time: 120

25th Percentile Intra-Svc Time: 30 75th Percentile Intra-Svc Time: 180 Low: 15 High: 190

Median Post-Service Time: 20

Level of Service by CPT Code

	Total Time	(List CPT Code & # of Visits)
Immediate Post Service Time:	20	Post-op care and visit included in code
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

CPT Code: 0055x

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVU_{Anes}
00540	Anesthesia for thoracotomy prcedures involving the lungs, pleura, diaphragm and mediastinum	13

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	12.5	12.5
Median Intra-Time	90	120
Median Immediate Post-service Time	20	20
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.48	3.87
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4	3.87
Urgency of medical decision making	3.667	3.77

Technical Skill/Physical Effort (Mean)

Technical skill required	3.73	4.23
Physical effort required	3.655	3.86

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.9	3.967
Outcome depends on the skill and judgement of physician	3.73	3.967

Estimated risk of malpractice suit with poor outcome	3.767	3.83

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.57	3.5
Intra-Service intensity/complexity	3.77	4.17
Post-Service intensity/complexity	3.53	3.73

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The ASA reached our final recommendation after consideration of this procedure by the ASA Committee on Economics (COE) and evaluation of the results of this survey by the ASA RVS committee, a subcommittee of the ASA COE, which has editorial responsibility of the ASA RVG.

FREQUENCY INFORMATION

How was this service previously reported? 00540

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

Specialty Anesthesiology ____Commonly x Sometimes _____Rarely

Specialty _____ _____Commonly _____Sometimes _____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology Frequency 7545

Specialty _____ Frequency_____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Anesthesiology Frequency 4980

Specialty _____ Frequency_____

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

PLEASE INSERT AND REPLACE IN TAB I

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 0056x1 Tracking Number: BB3 Global Period: XXX **Recommended RVU_{Anes}:** 25

CPT Descriptor: Anesthesia for procedures on heart, pericardium, and great vessels of chest; with pump oxygenator with hypothermic circulatory arrest.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A three-day old newborn female with transposition of the great arteries with ventricular defect is prepared for a Jatene type operation. Based upon the anatomy of this congenital heart defect, cardiac surgery with pump oxygenator using deep hypothermic circulatory arrest is selected for the surgical procedure.

Description of Pre-Service Work: Preoperative assessment by the anesthesiologist includes a thorough physical examination and a history taken from the family specific to co-morbidity in the patient, and any family history of anesthetic difficulty. In addition, there is a complete discussion with the patient's family outlining the procedures to be performed by the anesthesiologist pre- and post-induction of general anesthesia including the placement of arterial and central lines, and the certainty of blood product administration. Included in the discussion are the risks of these procedures, the risks of the anesthetic and a description of the child's expected postoperative course. The anesthesiologist conducts a careful evaluation of the patient, his cardiovascular status, his concomitant diseases and his physical condition and pertinent laboratory values. The anesthesiologist also sets up a wide array of anesthetic and cardiovascular drugs in preparation for the anesthetic, and checks anesthesia equipment, supplies and monitors. He consults with other physicians when needed.

Description of Intra-Service Work: Anesthetic goals include sufficient anesthetic depth to protect the brain, heart and other organ systems during deep hypothermic circulatory arrest as well as the avoidance of significant hemodynamic instability after CPB, which exacerbates ischemia and bleeding tendencies. The manipulation of blood gas management during cooling, topical head cooling, and the use of vasoactive substances is common before CPB. The introduction of air into the left and right heart due to cardiac surgical incision on the left side of the heart as well as the aortic and venous cannulae promotes the opportunity for air emboli. Meticulous monitoring and removal of air is required prior to the reinstitution of CPB and re-warming. Additional brain monitoring such as transcranial Doppler or the use of transesophogeal echocardiography may be indicated to treat the suspicion of air emboli. Episodes of hemodynamic instability after re-warming and the cessation of CPB are common due to mild cardiac ischemia, a direct result of the use of deep hypothermic circulatory arrest. Hemodynamic instability and low cardiac output can further aggravate any organ system dysfunction due to circulatory arrest and must be treated urgently and aggressively. Often this requires the careful titration of anesthetic drugs as well as the use of several inotropes or vasodilators. The anesthesiologist administers drugs so as to promote hemodynamic stability and to increase cardiac output. The use of deep hypothermic circulatory arrest also disrupts liver metabolism and the level of procoagulants, often resulting in excessive bleeding. This requires the anesthesiologist to more aggressively monitor the activated clotting time and platelet function, and often requires multiple blood component therapy. Once the bleeding issues have been controlled and the child's hemodynamics are stabilized, the chest is closed and the child is transferred to the pediatric intensive care unit for further management. The anesthesiologist accompanies the patient to the PICU and is responsible for patient care until directly transferred to the ICU attending physician.

Description of Post-Service Work: On the first and/or the second postoperative day, the anesthesiologist visits the child in the PICU specifically to assess the postoperative progress of the child and to inquire about complications that may be related to the anesthetic. In the child post deep hypothermic circulatory arrest, central nervous system events are the most worrisome; seizures, the most common.

SURVEY DATA:

Presenter(s) Karl E. Becker, Jr., M.D.

Specialty(s): Anesthesiology

Sample Size: 61 Response Rate: (%): 25% Median RVU_{Anes}: 25

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVU_{Anes}: 25 75th Percentile RVU_{Anes}: 26.5 Low: 25 High: 30

Median Pre-Service Time: 60 Median Intra-Service Time: 300

25th Percentile Intra-Svc Time: 270 75th Percentile Intra-Svc Time: 480 Low: 210 High: 720

Median Post-Service Time: 30

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:		
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

CPT Code: 0056x1

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVU_{Anes}
00564	Anesthesia for direct coronary artery grafting without pump oxygenator	25

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

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

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	60	50
Median Intra-Time	300	300
Median Immediate Post-service Time	30	30
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.53	4.23
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.6	4.23
Urgency of medical decision making	4.6	4.38

Technical Skill/Physical Effort (Mean)

Technical skill required	4.8	4.46
Physical effort required	4.66	4.15

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.86	4.38
Outcome depends on the skill and judgement of physician	4.8	4.61
Estimated risk of malpractice suit with poor outcome	4.33	4

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.4	4.23
Intra-Service intensity/complexity	4.93	4.46
Post-Service intensity/complexity	4.46	4.38

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The ASA reached our final recommendation after consideration of this procedure by the ASA Committee on Economics (COE) and after evaluation of the results of this survey by the ASA RVS committee, a subcommittee of the ASA COE, which has editorial responsibility for the ASA RVG.

FREQUENCY INFORMATION

How was this service previously reported? 00562

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

Specialty Anesthesiology ____Commonly x Sometimes ____Rarely

Specialty _____ ____Commonly ____Sometimes ____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology Frequency 3500-5000

Specialty _____ Frequency _____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Anesthesiology Frequency 200-500

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? ____Yes x No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 00566 Tracking Number: ____ Global Period: XXX **Recommended RVU_{Anes}:** 25

CPT Descriptor: Anesthesia for direct coronary artery bypass grafting without pump oxygenator

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old male with progressive coronary artery is prepared coronary artery bypass. Based upon the anatomy, a direct coronary artery bypass surgery without pump oxygenator is selected for the surgical procedure.

Description of Pre-Service Work: The preanesthetic care of the patient by the anesthesiologist is the same as that provided for surgery with cardiopulmonary bypass. Anesthetic goals include an awake, extubated patient at the end of the surgical operation and before the patient is transferred to the PACU or ICU. The anesthesiologist conducts a careful evaluation of the patient, his cardiovascular status, his concomitant diseases and his physical condition and pertinent laboratory values. The anesthesiologist also sets up a wide array of anesthetic and cardiovascular drugs in preparation for the anesthetic, and checks anesthesia equipment, supplies and monitors. He consults with other physicians when needed.

Description of Intra-Service Work: One-lung ventilation is common. Short acting drugs are used in the lowest doses required by the patient. Episodes of hemodynamic instability are common from ischemic preconditioning, coronary artery clamping which produces ventricular regional ischemia and contractile dysfunction, and cardiac manipulation. In contrast to CABG with CPB that may or may not have hemodynamic problems after CPB, the direct CABG operation always produces hemodynamic perturbations during the coronary artery grafting phase. Either a pulmonary artery catheter or transesophageal echocardiography or both may be indicated for diagnosis and treatment of sudden hemodynamic alterations including hypotension, hypertension, tachycardia, bradycardia, dysrhythmias, myocardial ischemia and ventricular dysfunction. Although the intention is to avoid CPB, anticoagulating doses of heparin are administered in case there is the need to use CPB emergently (i.e., "crash onto bypass"). It is desirable to slow the heart rate in order to facilitate the microsurgical opening of the coronary artery and sewing of the graft to it. The anesthesiologist administers drugs to slow the heart (e.g., beta blockers, adenosine) and in so doing, has to contend with the consequences of reduced cardiac output and hypotension. These same steps are repeated for each coronary artery to be grafted. This part of the procedure requires continuous and intense monitoring and treatment of the patient. At the end of surgery, the patient is transferred to the SICU and monitored and treated as necessary to assure stable respiratory and hemodynamic parameters. When stable, the patient is transferred to the care of the SICU nursing personnel

Description of Post-Service Work: The anesthesiologist will continue to evaluate the patient while in the SICU regarding pain control, nausea and cardiorespiratory instability. The anesthesiologist will visit the patient post-op within 24 hours of surgery, often several times. He will be involved in the post-operative care of the patient to varying degrees depending on the hospital milieu.

SURVEY DATA:

Presenter(s) Karl E. Becker, Jr., M.D.

Specialty(s): Anesthesiology

Sample Size: 27 Response Rate: (%): 56% Median RVU_{Anes}: 25

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: This procedure is not performed by all anesthesiologists. Sample population (48) should have been larger than or response rate higher than (56%).

25th Percentile RVU: 20 75th Percentile RVU: 25 Low: 8.93 High: 26.2

Median Pre-Service Time: 20 Median Intra-Service Time: 180

25th Percentile Intra-Svc Time: 56.25 75th Percentile Intra-Svc Time: 240 Low: 10 High: 360

Median Post-Service Time: 27.5

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	28	Post-op care and visits included in code
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVU_{Anes}
00562	Anesthesia for procedures on heart, pericardium and great vessels of chest, with pump oxygenator	20

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

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

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	20	20
Median Intra-Time	180	180
Median Immediate Post-service Time	30	27.5
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.58	4.19
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.38	4.23
Urgency of medical decision making	4.808	4.46

Technical Skill/Physical Effort (Mean)

Technical skill required	4.885	4.38
Physical effort required	4.769	4

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.88	4.423
Outcome depends on the skill and judgement of physician	4.77	4.385

Estimated risk of malpractice suit with poor outcome	4.077	3.81

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.23	4.04
Intra-Service intensity/complexity	4.81	4.19
Post-Service intensity/complexity	4.27	4.04

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The ASA reached our final recommendation after consideration of this procedure by the ASA Committee on Economics (COE) and evaluation of the results of this survey by the ASA RVS committee, a subcommittee of the ASA COE which has editorial responsibility of the ASA RVG.

FREQUENCY INFORMATION

How was this service previously reported? 00562

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

Specialty Anesthesiology ____Commonly x Sometimes ____Rarely

Specialty_____ ____Commonly ____Sometimes ____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology Frequency 15,091

Specialty _____ Frequency _____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Anesthesiology Frequency 10,000

Specialty _____ Frequency_____

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

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 0063x Tracking Number: BB4 Global Period: XXX **Recommended RVU_{Anes}:** 5

CPT Descriptor: Anesthesia for procedures in lumbar region; diagnostic or therapeutic lumbar puncture.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A four year-old patient with Down's syndrome was diagnosed with acute lymphoblastic leukemia after presenting with fatigue, fever and weight loss. Significant history includes surgical repair of a ventricular septal defect at two years of age. The patient is extremely anxious and the parents request the child be anesthetized for cerebral spinal fluid testing and administration of intrathecal methotrexate.

Description of Pre-Service Work: Anesthetic services for this patient include a pertinent history with emphasis on the present illness and significant past history specifically reviewing cardiac function and other systemic involvement from Trisomy 21. Previous anesthesia records are reviewed, and a physical examination is performed. An anesthetic plan is formed and discussed with the parents for approval. The anesthesiologist also sets up anesthetic and cardiovascular drugs in preparation for the anesthetic, and checks anesthesia equipment, supplies and monitors.

Description of Intra-Service Work: Premedication with agents used to decrease anxiety is used as needed. Monitors are placed and anesthesia is induced through the use of systemic medications or inhaled anesthetics alone or in combination. The patient is turned to allow access to the lumbar region after the airway is appropriately secured. General anesthesia is maintained and the patient's hemodynamics are maintained throughout the procedure, with vasoactive therapeutic agents given as necessary. At the end of the procedure anesthesia is discontinued and the patient is awakened. The patient is transported when stable to the postanesthesia care unit. When the patient has been observed to be adequately recovered from the anesthetic, the anesthetist will treansfer the care of the patient to the post-operative care unit personnel who he will continue to supervise in the care of this patient.

Description of Post-Service Work: The anesthesiologist will also be responsible for maintaining a stable patient during the early recovery period in the post anesthesia care unit as well as managing pain relief and controlling nausea during this period . The anesthesiologist will conduct a post-operative visit within 24 hours and further evaluate the post-operative progress of the patient.

SURVEY DATA:

Presenter(s) Karl E. Becker, Jr., M.D.

Specialty(s): Anesthesiology

Sample Size: 28 Response Rate: (%): 58% Median RVU_{Anes}: 5

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: The panel should have been larger since this procedure is not commonly performed by all members of the panel.

25th Percentile RVU: 5 75th Percentile RVU: 8 Low: 3 High: 12

Median Pre-Service Time: 12.5 Median Intra-Service Time: 42.5

25th Percentile Intra-Svc Time: 13.75 75th Percentile Intra-Svc Time: 90 Low: 5 High: 240

Median Post-Service Time: 15

Level of Service by CPT Code

	Total Time	(List CPT Code & # of Visits)
Immediate Post Service Time:	15	Post-op visit and care included in procedure
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

CPT Code: 0063x

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVU_{Anes}
00630	Anesthesia for procedures in the lumbar region; NOS	8

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

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

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	15	12.5
Median Intra-Time	20	42.5
Median Immediate Post-service Time	15	15
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.28	2.74
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.36	2.67
Urgency of medical decision making	3.18	2.85

Technical Skill/Physical Effort (Mean)

Technical skill required	3.5	2.81
Physical effort required	3.269	2.85

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.22	2.778
Outcome depends on the skill and judgement of physician	3.52	3.037
Estimated risk of malpractice suit with poor outcome	3.444	3.11

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3 18	2.71
Intra-Service intensity/complexity	3.25	2.79
Post-Service intensity/complexity	2.96	2.61

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The ASA reached our final recommendation after consideration of this procedure by the ASA Committee on Economics (COE) and evaluation of the results of this survey by the ASA RVS committee, a subcommittee of the ASA COE, which has editorial responsibility for the ASA RVG.

FREQUENCY INFORMATION

How was this service previously reported? 00630

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

Specialty Anesthesiology ____Commonly ____Sometimes x Rarely

Specialty _____ ____Commonly ____Sometimes ____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology Frequency 5109

Specialty _____ Frequency _____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty _____ Frequency 2000

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? ____Yes x No

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 0011x Tracking Number: BB5 Global Period: XXX **Recommended RVU_{Anes}:** 6

CPT Descriptor: Anesthesia for bone marrow aspiration and/or biopsy, anterior or posterior iliac crest.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A four year-old child presents for bone marrow aspiration and possible marrow harvest for autologous transplantation. The child was diagnosed earlier with acute myelogenous leukemia. A multiple agent anti-neoplastic chemotherapy regimen including busulfan was administered. The patient is now suspected to be in remission. The patient has been noted to become short of breath with minimal physical exertion. Because of the question of pulmonary fibrosis secondary to chemotherapy and the requirement of significant volume of marrow aspirate and potential hemodynamic instability, general anesthesia is requested for the procedure.

Description of Pre-Service Work: The anesthetic care of this patient begins with a pertinent history and physical with particular attention paid to specific organ systems that may be involved secondary to anti-neoplastic chemotherapy. A review of previous anesthetics is made. After discussion with and the consent of the parents, an anesthesia plan is devised that might include a preprocedure medicant to relieve anxiety. The anesthesiologist also sets up anesthetic and cardiovascular drugs in preparation for the anesthetic, and checks anesthesia equipment, supplies and monitors.

Description of Intra-Service Work: Appropriate monitors are placed with special attention to any involved body systems. The goal of anesthesia is to provide a quiet and comfortable patient for the hematologist to safely aspirate the bone marrow as needed. This can be accomplished with intravenous anesthetics or inhaled agents alone or in combination. Inhalational agents, narcotics, muscle relaxants and reversal drugs are used to induce and maintain an adequate level of anesthesia. Vital signs are monitored at least every 3-5 minutes and adjustments made in depth of anesthesia and IV fluid administration rates to assure a stable anesthetic and stable vital signs and adequate respiratory and hemodynamic parameters. At the end of the procedure the anesthetics will be discontinued and the patient awakened as deemed appropriate. The patient will be transferred to the recovery room and, when stable, left in the immediate care of the post-operative care personnel.

Description of Post-Service Work:. The anesthesiologist will also be responsible for maintaining a stable patient during the early recovery period in the post anesthesia care unit as well as managing pain relief during this period. He/she will make a post-operative visit within 24 hours.

SURVEY DATA:

Presenter(s) Karl E. Becker, Jr., M.D.

Specialty(s): Anesthesiology

Sample Size 28 Response Rate: (%): 58% Median RVU_{Anes}: 6

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: This procedure was not performed by some of our panel. Our panel needed to be larger than 48.

25th Percentile RVU: 5.1 75th Percentile RVU: 8 Low: 2.86 High: 15

Median Pre-Service Time: 11.25 Median Intra-Service Time: 52.5

25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 90 Low: 5 High: 180

Median Post-Service Time: 15

Level of Service by CPT Code

	Total Time	(List CPT Code & # of Visits)
Immediate Post Service Time:	15	Post-op care and visit included in code
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVU_{Anes}
01120	Anesthesia for procedures on bony pelvis	6

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

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

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	15	11.25
Median Intra-Time	45	52.5
Median Immediate Post-service Time	15	15
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.54	2.86
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.61	2.79
Urgency of medical decision making	3.357	2.82

Technical Skill/Physical Effort (Mean)

Technical skill required	3.519	2.93
Physical effort required	3.259	2.85

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.54	2.857
Outcome depends on the skill and judgement of physician	3.46	3.036
Estimated risk of malpractice suit with poor outcome	3.5	2.89

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.46	2.86
Intra-Service intensity/complexity	3.5	2.96
Post-Service intensity/complexity	3.18	2.82

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The ASA reached our final recommendation after consideration of this procedure by the ASA Committee on Economics (COE) and evaluation of the results of this survey by the ASA RVS committee, a subcommittee of the ASA COE, which has editorial responsibility for the ASA RVG.

FREQUENCY INFORMATION

How was this service previously reported? 01120

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

Specialty Anesthesiology ____Commonly x Sometimes ____Rarely

Specialty ____Commonly ____Sometimes ____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology Frequency 1517

Specialty ____ Frequency ____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Anesthesiololgy Frequency 455

Specialty ____ Frequency ____

Do many physicians perform this service across the United States? ____Yes x No

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 0121x Tracking Number: BB6 Global Period: XXX **Recommended RVU_{Anes}:** 10

CPT Descriptor: Anesthesia for open procedures involving hip joint; revision of total hip arthroplasty

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is a 72 year old woman who initially underwent left cemented total hip arthroplasty one year ago. After recovery from the first total hip replacement, the patient suffered two left hip dislocations. Radiographic studies revealed a loosening of the femoral component. The surgical plan includes removal and replacement of the femoral component and assessment and possible replacement of the acetabular components to prevent further dislocations

Description of Pre-Service Work: The service includes pre-anesthetic assessment of the patient; new and old chart review; development of an anesthetic plan; obtaining informed consent. Particular attention is paid to co-morbid diseases and cardiovascular status. The anesthesiologist also sets up anesthetic and cardiovascular drugs in preparation for the anesthetic, and checks anesthesia equipment, supplies and monitors.

Description of Intra-Service Work: Intra-service work includes assurance of adequate intravenous access; application and interpretation of non-invasive and indicated invasive monitoring; induction of anesthesia or initiation of a regional anesthetic; maintenance of anesthesia, ongoing intra-operative monitoring of vital signs, fluid balance, blood loss, and anesthetic depth; proper positioning of patient; and administration of IV fluids, including blood, as needed. The patient is transferred to recovery room and monitored until stable enough to be left in the care of the post-anesthesia care unit personnel. While in recovery room, the anesthesiologist further evaluates the patient's status and orders analgesics and fluids as required.

Description of Post-Service Work: The anesthesiologist is responsible for maintaining a stable patient during the early recovery period in the post anesthesia care unit and for providing control of pain and nausea during this period. Post-anesthesia care includes a post-op visit within 24 hours and further evaluation of the patient's fluid status and analgesic requirements if indicated.

SURVEY DATA:

Presenter(s) Karl E. Becker, Jr., M.D.

Specialty(s): Anesthesiology

Sample Size: 29 Response Rate: (%): 60% Median RVU_{Anes}: 10

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: Response rate was good but population sampled should have been slightly larger.

25th Percentile RVU: 10 75th Percentile RVU: 12 Low: 2.56 High: 14

Median Pre-Service Time: 15 Median Intra-Service Time: 120

25th Percentile Intra-Svc Time: 26.25 75th Percentile Intra-Svc Time: 180 Low: 10 High: 330

Median Post-Service Time: 15

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:		
Critical Care:		
Other Hospital Visits:	15	Post-op visit included in the code
Discharge Day Mgmt.:		
Office Visits:		

CPT Code: 0121x

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVU_{Anes}
01212	Anesthesia for open procedures involving hip joint; hip disarticulation	12

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

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

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	15	15
Median Intra-Time	150	120
Median Immediate Post-service Time	20	15
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.37	3.28
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.33	3.31
Urgency of medical decision making	3.185	3.10

Technical Skill/Physical Effort (Mean)

Technical skill required	3.643	3.48
Physical effort required	3.821	3.45

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.86	3.655
Outcome depends on the skill and judgement of physician	3.89	3.655
Estimated risk of malpractice suit with poor outcome	3.5	3.41

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.21	3.10
Intra-Service intensity/complexity	3.90	3.66
Post-Service intensity/complexity	3.34	3.17

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The ASA reached our final recommendation after consideration of this procedure by the ASA Committee on Economics (COE) and evaluation of the results of this survey by the ASA RVS committee, a subcommittee of the ASA COE, which has editorial responsibility for the ASA RVG.

FREQUENCY INFORMATION

How was this service previously reported? 01212

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

Specialty Anesthesiology x Commonly ____ Sometimes ____ Rarely

Specialty ____ ____ Commonly ____ Sometimes ____ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology Frequency 22,893

Specialty ____ Frequency ____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Anesthesiology Frequency 17,200

Specialty ____ Frequency ____

Do many physicians perform this service across the United States? x Yes ____ No

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 01214 Tracking Number: BB7 Global Period: XXX **Recommended RVW:** 8

CPT Descriptor: Anesthesia for open procedures involving hip joint; total hip replacement

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is a 73 year old man with a long history of hip pain and degenerative joint disease in his left hip. Radiographic studies revealed severe degenerative arthritis of femoral head and acetabulum. The patient has controlled hypertension and mild adult-onset diabetes. The surgical plan is for a hip arthroplasty with acetabular and proximal prosthetic replacement (total hip replacement).

Description of Pre-Service Work: Pre-operative preparation of the patient for anesthesia includes a history, physical examination, review of the patient's new and old medical records, review of laboratory studies and ordering of additional studies as indicated. The anesthesiologist discusses anesthetic and monitoring options and associated risks with the patient and obtains informed consent. Anesthetic approaches typically employed include spinal, epidural or general anesthesia. In addition to patient and surgeon preference, considerations in anesthetic choice include duration of the planned procedure, anticipated blood loss, surgical requirements, post-operative analgesic requirements, and the patient's health status. After obtaining adequate intravenous access and monitoring the patient as indicated by the patient's underlying medical condition, the anesthesiologist will initiate the selected anesthetic. The operating room staff, surgeon, and anesthesiologist will carefully position the patient in the lateral position, taking care to avoid stretch or pressure upon the nerves in the arms, axillae and lower extremities. Other positioning considerations include achieving a neutral position of the head and neck and avoiding pressure upon or abrasions to the eyes and ears. After securing the patient in the desired position, the nurse will prepare the patient's skin with an antimicrobial solution and the surgical team will drape the operative site in a sterile fashion. The anesthesiologist will employ measures to achieve normothermia, which may include active or passive warming of the patient, administered intravenous fluids and/or inspired respiratory gases.

Description of Intra-Service Work: Intra-operatively, the anesthesiologist will monitor the patient's vital signs, surgical blood loss, and anesthetic depth or level of sedation. Based on these observations, the anesthesiologist may choose to administer fluids, blood products, and medications to achieve hemodynamic stability, adequate oxygen carrying capacity and acceptable anesthetic depth or level of sedation. In addition, the anesthesiologist may obtain certain laboratory studies to better evaluate changes in the patient's clinical status. Depending on the results, the anesthesiologist may make additional medical interventions. At the conclusion of the procedure, the anesthesiologist will allow the patient to emerge from the anesthetic or sedation and will transport the patient to the Post-Anesthesia Care Unit (PACU). The anesthesiologist will intervene as necessary to achieve an acceptable level of hemodynamic stability, level of consciousness, patency of the airway, and analgesia. The anesthesiologist will report to the PACU nurse pertinent aspects of the patient's medical condition and intra-operative anesthetic course before transferring care of the patient to the PACU personnel

Description of Post-Service Work: The anesthesiologist will continue to assess the patient's recovery status in the PACU and make decisions on fluid and blood administration. When the patient is clinically stable and awake, the anesthesiologist with order the transfer of the patient to the surgical floor.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 01214 Tracking Number: __ Global Period: XXX **Recommended RVW:** 8

CPT Descriptor:

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Presenter(s)_____

Specialty(s). _____

Sample Size: 30 Response Rate: (%): 63% Median RVW: 8

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: _____

25th Percentile RVW: 8 75th Percentile RVW: 10 Low: 3.57 High: 12

Median Pre-Service Time: 12.50 Median Intra-Service Time: 120.00

25th Percentile Intra-Svc Time: 30.00 75th Percentile Intra-Svc Time: 170.00 Low: 10.00 High: 250.00

Median Post-Service Time: 20.00

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	_____	
Critical Care:	_____	_____
Other Hospital Visits:	_____	_____
Discharge Day Mgmt.:	_____	_____
Office Visits:	_____	_____

CPT Code: 01214

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
1210	Anesthesia for open procedures involving hip joint, NOS	6

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

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

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	12.5	12
Median Intra-Time	120	120
Median Immediate Post-service Time	20	15
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.47	3.27
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.43	3.27
Urgency of medical decision making	3.3	2.97

Technical Skill/Physical Effort (Mean)

Technical skill required	3.6	3.43
Physical effort required	3.433	3.23

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.77	3.517
Outcome depends on the skill and judgement of physician	3.73	3.550
Estimated risk of malpractice suit with poor outcome	3.367	3 20

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.2	3.07
Intra-Service intensity/complexity	3.57	3.4
Post-Service intensity/complexity	3.23	2 93

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

FREQUENCY INFORMATION

How was this service previously reported? _____

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

Specialty_____ _____Commonly _____Sometimes _____Rarely

Specialty_____ _____Commonly _____Sometimes _____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty _____ Frequency_____

Specialty _____ Frequency_____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty _____ Frequency_____

Specialty _____ Frequency_____

Do many physicians perform this service across the United States? _____Yes _____No

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 0200x Tracking Number: BB8 Global Period: XXX **Recommended RVU_{Anes}:** 3

CPT Descriptor: Anesthesia for second or third degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; Less than 1% TBSA

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A thirty-four year-old female is burned by a cooking oil fire on the right hand. The patient is in extreme pain from her burned hand. The patient is brought to the operating room emergently for debridement and dressing of the burn wound under general anesthesia.

Description of Pre-Service Work: The service includes pre-anesthetic assessment of the patient; new and old chart review; development of an anesthetic plan; obtaining informed consent. Particular attention is paid to NPO status. The anesthesiologist also sets up anesthetic and cardiovascular drugs in preparation for the anesthetic, andchecks anesthesia equipment, supplies and monitors.

Description of Intra-Service Work: Intra-service work includes assurance of adequate intravenous access; application and interpretation of non-invasive monitoring; induction of anesthesia or initiation of a regional anesthetic; maintenance of anesthesia, ongoing intra-operative monitoring of vital signs, fluid balance, blood loss, and anesthetic depth; and administration of IV fluids as needed. The patient is transferred to recovery room and monitored until stable enough to be left in the care of the post-anesthesia care unit personnel. While in recovery room, the anesthesiologist further evaluates the patient's status and orders analgesics and fluids as required.

Description of Post-Service Work: The anesthesiologist is responsible for maintaining a stable patient during the early recovery period in the post anesthesia care unit and for providing control of pain and nausea during this period. Post-anesthesia care includes a post-op visit within 24 hours.

SURVEY DATA:

Presenter(s) Karl E. Becker, Jr., M.D.

Specialty(s): Anesthesiology

Sample Size: 26 Response Rate: (%): 54% Median RVU_{Anes}: 5

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: Population sample size should have been larger. Not all anesthesiologists work on burn patients.

25th Percentile RVU: 4 75th Percentile RVU 7.75 Low: 2.14 High: 30

Median Pre-Service Time: 15 Median Intra-Service Time: 60

25th Percentile Intra-Svc Time: 30 75th Percentile Intra-Svc Time: 90 Low: 10 High: 120

Median Post-Service Time: 20

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	15	Post-op care and visit included in code
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

CPT Code: 0200x

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVU_{Anes}
00300	Anesthesia for procedures on integumentary system, muscles and nerves of head, neck and posterior trunk	5

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

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

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	15	15
Median Intra-Time	60	60
Median Immediate Post-service Time	20	15
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.29	2.63
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.96	2.42
Urgency of medical decision making	3.5	2.63

Technical Skill/Physical Effort (Mean)

Technical skill required	3.521	2.71
Physical effort required	3.188	2.54

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.42	2.708
Outcome depends on the skill and judgement of physician	3.46	2.833
Estimated risk of malpractice suit with poor outcome	3 063	2.83

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.04	2.57
Intra-Service intensity/complexity	3.26	2 57
Post-Service intensity/complexity	3 09	2.48

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The ASA reached our final recommendation after consideration of this procedure by the ASA Committee on Economics (COE) and evaluation of the results of this survey by the ASA RVS committee, a subcommittee of the ASA COE, which has editorial responsibility for the ASA RVG. The Anesthesiology RVS committee believes that this coded should be valued at 3.0 ASA RVUs, since the surgery generally involves an extremity .

FREQUENCY INFORMATION

How was this service previously reported? 00400, 01810

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

Specialty Anesthesiology ____Commonly x Sometimes ____Rarely

Specialty ____ ____Commonly ____Sometimes ____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology Frequency 25,000 to 50,000

Specialty ____ Frequency ____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Anesthesiology Frequency 6,000 to 12,000

Specialty ____ Frequency ____

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 0201x Tracking Number: BB9 Global Period: XXX **Recommended RVU_{Anes}:** 5

CPT Descriptor: Anesthesia for second or third degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; 1%-9% TBSA

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A thirty-four year-old female is burned by a cooking oil fire over the face, neck, anterior chest, forearms and hands. The patient is in extreme pain from her chest burns, but reports no pain on the face, neck, forearms or hands. There is obvious charred tissue over the anesthetic tissue in the face, neck, forearms and hands. The patient is brought to the operating room emergently for debridement and dressing of the wounds over face and neck under general anesthesia.

Description of Pre-Service Work: The patient is rapidly evaluated in the burn unit, especially for respiratory distress and airway patency. Initial IV fluid access is attained. Available history is reviewed and a physical exam performed. NPO status is evaluated. The patient may be intubated prior to the OR if airway is questionable. Laboratory studies including arterial blood gases, electrolytes, hemoglobin, and blood for X-matching are obtained. The patient is transferred to the OR with oxygen and monitoring. Anesthesia equipment and supplies are prepared, as are monitors for invasive monitoring.

Description of Intra-Service Work: On arrival in the OR, the patient is positioned on the OR table, monitors applied, oxygen continually administered, and anesthesia induced. If the patient is not alreadyintubated, the anesthesiologist accomplishes this as rapidly as possible—either with an awake or with fiber-optic intubation. The anesthesiologist maintains an adequate depth of anesthesia with inhalational agents and intravenous drugs. He administers blood and intravenous fluids as required to maintain homeostasis. He monitors vital signs, including temperature,closely and treats as necessary. At the end of the procedure, the anesthesiologist transports the patient to the Burn Intensive Care Unit and places the patient on a ventilator. After determining that the patienthas stable respiratory and circulatory parameters, the anesthesiologist transferred the patient to the care of the burn intensive care personnel. After attaining adequate sedation and pain control for the patient, the anesthesiologistreturns to the OR to clean equipment and dispose of unused anesthesia drugs and supplies.

Description of Post-Service Work: : The anesthesiologist will continue to evaluate the patient while in the BICU regarding pain control, nausea and cardiorespiratory instability. The anesthesiologist will visit the patient post-op within 24 hours of surgery, often several times. He will be involved in the post-operative care of the patient to varying degrees depending on the hospital milieu.

SURVEY DATA:

Presenter(s) Karl E. Becker, Jr., M.D.

Specialty(s): Anesthesiology

Sample Size: 26 Response Rate: (%): 54% Median RVU_{Anes}: 7

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: Sample population needed to be larger. Not all anesthesiologists treat burn patients.

25th Percentile RVU: 5.1 75th Percentile RVU: 10 Low: 5 High: 30

Median Pre-Service Time: 15 Median Intra-Service Time: 90

25th Percentile Intra-Svc Time: 33.75 75th Percentile Intra-Svc Time: 99.5 Low: 10 High. 300

Median Post-Service Time: 25

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	33.75	Post-op care and visits included in code
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

CPT Code: 0201x

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVU_{Anes}
00300	Anesthesia for procedures on integumentary system, muscles and nerves of head, neck and posterior trunk	5

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

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

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	15	10
Median Intra-Time	90	75
Median Immediate Post-service Time	25	15
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.52	2.6
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.12	2.52
Urgency of medical decision making	4 04	2.64

Technical Skill/Physical Effort (Mean)

Technical skill required	3.88	2.76
Physical effort required	3.68	2.76

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.0	2.8
Outcome depends on the skill and judgement of physician	4.0	2.84
Estimated risk of malpractice suit with poor outcome	3.28	2.80

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.62	2.73
Intra-Service intensity/complexity	3.88	2 69
Post-Service intensity/complexity	3.73	2.65

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The ASA reached our final recommendation after consideration of this procedure by the ASA Committee on Economics (COE) and evaluation of the results of this survey by the ASA RVS committee, a subcommittee of the ASA COE which has editorial responsibility of the ASA RVG. The ASA RVS committee believes that this code should be valued at 5.0 ASA RVUs since the majority of burns of this type do not involve more than 10% of TBSA.

FREQUENCY INFORMATION

How was this service previously reported? 00300,00400

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

Specialty Anesthesiology ____Commonly x Sometimes ____Rarely

Specialty ____ ____Commonly ____Sometimes ____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology Frequency ~20,000
Specialty ____ Frequency ____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Anesthesiology Frequency ~4,000

Specialty ____ Frequency ____

Do many physicians perform this service across the United States? ____Yes x No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 0202x Tracking Number BB10 Global Period: XXX **Recommended RVU_{Anes}:** 1.0

CPT Descriptor: Anesthesia for second or third degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; Each additional 9% TBSA or part thereof.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A thirty-four year-old female is burned by a cooking oil fire over the face, neck, anterior chest, forearms and hands. The patient is in extreme pain from her chest burns, but reports no pain on the face, neck, forearms or hands. There is obvious charred tissue over the anesthetic tissue in the face, neck, forearms and hands. The patient is brought to the operating room emergently for debridement and dressing of the wounds under general anesthesia. Second and third degree burns cover about 50% of TBSA.

Description of Pre-Service Work: The patient is rapidly evaluated in the burn unit, especially for respiratory distress and airway patency Initial IV fluid access is attained. Available history is reviewed and a physical exam performed. NPO status is evaluated. The patient may be intubated prior to the OR if airway is questionable. Laboratory studies including arterial blood gases, electrolytes, hemoglobin, and blood for X-matching are obtained. The patient is transferred to the OR with oxygen and monitoring. Anesthesia equipment and supplies are prepared, as are monitors for invasive monitoring.

Description of Intra-Service Work: On arrival in the OR, the patient is positioned on the OR table, monitors applied, oxygen continually administered, and anesthesia induced. If the patient is not alreadyintubated, the anesthesiologist accomplishes this as rapidly as possible—either with an awake or with fiber-optic intubation. The anesthesiologist maintains an adequate depth of anesthesia with inhalational agents and intravenous drugs. He administers blood and intravenous fluids as required to maintain homeostasis. He/she monitors vital signs, including temperature,closely and treats as necessary. At the end of the procedure, the anesthesiologist transports the patient to the Burn Intensive Care Unit and places the patient on a ventilator. After determining that the patienthas stable respiratory and circulatory parameters, the anesthesiologist transferred the patient to the care of the burn intensive care personnel. After attaining adequate sedation and pain control for the patient, the anesthesiologistreturns to the OR to clean equipment and dispose of unused anesthesia drugs and supplies.

Description of Post-Service Work: : The anesthesiologist will continue to evaluate the patient while in the BICU regarding pain control, nausea and cardiorespiratory instability. The anesthesiologist will visit the patient post-op within 24 hours of surgery, often several times. He/she will be involved in the post-operative care of the patient to varying degrees depending on the hospital milieu.

SURVEY DATA:

Presenter(s) Karl E. Becker, Jr., M.D.

Specialty(s): Anesthesiology

Sample Size: 26 Response Rate: (%): 54% Median RVU_{Anes}: 10

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: Population sample size was not sufficient since these procedures are not commonly performed by most anesthesiologists.

25th Percentile RVU: 7 75th Percentile RVU: 13 Low: 13 High. 202

Median Pre-Service Time: 20 Median Intra-Service Time: 120

25th Percentile Intra-Svc Time: 27.5 75th Percentile Intra-Svc Time: 97.5 Low: 10 High: 330

Median Post-Service Time: 30

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:		Post-op care and visits included in code
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

CPT Code: 0202x

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVU_{Anes}
00300	Anesthesia for procedures on integumentary system, muscles and nerves of head, neck and posterior trunk	5

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

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

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	20	15
Median Intra-Time	120	75
Median Immediate Post-service Time	30	15
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.15	2.81
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.76	2.64
Urgency of medical decision making	4 577	2.85

Technical Skill/Physical Effort (Mean)

Technical skill required	4.5	3
Physical effort required	4.231	2.81

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.62	2.962
Outcome depends on the skill and judgement of physician	4.54	3.0
Estimated risk of malpractice suit with poor outcome	3.423	2 88

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.21	2.74
Intra-Service intensity/complexity	4.5	2.87
Post-Service intensity/complexity	4 21	2.7

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The ASA reached our final recommendation after consideration of this procedure by the ASA Committee on Economics (COE) and evaluation of the results of this survey by the ASA RVS committee, a subcommittee of the ASA COE which has editorial responsibility of the ASA RVG. The ASA RVS committee believes that this code was misinterpreted by survey panel since they were not familiar with add-on codes. For this vignette, we think the ASA RVU for this code should be 1 to 2.

FREQUENCY INFORMATION

How was this service previously reported? 00300,00400,01810

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

Specialty Anesthesiology ____Commonly x Sometimes ____Rarely

Specialty ____ ____Commonly ____Sometimes ____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology Frequency 15,000 to 25,000

Specialty ____ Frequency ____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Anesthesiology Frequency 3,000 to 5,000

Specialty ____ Frequency ____

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

AMA SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Echocardiography

Work Relative Value Recommendations
The RUC will consider this issue along with the other anesthesia services during the October 2000 RUC meeting and will forward any recommendations to HCFA at that time.

Practice Expense Recommendations
The Specialty Society presented that these services are performed in the facility setting and; therefore, would not have any direct practice expense recommendations. **The RUC, therefore, recommends no direct practice expense inputs for these codes.**

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●00570	CC1	Echocardiography, transesophageal (TEE) for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis (Use 00570 in addition to anesthesia procedure performed)	XXX	No RUC recommendation at this time.

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Hormone Pellet Implantation

Work Relative Value Recommendation

For CPT 2000, a new CPT code 11980 *Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)* was added to describe the subcutaneous placement of hormone pellets. Hormone pellets are typically inserted every three-six months and do not have to be removed. Currently, CPT does not contain an existing code that accurately describes this service; therefore the unlisted code 17999 *Unlisted procedure, skin, mucous membrane and subcutaneous tissue* is reported.

When the RUC compared new code 11980 to the reference service code 11975 *Insertion, implantable contraceptive capsules* (work RVU = 1.48), the RUC noted that the work for new code 11980 was identical to the work described by the reference service code 11975 (work RVU = 1.48). As an interim value, HCFA previously assigned a work relative value of 1.48, which is identical to the reference service code (11975). The RUC agreed the work was comparable to the reference service code and agreed the recommended survey work value of 1.48 was appropriate. **The RUC recommends a work relative value of 1.48 for code 11980.**

Practice Expense Recommendations

The direct inputs were developed by a specialty consensus panel. This service may be performed in either a facility or non-facility setting. The RUC approved the use of the specialty's supply packages with the following changes:

- Deletion of the autoclave and fiberoptic exam light from the overhead equipment category for in-office services
- The Pre-clinical staff time of 2 minutes for in-office services was deleted
- The only direct input for out-of-office setting is 5 minutes of RN/LPN/MA time

Code (●New) (▲Revised) (D Deletion) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●11980	I1	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)	XXX	1.48

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 11980 Tracking Number: I1 Global Period: XXX **Recommended RVW:** 1.48

CPT Descriptor: Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 41-year old woman had a total abdominal hysterectomy and bilateral salpingo-oophorectomy 18 months ago for endometriosis. She experienced sudden and severe menopausal symptoms including hot flashes, insomnia, mood swings, loss of energy, and vaginal dryness. She has been treated with many different oral hormones including Premarin, Estrace, Ogen, and the patch with transdermal estradiol. Most of the oral estrogens helped with the hot flashes, but she still had insomnia and vaginal dryness. Premarin vaginal cream relieved the vaginal dryness, but she had headaches with the oral estrogens and still had some insomnia, mood swings, and loss of energy. The patient is advised to undergo implantation of estradiol and testosterone pellets.

Description of Pre-Service Work:

An explanation of the procedure is provided and informed consent is obtained. The patient is placed in either the supine or Sim's position and the patient's skin is scrubbed with iodine followed by alcohol.

Description of Intra-Service Work:

After draping with sterile towels, the skin area is anesthetized by raising a skin wheal with 1 cc 1% lidocaine. A pellet implanter is pushed through the skin with or without a small incision with a scalpel and the trocar is withdrawn. Forceps are used to place the hormone pellets in the external opening of the cannula and implant them 6 to 10 cm from the puncture wound with the blunt trocar into the subcutaneous area. Bleeding is controlled with a few minutes of pressure with sterile 4 x 4 gauze squares. The dressing is held in place with non-allergic tape. The sterile bandage is left in place overnight.

Description of Post-Service Work:

The patient is instructed to replace the bandage daily with band-aids until the puncture wound is completely closed.

SURVEY DATA:

Presenter(s) George Hill, MD and Sandra Reed, MD

Specialty(s): American College of Obstetricians and Gynecologists

Sample Size: 95 Response Rate: (%): 23 (24%) Median RVW: 1.5

Type of Sample (Circle One): random, **panel**, convenience. Explanation of sample size: Not widely performed

25th Percentile RVW: 1.48 75th Percentile RVW: 1.9 Low: 1.11 High: 2.3

Median Pre-Service Time: 15 Median Intra-Service Time: 12.5

25th Percentile Intra-Svc Time: 10 75th Percentile Intra-Svc Time: 20 Low: 5 High: 40

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	5	
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
11975	Insertion, implantable contraceptive capsules	1.48

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT 11975
Median Pre-Time	15	15
Median Intra-Time	12.5	15
Median Immediate Post-service Time	5	5
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.5	3
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3	2

Urgency of medical decision making	2	2

Technical Skill/Physical Effort (Mean)

Technical skill required	3	3
Physical effort required	2	2.5

Psychological Stress (Mean)

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

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3	3
Intra-Service intensity/complexity	3	3
Post-Service intensity/complexity	2	2

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

Survey respondents consistently reported that the work of this procedure was equivalent to work required for 11975 (Insertion of implantable contraceptive capsules). The procedures are very similar; both include administration of a local anesthetic, creation of space for the hormone pellets or contraceptive capsules, placement of multiple foreign objects beneath the skin; and counseling about follow-up care of the wound site and possible side effects of the hormones. The survey median was 1.5. HCFA assigned an interim value of 1.48, identical to 11975. We recommend maintaining the HCFA-assigned value.

FREQUENCY INFORMATION

How was this service previously reported? 17999

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty

Specialty___Ob/Gyn_____ _____Commonly __X__Sometimes _____Rarely

Specialty_____ _____Commonly _____Sometimes _____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty _____ Frequency_unknown_____

Specialty _____ Frequency_____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty _____ Frequency_____

Specialty _____ Frequency_____

Do many physicians perform this service across the United States? _____Yes ____No

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CPT Code: 11980

AMA/Specialty Society Update Process
Summary of Recommendation
XXX Global Period

In Office Direct Inputs

Sample Size:__6__ Response Rate: (%):_N/A_ Global Period:_XXX__

Tracking Number:__I1____ Reference Code 1_11975_ Reference Code 2_____

A consensus panel of 6 ACOG Fellows from various geographic locations and representing the range of ob-gyn specialties met to determine the direct practice inputs for a number of ob-gyn procedures.

Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)
RN/LPN/MA	~~2~~	40	10

Medical Supplies	Quantity of Supplies	Units Used for Purchase
Disinfectant solution	0.2 oz	14 oz. can
Drape, sheet 11106	1 item	100/case
~~Exam table paper~~	~~7 foot~~	~~125 ft/roll, 12 rolls/case~~
Gauze squares, 4" x 4"	2 item	50/box
~~Gloves, non-sterile~~	~~2 pair~~	~~100/box~~
Gloves, sterile	1 pair	100/box
1% lidocaine 51502	1 ml	
~~Paper towel~~	~~6 item~~	~~400 sheets~~
~~Patient gown, disposable~~	~~1 item~~	~~50/case~~
~~Pillowcase, disposable~~	~~1 item~~	~~100/case~~
~~Soap, antibacterial~~	~~3 ml~~	~~1500 ml~~
Tape	12 inch	1" x 72 yd.

Medical supplies should consist of the ACOG standard package A, plus the items listed above. See attached standard supply packages for ACOG.

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

CPT Code: 11980

Procedure Specific Medical Equipment	**No. of units in practice**	**Minutes of use per procedure**	**Hours per week in use for all services**
Minor surgical tray		12.5	

Overhead Medical Equipment	**No. of units in practice**
Power table	1
~~Autoclave~~	1
~~Fiberoptic exam light~~	1
Crash cart, no defibrillator	1

ACOG
Medical Supply Packages for Ob-Gyn Services

A. Minimum Supply Package for Office Visits

Supply Code Number	Description	Quantity
Multi-specialty minimum supply package for visits (developed by PEAC 2/00):		
11107	Patient gown, disposable	1 item
11111	Exam table paper	7 foot
11112	Pillowcase, disposable	1 item
11302	Gloves, non-sterile	2 pair
11509	Thermometer probe cover, disposable	1 item
ACOG Addition:		
52314	Disinfectant solution	0.2 oz

B. Minimum Supply Package for Pelvic Exam

Supply Code Number	Description	Quantity
31105	KY jelly, single use pack, 5 grams	1 item
31511	Mini pad	1 item
11507	Speculum, disposable	1 item
11513	Swabs, procto	2 item

C. Basic Post-Operative Incision Care Kit for Ob-Gyn Services

Supply Code Number	Description	Quantity
Basic Post-Operative Incision Care Kit (developed by PEAC 2/00):		
14005	Gloves, sterile	1 pair
31101	Swabs, alcohol	2 item
31513	Steri-strips	2 package
31514	Tape	12 inch
31702	Staple removal kit	1 item
52301	Betadine	10 ml
31505	Gauze, sterile 4 x 4	1 item
52308	Swab, tincture benzoin	1 item
ACOG Addition:		
11106	Drape, sheet	1 item

Type of Visit	Basic Supply Package
Ob-gyn office visit with pelvic exam	**A + B + drape sheet (1 item, supply code 11106)**
Ob-gyn in-office procedure	**A + B + sterile gloves (1 pair, supply code 14005) + drape sheet (1 item, supply code 11106)**
Ob-gyn post-operative incision care visit	**A + C**
Ob-gyn post-operative incision care visit with pelvic exam	**A + B + C**

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

CPT Code: 11980

Type of Service: Evaluation/Management Services or Diagnostic Tests
XXX Global Period

SITE OF SERVICE: In-Office

Clinical Services	MINUTES	Staff Type – Circle
Pre-Service Period		
Start: When appointment for service is made		
Review/read X-ray, lab, and pathology reports	2	RN, LPN, MA, Other _____
Other Clinical Activity (please specify)	0	
_____		RN, LPN, MA, Other _____
End: Patient arrival at office for service		
Service Period		
Start: Patient arrival at office for service		
Greet patient/provide gowning	3	RN, LPN, MA, Other _____
Obtain vital signs	5	RN, LPN, MA, Other _____
Prep and position patient	2	RN, LPN, MA, Other _____
Review history, systems, medications	6	
Prepare room, equipment, supplies	2	RN, LPN, MA, Other _____
Assist physician during exam	10	RN, LPN, MA, Other _____
Education/instruction/ counseling	5	RN, LPN, MA, Other _____
Coordinate home or outpatient care	0	RN, LPN, MA, Other _____
Clean room/equipment *Additional time required for adhering to OSHA guidelines for handling contaminated materials, disinfecting room*	4	RN, LPN, MA, Other _____
Other Clinical Activity (please specify) *Complete lab forms, schedule diagnostic tests, e.g. pap smears, vaginal cultures, scheduling of mammograms)*	3	RN, LPN, MA, Other _____
End: Patient leaves office		
Post-Service Period		
Start: Patient leaves office		
Phone calls between visits with patient, family pharmacy *2 phone calls, 5 minutes per phone call*	10	RN, LPN, MA, Other _____
Other Activity (please specify)		
		RN, LPN, MA, Other _____

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs
CPT Code: 11980

AMA/Specialty Society Update Process
Summary of Recommendation
XXX Global Period
Out-Of-Office Direct Inputs

Sample Size:__6___ Response Rate: (%): _N/A__ Global Period:_XXX__

Tracking Number:_I1_____ Reference Code 1_11975_ Reference Code 2_____

A consensus panel of 6 ACOG Fellows from various geographic locations and representing the range of ob-gyn specialties met to determine the direct practice inputs for a number of ob-gyn procedures.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

One five minute phone call during which pre-service education is provided and consent is obtained.

Intra-Service Clinical Labor Activities:
none
Post-Service Clinical Labor Activities:
none

Clinical Labor	Pre-Service Time	Service Period	Coordination of Care*	Post-Service Time
RN/LPN/MA	5	0	0	0

*By staff in the physician's office during the service period.

Medical Supplies	Quantity of Supplies	Units Used for Purchase
None		

Procedure Specific Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Equipment Cost
None				

Overhead Medical Equipment	No. of units in practice
~~Power table~~	~~1~~
~~Autoclave~~	~~1~~
~~Fiberoptic exam light~~	~~1~~
~~Crash cart, no defibrillator~~	~~1~~

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

CPT Code: 11980

Type of Service: Evaluation/Management and Diagnostic Tests
XXX Global Period

SITE OF SERVICE: Out-of-Office

Clinical Services	Minutes	Staff Type – Circle
Pre-Service Period		
Start: When appointment for service is made.		
Schedule space and equipment in facility	_____	RN, LPN, MA, Other _____
Review/read X-ray, lab, and pathology reports	_____	RN, LPN, MA, Other _____
Other Clinical Activity (please specify) *Pre-service education is provided during phone call, patient's questions are answered*	5	RN, LPN, MA, Other _____
End: Patient arrival for service or physician arrives at patient's hospital unit. (ie: contact between physician and patient for service)		
Service Period		
Start: Patient arrival for service or physician arrives at patient's hospital unit		
Greet patient/provide gowning	_____	RN, LPN, MA, Other _____
Obtain vital signs	_____	RN, LPN, MA, Other _____
Prep and position patient	_____	RN, LPN, MA, Other _____
Prepare room, equipment, supplies	_____	RN, LPN, MA, Other _____
Assist physician during exam	_____	RN, LPN, MA, Other _____
Education/instruction/ counseling	_____	RN, LPN, MA, Other _____
Coordinate home or outpatient care	_____	RN, LPN, MA, Other _____
Clean room/equipment by physician staff	_____	RN, LPN, MA, Other _____
Coordination of care by staff in office	_____	RN, LPN, MA, Other _____
Other Activity (please specify) _____	_____	RN, LPN, MA, Other _____
End. Patient leaves facility or physician leaves patient's hospital unit.		
Post-Service Period		
Start: Patient leaves facility or physician leaves patient's hospital unit.		
Phone calls between visits with patient, family pharmacy	_____	RN, LPN, MA, Other _____

End: When appointment for next office visit is made.

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

Bioengineered Tissue Grafts

15342 and 15343

The RUC recommends that the HCFA interim work value units and direct practice expense inputs for codes 15342 and 15343 be maintained until the RUC has the opportunity to review this issue in February 2001.

Integumentary System
Free Skin Grafts

For tissue-cultured skin grafts, including bilaminate skin substitutes/neodermis, use 15000 for initial wound preparation. Th~~ese c~~Codes 15342-15343 include ~~harvesting of keratinocytes and/or~~ application of skin substitute/neodermis. Procedures are coded by recipient site. Use modifier '58' for staged application procedure(s).

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●15342	M1	Application of bilaminate skin substitute/neodermis; 25 sq cm	090	Interim Recommendation 1.5
●15343	M2	each additional 25 sq cm (List separately in addition to code for primary procedure) (Use 15343 in conjunction with code 15342)	ZZZ	Interim Recommendation .38

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Escharotomy

16035

Work Relative Value Recommendation

CPT code16035 *Escharotomy; initial incision* was revised to clarify that code 16035 should be reported for a single escharotomy incision. This procedure is used in preserving pulmonary function and circulation in burn extremities. Patients requiring escharotomies generally present as emergency cases.

The RUC compared code 16035 to the reference service code 15000 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissue); first 100 sq cm or one percent of body area of infants and children* which has a work RVU of 4.00. When evaluating code 16035, the RUC noted that the urgency of medical decision-making and the risk of complications, morbidity and mortality were higher than the reference service code. As new code 16035 has greater mental effort and psychological stress, the RUC agreed that the survey recommended work RVU of 3.75, which was also the survey median value, was appropriate. In addition, the RUC noted that the current work relative value for 16035 is 4.82. A reduction to 3.75 is appropriate as the code will now be reported for the initial incision. If an additional incision is necessary, it will be reported with new code 16036. **The RUC recommends a work relative value of 3.75 for code 16035.**

Practice Expense Recommendation

There are no direct practice expense inputs for this service, as this service is performed in a facility on an emergent basis.

16036

Work Relative Value Recommendation

CPT code 16036 *Escharotomy; each additional incision (List separately in addition to code for primary procedure)* was created to describe additional escharotomy incisions performed. Patients requiring additional escharotomy incisions are urgent cases. Currently, CPT does not contain a code that describes additional escharotomy incisions performed on a patient. CPT code 16035 *Escharotomy; initial incision* with the modifier –22 (Unusual procedural services) appended was used to describe this service. At the RUC meeting, the presenter noted that the frequency data for 16036 in the CPT Proposal was incorrect and indicated that it is estimated that 10-13% of patients require at least two incisions on a single extremity and at least four separate incisions on the chest wall.

The RUC compared new code 16036 to the reference service code 15001 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); each additional 100 sq cm or each additional one percent of body area of infants and children (List separately in addition to code for primary procedure)* which has a work RVU of 1.00. The RUC noted that the complications, morbidity and mortality were greater for new code 16036 than the reference service code. There is also greater technical skill, physical and mental effort and psychological stress associated with this new procedure. Therefore, the RUC agreed that the recommended Work RVU of 1.50, which was also the survey median work value, was appropriate. **The RUC recommends a work relative value of 1.50 for code 16036.**

Practice Expense Recommendation.

There are no direct practice expense inputs for this service, as this service is performed in a facility on an emergent basis.

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲16035	A1	Escharotomy; initial incision	000	3 75
●16036	A2	each additional incision (List separately in addition to code for primary procedure) (Use 16036 in conjunction with code 16035)	ZZZ	1 50

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

(April 2000)

CPT Code: 16035 (A1) **Global Period** 000 **Recommended RVW**. 3.75

CPT Descriptor: Escharotomy, initial incision

Typical Patient (*Survey Vignette*).
A 30-year-old male experienced a circumferential full thickness third degree burn of his arm with circulatory compromise. A lateral escharotomy is performed on the arm Prompt return of a palpable pulse is identified at the wrist confirming return of circulation.

CLINICAL DESCRIPTION OF SERVICE:

Pre-service work – Prior to emergent surgery:
- Burns are classified 1st/2nd/3rd degree and assessment is made of the functional impairments caused by the burn injury
- Write pre-operative orders for peri-operative medications
- Review pre-operative history and physical
- Review planned incision and procedure
- Change into scrub clothes
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions and obtain informed consent
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Review length and type of anesthesia with anesthesiologist (if time permits)
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work - Skin to skin:
- An incision is made beginning at the shoulder and progressing though the burned skin and subcutaneous tissue to decompress the circulation by releasing the burned tissue
- Electrocautery is used to control bleeding and saline irrigation is used to cleanse the wound created
- The incision is carried along the lateral surface of the arm avoiding nerves and blood vessels at the elbow and wrist
- A physical exam is performed in the OR to confirm return of circulation

Post-op Same day work through discharge from recovery
- Irrigate wounds with saline
- Obtain hemostasis
- Apply dressings
- Write orders for post-op labs, films, medications
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for primary care physician and / or insurance company

Post-op Same day work after discharge from recovery
- Examine patient, check wounds and confirm continued adequate circulatory function
- Confirm that dressings continue to be appropriately applied and in place
- Review nursing/other staff patient chart notes
- Answer patient family questions
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, as necessary
- Chart patient progress notes

SURVEY DATA

Presenter(s): Robert W. Gillespie, MD; John W. Derr, Jr., MD
Specialty(s): American Burn Association; American Society of Plastic Surgeons
Sample Size: 68 **Response Rate**: 34 (50%):
Type of Sample: Convenience (distributed at national meeting of burn surgeons)

	Low	25th pctl	Median	75th pctl	High
Survey RVW	0.60	2.38	**3.75**	4.00	7.00
Pre-Service			**30**		
Intra-Service	5	18	**20**	30	60
Post-Service			**20**		

KEY REFERENCE SERVICE(S):

'00 RVW	Global	CPT	Descriptor
4.00	000	15000	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); first 100 sq cm or one percent of body area of infants and children

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

TIME ESTIMATES (MEDIAN)	Survey CPT 16035 (n=24)	Ref CPT 15000 (n=17)
Pre-service time	30	45
Intra-service time	20	30
Post-service time	20	30
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	3.33	3.13
Intra-service	3.36	3.69
Post-service	2.97	2.81
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3.03	3.06
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.74	2.65
Urgency of medical decision making	4.76	2.94
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	3.12	3.41
Physical effort required	2.62	3.06
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	3.85	3.65
Outcome depends on the skill and judgement of physician	4.15	3.88
Estimated risk of malpractice suit with poor outcome	3.82	3.35

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation

Patients requiring an escharatomy present as emergency cases. Significant preservice work needs to be accomplished in as short a time as possible. In contrast, 15000 is a non-emergent, planned procedure. The emergent nature of the A1 case continues through the intraoperative work. The urgency of medical decision making and risk of significant complications, morbidity, and/or mortality is greater for A1, as compared with 15000. The survey median RVW of 3.75 is recommended for 16035 (A1). This value is comparable to the reference service.

FREQUENCY INFORMATION

How was this service previously reported?

16035 Escharotomy

How often do physicians in your specialty perform this service?

Commonly ~~Sometimes~~ ~~Rarely~~

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

There are, on average, 51,000 acute burn admissions in the U.S. annually, with approximately 20% of these patients requiring an escharotomy on one or more extremities and/or an escharotomy on the chest wall.

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

No

CPT Code: 16036 (A2) **Global Period** ZZZ **Recommended RVW**: 1.50

CPT Descriptor: Escharotomy; each additional incision

Typical Patient (*Survey Vignette*):
A 30 year-old male experienced a circumferential full thickness third degree burn of his arm with circulatory compromise, and a lateral escharotomy had been performed. No palpable pulse is identified at the wrist. A medial escharotomy is immediately performed with prompt return of a palpable pulse at the wrist
[For this survey, you are being asked to provide information ONLY about the additional escharotomy The pre-service work, first escharotomy, and post-service work are separately reportable using the primary code. THIS SURVEY IS ONLY FOR THE ADDITIONAL ESCHAROTOMY.]

CLINICAL DESCRIPTION OF SERVICE:

Intra-service work - Skin to skin:
- After initial escharotomy, an intra-operative exam reveals continued compromise of circulation, and an additional escharotomy incision is made on the medial aspect of the arm
- Review of intra-operative pulses reveals excellent response in the palmer arch circulation and digital vessels.

SURVEY DATA

Presenter(s): Robert W. Gillespie, MD; John W. Derr, Jr., MD

Specialty(s): American Burn Association; American Society of Plastic Surgeons

Sample Size: 68 **Response Rate**: 32 (47%):

Type of Sample: Convenience (distributed at national meeting of burn surgeons)

	Low	25th pctl	Median	75th pctl	High
Survey RVW	0.75	1.00	**1.50**	2.58	5.00
Intra-Service Time	4	15	**20**	29	45

KEY REFERENCE SERVICE(S):

'00 RVW	Global	CPT	Descriptor
1.00ZZZ		15001	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); each additional 100 sq cm or each additional one percent of body area of infants and children (List separately in addition to code for primary procedure)

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

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

	Survey CPT 16036 (n=32)	Ref CPT 15001 (n=14)
TIME ESTIMATES (MEDIAN)		
Intra-service time	20	18
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Intra-service	3.38	2.83
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3.18	2.85
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.55	2.08
Urgency of medical decision making	4.67	2 46
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	3.21	3.08
Physical effort required	2.79	2.69
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	3.97	3.00
Outcome depends on the skill and judgement of physician	4.12	3.46
Estimated risk of malpractice suit with poor outcome	4.00	2.92

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

Similar to the parent code A1, patients requiring A2 are urgent cases. The urgency of medical decision making and risk of significant complications, morbidity, and/or mortality is greater for A2, as compared with 15001. The survey median RVW of 1.50 is recommended for 16036 (A2). This value is comparable to the reference service and fairly represents the greater intraoperative intensity/complexity for A2 compared with 15001.

The table below presents intraservice RUC (or Harvard) time for ZZZ global services that were included on the Reference List for this survey. This information is presented to demonstrate the variability of the work and time relationship for add-on services currently valued in the Medicare fee schedule. It also demonstrates how urgent/high intensity work may impact the relative physician work value (eg, 19126 vs 92981; 44015 vs 32051; 37206 vs 61609).

CPT	Descriptor for ZZZ-global services	2000 work RVU	Time Source	Intra Time (min)
15001	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); each additional 100 sq cm or each additional one percent of body area of infants and children (List separately in addition to code for primary procedure)	1.00	RUC	20
44015	Tube or needle catheter jejunostomy for enteral alimentation, intraoperative, any method (List separately in addition to primary procedure)	2.62	HVD	24
19126	Excision of breast lesion identified by preoperative placement of radiological marker, each additional lesion separately identified by a radiological marker (List separately in addition to code for primary procedure)	2.93	RUC	60
64778	Excision of neuroma, digital nerve, each additional digit (List separately in addition to code for primary procedure)	3.11	HCFA	36
37206	Transcatheter placement of an intravascular stent(s), (non-coronary vessel), percutaneous, each additional vessel (List separately in addition to code for primary procedure)	4.13	HCFA	105
92981	Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel (List separately in addition to code for primary procedure)	4.17	RUC	60
32501	Resection and repair of portion of bronchus (bronchoplasty) when performed at time of lobectomy or segmentectomy (List separately in addition to code for primary procedure)	4.69	RUC	25
33924	Ligation and takedown of a systemic-to-pulmonary artery shunt, performed in conjunction with a congenital heart procedure (List separately in addition to code for primary procedure)	5.50	RUC	30
61609	Transection or ligation, carotid artery in cavernous sinus; without repair (List separately in addition to code for primary procedure)	9.89	RUC	120

FREQUENCY INFORMATION

How was this service previously reported?

16035(-22) Escharotomy

How often do physicians in your specialty perform this service?

Commonly ~~Sometimes~~ ~~Rarely~~

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

There are, on average, 51,000 acute burn admissions in the U.S. annually, with approximately 20% of these patients requiring an escharotomy on one or more extremities and/or an escharotomy on the chest wall.

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

No

AMA SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Stereotactic Breast Biopsy

19102

Work Relative Value Recommendations
New code 19102 *Biopsy of breast; percutaneous, needle core, using imaging guidance* was created to describe breast biopsy performed using imaging guidance. This procedure reflects new technology, which provides a method of breast biopsy that is minimally invasive. Per existing HCFA instructions, this service is currently being reported using CPT code 19101 *Biopsy of breast; incisional* (work RVU = 3.18).

When evaluating new code 19102 with the reference service code 19100 *Biopsy of breast; needle core (separate procedure)* (work RVU = 1.27), the RUC noted that the time and intensity and complexity measures are higher than the reference service code 19100. The RUC considered work survey results, which provided a survey median work value of 2.00. New code 19102 requires 30 minutes intra-service time compared to 10 minutes for the reference service code 19100; therefore, the RUC agreed that the recommended work relative value of 2.00 was appropriate. **The RUC recommends a work relative value of 2.00 for code 19102.**

Practice Expense Recommendations
The RUC is providing recommendations for direct inputs when this service is performed in a non-facility setting only. The RUC agreed that an appropriate method for establishing clinical staff time would be to crosswalk the existing inputs from code 76942. The RUC agreed that the clinical staff activities were comparable in time (102 minutes). Additionally, both codes 19102 and 76942 have an intra-service time of 30 minutes. The RUC further refined the clinical inputs as reflected in the attachment and recommends a total clinical staff time of 100 minutes.

19103

Work Relative Value Recommendations

New code 19103 *Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance* was created as new technology and equipment provided a new method of breast biopsy which is minimally invasive. Many of these devices are able to biopsy and remove the lesion via a minimally invasive technique. Per existing HCFA instructions, this service is currently being reported using CPT code 19101 *Biopsy of breast; incisional* (work RVU = 3.18).

The RUC agreed that the physician work and intensity and complexity factors are greater for new code 19103 than the reference service code 19100 (work RVU = 1.27). New code 19103 has a greater complexity due to the involvement of the biopsy device, which involves complex manipulation of the device and requires additional physician time. In addition, the RUC compared new codes 19102 and 19103 and agreed that the intensity measures in the RUC survey for 19103 reflected a more complex service than 19102. Given the additional complexity of performing the procedure, the RUC agreed that the median survey value of 2.37 was appropriate. **The RUC recommends a work relative value of 2.37 for code 19103.**

Practice Expense Recommendations

The RUC is providing recommendations for direct inputs when provided in a non-facility setting only. The RUC agreed that an appropriate method for establishing clinical staff time would be to crosswalk the existing inputs from code 76942. The RUC agreed that the clinical staff activities were comparable in time (102) minutes. Additionally, both codes 19103 and 76942 have an intra-service time of 30 minutes. The RUC further refined the clinical inputs as reflected in the attachment and recommends total clinical staff time of 100 minutes.

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲19100*(e)		Biopsy of breast; percutaneous, needle core, not using imaging guidance *(For fine needle aspiration, use 88170)* (For ~~stereotactic~~ image guided breast biopsy, see ~~19100, 19101,~~ 19102, 19103, 88170) *(For radiologic guidance performed in conjunction with breast biopsy, see 76095, 76360, 76393, 76942)*	000	1.27 (no change)
▲19101(e)		Open, incisional	010	3.18 (no change)
●19102	X1	Percutaneous, needle core, using imaging guidance	000	2.00
●19103	X2	Percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance (For imaging guidance performed in conjunction with 19102, 19103, see 76095, 76360, 76393, 76942)	000	2.37

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲19120(e)		Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion (except 19140), open, male or female, one or more lesions	090	5.56 (no change)
▲19125(e)		Excision of breast lesion identified by preoperative placement of radiological marker, open; single lesion	090	6.06 (no change)
+▲19126(e)		each additional lesion separately identified by a preoperative radiological marker (List separately in addition to code for primary procedure) *(Use 19126 in conjunction with 19125)*	ZZZ	2.93 (no change)

Combined
AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:	19102	Tracking Number.	X1	Global Period	000	Recommended RVW:	2.00

CPT Descriptor.
Biopsy of breast; percutaneous, needle core, using imaging guidance

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A fifty-seven year-old female presents after having a routine mammogram, which shows a 1.5 cm ill-defined mass in the left breast, and an ultrasound, in which the mass is found to be heterogenous and solid. A histologic diagnosis is indicated. In order to more accurately discuss her diagnosis and treatment options, the decision is made, with the patient's consent, to perform an image guided percutaneous needle core breast biopsy, with the image guidance reported separately. The biopsy is performed.

Description of Pre-Service Work:

A pertinent review of the patient's history and medications is performed with special attention to problems with bleeding and musculoskeletal conditions. The appropriate modality of image guidance is selected. Imaging guidance is billed separately. Informed consent is obtained, discussing the details of the procedure and its potential risks. The other biopsy options are explained

Prior to the start of the procedure, the mammographic and ultrasound images are again reviewed by the physician to decide on the appropriate position and approach within the breast. The physician assures that all necessary instruments and supplies are present and available in the biopsy suite. The physician must explain the procedure to the patient and obtain informed consent.

Description of Intra-Service Work:

The skin is prepped with an appropriate surgical antiseptic solution. The skin is anesthetized using 1% xylocaine, using a 10-ml disposable syringe and a 1 ½ inch long 25-gauge hypodermic needle. A small puncture incision is made with a no. 11 scalpel. During the course of the procedure more anesthetic is injected into the deeper portions of the breast to help alleviate discomfort. The biopsy needle is advanced into the breast to the front of the lesion under ultrasound visualization. Meticulous care is taken to assure that the biopsy needle is accurately positioned. During entry of the needle or as a result of injection of deep local anesthesia, the lesion may move. After proper position is obtained, multiple cores of tissue are removed. Hemostasis is obtained with manual compression over the biopsy site for 5-10 minutes. A dressing is applied.

Description of Post-Service Work:

The biopsy specimens are transferred into formalin prior to being sent to pathology. The clinical and ultrasound information are provided to the pathologist. The patient's condition is monitored prior to discharge including wound check and vital signs. An operative note is dictated, reviewed and signed. The initial findings are discussed with the patient and her family. Post biopsy instructions are provided to the patient and her family. The physician also discusses the final pathologic results including a pathologic and radiologic correlation. The appropriate radiologic follow up (for a benign diagnosis) or surgical consultation (for a malignant diagnosis) is obtained. The pathology is discussed with the patient's personal physician.

SURVEY DATA:

Presenter(s): Mark Gittleman, MD (ACBS)
James P Borgstede MD (ACR)
Charles D Mabry, MD (ACS)

Specialty(s): The American Society of Breast Surgery
The American College of Radiology
The American College of Surgeons
The Society of Cardiovascular and Interventional Radiology

Sample Size. 349 Response Rate: (%) 70 (20%) Median RVW: 2.0

Type of Sample (Circle One): random panel convenience Explanation of sample size:

25th Percentile RVW. 1.6 75th Percentile RVW. 3 2 Low: 0.67 High: 7.6

Median Pre-Service Time: 18.00 Median Intra-Service Time: 30.00

25th Percentile Intra-Service Time: 20.00 75th Percentile Intra-Svc Time: 33.75 Low: 3 High: 120

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	15	N/A
Critical Care:	N/A	N/A
Other Hospital Visits:	N/A	N/A
Discharge Day Mgmt.:	N/A	N/A
Office Visits:	N/A	N/A

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
19100	Biopsy of Breast	1.27

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	18	13
Median Intra-Time	30	10
Median Immediate Post-service Time	15	10
Median of Aggregate Critical Care Times	N/A	N/A
Median of Aggregate Other Hospital Visit Times	N/A	N/A
Median Discharge Day Management Time	N/A	N/A
Median of Aggregate Office Visit Times	N/A	N/A

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.65	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.54	2.88
Urgency of medical decision making	3.33	3.41
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.06	2.59
Physical effort required	3.12	2.53
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.87	2.18
Outcome depends on the skill and judgement of physician	4.13	3.06
Estimated risk of malpractice suit with poor outcome	4.35	4.12

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3 24	2.29
Intra-Service intensity/complexity	3 96	2 41
Post-Service intensity/complexity	2.80	2.06

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation

It is the rationale of the Intraspecialty Consensus Panel that the median RVU appropriately reflects the response of our surveyees.

FREQUENCY INFORMATION

How was this service previously reported? 19101

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty

Specialty Radiology X Commonly ___ Sometimes ___ Rarely

Specialty Surgery X Commonly ___ Sometimes ___ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Radiology and Surgery Frequency 32,000 *

Specialty ___ Frequency ___

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty

Specialty Radiology and Surgery Frequency 11,000 *

Specialty ___ Frequency ___

Do many physicians perform this service across the United States?

X Yes ___ No

* These numbers are based on 1998 BMAD data for CPT code 19101.

Combined
AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:	19103	Tracking Number:	X2	Global Period.	000	Recommended RVW:	2.37

CPT Descriptor:
Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance

(For imaging guidance performed in conjunction with 19102, 19103, see 76095, 76360, 7639X, 76942)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A fifty-five year old female presents after having a screening mammogram which shows a new cluster of suspicious appearing microcalcifications in the right breast. These are in an area of approximately 4 sq mm. in each view. A histologic diagnosis is indicated. The decision is made, with the patient's consent, to perform an image guided breast biopsy. The physician feels that an using an automated vacuum assisted biopsy device (or alternatively the rotating biopsy device) will best obtain a diagnostic specimen, including the microcalcifications The biopsy is performed.

Description of Pre-Service Work:

Pre-service work begins after making the decision to perform an image guided percutaneous breast biopsy. A pertinent review of the patient's history and medications is essential, with special attention to problems with bleeding and musculoskeletal conditions. The appropriate modality of image guidance is chosen Imaging guidance is billed separately. Informed consent is obtained discussing the details of the procedure and its potential risks. The other biopsy options are explained. Percutaneous biopsy devices capable of providing adequate and accurate biopsy material are discussed with the patient.

Prior to the start of the procedure, the mammogram is again reviewed by the physician to decide on the shortest approach to the lesion (cranio-caudad, caudad cranio, medial lateral, or lateral medial) based on the position of the lesion within the breast The physician assures that all necessary surgical instruments and supplies are present and available in the biopsy suite. The physician must verify that the equipment has been appropriately calibrated and he or she oversees the positioning and preparation of the patient.

Description of Intra-Service Work:

The skin is prepped with an appropriate surgical antiseptic solution. The skin is anesthetized using 1% xylocaine, using a 10-ml disposable syringe and a 1 ½ inch long 25-gauge hypodermic needle. A small incision is made with a scalpel. During the course of the procedure more anesthetic is injected into the deeper portions of the breast to help alleviate discomfort. Care must be taken to properly inject anesthetic to prevent obscuring or moving the mammographic lesion. Meticulous care is taken to assure that the biopsy device is accurately positioned. During entry of the device or as a result of injection of deep local anesthesia, the lesion may move, requiring retargeting and repositioning with stereotactic guidance. After proper position is obtained, multiple samples of tissue are removed. Once the tissue is removed the biopsy device is also removed from the breast. Post-procedural breast imaging assures that the imaged lesion has been partially or totally removed Hemostasis is obtained with manual compression over the biopsy site for 5-10 minutes. The skin incision is closed with fine absorbable subcuticular sutures. A dressing is applied.

Description of Post-Service Work:

The biopsy specimens are transferred into formalin prior to being sent to pathology. The clinical and radiographic information are provided to the pathologist The patient's condition is monitored prior to discharge including wound check and basic vitals. An operative or procedure note is dictated The initial findings are discussed with the patient and her family. Post biopsy instructions are provided to the patient and her family. The physician also discusses the final pathologic results including a pathologic and radiologic correlation. The appropriate radiologic follow up (for a benign diagnosis) or consultation (for a malignant diagnosis) is arranged. The pathology is discussed with the patient's personal physician.

SURVEY DATA:

Presenter(s): James P Borgstede MD
The American College of Radiology
Charles D. Mabry, MD
The American College of Surgeons
Mark Gittleman, MD
The American College of Breast Surgery

Specialty(s): The American Society of Breast Surgery
The American College of Radiology
The American College of Surgeons
The Society of Cardiovascular and Interventional Radiology

Sample Size: 349 Response Rate: (%). 70 (20%) Median RVW: 2.37

Type of Sample (Circle One): random panel convenience Explanation of sample size: _____

25th Percentile RVW. 1.91 75th Percentile RVW: 3.48 Low 0 4 High: 10.1

Median Pre-Service Time: 20 Median Intra-Service Time. 30.00

25th Percentile Intra-Service Time: 30.00 75th Percentile Intra-Svc Time: 45 Low: 5 High: 120

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	15	N/A
Critical Care:	N/A	N/A
Other Hospital Visits:	N/A	N/A
Discharge Day Mgmt.:	N/A	N/A
Office Visits:	N/A	N/A

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
19100	Biopsy of Breast	1 27

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	20	10
Median Intra-Time	30	10
Median Immediate Post-service Time	15	10
Median of Aggregate Critical Care Times	N/A	N/A
Median of Aggregate Other Hospital Visit Times	N/A	N/A
Median Discharge Day Management Time	N/A	N/A
Median of Aggregate Office Visit Times	N/A	N/A

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3 77	3 08
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.67	2.85
Urgency of medical decision making	3 51	3.38

Technical Skill/Physical Effort (Mean)

Technical skill required	4.12	2.54
Physical effort required	3.39	2.54

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.13	2.38
Outcome depends on the skill and judgement of physician	4.11	3.00
Estimated risk of malpractice suit with poor outcome	4.43	4.5

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3 39	2 15
Intra-Service intensity/complexity	4 19	2 54
Post-Service intensity/complexity	3 00	2.08

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

It is the rationale of the Intraspecialty Consensus Panel that the median RVU appropriately reflects the response of our surveyees.

FREQUENCY INFORMATION

How was this service previously reported? 19101

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty

Specialty Radiology X Commonly ___ Sometimes ___ Rarely

Specialty Surgery X Commonly ___ Sometimes ___ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Radiology and Surgery Frequency 95,000

Specialty ___ Frequency ___

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty

Specialty Radiology and Surgery Frequency 32,000

Specialty ___ Frequency ___

Do many physicians perform this service across the United States? ___ Yes ___ No

* These numbers are based on 1998 BMAD data for CPT code 19101.

CPT Code: 19102

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

AMA/Specialty Society Update Process
Summary of Recommendation
000 Day Global Period

In Office Direct Inputs

These recommendations were derived from a Consensus Panel.

Sample Size: N/A Response Rate: (%) N/A Global Period: 000
Tracking Number: X1 Reference Code 1 _____ Reference Code 2 _____

Geographic Practice Setting %: Rural _____ Suburban _____ Urban _____

Type of Practice %:
_____ Solo Practice
_____ Single Specialty Group
_____ Multispecialty Group
_____ Medical School Faculty Practice Plan

Please describe the clinical activities of your staff:

Service Period Clinical Labor Activities:

The RT makes an initial call to the patient in the pre service period to identify any potential contraindications to the biopsy such as anticoagulant usage. The RT confirms the availability of prior mammograms for physician review.

The day of the procedure the RT prepares the mammograms for physician review. The patient is greeted and gowned. The procedure is briefly explained to the patient. The biopsy devise is set up. The patient is positioned for maximal comfort so that they will remain motionless throughout the biopsy procedure. The physician is assisted in collecting the specimens and preparing them for transport to pathology.

After the procedure is complete the wound is cleaned and a pressure dressing and ice pack are applied. Wound care is explained to the patient. The patient is discharged.

Clinical Labor	**Pre-Service Time**	**Service Period (Day of service)**
RN		
LPN		
MA		
X-Ray Technologist ~~Registered Mammo Technologist RT(M)~~		~~136~~ 100 minutes

CPT Code: 19102

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

Medical Supplies	Quantity of Supplies		Units Used for Purchase
.5 Xylocaine	1	$3 83 Winchester	~~VIAL~~ Vial
~~9% NaCl~~ 9% NaCl	~~10~~10	$14.60 McKesson	~~PKG~~ PKG
10 cc Syringe 91407	2		EACH
~~11 G Biopsy Needle~~	~~1~~		~~EACH~~
~~11G biopsy probe~~	~~1~~		~~EACH~~
~~14 G Biopsy Needle~~ 14 G Biopsy Needle	~~1~~1	$65.09 Picker	~~EACH~~ Each
19G Needles	~~1~~1		EACH
~~20G Needle~~ 20 G Needle	~~1~~1		~~EACH~~Each
~~27~~ 27G Needle	1	$0.10 Winchester	EACH
4x4 Gauze Pads	1		PKG
Betadine Swabs, 3 pack	~~3~~ 1		EACH
Cidex, 10 ml	1		EACH
Disposable Scalpel , 11504	1		EACH
~~Drape Towel~~ drape towel	~~4~~	$3.38 Maximum Medical	~~2/PKG~~2/pack
~~Exam Gloves~~ gloves, non sterile	~~1~~1		~~EACH~~ pair
Face Mask, 11306	2		EACH
~~Formalin Formalin 10 ml x 2, 92006~~	~~20 20 ml~~		~~cc~~ ml
Gloves Sterile, 14005	2		EACH
Ice Pack, 11130	1	$1.11 Winchester	EACH
Needle Guide, 20015	1		EACH
~~Pressure Dressing~~ Pressure Dressing	~~1~~ 1	$3 50 McKesson	~~EACH~~
~~Purple Skin Marker~~ skin marking pen (Skin Scribe)	~~1~~ 1		~~EACH~~
~~Red Biohazard Bag~~ Bag, red bioharzard	~~1~~ 1	$6 92 McKesson	~~EACH~~
~~Sensor Cain~~ Sensor Cain	~~1~~ 1	$13.93 McKesson	~~VIAL~~ McKesson
Sodium Chloride, 53062	~~2~~ 500		~~VIAL~~ Grams
~~Specimen Bags~~ Specimen Bags	~~1~~ 1	$10.49 Moore Medical	~~PKG~~ PKG
~~Sterile Drape For Gun~~ Sterile drape for Gun	~~1~~ 1	$0.60 McKesson	~~EACH~~ Item
~~Sterile Saline Cup~~ Sterile saline cup	~~1~~ 1	$.12 Moore Medical	~~EACH~~ Each
Steri-Strips, 31513	1		EACH
Telfa Ouchless Pad, 31512	1		EACH

delete Per HCFA

supplied by lab?

Procedure Specific Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Equipment Cost
~~Bioptysy Gun Handle~~ Handle	~~1~~	~~30~~	~~8~~	~~$225.00 Picker~~
~~Stereotactic Unit~~	~~1~~	~~14~~	~~8~~	

$1500

Overhead Medical Equipment	No. of units in practice	Equipment Cost
Crash Cart	1	

CPT Code: 19102

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

~~Printer~~	~~4~~	

TYPE OF SERVICE: Surgical Procedures
000 Global Period
SITE OF SERVICE: In-OFFICE

Clinical Services	Minutes	Staff Type – Circle	
Pre-Service Period			
Start: Following visit when decision for surgery or procedure made			
Complete pre-service diagnostic & referral forms		**RN, LPN, MA, Other**	
Coordinate pre-surgery services		RN, LPN, MA, Other	
Office visit before surgery/procedure Review test and exam results		RN, LPN, MA, Other	
Provide pre-service education/obtain consent		RN, LPN, MA, Other	
Follow-up phone calls & prescriptions		RN, LPN, MA, Other	
Other Clinical Activity (please specify)		RN, LPN, MA, Other	
End When patient enters office for surgery/procedure			
Service Period			
Start: When patient enters office for surgery/procedure			
Pre-service services			
Review charts	~~12~~ 6	RN, LPN, MA, Other	X –ray Tech~~RT(M)~~
Greet patient and provide gowning	2	RN, LPN, MA, Other	X –ray Tech~~RT(M)~~
Obtain vital signs	4	RN, LPN, MA, Other	X –ray Tech~~RT(M)~~
Provide pre-service education/obtain consent	~~15~~ 12	RN, LPN, MA, Other	X –ray Tech~~RT(M)~~
Prepare room, equipment, supplies	~~11~~ 8	RN, LPN, MA, Other	X –ray Tech~~RT(M)~~
Prepare and position patient/ monitor patient/ set up IV	~~8~~ 5	RN, LPN, MA, Other	X –ray Tech~~RT(M)~~
Sedate/apply anesthesia	~~5~~ 2	RN, LPN, MA, Other	X –ray Tech~~RT(M)~~
Intra-service Assist physician in performing procedure	30	RN, LPN, MA, Other	X –ray Tech~~RT(M)~~
Monitor pt. following service/check tubes, monitors, drains	~~15~~ 9	RN, LPN, MA, Other	X –ray Tech~~RT(M)~~
Clean room/equipment by physician staff	~~12~~ 9	RN, LPN, MA, Other	X –ray Tech~~RT(M)~~
Complete diagnostic forms, lab & X-ray requisitions	~~7~~ 4	RN, LPN, MA, Other	X –ray Tech~~RT(M)~~
Review/read X-ray, lab, and pathology reports	~~8~~ 5	RN, LPN, MA, Other	X –ray Tech~~RT(M)~~
Check dressings & wound/ home care instructions/coordinate office visits/prescriptions	~~7~~ 4	RN, LPN, MA, Other	X –ray Tech~~RT(M)~~
Other Clinical Activity (please specify)		RN, LPN, MA, Other	

CPT Code: 19102

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

End: Patient leaves office

CPT Code: 19103

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

AMA/Specialty Society Update Process
Summary of Recommendation
000 Day Global Period

In Office Direct Inputs

These recommendations were derived from a Consensus Panel.

Sample Size: N/A Response Rate: (%) N/A Global Period: 000
Tracking Number: X2 Reference Code 1 _____ Reference Code 2 _____

Geographic Practice Setting %: Rural _____ Suburban _____ Urban _____

Type of Practice %:
_____ Solo Practice
_____ Single Specialty Group
_____ Multispecialty Group
_____ Medical School Faculty Practice Plan

Please describe the clinical activities of your staff:

Service Period Clinical Labor Activities:

The RT makes an initial call to the patient in the pre service period to identify any potential contraindications to the biopsy such as anticoagulant usage. The RT confirms the availability of prior mammograms for physician review.

The day of the procedure the RT prepares the mammograms for physician review. The patient is greeted and gowned. The procedure is briefly explained to the patient. If a marker clip is potentially to be used, a sample clip is shown to the patient and the potential of clip placement is discussed with the patient. The biopsy devise is set up. The patient is positioned for maximal comfort so that they will remain motionless throughout the biopsy procedure. The physician is assisted in collecting the specimens and preparing them for transport to pathology.

After the procedure is complete the wound is cleaned and a pressure dressing and ice pack are applied. Wound care is explained to the patient. The patient is discharged.

Clinical Labor	**Pre-Service Time**	**Service Period (Day of service)**
RN		
LPN		
MA		
X -Ray Technologist ~~Registered Mammo Technologist - RT(M)~~		~~142~~ 100 minutes

CPT Code: 19103

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

Medical Supplies	Quantity of Supplies	Cost and Source	Units Used for Purchase
.5 Xylocaine	1	3.83 Winchester	~~VIAL~~ vial
~~.9% NaCl~~ Sodium Chloride, .9%	~~10~~ 10	14.60 McKesson	~~PKG~~ Pkg
10 cc Syringe, 91407	2		EACH
19 G Needles, 91402	~~1~~ 1		EACH
~~20 G Needle~~ 20 G Needle	~~1~~ 1		~~EACH~~ Each
~~27~~ 27 G Needle	1	.10 Winchester	EACH
4x4 Gauze Pads	1		PKG
Betadine Swabs	3		EACH
Cidex, 10 ml	1		EACH
Disposable Scalpel, 11504	1		EACH
~~Drape Towel~~ Draped Towel	~~4~~	~~3.38 Maxium Medical~~	~~2/PKG~~ 2 pack
~~Exam Gloves~~ gloves, non-sterile	~~1~~ 1		~~EACH~~ pair
~~Face Mask~~ Mask, surgical	~~2~~ 2		~~EACH~~ Items
~~Formalin Formalin, 10 cc x 2~~	~~20~~ 20		~~cc~~ cc
Gloves Sterile, 14005	1		EACH
Ice Pack, 11130	1		EACH
Mammotome Probe or Mibb or Abbi Biopsy Devices	1	180.00 J& J	EACH
~~Mammotome or Mibb or Abbi Biopsy Devices~~	~~1~~		~~EACH~~
~~Needle Guide~~	~~1~~		~~EACH~~
~~Pressure Dressing~~	~~1~~		~~EACH~~
~~Probe Guide~~	~~1~~		~~BOX~~
~~Purple Skin Marker~~	~~1~~		~~EACH~~
~~Red Biohazard Bag~~	~~1~~		~~EACH~~
Needle, guide Vacum tubing Prob guide	1 of each	220 00 U.S Surgical	
Skin marking pen (Skin Scribe)	1		Item
Bag, red biohazard	1	6 92 McKesson	
~~Sensor Cain~~ Sensor Cain	~~1~~ 1	13.93 McKesson	~~VIAL~~ Vial
Sodium Chloride, 53062	~~2~~ 500		~~VIAL~~ grams
~~Specimen Bags~~ Bag, specimen	~~1~~ 1	~~10.49 Moore Medical~~	~~PKG~~ pkg
~~Sterile Drape For Gun~~ Sterile drape for gun	~~1~~ 1	0.60 McKesson	~~EACH~~
~~Sterile Saline Cup~~ sterile saline cup	~~1~~ 1	0.12 Moore Medical	~~EACH~~ each
Steri-Strips, 31513	1		EACH
Telfa Ouchless Pad, 31512	1		EACH
Vacuum Canister	1	$5.00	EACH
~~Vacuum Tubing~~	~~1~~		~~EACH~~
Pressure dressing	1	3.50 McKesson	each

delete for HCFA

supplied by LAB?

-HCFA

Procedure Specific Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Equipment Cost
~~Stereotactic Unit~~	~~1~~	~~14~~	~~8~~	
Mammotome Driver	1	60	20	9,950 US Surgical

CPT Code: 19103

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

Overhead **Medical Equipment**	**No. of units in practice**	**Equipment Cost**
Crash Cart	1	
~~Printer~~	~~1~~	

CPT Code: 19103

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

TYPE OF SERVICE: Surgical Procedures

000 Global Period

SITE OF SERVICE: In-OFFICE

Clinical Services	Minutes	Staff Type – Circle	
Pre-Service Period			
Start: Following visit when decision for surgery or procedure made			
		RN, LPN, MA, Other	
Complete pre-service diagnostic & referral forms		RN, LPN, MA, Other	
Coordinate pre-surgery services		RN, LPN, MA, Other	
Office visit before surgery/procedure Review test and exam results		RN, LPN, MA, Other	
Provide pre-service education/obtain consent		RN, LPN, MA, Other	
Follow-up phone calls & prescriptions			
Other Clinical Activity (please specify)		RN, LPN, MA, Other	
End. When patient enters office for surgery/procedure			
Service Period			
Start· When patient enters office for surgery/procedure			
Pre-service services			
Review charts	~~12~~ 6	RN, LPN, MA, Other	~~RT(M)~~ X-ray Tech
Greet patient and provide gowning	2	RN, LPN, MA, Other	~~RT(M)~~ X-ray Tech
Obtain vital signs	4	RN, LPN, MA, Other	X-ray Tech ~~RT(M)~~
Provide pre-service education/obtain consent	~~15~~ 12	RN, LPN, MA, Other	X-ray Tech ~~RT(M)~~
Prepare room, equipment, supplies	~~11~~ 8	RN, LPN, MA, Other	X-ray Tech ~~RT(M)~~
Prepare and position patient/ monitor patient/ set up IV	~~8~~ 5	RN, LPN, MA, Other	X-ray Tech ~~RT(M)~~
Sedate/apply anesthesia	~~5~~ 2	RN, LPN, MA, Other	X-ray Tech ~~RT(M)~~
Intra-service Assist physician in performing procedure	~~36~~ 30	RN, LPN, MA, Other	X-ray Tech ~~RT(M)~~
Monitor pt. following service/check tubes, monitors, drains	~~15~~ 9	RN, LPN, MA, Other	X-ray Tech ~~RT(M)~~
Clean room/equipment by physician staff	~~12~~ 9	RN, LPN, MA, Other	X-ray Tech ~~RT(M)~~
Complete diagnostic forms, lab & X-ray requisitions	~~7~~ 4	RN, LPN, MA, Other	X-ray Tech ~~RT(M)~~
Review/read X-ray, lab, and pathology reports	~~8~~ 5	RN, LPN, MA, Other	X-ray Tech ~~RT(M)~~
Check dressings & wound/ home care instructions/coordinate office visits/prescriptions	~~7~~ 4	RN, LPN, MA, Other	X-ray Tech ~~RT(M)~~
Other Clinical Activity (please specify)		RN, LPN, MA, Other	
End: Patient leaves office			

AMA SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Insertion of Breast Markers

Work Relative Value Recommendation
CPT code 19295 *Image guided placement, metallic localization clip, percutaneous, during breast biopsy (List separately in addition to code for primary procedure)* was created to describe the placement of a metallic clip during a breast biopsy. CPT code 19295 is to be reported in addition to the code for breast biopsy.

There are no work relative value recommendations, as the RUC agreed the work for placement of the clip marker code is included in the work of the parent code. **The RUC agreed that there is minimal additional work and recommends a 0.00 work RVU for code 19295.**

Practice Expense Recommendations
The RUC recommends the attached direct inputs for the non-facility setting. The RUC reduced the clinical staff time to two minutes to reflect an appropriate clinical staff time. Also, the RUC recommends the inclusion of marker clip as the only other practice expense input.

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	**Tracking Number**	**CPT Descriptor**	**Global Period**	**Work RVU Recommendation**
● 19295	DD1	Image guided placement, metallic localization clip, percutaneous, during breast biopsy (List separately in addition to code for primary procedure) (Use 19295 in conjunction with code 19102)	ZZZ	0.00

AMA/Specialty Society Update Process
Summary of Recommendation
ZZZ Global Period

In Office Direct Inputs

These recommendations were derived from a Consensus Panel.

Sample Size: N/A Response Rate: (%) N/A Global Period: ZZZ
Tracking Number: DD1 Reference Code 1 _____ Reference Code 2 _____

Geographic Practice Setting %: Rural _____ Suburban _____ Urban _____

Type of Practice %:
_____ Solo Practice
_____ Single Specialty Group
_____ Multispecialty Group
_____ Medical School Faculty Practice Plan

Please describe the clinical activities of your staff:

Intra-Service Clinical Labor Activities:

Technologist removes marker equipment from package. The technologist then assists the physician in placing marker in the vacuum assistance device.

Clinical Labor	Service Period
RN	
LPN	
MA	
~~Registered Mammo Technologist RT(M)~~ X-Ray Tchnologist	~~17~~ 2 minutes

Medical Supplies	Quantity of Supplies	Units Used for Purchase
Marker Clip with Introducer	1	EACH $75.00 US Surgical
~~Biopsy Micromarker cup~~	~~1~~	~~EACH~~

Procedure Specific Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Equipment Cost

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs
CPT Code: 19295

Overhead Medical Equipment	No. of units in practice	Equipment Cost

TYPE OF SERVICE: ZZZ Global Period

SITE OF SERVICE: In-OFFICE

Clinical Services	Minutes	Staff Type – Circle
Intra-service		
Assist physician in performing procedure	~~5~~ 2	RN, LPN, MA, Other **RT(M)**
Other Clinical Activity (please specify)		
Explain clip placement	~~5~~	RN, LPN, MA, Other ~~RT(M)~~

AMA SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Mandibular Osteotomy and Genioglossus Advancement

Work Relative Value Recommendations

New code 21199 *Osteotomy, mandible, segmental; with genioglossus advancement* was created to describe mandibular osteotomies performed with genioglossus advancement for treatment of sleep disordered breathing. Currently, CPT does not contain a code that accurately describes this procedure and this service was reported using CPT code 21198 *Osteotomy, mandible, segmental* (work RVU = 14.16) with the modifier –22 (Unusual Procedural Services).

When the RUC evaluated new code 21199, the RUC determined this new service required greater work, complexity and risk than the reference service code 21198 *Osteotomy, mandible, segmental* (work RVU = 14.16). Complex osteotomy cuts are made into the mandible to create a large window, which may weaken the bone, thereby increasing the risk for fracture during the procedure. This new service has a greater intra and post-operative risk as the patient has an obstructed airway, which can cause the patient to go from stable to worse in a matter of seconds. Typically, the patient has failed other treatments, for example continuous positive airway pressure (CPAP) and uvuloplasty before undergoing this procedure. Also, new code 21199 is more difficult than code 21470 *Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints* (work RVU = 15.34) and code 21045 *Excision of malignant tumor of mandible; radical resection* (work RVU = 16.17). The RUC agreed that the recommended survey work value of 16.00, which was the median survey work value, was appropriate due to the greater intensity and complexity measures and increased risk to the patient. **The RUC recommends a work relative value of 16.00 for code 21199.**

Practice Expense Recommendations

The direct inputs were developed by a specialty consensus panel. The specialty society used the E/M standard clinical staff time for the post-operative office visits. The specialty also explained the coordination of appropriate direct inputs. The RUC approved the practice expense inputs for 21199 with minor modifications to the supply list. This service is provided in a facility setting.

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●21199	FF1	Osteotomy, mandible, segmental; with genioglossus advancement	090	16.00

CPT Code: 21199 **Global Period:** 090 **Recommended RVW** 16.00

CPT Descriptor: Osteotomy, mandible, segmental; with genioglossus advancement

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Typical Patient (*Survey Vignette*):
A 55-year-old male presents with excessive daytime sleepiness, decreased cognitive function, morning headaches, memory loss, and snoring Past medical history is significant for coronary artery disease, hypertension, obesity, gastroesophageal reflux disease, and depression History also includes a recent sleep study that revealed moderate obstructive sleep apnea syndrome, which was unresponsive to medical therapy of nasal continuous positive airway pressure A mandibular osteotomy with genioglossus advancement is performed The patient is followed by the surgeon, as necessary, postoperatively through the 90-day global period.

CLINICAL DESCRIPTION OF SERVICE:

Pre-service work - Day before surgery:
- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up, with particular attention to cardiopulmonary risk assessment and cephalometrics
- Review planned incisions and procedure

Pre-service work - Day of surgery:
- Change into scrub clothes
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions and obtain informed consent
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work:
- Xylocaine with epinephrine is injected along the proposed skin/mucosal incision to provide hemostasis.
- The mucosa and mentalis muscle are incised
- Periosteal attachments are removed form the anterior mandible from premolars to premolars down to the inferior border of the mandible
- The geniotubercle is located by both radiographic correlations with pa panoramic radiograph (separately billable) and palpation of the floor of the mouth
- Inferior and superior parallel horizontal osteotomies are performed on either side of the tubercle
- Bilateral vertical osteotomies are performed to connect the horizontal osteotomies between the lateral incisor and canine tooth roots
- A miniscrew is placed in the center of the tubercle
- The tubercle is advanced
- The genioglossus muscle is stretched to allow for adequate advancement
- Osteotomy revisions are made, as necessary, to allow the fragment to be manipulated
- The fragment is placed into the floor of the mouth and hemostasis is obtained
- The tubercle is advanced and the fragment is rotated to allow bony overlap
- The outer mandibular cortex is removed with a saw blade
- The fragment is immobilized to the anterior mandible by a lag screw technique
- The remainder of the tubercle bone is smoothed with a cutting burr
- A superiorly placed microscrew is used between the incisor roots to add fixation if the fragment is loose
- The wound is closed in layers, over a drain, as needed

Post-op work through discharge

- Apply initial postoperative dressings
- Write orders for post-op labs and medications, with special emphasis on treating hypertension aggressively to decrease the risk of a floor of mouth hematoma
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Answer patient/family questions
- Dictate post-op report
- Reapply dressings until discharge, as necessary
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company
- Assess airway prior to discharge to determine the safety of breathing in an unmonitored setting
- Review instructions for post-discharge wound care and home care with patient and family
- Answer insurance staff questions
- Write orders for post-discharge medications
- Chart patient discharge notes

Post-op Office work - After discharge from hospital

- Examine and talk with patient
- Check wounds weekly until healing is complete to rule out a dehiscence
- Remove drain, if placed
- Order and review radiographs to assess the osteotomy cuts and dental status compared with pre-operative films
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician
- Write orders for medications
- Discuss progress with patient/family
- Dictate patient progress notes for medical chart
- Dictate procedure outcome letter for referring physician

SURVEY DATA

Presenter(s): Lanny R. Garvar, D.M.D. (AAOMS)
James H. Kelly, MD (AAO-HNS)
Sam Mc Kenna, D.D.S., M.D

Specialty(s): American Academy of Otolaryngology – Head and Neck Surgery, Inc.
American Association of Oral & Maxillofacial Surgeons

Sample Size: 82 **Response Rate**: 23 (28%):

Type of Sample: random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	8.69	14.16	**16.00**	17.58	25.00
Time (min) and Visits					
24 Hr Preceding Service			**30**		
Day Of Service					
Pre-Service			**30**		
Intra-Service	45	90	**90**	120	240
Immed. Post-Service			**30**		
Post-Service	**Total Time**	**CPT code / # of visits**			
Critical Care		none			
Other Hospital	30	99232 x 1			
Discharge Management	36	99238			
Office Visits	53	99213 x 1, 99212 x 2			

KEY REFERENCE SERVICE(S):

'00 RVW	Global	CPT	Descriptor
14.16	090	21198	Osteotomy, mandible, segmental

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

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

TIME ESTIMATES (MEDIAN)	Survey CPT 21199 (n=23)	Ref CPT 21198 (n=13)
Pre-service time	60	65
Intra-service time	90	90
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	30	30
Discharge management time	26	29
Total office visit time	53	53
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	3.73	3.00
Intra-service	3.73	3.42
Post-service	3.64	2.67
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3.95	3.08
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.09	3.25
Urgency of medical decision making	3.50	2.58
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	3.73	3.42
Physical effort required	3.59	3.17
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	4.00	3.33
Outcome depends on the skill and judgement of physician	3.95	3.50
Estimated risk of malpractice suit with poor outcome	3.77	3.33

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation

When comparing the reference code 21198 to new code 21199, the specialty societies have agreed that this procedure, performed for the treatment of obstructed sleep apnea, is indeed more technically difficult than the reference code and carries a greater intra-operative and post-operative risk. The complex osteotomy cuts made into the symphysis of the mandible create a large window, which may significantly weaken the surrounding bone, thereby increasing the risk for fracture during the procedure. Consideration is also given to the close proximity of the osteotomy cut to the dentition, creating again a greater post-operative risk for the loss and/or damage to the teeth. The critical placement of the osteotomy cuts, which facilitate the genioglossus advancement, are more complex than the reference code.

The survey median RVW of 16.00 is recommended for 21199. This value recognizes the survey respondents indication of the increased intensity/complexity of 21199 over 21198 for all measures: time segments, mental effort and judgment; technical skill/physical effort, and psychological stress.

FREQUENCY INFORMATION

How was this service previously reported?

21198-22

How often do physicians in your specialty perform this service?

Specialty. Otolaryngology	~~Commonly~~	**Sometimes**	~~Rarely~~
Specialty: Oral & maxillofacial surgery	~~Commonly~~	**Sometimes**	~~Rarely~~

For your specialty, estimate the number of times this service might be provided nationally in a one-year period?

The estimated frequency for this new code is a small percentage of the frequency for 21198 most likely similar to the frequency for 21198-22. In 1998, the Medicare frequency for 21198-22 was three.

Do many physicians perform this service across the United States? **No**

CPT Code: 21199 Osteotomy, mandible, segmental; with genioglossus advancement

AMA/Specialty Society Update Process
Summary of Recommendation
010 or 090 Day Global Periods
Out-Of-Office Direct Inputs

Sample Size:_____ Response Rate: (%):_____ Global Period: 90

Tracking Number:_____ Reference Code 1 _____ Reference Code 2_____

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

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

A work group of 7 practicing otolaryngologists was convened to review the survey results for physician work. 's work group included 3 subspecialists, two individuals in academic practice, three in private practice and in a large multispecialty private practice. Three are from the middle Atlantic region, two are from the southwest, one is from the mid-west, and one is from the west. This group identified a reference code with comparable resource inputs. AAO-HNS staff then reviewed the identified reference code and made adjustments as needed to be consistent with the number of post-operative office visits identified by the survey on physician work and to be consistent with the RUC instructions for developing direct practice expense inputs for new/revised codes. The reference code used for new code 21199 was existing code 21198.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Complete pre-service diagnostic and referral forms, coordinate pre-surgery services, schedule space and equipment in facility, review test and exam results, provide pre-service education and obtain consent, follow-up phone calls and respond to clinical questions from patient.

Intra-Service Clinical Labor Activities:

Provide coordination of care activities while patient is in hospital; e.g., coordination of home or outpatient care, provide education, instructions and counseling to family members. The patient is treated by a variety of physicians; anesthesiologists, cardiologists, pulmonary medicine, etc., each providing recommendations, and consultations with family members.

Post-Service Clinical Labor Activities:

duct phone calls and call in prescriptions; three office visits (99213- 1; 99212- 2); conduct phone calls with patient and/or family members between visits.

CPT Code: 21199 Osteotomy, mandible, segmental; with genioglossus advancement

Clinical Labor	Pre-Service Time Prior to Admission	Service Period (Admission to Discharge)	Coordination of Care*	Post-Service Time After Discharge **	Number of Office Visits	Total Time of Office Visits
RN						
LPN						
MA						
RN/LPN/MA	75		30	30	3	90

*By staff in the physician's office during the service period.
**Excluding Time of Office Visits

Medical Supplies	Quantity of Supplies	Units Used for Purchase
~~Patient gown, disposable~~	~~3~~	~~Item~~
~~Pillow case, disposable~~	~~3~~	~~Item~~
Gloves, non sterile	3	Pair
Thermometer probe cover	3	Item
Tongue depressor	3	Item
~~Exam table paper~~	~~21~~	~~Feet~~

Procedure Specific Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Equipment Cost
None				

2

CPT Code: 21199 Osteotomy, mandible, segmental; with genioglossus advancement

Overhead Medical Equipment	No. of units in practice	Equipment Cost
Fiberoptic exam light		$609
Reclining exam chair w/headrest		$4495
Light Source		$1700
Suction machine		$732
Crash cart, no defibrillator		$1136

CPT Code: 21199 Osteotomy, mandible, segmental; with genioglossus advancement

TYPE OF SERVICE: Surgical Procedures
010 and 090 Global Periods

SITE OF SERVICE: OUT-OF-OFFICE

Clinical Services	Minutes	Staff Type – Circle
Pre-Service Period		
Start: Following visit when decision for surgery or procedure made		
Complete pre-service diagnostic & referral forms	12	RN, LPN, MA, Other: RN/LPN/MA
Coordinate pre-surgery services	10	RN, LPN, MA, Other RN/LPN/MA
Schedule space and equipment in facility	10	RN, LPN, MA, Other RN/LPN/MA
Office visit before surgery/procedure Review test and exam results	27	RN, LPN, MA, Other RN/LPN/MA
Provide pre-service education/obtain consent	10	RN, LPN, MA, Other RN/LPN/MA
Follow-up phone calls & prescriptions	6	RN, LPN, MA, Other RN/LPN/MA
Other Activity (please specify)		RN, LPN. MA, Other RN/LPN/MA
End: When patient enters hospital for surgery/procedure		
Service Period		
Start: Patient admitted to hospital for surgery/procedure		
Pre-service services		
Review charts		RN, LPN, MA, Other
Greet patient and provide gowning		RN, LPN, MA, Other
Obtain vital signs		RN, LPN, MA, Other
Provide pre-service education/obtain consent		RN, LPN, MA, Other
Prepare room, equipment, supplies		RN, LPN, MA, Other
Prepare and position patient/ monitor patient/ set up IV		RN, LPN, MA, Other
Sedate/apply anesthesia		RN, LPN, MA, Other
Intra-service		
Assist physician in performing surgery/procedure		RN, LPN, MA, Other

CPT Code: 21199 Osteotomy, mandible, segmental; with genioglossus advancement

st-service

Monitor pt. following service/check tubes, monitors, drains	_____	RN, LPN, MA, Other _____
Clean room/equipment by physician staff	_____	RN, LPN, MA, Other _____
Assist with ICU or hospital visits	_____	RN, LPN, MA, Other _____
Total Number of ICU visits	_____	
Total Number of hospital visits	_____	
Complete diagnostic forms, lab & X-ray requisitions	_____	RN, LPN, MA, Other _____
Review/read X-ray, lab, and pathology reports	_____	RN, LPN, MA, Other _____
Discharge day management services, check dressings & wound/ home care instructions/coordinate office visits/prescriptions	_____	RN, LPN, MA, Other _____
Coordination of care by staff in office	30	RN, LPN, MA, Other _____
Other Activity (please specify)		
_____	_____	RN, LPN, MA, Other _____

End: Patient discharge from hospital

_____

t-Service Period

art: Patient discharge from hospital

Conduct phone calls/call in prescriptions	15	RN, LPN, MA, Other RN/LPN/MA
Office visits Greet patient, escort to room Provide gowning Interval history & vital signs & chart Assemble previous test reports/results Assist physician during exam Assist with dressings, wound care, suture removal Prepare Dx test, prescription forms Post service education, instruction, counseling Clean room/equip, check supplies Coordinate home or outpatient care	_____	RN, LPN, MA, Other RN/LPN/MA
List total number of office visits (99213 x 1) + (99212 x 2) = 90 minutes	A 3	
Total office visit time (A * B)	**B 90**	
Conduct phone calls between office visits	15	RN, LPN, MA, Other RN/LPN/MA
Other Activity (please specify)		
	_____	RN, LPN, MA, Other _____

End: With last office visit before end of global period

AMA SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Percutaneous Vertebroplasty

22520

Work Relative Value Recommendations
New code 22520 *Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic* was created to describe minimally invasive vertebroplasty in the thoracic vertebrae. Vertebroplasty is the percutaneous skeletal fixation of a collapsed vertebral body, with access into the vertebral body achieved using radiologic imaging to access the specific vertebra and to monitor the injection of polymethylmethacrylate. Currently, CPT does not contain an existing code that accurately describes this service; therefore, the unlisted code 22899 *Unlisted procedure, spine* is reported.

The RUC did not accept the initial specialty society work value recommendation. Facilitation Committee Two reviewed this issue and presented the following information.

The RUC discussed the pre-service time of 60 minutes for new code 22520 and agreed the time was appropriate. The RUC also agreed that the intra-service time of 80 minutes for code 22520 was appropriate. The RUC discussed the post-service time on the day of the procedure and agreed that the discharge management was appropriate. However, the 99231 Hospital visit time and work should be deducted from the total time and work, as the patient is usually discharged on the same date. The RUC agreed that the service should include one 99213 office visit, not the two visits as indicated in the survey. The RUC deducted the hospital visit and one office visit to arrive at a work value of 8.91 for code 22520. **The RUC recommends a work relative value of 8.91 for code 22520.**

Practice Expense Recommendations
This service is only provided in a facility setting; therefore, the RUC recommends that the E/M package for clinical staff time, supplies and equipment for the 99213 level of office visit be included in the post-operative period for code 22520. The E/M standard package for 99213 is listed below:

Clinical Labor	RN/LPN/MA	36 minutes

Medical Supplies:

Drape Sheet	1 item
Exam table paper	7 feet
Pillow case	1 item
Gloves, non-sterile	2 pair
Otoscope speculum disposable	1 item
Patient education booklet	1 item
Patient gown, disposable	1 item
Swab, alcohol	2 items
Thermometer probe cover, disposable	1 item
Tongue depressor	1 item

Overhead Equipment:

Exam table

Crash cart, no defibrillator

Otoscope-ophthalmoscope

This service is only provided in a facility setting, therefore, the RUC agreed that 1 post operative visit was appropriate within the global period.

22521

Work Relative Value Recommendations

New code 22521 *Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar* was created to describe minimally invasive vertebroplasty in the lumbar vertebrae. Currently, CPT does not contain an existing code that accurately describes this service; therefore, the unlisted code 22899 *Unlisted procedure, spine* is reported.

The RUC did not accept the initial specialty society work value recommendation. Facilitation Committee Two reviewed this issue and presented the following information.

The RUC discussed the pre-service time of 60 minutes for new code 22521 and agreed the time was appropriate. The RUC also agreed that the intra-service time of 80 minutes for code 22521 was appropriate. The RUC discussed the post-service time on the day of the procedure and agreed that the discharge management was appropriate.

However, the 99231 Hospital visit time and work should be deducted from the total time and work, as the patient is usually discharged on the same date. The RUC agreed that the service should include one 99213 office visit, not the two visits as indicated in the survey.

The RUC deducted the hospital visit and one office visit to arrive at a work value of 8.34 for code 22521. **The RUC recommends a work relative value of 8.34 for code 22521.**

Practice Expense Recommendations

This service is performed only in a facility setting; therefore, the RUC recommends that the E/M package for clinical staff time, supplies and equipment for the 99213 level of office visit be included in the post-operative period for code 22521. The E/M standard package for 99213 is listed below:

Clinical Labor	RN/LPN/MA	36 minutes
Medical Supplies:		
Drape Sheet		1 item
Exam table paper		7 feet
Pillow case		1 item
Gloves, non-sterile		2 pair
Otoscope speculum disposable		1 item
Patient education booklet		1 item
Patient gown, disposable		1 item
Swab, alcohol		2 items
Thermometer probe cover, disposable		1 item
Tongue depressor		1 item
Overhead Equipment:		
Exam table		
Crash cart, no defibrillator		
Otoscope-ophthalmoscope		

This service is only provided in a facility setting, therefore, the RUC agreed that 1 post operative visit was appropriate within the global period.

22522

Work Relative Value Recommendations
New code 22522 *Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)* was created to describe minimally invasive vertebroplasty in additional lumbar or thoracic vertebrae. Currently, CPT does not contain an existing code that accurately describes this service; therefore, the unlisted code 22899 *Unlisted procedure, spine* is reported.

The RUC did not accept the initial specialty society work value recommendation. Facilitation Committee Two reviewed this issue and presented the following information.

The RUC agreed that code 22522 should represent an average of half (50%) of the recommended work RVU of 22520 (4.45), and 22521 (4.17), which is a total of 4.31 work RVU's. **The RUC recommends a work relative value of 4.31 for code 22522.**

Practice Expense Recommendations
There are no direct practice expense inputs, as code 22522 is on add-on code performed only in a facility setting.

76012

Work Relative Value Recommendations
New code 76012 *Radiological supervision and interpretation, percutaneous vertebroplasty, per vertebral body; under fluoroscopic guidance* describes the radiologic portion of using fluoroscopy to access the specific vertebra, place the needle and monitor the injection of polymethylmethacrylate.

The survey median for code 76012 was 1.31. The RUC agreed that this value was appropriate for the work involved. The RUC compared new code 76012 to the reference service code 75894 *Transcatheter therapy, embolization, any method, radiological supervision and interpretation*, which has the same intra-service time. The RUC agreed that the physician pre-service time for 76012 should be deleted, as it overlaps with the percutaneous vertebroplasty codes.
The RUC recommends that the survey work relative value median be approved for 1.31. **The RUC recommends a work relative value of 1.31 for code 76012.**

Practice Expense Recommendations
There are no direct practice expense inputs, as this service is only performed in a facility setting.

76013
Work Relative Value Recommendations
New code 76013 *Radiological supervision and interpretation, percutaneous vertebroplasty, per vertebral body; under CT guidance* describes the radiologic portion of using CT guidance to access the specific vertebra, place the needle and monitor the injection of polymethylmethacrylate.

The RUC compared code 76013 and agreed the intensity and number of films to be taken are greater in code 76013 than 76012. The RUC agreed that the relativity of the original specialty recommendations presented for codes 76012 (1.16) and 76013 (1.22) be maintained and therefore; the RUC agreed that a work relative value of 1.38 was appropriate. **The RUC recommends a work relative value of 1.38 for code 76013.**

Practice Expense Recommendations
There are no direct practice expense inputs, as this service is performed only in a facility.

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		Musculoskeletal System Spine Vertebral Body, Embolization or Injection		
●22520	GG1	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic	010	8.91
●22521	GG2	lumbar	010	8.34
●22522	GG3	each additional thoracic or lumbar vertebral body (List separately in addition code for primary procedure) (Use 22522 in conjunction with codes 22520, 22521 as appropriate) (For radiological supervision and interpretation, see 76012, 76013)	ZZZ	4.31
●76012	GG4	Radiological supervision and interpretation, percutaneous vertebroplasty, per vertebral body; under fluoroscopic guidance	XXX	1.31
●76013	GG5	under CT guidance (For procedure, see 22520-22522)	XXX	1.38

CPT Code: 22520 (GG1) **Global Period**: 010 **Recommended RVW**: ~~10.00~~ **8.91 (RUC)**

CPT Code Descriptor: Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic
(For radiological supervision and interpretation, see 7601X1, 7601X2)

Typical Patient (*Survey Vignette*):
A 70-year-old male with hypernephroma and severe thoraco-lumbar junction pain presents with a two-year history that includes a nephrectomy, spinal radiation, and chemotherapy A previous MRI revealed tumor infiltration of the T9 vertebrae, which has destroyed the posterior cortex, with mild spinal canal encroachment. Narcotic analgesics have not helped; additional chemotherapy has been ruled out as ineffective and/or poorly tolerated; additional radiation therapy is not possible because the maximum spinal dose has already been given; and corpectomy and fixation are not possible due to the patient's cachexia, the vascular nature of the tumor, and possible spinal column collapse that may result in paraparesis and incontinence The patient and his family understand that his condition is terminal and that the palliative treatment of a percutaneous vertebroplasty is being offered primarily to control pain and prevent incontinence and paraparesis. The percutaneous thoracic vertebroplasty is performed. The patient is discharged several hours after the procedure and followed as necessary in the office through the 10-day global period.

CLINICAL DESCRIPTION OF SERVICE

Pre-Service Work:
- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up; with special attention to previous radiographs
- Counsel patient and obtain informed consent
- Change into scrub clothes
- Review planned procedure with other health care professionals
- Supervise positioning, draping, and prepping of the patient on the angiography/fluoroscopy table
- Verify that all necessary surgical instruments and supplies are readily available
- Verify that the equipment has been appropriately calibrated
- Scrub and gown

Description of Intra-Service Work:
- After sedation is achieved and the T9 pedicle is fluoroscopically localized (separately reportable), the skin, subcutaneous tissues, and periosteum are locally anesthetized
- An incision is made with a scalpel
- An 11G bone biopsy needle is directed into the anterior third of the vertebral body utilizing AP and lateral fluoroscopy, supplemented with CT imaging as required for adequate visualization (imaging is separately billable).
- Following needle placement, injection of 3-5 ml of Omnipaque 300 with filming in the AP and lateral planes is performed to reveal needle position within the trabecular space, with preferential filling to the anterior internal epidural venous plexus via the basivertebral plexus.
- PMMA cement is mixed and injected, using 1.0 ml aliquots, under fluoroscopic control, utilizing both the AP and lateral planes. [Injection is terminated after the material reaches the posterior fourth of the vertebral body. During the injection process, the epidural venogram is consulted to insure that PMMA has not migrated into or towards the outlined venous plexus.]
- Remove needle and review control film to determine PMMA penetration. [Note: If the PMMA has not crossed into the opposite vertebral half of the vertebral body, the procedure is repeated in the contralateral side of the vertebra.]
- Final control AP and lateral images of the lumbar spine are made to confirm no migration into the surrounding veins

Post-service Work (day of service):
- Clean wounds and apply sterile dressings and transfer patient to recovery room.
- Clean wounds and apply sterile dressings
- Review recovery room care and medications with staff

- Write outpatient medication orders for patient
- Dictate operative report
- Examine patient, check wound(s) and patient progress
- Discuss procedure outcome with patient and family and schedule follow-up visit in office
- Discuss wound care with patient, prior to discharge
- Discuss procedure outcome with referring physician
- Dictate procedure outcome letter for referring physician and/or insurance company

Post-service Work (post-discharge):
- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Write orders for medications
- Dictate patient progress notes for medical chart

SURVEY DATA

Presenter(s): J. Arliss Pollock, MD (ASNR)
John Barr, MD (ASNR)
James P. Borgstede, MD (ACR)
Bernard A. Pfeifer, MD (NASS)
Gregory Przybylski, MD (AANS/CNS)
Robert L. Vogelzand, MD (SCVIR)

Specialty(s): American Association of Neurological Surgeons
American College of Radiology
American Society of Neuroradiology
North American Spine Association
Society of Cardiovascular & Interventional Radiology

Sample Size: 649 **Response Rate**: 41 (6%):

Type of Sample: Panel

	Low	25th pctl	Median	75th pctl	High
Survey RVW	1.80	6.37	**10.00**	15.00	20.00
Time (min) and Visits					
24 Hr Preceding Service			**30**		
Day Of Service					
Pre-Service			**30**		
Intra-Service	30	60	**80**	90	120
Immed. Post-Service			**30**		
Post-Service	**Total Time**	**CPT code / # of visits**			
Critical Care		none			
Other Hospital					
Discharge Management	36	99238			
Office Visits	23	99213 x 1			

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2000 work RVU	global
62287	Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumbar (eg, manual or automated percutaneous diskectomy, percutaneous laser diskectomy)	8.08	90
62292	Injection procedure for chemonucleolysis, including diskography, intervertebral disk, single or multiple levels, lumbar	7.86	90
20225	Biopsy, bone, trocar, or needle, deep (vertebral body, femur)	1.87	0

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

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

TIME ESTIMATES (MEDIAN)	Survey CPT 22520	Ref CPT 20225	Ref CPT 62287	Ref CPT 62292
Pre-service time	60	See previous survey data shown on table presented in additional rationale section.		
Intra-service time	80			
Immediate Post-service time	30			
Total critical care time	0			
Total other hospital visit time	19			
Discharge management time	36			
Total office visit time	38			
INTENSITY/COMPLEXITY MEASURES (mean)				
TIME SEGMENTS				
Pre-service	3.49	3.50	3.00	3.25
Intra-service	3.95	3.33	3.17	2.75
Post-service	2.64	2.38	2.83	2.50
MENTAL EFFORT AND JUDGMENT				
The number of possible diagnosis and/or the number of management options that must be considered	3.54	3.00	3.17	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.68	3.22	3.50	2.50
Urgency of medical decision making	3.22	3.44	2 67	2.50
TECHNICAL SKILL/PHYSICAL EFFORT				
Technical skill required	4.12	3.89	3.33	3.50
Physical effort required	3.98	3.33	2.83	3.00
PSYCHOLOGICAL STRESS				
The risk of significant complications, morbidity and/or mortality	3.98	3.67	3.00	3.25
Outcome depends on the skill and judgement of physician	4.20	3.67	3.50	2.75
Estimated risk of malpractice suit with poor outcome	3.93	4.00	3 50	3.25

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The principal reference codes cited were 62287, 62292, 20225. Each of these codes has elements of the physician work of 22520, while having important dissimilar features. When comparing codes with different global periods, efforts to normalize them using a building block method to measure the pre- and post-work, and then calculating the intra-service work RVUs, affords a way to help with such comparisons.

CPT 62287 is the code for percutaneous lumbar diskectomy and has a 90-day global, while 22520 has a 10-day global period. CPT 62292 is the code for chemonucleolysis of a lumbar disk, also with a 90-day global CPT 20225 describes a biopsy of a vertebral body by needle or trocar, using similar needle guidance and insertion techniques to the new codes The respective RVWs and survey data for these reference codes are shown in the table below·

CPT	Descriptor	2000 work RVU	global	Previous survey data for ref codes					
				pre min	intra min	post min	ICU visits	ACU visits	Office visits
62287	Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumbar (eg, manual or automated percutaneous diskectomy, percutaneous laser diskectomy)	**8.08**	90	70	60		0	2	3
62292	Injection procedure for chemonucleolysis, including diskography, intervertebral disk, single or multiple levels, lumbar	**7.86**	90	23	47		1	3	2
20225	Biopsy, bone, trocar, or needle; deep (vertebral body, femur)	**1.87**	0	45	60	30	n/a	n/a	n/a

Since a number of survey respondents indicated they felt 62287 was the best reference code for 2258X3, we dissected 62287 to understand how the work RVU of 8.08 was derived. This code was surveyed in 1995 as part of the 5-year-review second phase study by AANS. A total work value of 8.60 was calculated at that time. The intra-service work in that survey was 4.00, with an IWPUT of 0.067 and pre/post service work of 4.60 RVUs.

The current work of the pre/post service for CPT 62287 can be calculated using a building block approach for the time in each segment as allocated to the equivalent EM codes and the associated work value for the EM code(s). When this methodology is applied to the time and visit codes in the year 2000 table above, the sum of work RVUs for pre/post service are 4.30 RVWs. When this is subtracted from the current total work RVU for 62287, the remainder is 3.78 RVW which represents the intra-service work of this code. The current IWPUT can then be derived by dividing the intra-service 3.78 RVWs by the intra time of 60 minutes, which equals an IWPUT of 0.063.

This method, when applied to 22520, produces the following results:
The sum of all the pre- and post-service work in terms of RVUs (not including the intra-service work), is 4.93 RVWs. When this is subtracted from the median survey estimate for total work of 10.00, the remainder is 5.07 which represents the intra-service RVW of this code. The IWPUT for this code is 0.063 (10.00 rvu's / 80 min). This matches that of the initial reference code exactly, supporting the comparability of these two codes and their work RVUs.

Use of IWPUT to place a new code among a group of reference services with differing globals and variations in operative technique is a useful way to judge the relative value of the code among it's peers. In this case, the IWPUT of the second reference code matches 22520 remarkably well. For example, reference code 62292 *chemonucleolysis of a lumbar disk* has a total RVW of 7.86, an intra-service RVW of 2.94, and an IWPUT of 0.063. However, the third reference code, 20225 fails this relational methodology badly. The total RVW of 1.87 divided by the intra-service time of 60 minutes produces an IWPUT of 0.031, which is equal to that of an EM code. However this code has a 000 global with some pre- and post-time associated. If this additional time is included in the calculation of intra-service work, the IWPUT drops to 0.001. This is clearly an anomaly and reflects misvaluation of the total RVW for 20225. This is clearly an anomaly and reflects misvaluation of the total RVW for 20225. This anomaly is further supported by the poor comparison of 20225 (IWPUT=0.001; RVW=1.87; intra-service time of 60 minutes; total time of 135 minutes) to the EM code 99215 (IWPUT=0.031; RVW=1.51; intra-service time of 40 minutes; total time of 59 minutes)

Using other parameters for comparisons, the time value for the intra-service component of 22520 from the median survey value was 80 minutes. Compared to the reference codes 62287 (60 min) , 62292 (47 min), and 20225 (60 min), the amount of time required for this service is justified considering the number of tasks involved in a single thoracic vertebroplasty. The extra time for imaging confirmation of needle placement and the location of the injected methacrylate easily account for the additional 20 minutes in this new code

We recommend the survey value of 10.00 RVUs for 22520.

FREQUENCY INFORMATION

How was this service previously reported?

22899 Unlisted procedure, spine

How often do physicians in your specialty perform this service?

Specialties: American Association of Neurological Surgeons
American College of Radiology
American Society of Neuroradiology
North American Spine Association
Society of Cardiovascular & Interventional Radiology

Sometimes

For your specialty, estimate the number of times this service might be provided nationally in a one-year period?

It is estimated that 115,000 hospital admissions per year are the result of vertebral body fractures. These patients are all possible candidates for vertebroplasty, however, not all of these patients will receive this treatment. It is difficult to estimate the percentage of patients that may go on to have vertebroplasty.

Do many physicians perform this service across the United States? No

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CPT Code: 22521 (GG2) **Global Period**: 010 **Recommended RVW**: ~~9.43~~ **8.34 (RUC)**

CPT Code Descriptor: Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar
(For radiological supervision and interpretation, see 7601X1, 7601X2)

Typical Patient (*Survey Vignette*):
A 75-year-old female presents for percutaneous vertebroplasty Her history includes sudden, severe low back pain after bending over to retrieve a laundry item; a plain film spine series that revealed an acute compression fracture of L2; and subsequent prescribed bedrest and narcotic analgesic for two weeks with minimal relief The percutaneous lumbar vertebroplasty is performed. The patient is discharged several hours after the procedure and followed as necessary in the office through the 10-day global period.

CLINICAL DESCRIPTION OF SERVICE

Pre-Service Work:
- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up; with special attention to previous radiographs
- Counsel patient and obtain informed consent
- Change into scrub clothes
- Review planned procedure with other health care professionals
- Supervise positioning, draping, and prepping of the patient on the angiography//fluoroscopy table
- Verify that all necessary surgical instruments and supplies are readily available
- Verify that the equipment has been appropriately calibrated
- Scrub and gown

Intra-Service Work:
- After sedation is achieved and the L2 pedicle is fluoroscopically localized (separately reportable), the skin, subcutaneous tissues, and periosteum are locally anesthetized
- An incision is made with a scalpel
- An 11G bone biopsy needle is directed into the anterior third of the vertebral body utilizing AP and lateral fluoroscopy, supplemented with CT imaging as required for adequate visualization
- Following needle placement, injection of 3-5 ml of Omnipaque 300 with filming in the AP and lateral planes is performed to reveal needle position within the trabecular space, with preferential filling to the anterior internal epidural venous plexus via the basivertebral plexus.
- PMMA cement is mixed and injected, using 1.0 ml aliquots, under fluoroscopic control, utilizing both the AP and lateral planes. [Injection is terminated after the material reaches the posterior fourth of the vertebral body. During the injection process, the epidural venogram is consulted to insure that PMMA has not migrated into or towards the outlined venous plexus.]
- Remove needle and review control film to determine PMMA penetration [Note: If the PMMA has not crossed into the opposite vertebral hemisphere, the procedure is repeated in the contralateral side of the vertebral body.]
- Final control AP and lateral images of the lumbar spine are reviewed to confirm no migration into the surrounding veins

Post-service Work (day of service):
- Clean wounds and apply sterile dressings and transfer patient to recovery room.
- Review recovery room care and medications with staff
- Write outpatient medication orders for patient
- Dictate operative report
- Examine patient, check wound(s) and patient progress
- Discuss procedure outcome with patient and family and schedule follow-up visit in office
- Discuss wound care with patient, prior to discharge
- Discuss procedure outcome with referring physician
- Dictate procedure outcome letter for referring physician and/or insurance company

Post-service Work (post-discharge):

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Write orders for medications
- Dictate patient progress notes for medical chart

SURVEY DATA

Presenter(s): J Arliss Pollock, MD (ASNR)
John Barr, MD (ASNR)
James P Borgstede, MD (ACR)
Bernard A Pfeifer, MD (NASS)
Gregory Przybylski, MD (AANS/CNS)
Robert L Vogelzand, MD (SCVIR)

Specialty(s): American Association of Neurological Surgeons
American College of Radiology
American Society of Neuroradiology
North American Spine Association
Society of Cardiovascular & Interventional Radiology

Sample Size: 649 **Response Rate**: 37 (6%):

Type of Sample: Random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	2.50	7.00	**10.00**	15.00	18.14
Time (min) and Visits					
24 Hr Preceding Service			**30**		
Day Of Service					
Pre-Service			**30**		
Intra-Service	30	60	**75**	90	120
Immed. Post-Service			**30**		
Post-Service	**Total Time**	**CPT code / # of visits**			
Critical Care		none			
Other Hospital					
Discharge Management	36	99238			
Office Visits	23	99213 x 1			

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2000 work RVU	global
62287	Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumbar (eg, manual or automated percutaneous diskectomy, percutaneous laser diskectomy)	8 08	90
62292	Injection procedure for chemonucleolysis, including diskography, intervertebral disk, single or multiple levels, lumbar	7.86	90
20225	Biopsy, bone, trocar, or needle, deep (vertebral body, femur)	1.87	0

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

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

TIME ESTIMATES (MEDIAN)	Survey CPT 22521	Ref CPT 20225	Ref CPT 62287	Ref CPT 62292
Pre-service time	60	See previous survey data shown on table presented in additional rationale section.		
Intra-service time	75			
Immediate Post-service time	30			
Total critical care time	0			
Total other hospital visit time	19			
Discharge management time	36			
Total office visit time	38			
INTENSITY/COMPLEXITY MEASURES (mean)				
TIME SEGMENTS				
Pre-service	3.26	3.00	3 00	2.67
Intra-service	3.97	3.00	3 17	3.00
Post-service	2 63	2.29	2.83	2.33
MENTAL EFFORT AND JUDGMENT				
The number of possible diagnosis and/or the number of management options that must be considered	3.17	2.86	3.17	2.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.42	2.86	3.50	2.33
Urgency of medical decision making	2.83	3.29	2.67	2.67
TECHNICAL SKILL/PHYSICAL EFFORT				
Technical skill required	3.89	3.71	3.33	3.33
Physical effort required	3.89	3.29	2.83	3.00
PSYCHOLOGICAL STRESS				
The risk of significant complications, morbidity and/or mortality	3.64	3.29	3.00	3.00
Outcome depends on the skill and judgement of physician	4.03	3.29	3.50	3.00
Estimated risk of malpractice suit with poor outcome	3 83	3.43	3.50	3.53

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The principal reference codes cited were 62287, 62292, 20225. Each of these codes has elements of the physician work of 22521, while having important dissimilar features. When comparing codes with different global periods, efforts to normalize them using a building block method to measure the pre- and post-work, and then calculating the intra-service work RVUs, affords a way to help with such comparisons.

CPT 62287 is the code for percutaneous lumbar diskectomy and has a 90-day global, while 22521 has a 10-day global period CPT 62292 is the code for chemonucleolysis of a lumbar disk, also with a 90-day global CPT 20225 describes a biopsy of a vertebral body by needle or trocar, using similar needle guidance and insertion techniques to the new codes. The respective RVWs and survey data for these reference codes are shown in the table below:

CPT	Descriptor	2000 work RVU	global	Previous survey data for ref. codes*					
				pre min	intra min	post min	ICU visits	ACU visits	Office visits
62287	Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumbar (eg, manual or automated percutaneous diskectomy, percutaneous laser diskectomy)	**8.08**	90	70	60		0	2	3
62292	Injection procedure for chemonucleolysis, including diskography, intervertebral disk, single or multiple levels, lumbar	**7.86**	90	23	47		1	3	2
20225	Biopsy, bone, trocar, or needle; deep (vertebral body, femur)	**1.87**	0	45	60	30	n/a	n/a	n/a

Since a number of survey respondents indicated they felt 62287 was the best reference code for 2258X3, we dissected 62287 to understand how the work RVU of 8.08 was derived This code was surveyed in 1995 as part of the 5-year-review second phase study by AANS. A total work value of 8 60 was calculated at that time The intra-service work in that survey was 4.00, with an IWPUT of 0.067 and pre/post service work of 4 60 RVUs

The current work of the pre/post service in 62287 can be calculated from a building block approach to the time in each segment as allocated to the equivalent EM codes and the associated work value for the EM code(s). When this is applied to the time and visit codes in the year 2000 table above, the sum of work RVUs for pre/post service are 4 30 RVWs When this is subtracted from the current total work RVU for 62287, the remainder is 3 78 RVW which represents the intra service work of this code. The current IWPUT can then be derived by dividing the intra-service 3.78 RVWs by the intra time of 60 minutes, which equals an IWPUT of 0.063.

This method, when applied to 22521, produces the following results:
The sum of all the pre- and post-service work in terms of RVUs (not including the intra-service work), is 4.93 RVWs. We estimate that the IWPUT for this lumbar code is approximately 5% less than the IWPUT for the thoracic code 22520. This equates to an IWPUT of 0 060 and an intra-service RVW of 4.50 (0.060 x 75 min). Adding this intra-service RVW to the pre/post-service RVWs produces a total RVW for 22521 of 9.43 (4.93 + 4.50). We recommended an RVW of 9.43 for 22521. This RVW fairly sets the value for this code relative to 22520 and the reference codes.

Use of IWPUT to place a new code among a group of reference services with differing globals and variations in operative technique is a useful way to judge the relative value of the code among it's peers. In this case, the IWPUT of the second reference code matches 22521 remarkably well. For example, reference code 62292 *chemonucleolysis of a lumbar disk* has a total RVW of 7.86, an intra-service RVW of 2.94, and an IWPUT of 0.063. However, the third reference code, 20225 fails this relational methodology badly. The total RVW of 1.87 divided by the intra-service time of 60 minutes produces an IWPUT of 0.031, which is equal to that of an EM code However this code has a 000 global with some pre- and post-time associated. If this additional time is included in the calculation of intra-service work, the IWPUT drops to 0 001. This is clearly an anomaly and reflects misvaluation of the total RVW for 20225. This anomaly is further supported by the poor comparison of 20225 (IWPUT=0.001; RVW=1.87; intra-service time of 60 minutes; total time of 135 minutes) to the EM code 99215 (IWPUT=0.031; RVW=1.51; intra-service time of 40 minutes; total time of 59 minutes).

Using other parameters for comparisons, the time value for the intra-service component of 22521 from the median survey value was 75 minutes. Compared to the reference codes 62287 (60 min) , 62292 (47 min), and 20225 (60 min), the amount of time required for this service is justified considering the number of tasks involved in a single lumbar vertebroplasty. The extra time for imaging confirmation of needle placement and the location of the injected methacrylate easily account for the additional 15 minutes in this new code.

We recommend an RVW of 9.43 for 22521. This value is less than the survey median, but fairly accounts for the slight decrease in time and intensity for this procedure in comparison to the thoracic procedure 22520.

FREQUENCY INFORMATION

How was this service previously reported?

22899 Unlisted procedure, spine

How often do physicians in your specialty perform this service?

Specialties: American Association of Neurological Surgeons
American College of Radiology
American Society of Neuroradiology
North American Spine Association
Society of Cardiovascular & Interventional Radiology

Sometimes

For your specialty, estimate the number of times this service might be provided nationally in a one-year period?

It is estimated that 115,000 hospital admissions per year are the result of vertebral body fractures. These patients are all possible candidates for vertebroplasty, however, not all of these patients will receive this treatment. It is difficult to estimate the percentage of patients that may go on to have vertebroplasty.

Do many physicians perform this service across the United States? No

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CPT Code: 22522 (GG3) **Global Period:** ZZZ **Recommended RVW:** ~~4.41~~ **4.31 (RUC)**

CPT Code Descriptor: Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

(Use 22522 in conjunction with codes 22520, 22521 as appropriate)
(For radiological supervision and interpretation, see 7601X1, 7601X2)

Typical Patient (*Survey Vignette*):
A 70-year-old male with hypernephroma and severe thoraco-lumbar junction pain presents with a two-year history that includes a nephrectomy, spinal radiation, and chemotherapy. A previous MRI revealed tumor infiltration of the T9 and L1 through L3 vertebrae, which has destroyed the posterior cortex at all levels, with mild spinal canal encroachment Narcotic analgesics have not helped; additional chemotherapy has been ruled out as ineffective and/or poorly tolerated, additional radiation therapy is not possible because the maximum spinal dose has already been given; and corpectomy and fixation are not possible due to the patient's cachexia, the vascular nature of the tumor, and possible spinal column collapse that may result in paraparesis and incontinence. The patient and his family understand that his condition is terminal and that the palliative treatment of a percutaneous vertebroplasty is being offered primarily to control pain and prevent incontinence and paraparesis Percutaneous vertebroplasty is performed [Please NOTE that this new code is an "add-on" code for the percutaneous vertebroplasty of "each additional" thoracic or lumbar vertebral body. When completing this survey, please ONLY consider the intra-operative physician work related to performing ONE ADDITIONAL vertebral body. All pre-service and post-service work will be captured in the total work of the separately billable primary procedure.]

CLINICAL DESCRIPTION OF SERVICE

Pre-Service Work:
- N/A

Intra-Service Work:
- Following completion of injections at the T9 level, the additional work of the vertebroplasty at L1 commences:
- Adjust drapes to allow access to the LI area and do antiseptic skin prep. A small skin incision is made over the entry sites for each pedicle of L1.
- 11G needles are placed through the left and right pedicles at L1 with (separately billable) CT guidance
- Lateral visualization is reviewed as the patient is withdrawn from the CT gantry and a portable C-arm digital angiography unit (covered with sterile drapes) is positioned
- Intraosseous venography is performed (separately billable) by injection of non-ionic contrast to confirm satisfactory needle positions
- PMMA cement is mixed and slowly injected at L1 under fluoroscopic control.
- The patient is quickly advanced into the CT scanner and images of L1 are reviewed to determine the extent of injection material penetration. Often times additional cement indicated.
- The patient is withdrawn from the CT gantry, a new batch of cement is injected, as needed, under fluoroscopic control
- CT scans obtained through L1 are reviewed and show filling of only the left half of the L1 vertebra. No cement has reached the spinal canal or neural foramen. The needle in the opposite pedicle of L1 is then injected by contrast and the intraosseous venography is monitored by fluoroscopy. Using sequential CT scans for guidance, 3 ml of cement is injected on this side, which adequately fills the posterior vertebral body..
- A final CT confirms adequate bilateral cement filling at this level without encroachment upon the spinal canal or neural foramen.
- The needles are removed and a suture is placed in the small skin incision on each side
-

Post-service Work
- N/A

SURVEY DATA

Presenter(s): J Arliss Pollock, MD (ASNR)
John Barr, MD (ASNR)
James P Borgstede, MD (ACR)
Bernard A Pfeifer, MD (NASS)
Gregory Przybylski, MD (AANS/CNS)
Robert L Vogelzand, MD (SCVIR)

Specialty(s): American Association of Neurological Surgeons
American College of Radiology
American Society of Neuroradiology
North American Spine Association
Society of Cardiovascular & Interventional Radiology

Sample Size: 649 **Response Rate**: 38 (6%):

Type of Sample: Random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	2.00	4.00	**8.00**	10.00	20.00
Time (min) and Visits					
Intra-Service	20	30	**50**	60	135

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2000 work RVU	global
62287	Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumbar (eg, manual or automated percutaneous diskectomy, percutaneous laser diskectomy)	8 08	90
62292	Injection procedure for chemonucleolysis, including diskography, intervertebral disk, single or multiple levels, lumbar	7.86	90
20225	Biopsy, bone, trocar, or needle, deep (vertebral body, femur)	1.87	0

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

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

TIME ESTIMATES (MEDIAN)	Survey CPT 22522	Ref CPT 20225	Ref CPT 62287	Ref CPT 62292
Pre-service time	n/a	See previous survey data shown on table presented in additional rationale section.		
Intra-service time	50			
Immediate Post-service time	n/a			
Total critical care time	n/a			
Total other hospital visit time	n/a			
Discharge management time	n/a			
Total office visit time	n/a			
INTENSITY/COMPLEXITY MEASURES (mean)				
TIME SEGMENTS				
Pre-service	n/a	n/a	n/a	n/a
Intra-service	3.83	3.25	3.33	2.67
Post-service	n/a	n/a	n/a	n/a
MENTAL EFFORT AND JUDGMENT				
The number of possible diagnosis and/or the number of management options that must be considered	3.27	2.80	3.33	2.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.43	2.80	3.50	2.67
Urgency of medical decision making	3.32	3.60	2.67	2.67
TECHNICAL SKILL/PHYSICAL EFFORT				
Technical skill required	4.03	3.80	3.33	3.33
Physical effort required	3.97	3.40	2.83	3.00
PSYCHOLOGICAL STRESS				
The risk of significant complications, morbidity and/or mortality	3.95	3.40	3.00	2.67
Outcome depends on the skill and judgement of physician	4.11	3.80	3 33	3.67
Estimated risk of malpractice suit with poor outcome	3.92	4.40	3.33	2.67

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The principal reference codes cited were 62287, 62292, 20225. Each of these codes has elements of the physician work of 22522, while having important dissimilar features. When comparing codes with different global periods, efforts to normalize them using a building block method to measure the pre- and post-work, and then calculating the intra-service work RVUs, affords a way to help with such comparisons.

CPT 62287 is the code for percutaneous lumbar diskectomy and has a 90-day global, while 22522 has a ZZZ global period CPT 62292 is the code for chemonucleolysis of a lumbar disk, also with a 90-day global. CPT 20225 describes a biopsy of a vertebral body by needle or trocar, using similar needle guidance and insertion techniques to the new codes. The respective RVWs and survey data for these reference codes are shown in the table below:

CPT	Descriptor	2000 work RVU	global	Previous survey data for ref. codes					
				pre min	intra min	post min	ICU visits	ACU visits	Office visits
62287	Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumbar (eg, manual or automated percutaneous diskectomy, percutaneous laser diskectomy)	**8.08**	90	70	60		0	2	3
62292	Injection procedure for chemonucleolysis, including diskography, intervertebral disk, single or multiple levels, lumbar	**7.86**	90	23	47		1	3	2
20225	Biopsy, bone, trocar, or needle, deep (vertebral body, femur)	**1.87**	0	45	60	30	n/a	n/a	n/a

Since a number of survey respondents indicated they felt 62287 was the best reference code for 2258X3, we dissected 62287 to understand how the work RVU of 8.08 was derived. This code was surveyed in 1995 as part of the 5-year-review second phase study by AANS. A total work value of 8.60 was calculated at that time. The intra-service work in that survey was 4.00, with an IWPUT of 0.067 and pre/post service work of 4.60 RVUs.

The current work of the pre/post service for CPT 62287 can be calculated using a building block approach for the time in each segment as allocated to the equivalent EM codes and the associated work value for the EM code(s). When this methodology is applied to the time and visit codes in the year 2000 table above, the sum of work RVUs for pre/post service are 4.30 RVWs. When this is subtracted from the current total work RVU for 62287, the remainder is 3.78 RVW which represents the intra-service work of this code. The current IWPUT can then be derived by dividing the intra-service 3.78 RVWs by the intra time of 60 minutes, which equals an IWPUT of 0.063.

This method when applied to 22522 produces the following results:
There is no pre- or post-service work for a ZZZ code. The IWPUT for this code based on the median survey RVW of 8.00 and a median time of 50 minutes is 0.160. This is clearly too high, ranking above the IWPUT for almost all surgical services. If we apply the IWPUT used for the parent codes of 0.063 to the median time of 50 minutes, the resulting intra-service RVW is 3.15. This fails to match either of the intra-service RVWs for 22520 or 22521, which are in the range of 4 to 5 RVWs.

When we compare the median survey time of 50 minutes for this add-on code to the 80 or 75 minutes for the parent codes (GG1 and GG2), it appears that the survey respondents underestimated the time required for this additional vertebroplasty code. The work involved for the vertebroplasty of an additional vertebral body is the same as the intra-service work for the parent codes.

Compared to the intra-service time for the reference codes 62287 (60 min) , 62292 (47 min), and 20225 (60 min), the survey time for this service is too low considering the number of tasks involved in a single vertebroplasty. We estimate that a time of 70 minutes would be reasonable for this service. When a 70 minute intra-service time is multiplied by the family IWPUT of 0.063, the resulting work RVU is 4.41, which is our recommended value.

We recommend 4.41 RVUs for 22522.

FREQUENCY INFORMATION

How was this service previously reported?

22899 Unlisted procedure, spine

How often do physicians in your specialty perform this service?

Specialties. American Association of Neurological Surgeons
American College of Radiology
American Society of Neuroradiology
North American Spine Association
Society of Cardiovascular & Interventional Radiology

Sometimes

For your specialty, estimate the number of times this service might be provided nationally in a one-year period?

It is estimated that 115,000 hospital admissions per year are the result of vertebral body fractures. These patients are all possible candidates for vertebroplasty, however, not all of these patients will receive this treatment. It is difficult to estimate the percentage of patients that may go on to have vertebroplasty.

Do many physicians perform this service across the United States? No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:	**76012**	Tracking Number:	**GG4**	Global Period:	XXX	**Recommended RVW:**	~~1.16~~—**1.31 (RUC)**

CPT Descriptor.

Radiological supervision and interpretation, percutaneous vertebroplasty, per vertebral body; under fluoroscopic guidance

(For procedure, see 22520 – 22522)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
A 75 year old white female who had been living independently develops sudden, severe low back pain after bending over to retrieve a laundry item. Her family physician orders a plain film spine series that reveals an acute compression fracture of L2. He prescribes bedrest and narcotic analgesic to be taken as needed. The pain is unrelieved with medication, and immobilization provides minimal relief. The medication is increased to four to six times daily, with no significant change. After two weeks of immobilization and narcotic analgesics, the patient remains bed-ridden with a clouded sense of sensorium from narcotics No improvement in pain or mobility is seen.

Description of Pre-Service Work:
The physician reviews all previous studies and imaging to determine level for percutaneous vertebroplasty.

Description of Intra-Service Work:
The patient is placed in the prone position on the angiography/fluoroscopy table The left L2 pedicle is fluoroscopically localized. Needle placement is monitored fluroscopically to confirm needle position within the trabecular space. Injection of contrast is monitored fluoroscopically to obtain the epidural venogram. Injection of PMMA is monitored to ensure no migration occurs into or towards the outlined venous plexus. This procedure is repeated if bilateral pedicular injections are required. Radiologist review of final AP and lateral images of the lumbar spine show PMMA within the vertebral body with no migration into the surrounding veins.

Description of Post-Service Work:
The physician dictates a report of the fluoroscopy and interprets the epidural venogram. The physician reviews and signs the report.

SURVEY DATA:

Presenter(s): J Arliss Pollock, MD (ASNR)
John D. Barr, MD (ASNR)
James P. Borgstede, MD (ACR)
Robert L Vogelzang, MD (SCVIR)

Specialty(s). American Society of Neuroradiology
American Society of Neuroradiology
American College of Radiology
Society of Cardiovascular & Interventional Radiology

Sample Size: 455 Response Rate: (%): 32/455 (7.0%) Median RVW: 1.31

Type of Sample (Circle One): random panel Convenience Explanation of sample size: _____

25th Percentile RVW. 1.16 75th Percentile RVW: 6.01 Low. 0.4 High: 18

Median Pre-Service Time: 45.00 Median Intra-Service Time: 60.00

25th Percentile Intra-Service Time. 15.00 75th Percentile Intra-Svc Time: 90.00 Low: 5 High: 185

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	15	
Critical Care:	N/A	
Other Hospital Visits:	N/A	
Discharge Day Mgmt.:	N/A	
Office Visits:	N/A	

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
75894	Transcatheter therapy, embolization, any method, radiological supervision and interpretation	1.31

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	45.00	40 00
Median Intra-Time	60.00	60 00
Median Immediate Post-service Time	15.00	15.00
Median of Aggregate Critical Care Times	N/A	N/A
Median of Aggregate Other Hospital Visit Times	N/A	N/A
Median Discharge Day Management Time	N/A	N/A
Median of Aggregate Office Visit Times	N/A	N/A
INTENSITY/COMPLEXITY MEASURES (Mean)		
Mental Effort and Judgement (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.28	3.14
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.22	3.43
Urgency of medical decision making	3.16	3.57
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.63	4.00
Physical effort required	3.00	2.86
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.75	3.71
Outcome depends on the skill and judgement of physician	3.94	3.71
Estimated risk of malpractice suit with poor outcome	3.91	4.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.11	3.0
Intra-Service intensity/complexity	3.88	3.86
Post-Service intensity/complexity	2.68	2.43

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

Despite similarities between the new code and reference code in terms of intensity, effort, and complexity, we are recommending that the 25th percentile RVW of 1.16 be accepted. We are taking the 25th percentile RVW because respondents revealed some confusion between the procedural and S & I components of the procedure in terms of time

FREQUENCY INFORMATION

How was this service previously reported?

20225 – Biopsy, bone, trocar, or needle; deep (vertebral body, femur)
22851 – Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), threaded bone dowel(s), methylmethacrylate) to vertebral defect or interspace
76003 – Fluoroscopic localization for needle biopsy or fine needle aspiration
36005 - Injection procedure for contrast venography (including introduction of needle or intracatheter)
75872 – Venography, epidural, radiological supervision and interpretation
22899 – Unlisted procedure, spine

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

Specialty	Neuroradiolgy	___	Commonly	X	Sometimes	___	Rarely
Specialty	Radiology	___	Commonly	X	Sometimes	___	Rarely
Specialty	Interventional Radiology	___	Commonly	X	Sometimes	___	Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty	Neuroradiology	Frequency	35,000
Specialty	Radiology	Frequency	

Specialty Interventional Radiology Frequency _____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty

Specialty Neuroradiology Frequency 28,000

Specialty Radiology Frequency _____

Specialty Interventional Radiology Frequency _____

Do many physicians perform this service across the United States? Yes X No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:	**76013**	Tracking Number:	**GG5**	Global Period.	XXX	**Recommended RVW:**	~~1.22~~—**1.38 (RUC)**

CPT Descriptor

Radiological supervision and interpretation, percutaneous vertebroplasty, per vertebral body; under CT guidance

(For procedure, see 22520 – 22522

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 70 year-old male with a h/o hypernephroma presents with severe thoraco-lumbar junction pain. Two years previously, he had undergone a nephrectomy, spinal radiation and chemotherapy His oncologist orders an MRI that reveals tumor infiltration of the T12 through L3 vertebrae. Tumor has destroyed the posterior cortex at all levels and there is mild spinal canal encroachment. The patient is almost non-ambulatory due to pain. The oncologist prescribes a narcotic analgesic, but this causes excessive sedation at doses that even partially relieve the patient's pain. The oncologist feels that additional chemotherapy will be ineffective and poorly tolerated. Additional radiation therapy is not possible because the maximum spinal dose has already been given A spine surgeon is consulted. He feels that the patient would not survive a complex anterior and posterior approach for multilevel corpectomy and fixation, due to the patient's cachexia and the vascular nature of the tumor. He also states there is a high probability that spinal column collapse may occur with continued weight bearing, likely resulting in paraparesis and incontinence.

Although there is severe bony destruction at multiple levels (a relative contraindication to vertebroplasty) and a mild degree of spinal canal compromise caused by tumor invasion. A consultation is made regarding percutaneous vertebroplasty. Following review of patient history, physical findings and prior imaging studies, the consulted physician feels that CT guidance is indicated for maximum patient safety and effectiveness of treatment.

Description of Pre-Service Work:

All previous imaging studies are reviewed to determine levels for percutaneous vertebroplasty

Description of Intra-Service Work:

Patient positioning and imaging setup is confirmed. Sequential CT images are obtained to guide 11G needles through the left and right pedicles at the designated vertebral level. Intraosseous venography performed with injection of 5mL iohexol 300 non-ionic contrast. Sequential CT images and possible fluoroscopy images are obtained, as necessary, to guide injection of PMMA cement and to access vertebral filling. Final CT images are obtained and all images are interpreted.

Description of Post-Service Work:

The physician dictates a report of the fluoroscopy and interprets the epidural venogram and CT scan. The physician reviews and signs the report. The results are discussed with the patient, family, and referring physician.

SURVEY DATA:

Presenter(s): J. Arliss Pollock, MD (ASNR)
John D. Barr, MD (ASNR)
James P. Borgstede, MD (ACR)
Robert L. Vogelzang, MD (SCVIR)

Specialty(s): American Society of Neuroradiology
American Society of Neuroradiology
American College of Radiology
Society of Cardiovascular & Interventional Radiology

Sample Size: 455 Response Rate (%): 30/455 (6 6%) Median RVW: 1.9

Type of Sample (Circle One): random panel convenience Explanation of sample size:

25th Percentile RVW: 1.22 75th Percentile RVW: 5 85 Low: 1.0 High. 19

Median Pre-Service Time: 37.50 Median Intra-Service Time: 60

25th Percentile Intra-Service Time: 30 75th Percentile Intra-Svc Time: 90 Low: 5 High: 120

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	15	
Critical Care:	N/A	
Other Hospital Visits:	N/A	
Discharge Day Mgmt.:	N/A	
Office Visits:	N/A	

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
76360	Computerized tomography guidance for needle biopsy, radiological supervision and interpretation	1.16

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	37 50	10.00
Median Intra-Time	60.00	45.00
Median Immediate Post-service Time	15.00	10.00
Median of Aggregate Critical Care Times	N/A	N/A
Median of Aggregate Other Hospital Visit Times	N/A	N/A
Median Discharge Day Management Time	N/A	N/A
Median of Aggregate Office Visit Times	N/A	N/A

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.36	2.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.46	2.63
Urgency of medical decision making	3.32	2.5
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.07	3.00
Physical effort required	3.46	2.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4 14	3.13
Outcome depends on the skill and judgement of physician	4.25	3.50
Estimated risk of malpractice suit with poor outcome	4.04	3.38

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3 19	2.50
Intra-Service intensity/complexity	4.20	3.25
Post-Service intensity/complexity	2 81	2.17

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

Although the new code is consistently rated higher than the reference code in terms of time, intensity, effort, and complexity, we are recommending that the 25th percentile RVW of 1.22 be accepted. We are taking the 25th percentile RVW because it appears that respondents revealed some confusion between the procedural and S & I components of the procedure in terms of time.

FREQUENCY INFORMATION

How was this service previously reported?

20225 – Biopsy, bone, trocar, or needle; deep (vertebral body, femur)
22851 – Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), threaded bone dowel(s), methylmethacrylate) to vertebral defect or interspace
76003 – Fluoroscopic localization for needle biopsy or fine needle aspiration
36005 - Injection procedure for contrast venography (including introduction of needle or intracatheter)
75872 – Venography, epidural, radiological supervision and interpretation
22899 – Unlisted procedure, spine

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

Specialty	Neuroradiolgy	___	Commonly	X	Sometimes	___	Rarely
Specialty	Radiology	___	Commonly	X	Sometimes	___	Rarely
Specialty	Interventional Radiology	___	Commonly	X	Sometimes	___	Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty	Neuroradiology	Frequency	35,000
Specialty	Radiology	Frequency	
Specialty	Interventional Radiology	Frequency	

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty

Specialty	Neuroradiology	Frequency	28,000
Specialty	Radiology	Frequency	
Specialty	Interventional Radiology	Frequency	

Do many physicians perform this service across the United States? ____ Yes X No

AMA SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Nose Repair

Work Relative Value Recommendations

New code 30465 *Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)* was created to describe surgical management of nasal obstruction due to nasal vestibular stenosis. The patient presents with collapsed valves within the nose. This procedure requires two components, revision of the nasal tip with excision of dorsal nasal skin and placement of a support so the nasal tip does not collapse. New code 30465 excludes obtaining a graft, which is obtained from a distal site and is a separately reportable service using the appropriate graft procedure code (20900-20926, 21210). Currently, CPT does not contain a code that accurately describes this service; therefore, the unlisted code 30999 *Unlisted procedure, nose* was reported.

The RUC evaluated the work survey results for code 30465, which had a recommended work survey value of 11.64, which was also the median survey work value. When the RUC compared the new code with the reference service code 30400 *Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip* (work RVU = 9.83), the new code had greater time and complexity and intensity measures, as the patients are generally sicker with comorbid conditions. The pre- and post-service work for new code 30465 includes extensive patient support in terms of the physical disfigurement that results from the procedure. This new procedure has greater technical difficulties due to the elevation and stabilization of the nasal tip. Additionally, resection of excessive dorsal skin is performed in conjunction with the repair of the tip ptosis. Due to the significant risk to the patient and the technical difficulty of the procedure, the RUC agreed that the recommended value of 11.64 was appropriate. **The RUC recommends a work relative value of 11.64 for code 30465.**

Practice Expense Recommendations

The direct practice expense inputs were developed by a specialty consensus panel. The society used code 30400 as a reference service to determine appropriate direct inputs. The specialty also explained the coordination of care activities required. The RUC accepted the attached direct inputs with minor modifications to the supplies. The specialty society used the E/M standard clinical staff time for their post-operative office visits.

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●30465	HH1	Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction) (30465 excludes obtaining graft. For graft procedure, see 20900-20926, 21210) (30465 is used to report a bilateral procedure. For unilateral procedure, use modifier '-52')	090	11.64

CPT Code: 30465 **Global Period**: 090 **Recommended RVW**: 11.64

CPT Descriptor: Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)
(30465 excludes obtaining graft. For graft procedure, see 20900-20926, 21210)
(30465 is used to report a bilateral procedure. For unilateral procedure, use modifier '-52')

Typical Patient (*Survey Vignette*):
A 67-year-old male with compensated congestive heart failure presents with complaints of progressive nasal obstruction because the nasal vestibules are severely narrowed both by ptosis of the thickened nasal tip and by collapse of the flaccid lateral nasal walls. He requires repair of nasal vestibular stenosis. At operation, cartilage grafts are placed in the lateral nasal walls, as well as elevation of the nasal tip Excessive dorsal nasal skin is resected directly with horizontal closure. The patient is followed by the surgeon, as necessary, postoperatively through the 90-day global period. [PLEASE NOTE that obtaining grafts is separately reportable with another code. In completing this survey, do NOT include your work related to obtaining the graft]

CLINICAL DESCRIPTION OF SERVICE

Pre-service work - Day before surgery:
- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up, with particular attention to particular attention to medical status and potential complications
- Review diagnostic evaluation and choice of procedures to select appropriate treatment plant
- Review planned incisions and procedure

Pre-service work - Day of surgery:
- Change into scrub clothes
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family , especially the likely negative cosmetic change attendant on surgery
- Answer patient and family questions and obtain informed consent
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Note: If graft is used, patient may have to be repositioned, prepped and draped again after harvesting (harvesting is separately billable)
- Scrub and gown

Intra-service work:
- Anesthetize operative site
- Make incisions
- Isolate and define nasal structure to be manipulated
  - e.g. separate upper lateral cartilage from septal dorsum to place spreader grafts
  - e.g. isolate cephalic margins of lower lateral cartilage to place tip suspension / dilation sutures
  - e.g. separate medial crura of lower lateral cartilage and create an intercrural pocket for placement of columellar strut graft
  - e.g. create subcutaneous pockets in lateral nasal walls via intercartilaginous incisions for lateral wall batten grafts
- Prepare graft(s) to proper size and shape (if used)
- Place and secure graft(s)
- Place suspension / flaring sutures
- Secure tip support (septocolumellar sutures etc)
- Close wounds

Post-op Same day work through discharge from recovery
- Apply dressings / splint, as indicated
- Write orders for post-op labs and medications
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Answer patient/family questions
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company
- Review instructions for post-discharge wound care and home care with patient and family
- Answer insurance staff questions
- Write orders for post-discharge medications
- Chart patient discharge notes

Post-op Office work - After discharge from hospital
- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician
- Write orders for medications
- Discuss progress with patient/family
- Dictate patient progress notes for medical chart
- Dictate procedure outcome letter for referring physician

SURVEY DATA

Presenter(s): James H. Kelly, MD

Specialty(s): American Academy of Otolaryngology – Head and Neck Surgery, Inc.

Sample Size: 88 **Response Rate**: 26 (30%):

Type of Sample: Random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	5.38	9.83	**11.64**	15.13	16.00
Time (min) and Visits					
24 Hr Preceding Service			**30**		
Day Of Service					
Pre-Service			**30**		
Intra-Service	38	60	**120**	150	180
Immed. Post-Service			**30**		
Post-Service	**Total Time**	**CPT code / # of visits**			
Critical Care		none			
Other Hospital		none			
Discharge Management	36	99238			
Office Visits	76	99213 x 2; 99212 x 2			

KEY REFERENCE SERVICE(S):

'00 RVW	Global	CPT	Descriptor
9.83	090	30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
12.98	090	30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip

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

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

TIME ESTIMATES (MEDIAN)	Survey CPT 30465 (n=26)	Ref CPT 30400 (n=12)
Pre-service time	60	60
Intra-service time	120	75
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	0	0
Discharge management time	31	31
Total office visit time	76	53
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	3 42	2.75
Intra-service	3.88	3.42
Post-service	2.96	2.58
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3.64	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.16	2.58
Urgency of medical decision making	2.48	2.08
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	4.36	4.00
Physical effort required	3.52	3.33
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	3.44	3.00
Outcome depends on the skill and judgement of physician	4.60	4.25
Estimated risk of malpractice suit with poor outcome	3.32	3.42

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

New code 30465 is more work than the cosmetic procedure 30400 for several reasons. Pre- and post-service work include extensive patient support in terms of the physical disfigurement that results from this procedure. The patients are generally older and sicker, with comorbid diseases, and are willing to undergo this disfiguring procedure to be able to breath normally. Because the patients are elderly and/or are post-traumatic, the operative site is lax/inelastic or scarred. Although the survey median indicates that this is an outpatient procedure, often (by not typically) the patient is required to stay overnight for supported breathing and monitoring of the wound, especially if the nose is packed. Additionally, the elderly required an additional office visit (as compare with the cosmetic rhinoplasty) for wound care and support

There are also technical differences which add to the work of 30465 as compare with 30400. Elevation and stabilization of the nasal tip as typified by the Davidson suspension suture technique are done primarily (if not exclusively) for elderly patients with tip ptosis. It would not be a useful technique in cosmetic rhinoplasty as the cephalic margins of the lower lateral cartilages must be preserved or augmented to permit adequate suture purchase In addition, resection of excessive dorsal skin is virtually never done in cosmetic rhinoplasty, as it leaves a grossly visible scar line across the nasal dorsum. It is done in conjunction with repair of tip ptosis because the elderly often have thick and redundant nasal dorsal skin that limits unhooding of the nares unless it is resected.

We believe that the comparison of 30465 versus 30400 survey time and complexity/intensity measures as shown in the table above, along with the additional rationale presented here, support our recommendation for the survey median RVW of 11.64

FREQUENCY INFORMATION

How was this service previously reported?

The "total procedure" was either billed with an "unlisted procedure" code, or some combination of the following codes, along with grafting codes, if applicable.

21188 Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)
30400 Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410 Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420 Rhinoplasty, primary; including major septal repair

How often do physicians in your specialty perform this service?

Specialty: Facial plastic surgery	**Commonly**	~~Sometimes~~	~~Rarely~~
Specialty: General plastic surgery	~~Commonly~~	**Sometimes**	~~Rarely~~
Specialty: Otolaryngology	~~Commonly~~	**Sometimes**	~~Rarely~~

For your specialty, estimate the number of times this service might be provided nationally in a one-year period?

5,000

Do many physicians perform this service across the United States? ~~Yes~~ **No**

CPT Code: 30465 Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)

AMA/Specialty Society Update Process
Summary of Recommendation
010 or 090 Day Global Periods
Out-Of-Office Direct Inputs

Sample Size:_____ Response Rate: (%):_____ Global Period:_____

Tracking Number:_____ Reference Code 1_____ Reference Code 2 _____

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

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

A work group of 7 practicing otolaryngologists was convened to review the survey results for physician work. This work group included 3 subspecialists, two individuals in academic practice, three in private practice and one in a large multispecialty private practice. Three are from the middle Atlantic region, two are from the southwest, one is from the mid-west, and one is from the west. This group identified a reference code with comparable resource inputs. AAO-HNS staff then reviewed the identified reference code and made adjustments as needed to be consistent with the number of post-operative office visits identified by the survey on physician work and to be consistent with the RUC instructions for developing direct practice expense inputs for new/revised codes. The reference code used for new code 30465 was existing code 30400.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Complete pre-service diagnostic and referral forms, coordinate pre-surgery services, schedule space and equipment in facility, review test and exam results, provide pre-service education and obtain consent, follow-up phone calls and respond to clinical questions from patient.

Intra-Service Clinical Labor Activities:

Provide coordination of care activities while patient is in hospital; e.g., coordination of home or outpatient care, provide education, instructions and counseling to family members. The patient is treated by a variety of physicians; anestheiologists, cardiologists, pulmonary medicine, etc., each providing recommendations, and consultation to family members.

Post-Service Clinical Labor Activities:

CPT Code: 304 65 Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)

Conduct phone calls and call in prescriptions; four office visits (99213- 2; 99212- 2); conduct phone calls with patient and/or family members between visits

Clinical Labor	Pre-Service Time Prior to Admission	Service Period (Admission to Discharge)	Coordination of Care*	Post-Service Time After Discharge**	Number of Office Visits	Total Time of Office Visits
RN						
LPN						
MA						
RN/LPN/MA	73		30	30	4	126

*By staff in the physician's office during the service period.
**Excluding Time of Office Visits

Medical Supplies	Quantity of Supplies	Units Used for Purchase
~~Patient gown, disposable~~	~~4~~	~~Item~~
~~illow case, disposable~~	~~4~~	~~Item~~
Gloves, non sterile	4	Pair
Thermometer probe cover	4	Item
Tongue depressor	4	Item
~~Exam table paper~~	~~28~~	~~Feet~~

Procedure Specific Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Equipment Cost
No equipment				

CPT Code: 30465 Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)

Overhead Medical Equipment	**No. of units in practice**	**Equipment Cost**
Fiberoptic exam light		$609
Reclining exam chair w/headrest		$4495
Light Source		$1700
Suction machine		$732
Crash cart, no defibrillator		$1136

CPT Code: 30465 Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)

TYPE OF SERVICE: Surgical Procedures
010 and 090 Global Periods

SITE OF SERVICE: OUT-OF-OFFICE

Clinical Services	Minutes	Staff Type – Circle
Pre-Service Period		
Start. Following visit when decision for surgery or procedure made		
Complete pre-service diagnostic & referral forms	10	RN, LPN, MA, Other RN/LPN/MA
Coordinate pre-surgery services	10	RN, LPN, MA, Other RN/LPN/MA
Schedule space and equipment in facility	10	RN, LPN, MA, Other RN/LPN/MA
Office visit before surgery/procedure Review test and exam results	27	RN, LPN, MA, Other RN/LPN/MA
Provide pre-service education/obtain consent	10	RN, LPN, MA, Other RN/LPN/MA
ollow-up phone calls & prescriptions	6	RN, LPN, MA, Other RN/LPN/MA
Other Activity (please specify)		
_____	_____	RN, LPN, MA, Other _____
End: When patient enters hospital for surgery/procedure		
Service Period		
Start: Patient admitted to hospital for surgery/procedure		
Pre-service services		
Review charts	_____	RN, LPN, MA, Other _____
Greet patient and provide gowning	_____	RN, LPN, MA, Other _____
Obtain vital signs	_____	RN, LPN, MA, Other _____
Provide pre-service education/obtain consent	_____	RN, LPN, MA, Other _____
Prepare room, equipment, supplies	_____	RN, LPN, MA, Other _____
Prepare and position patient/ monitor patient/ set up IV	_____	RN, LPN, MA, Other _____
Sedate/apply anesthesia	_____	RN, LPN, MA, Other _____
Intra-service		
ssist physician in performing surgery/procedure	_____	RN, LPN, MA, Other _____

CPT Code: 304 65 Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)

Post-service

Monitor pt. following service/check tubes, monitors, drains	_____	RN, LPN, MA, Other _____
Clean room/equipment by physician staff	_____	RN, LPN, MA, Other _____
Assist with ICU or hospital visits	_____	RN, LPN, MA, Other _____
Total Number of ICU visits	_____	
Total Number of hospital visits	_____	
Complete diagnostic forms, lab & X-ray requisitions	_____	RN, LPN, MA, Other _____
Review/read X-ray, lab, and pathology reports	_____	RN, LPN, MA, Other _____
Discharge day management services, check dressings & wound/ home care instructions/coordinate office visits/prescriptions	_____	RN, LPN, MA, Other _____
Coordination of care by staff in office	30	RN, LPN, MA, Other _____
Other Activity (please specify)		
_____	_____	RN, LPN, MA, Other _____

End: Patient discharge from hospital

_____

Post-Service Period
Start: Patient discharge from hospital

Conduct phone calls/call in prescriptions	15	RN, LPN, MA, Other RN/LPN/MA
Office visits Greet patient, escort to room Provide gowning Interval history & vital signs & chart Assemble previous test reports/results Assist physician during exam Assist with dressings, wound care, suture removal Prepare Dx test, prescription forms Post service education, instruction, counseling Clean room/equip, check supplies Coordinate home or outpatient care	_____	RN, LPN, MA, Other RN/LPN/MA
List total number of office visits (99213 x 2 + 99212 x 2)	A 4	
Total office visit time (A * B)	**B 126**	
Conduct phone calls between office visits	15	RN, LPN, MA, Other RN/LPN/MA
Other Activity (please specify)		
	_____	RN, LPN, MA, Other RN/LPN/MA

End: With last office visit before end of global period

AMA SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Transmyocardial Laser Revascularization

Work Relative Value Recommendations
New code 33141 *Transmyocardial laser revascularization, by thoractomy; performed at the time of other open cardiac procedure(s) (List separately in addition to code for primary procedure)* was created to describe transmyocardial revascularization (TMR) performed as a useful alternative or adjunct to coronary artery bypass grafting. It is especially pertinent to patients who are not candidates for coronary artery bypass grafting due to non-graftable vessels.

The RUC did not accept the initial specialty society work value recommendation. Facilitation Committee Three reviewed this issue and presented the following information.

There is no pre and post-service work associated with this service. There is only intra-service work associated with CPT code 33141, as code 33141 is an add-on code and is always reported in addition to another code. It was recognized that the only way to make the determination that the vessel was unsuitable for replacement would be after dissection and evaluation, and that such work would not be covered under the vessel graft service. Also, it was recognized that preparing the TMR equipment for surgical use was not included in the graft service.

In determining the intra-service work value, the RUC reviewed three activities:
1) For the first step, the RUC reviewed the differential RVU's from the CABG (vein) codes for 33510 *Coronary artery bypass, vein only; single coronary venous graft* (work RVU = 25.00), 33512 *Coronary artery bypass, vein only; three coronary venous grafts* (work RVU = 27.40), 33513 *Coronary artery bypass, vein only; four coronary venous grafts* (work RVU = 29.67), and 33514 *Coronary artery bypass, vein only; five coronary venous grafts* (work RVU = 31.95). The average differential between respective codes is 2.28 (i.e, the incremental work of dissection and replacement of a single vessel). This recognizes the incremental value of dissecting down to the vessel. The RUC agreed that for dissecting down to a vessel and then evaluating that the vessel could not be replaced, half of 2.28 (1.14) was an appropriate value.

2) For the second step, the RUC was advised that it takes approximately 20 minutes to prepare the TMR equipment for surgical use, a time component that was not considered by the surveyors. The value of this 20 minutes waiting for the equipment with a patient with an open chest and on bypass, was deemed to be similar to a little less than a half hour of critical care (1.80), and attributed 1.4 work RVU's for this element of work.

3) The Committee deemed that the 30 minutes of actual intra service time was equal to a half- hour of critical care (1.8 work RVU's) plus 0.5 work RVU's for using the laser for a total of 2.3 work RVU's.

The RUC then added these three increments of 1.14 (dissecting down to the vessel) + 1.40 (20 minutes prepare the TMR equipment) + 2.30 (actual procedure time of 30 minutes using the laser) = 4.84. **The RUC recommends a work relative value of 4.84 for code 33141.**

Practice Expense Recommendations

This add-on code is only performed in a facility setting. **The RUC recommends no direct practice expense inputs.**

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	**Tracking Number**	**CPT Descriptor**	**Global Period**	**Work RVU Recommendation**
33140		*Transmyocardial laser revascularization, by thoracotomy; (separate procedure)*	090	20.00 (no change)
+●33141	N1	performed at the time of other open cardiac procedure(s) (List separately in addition to code for primary procedure) *(Use code 33141 in conjunction with codes 33510-33572)*	ZZZ	4.84

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 33141 Tracking Number: N1 Global Period: ZZZ **Recommended RVW: ~~9.00~~ 4.84 (RUC)**

CPT Descriptor: Transmyocardial laser revascularization by thoracotomy: performed at the time of other open cardiac procedure(s) (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 51 year-old-man has a history of coronary artery disease. Patient presents with shortness of breath and chest pressure with exertion. Cardiac catheterization demonstrates severe three-vessel coronary artery disease with well-preserved myocardial function. The disease in his left anterior descending and diagonal arteries was quite extensive and it is not clear, based on the angiogram whether these vessels will be graftable. Trans-myocardial laser revascularization may be needed to completely revascularize his heart.

The patient was prepped and draped for operation and a median sternotomy was performed. A CABG x3 was performed to the left anterior descending coronary artery using the left internal mammary artery and reversed autogenous saphenous vein grafts to the first diagonal, and circumflex marginal arteries. The right coronary was unsuitable for bypass grafting and was treated with Transmyocardial Revascularization (TMR) procedure. After cardiopulmonary bypass was terminated, TMR was performed using the laser, beginning on the right posterolateral wall in the distribution of the posterior descending coronary artery. There were a total of 20 laser sinusoids made in grid formation. Bleeding from the site was controlled with a local hemostatic agent. Each cardiac penetrating opening was verified with a transesophageal echocardiogram. The patient tolerated the procedure well and remained hemodynamically stable.

Description of Pre-Service Work: Not applicable

Description of Intra-Service Work: The right coronary was unsuitable for bypass grafting and was treated with Transmyocardial Revascularization (TMR) procedure. After cardiopulmonary bypass was terminated, TMR was performed using the laser, beginning on the right posterolateral wall in the distribution of the posterior descending coronary artery. There were a total of 20 laser sinusoids made in grid formation. Bleeding from the site was controlled with a local hemostatic agent. Each cardiac penetrating opening was verified with a transesophageal echocardiogram. The patient tolerated the procedure well and remained hemodynamically stable.

Description of Post-Service Work: Not applicable

SURVEY DATA:

Presenter(s): Sidney Levitsky, M.D.

Specialty(s): Society of Thoracic Surgeons/American Association for Thoracic Surgery

Sample Size: 80 Response Rate: (%): 35% (28) Median RVW: 10

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: Small subset cardiac surgeons

25th Percentile RVW: 9 75th Percentile RVW: 15 Low: 5 High: 20

Median Pre-Service Time: N/A Median Intra-Service Time: 30 min

25th Percentile Intra-Svc Time: 20 min 75th Percentile Intra-Svc Time: 40 min Low: 15 min High: 50 min

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	N/A	
Critical Care:	N/A	
Other Hospital Visits:	N/A	
Discharge Day Mgmt.:	N/A	
Office Visits:	N/A	

CPT Code: 33141

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
33464	Valvuloplasty, tricuspid valve; with ring insertion	27.33

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

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

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	N/A	N/A
Median Intra-Time	30	120
Median Immediate Post-service Time	N/A	N/A
Median of Aggregate Critical Care Times	N/A	N/A
Median of Aggregate Other Hospital Visit Times	N/A	N/A
Median Discharge Day Management Time	N/A	N/A
Median of Aggregate Office Visit Times	N/A	N/A

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.25	4.65
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.3	4.6
Urgency of medical decision making	3.8	4.4

Technical Skill/Physical Effort (Mean)

Technical skill required	3.9	4.7
Physical effort required	4.1	4.8

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.9	4.1
Outcome depends on the skill and judgement of physician	4.4	4.7

Estimated risk of malpractice suit with poor outcome	4.2	4.1

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	N/A	N/A
Intra-Service intensity/complexity	3.8	4.8
Post-Service intensity/complexity	N/A	N/A

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
The patient population receiving TMR with CABG is the sickest and most fragile 20% of all CABG patients. These patients generally have more complicated pre and post surgical experience. These patients's have a higher incidence for intra-operative bleeding

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FREQUENCY INFORMATION

How was this service previously reported? 33140-51

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

Specialty STS/AATS ____Commonly ____Sometimes X Rarely

Specialty ____ ____Commonly ____Sometimes ____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty STS/AATS Frequency 700-1000

Specialty ____ Frequency ____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty STS/AATS Frequency 350-500

Specialty _____ Frequency_____

Do many physicians perform this service across the United States? _____Yes ___X__No

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AMA SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Endovascular Graft for Abdominal Aortic Aneurysm

New CPT codes were created to describe procedures related to endovascular abdominal aortic aneurysm repair. New codes 34800-34826 describe the placement of the endovascular graft for abdominal aortic aneurysm repair under fluoroscopic guidance. New codes 34830- 34832 describe open repair of an infrarenal aortic aneurysm following unsuccessful endovascular repair. Two new codes 75952 and 75953 were created to describe fluoroscopic guidance in conjunction with endovascular aneurysm repair.

The RUC did not accept the initial specialty society work value recommendation. Facilitation Committee Three reviewed this issue and presented the following information.

The Committee considered whether or not the Societies' description of the coding for services adjunctive to the respective presented services was consistent with current accepted coding practices. The Committee was advised that the society's description was correct. However, it was suggested that the **CPT introductory notes to "Endovascular Repair of Abdominal Aortic Aneurysm" be revised to better clarify the appropriate coding of relevant multiple services provided in a single session.**

The RUC considered the format of the survey instruments utilized in the presentation. It was clarified that in each case, the surveys included CPT code, global period designation, CPT descriptor, vignette, and descriptions of pre-service work, intra-service work inclusions, post-work, and services that could be separately billable and therefore not included in the surveyed service. The clinical description of pre-intra-post-service work was not provided to the surveyees. There was discussion of possible effects of the statement of the excluded services. It was the consensus of the committee that given the intricacies of the accepted coding for these types of services, stimulating the list of excluded services better ensured that the work of the respective presented service was appropriately surveyed.

34800

New code 34800 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis* was created to describe deployment of an aorto-aortic tube prosthesis. The RUC reviewed codes 35102 *Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, external)* (work RVU = 30.76; global 090) and reference service code 35081 *Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm and associated occlusive disease, abdominal aorta* (work RVU = 28.01; global 090) and determined a difference of 2.75 work RVU's for involvement of iliac vessels. This was compared to the differential of 2.25 between 34800 and 34802. The RUC agreed that this differential was appropriate. **The RUC recommends a work value of 20.75 for code 34800.**

34802

New code 34802 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (one docking limb)* describes the deployment of a modular bifurcated endovascular prosthesis. When performing this service, there is a need to access the femoral artery (34812), which is the open femoral artery exposure. Imaging 75952 constitutes the imaging of all the services (e.g., ballooning, stenting) and is only reported one time.

The recommended work value for code 34802 is 23.00. The pre-service time (135 minutes) is relatively higher than the reference service code 35102 (95 minutes), as review of CT scans and aortograms is performed, measurement of the diameter and length of the graft is needed and ordering of the graft is performed, which is included in the new code and is not captured with a separate E/M code or other service code.

The RUC agreed that CPT code 35102 *Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft;* (work RVU = 30.76; global 090) was a reasonable reference code for this service. The RUC discussed the service times for reference service code 35102 (180 minutes) and noted they are higher than compared to the new code 34802 (150 minutes). The RUC recognized that the societies recommended the 25th percentile work RVU = 23.00 based upon two validation methodologies. The RUC agreed that the recommended work value of 23.00 was appropriate. **The RUC recommends a work relative value of 23.00 for code 34802.**

34804

New code 34804 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using unibody bifurcated prosthesis* was created to describe deployment of a unibody bifurcated endovascular prosthesis.

The specialty society presented the survey 25th percentile work RVU of 23.00. The RUC was comfortable that this service was similar in work to 34802. The RUC agreed that this was an appropriate work relative value for this service. **The RUC recommends a work relative value of 23.00 for code 34804.**

34808

New code 34808 *Endovascular placement of iliac artery occlusion device (List separately in addition to code for primary procedure)* was created to describe endovascular placement of an iliac artery occlusion device.

The RUC determined that this code would not be independently performed. **Therefore, the RUC recommends that it be designated a ZZZ global.** The RUC reviewed code 37206 *Transcatheter placement of an intravascular stent(s), (non-coronary vessel), percutaneous; each additional vessel (List separately in addition to code for primary procedure)* (work RVU = 4.13; global ZZZ) and agreed that it was comparable to 34808. **The RUC recommends a work value of 4.13 for code 34808.**

34812

New code 34812 *Open femoral artery exposure for delivery of aortic endovascular prosthesis, by groin incision, unilateral* was created to describe open surgical exposure of the femoral artery via a unilateral groin incision to expose a site on the artery through which catheters, guidewires, and endovascular prosthetic components are delivered.

After much discussion, the RUC deemed that this service was very similar in work to 33970 *Insertion of intra-aortic balloon assist device through the femoral artery, open approach* (work RVU = 6.75; global 000) and that the 090 global designation was inappropriate for 34812. **With reduction to a 000 global the RUC recommends the work relative value of 6.75 for code 34812.**

34813

New code 34813 *Placement of femoral-femoral prosthetic graft during endovascular aortic aneurysm repair (List separately in addition to code for primary procedure)* was created to describe the open bilateral femoral artery exposure for the deployment of the endovascular prosthesis. The RUC reviewed code 35661 *Bypass graft, with other than vein; femoral-femoral* (work RVU = 13.81; global 090) and reduced this value by 6.75 work RVU for one groin and half of 6.75 (3.38) for the second groin to arrive at a work value of 3.68. In addition, the combination of two artery exposures plus one femoral-femoral graft has very close work equivalent to the reference service code 35656 *Bypass graft, with other than vein; femoral-popliteal.* Given these calculations, the RUC agreed comfortable with the originally recommended value of 4.80.

The question was raised regarding what would be done if 34812 and 34813 were performed without introduction of a device. The RUC agreed that there should be a CPT note that indicates that if these are performed without the delivery of an endovascular prosthesis, there should be an appropriate cross reference in CPT (perhaps directing to 35661). The presenters agreed that it would be appropriate to ask for such an editorial change. **The RUC recommends a work relative value of 4.80 for code 34813. The RUC recommends that CPT review appropriate guidelines when 34812 and 34813 are performed without introduction of an endovascular prosthesis.**

34820

New code 34820 *Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision; unilateral* was created to describe the open surgical exposure of the iliac arteries via a retroperitoneal or abdominal approach. This procedure may be performed when the femoral arteries are diseased or inadequate diameter to allow passage of the large endovascular introducer sheaths.

The RUC compared code 49010 *Exploration, retroperitoneal area with or without biopsy(s) (separate procedure)* (work RVU = 12.28; global 090) and agreed that this service was roughly comparable to the work of 34820. However, the RUC agreed that 34820 would be better designated as a 000 global and decided to delete the after service care resulting in a work RVU of 9.75. **The RUC recommends a work relative value of 9.75 for code 34820. The Committee also recommends a 000 global.**

34825

New code 34825 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic aneurysm; initial vessel* was created to describe placement of a proximal or distal extension prosthesis in an initial vessel for endovascular repair of an infrarenal abdominal aortic aneurysm. The RUC agreed with the survey median of which 54 vascular surgeons indicated the appropriate work relative value should be 12.00. **The RUC recommends a work relative value of 12.00 for code 34825.**

34826

New code 34826 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic aneurysm; each additional vessel (List separately in addition to code for primary procedure)* was created to describe placement of a proximal or distal extension prosthesis in each additional vessel, for endovascular repair of an infrarenal abdominal aortic aneurysm. The RUC compared new code 34826 to the reference service code 37208 *Transcatheter placement of an intravascular stent(s), (non-coronary vessel), open; each additional vessel (List separately in addition to code for primary procedure)* and noted that the intra-service time is identical. However, new code 34826 has greater time, and intensity and complexity measures than the reference service code. **The RUC identified that this would only be performed with 34825 and agreed the recommended work value of 4.13 was appropriate for code 34826.**

34830

New code 34830 *Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; tube prosthesis* describes open repair of an abdominal aortic aneurysm following unsuccessful endovascular approach. This code is used in the instance when an endovascular approach was unsuccessful and a conversion to open repair is performed.

The RUC compared 35081(work RVU = 28.01) and 35082 *Direct repair or aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta* (work RVU = 36.35) and agreed that the work of 34830 was roughly in the mid-range of these two services. **The RUC recommends a work relative value of 32.59 for code 34830.**

34831

New code 34831 *Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; aorto-bi-iliac prosthesis* describes open repair of an abdominal aortic aneurysm following unsuccessful endovascular approach. This code is used in the instance when an endovascular approach was unsuccessful and a conversion to open repair is performed.

The RUC compared reference service codes 35081 (work RVU = 28.01) and 35102 (work RVU = 30.76) and calculated a difference of 2.75 work RVU's between these two codes. When this was added to 34830, the resulting work RVU was 35.34. **The RUC recommends a work relative value of 35.34 for code 34831.**

34832

New code 34832 *Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; aorto-bifemoral prosthesis* describes open repair of an abdominal aortic aneurysm following unsuccessful endovascular approach. This code is used in the instance when an endovascular approach was unsuccessful and a conversion to open repair is performed.

The RUC determined that the work of 34832 was equivalent to 34831. **Therefore, the RUC recommends a work relative value of 35.34 for code 34832.**

75952

New code 75952 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation* was created to describe the radiological supervision and interpretation which includes angiography of the aorta and its branches for diagnostic imaging prior to deployment of the endovascular device(s), fluoroscopy for guidance in the delivery of the endovascular components and subsequent arterial imaging to confirm appropriate position of the graft, detect endoleaks, and evaluate the status of the runoff vessels.

The RUC was concerned that the low number of survey responses from Interventional Radiologists might have inappropriately skewed the survey results. Therefore, the RUC agreed that any value approved should be an interim value until the Interventional Radiologists conduct another survey. Based upon this concern, the RUC decided to take the mid-point value between the median of 3.50 work RVU and the Society's recommended work value of 4.50. **The RUC recommends an interim work relative value of 4.00 for code 75952.**

75953

New code 75953 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic aneurysm, radiological supervision and interpretation* describes the radiological supervision and interpretation for the placement of the proximal or distal extension prosthesis.

The RUC noted that the Society's presented a recommendation of 1.36 work RVU, which was less than their 25th percentile. **The Committee recommends a work value of 1.36 for code 75953.**

Practice Expense Recommendations

The RUC approved a Facilitation Committee report that reviewed the direct inputs for the new endovascular graft codes. The RUC agreed to a standard pre-service time of 45 minutes for the 090 day global codes 34800, 34802, 34804, 34825 and 34830, 34831, and 34832. The RUC then assigned the standard E/M clinical staff times for the number and levels of office visits for each of these codes. In addition, these codes also were assigned the standard basic post operative incision care kit for the first office visit and then the standard minimum E/M supply packaged for each office visit. Since these procedures are performed in the facility setting, the RUC did not assign any procedure specific equipment. However, the standard E/M overhead equipment was included.

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Cardiovascular System **Arteries and Veins** Endovascular Repair of Abdominal Aortic Aneurysm Codes 34800-34826 describe placement of an endovascular graft for abdominal aortic aneurysm repair under fluoroscopic guidance and include vascular access, all catheter manipulations, balloon angioplasty within the endovascular prosthesis (for full expansion of the endoprosthesis) and closure of the arteriotomy site Extensive repair or replacement of an artery should be additionally reported (eg 35226 or 35286). For fluoroscopic guidance in conjunction with endovascular aneurysm repair, see code 75952 or 75953, as appropriate. Code 75952 includes angiography of the aorta and its branches for diagnostic imaging prior to deployment of the endovascular device (including all routine components of modular devices), fluoroscopic guidance in the delivery of the endovascular components, and intraprocedural arterial angiography (eg, confirm position, detect endoleak, evaluate runoff). Code 75953 includes the analogous services for placement of additional extension prostheses (not for routine components of modular devices).				
Other interventional procedures performed at the time of endovascular abdominal aortic aneurysm repair should be additionally reported (eg, aortography before deployment of endoprosthesis, renal transluminal angioplasty, arterial embolization, intravascular ultrasound, balloon angioplasty of native artery(s) outside the graft (eg, aortic or iliac) before deployment of endoprosthesis.				

●34800	QQ1	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis	090	20.75
●34802	QQ2	using modular bifurcated prosthesis (one docking limb)	090	23.00
●34804	QQ3	using unibody bifurcated prosthesis	090	23.00
●34808	QQ4	Endovascular placement of iliac artery occlusion device (List separately in addition to code for primary procedure) (For radiological supervision and interpretation, use 75952 in conjunction with 34800, 34802, 34804, 34808) (For open approach, report codes 34812-34820 in addition to codes 34800, 34802, 34804, 34808 as appropriate)	ZZZ	4.13
●34812	QQ5	Open femoral artery exposure for delivery of aortic endovascular prosthesis, by groin incision, unilateral (For bilateral procedure, use modifier '-50')	000	6.75
+ ●34813	QQ6	Placement of femoral-femoral prosthetic graft during endovascular aortic aneurysm repair (List separately in addition to code for primary procedure (Use 34813 in conjunction with code 34812)	ZZZ	4 80
●34820	QQ7	Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision; unilateral (For bilateral procedure, use modifier '-50')	000	9.75

●34825	QQ8	Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic aneurysm; initial vessel	090	12.00
+●34826	QQ9	each additional vessel (List separately in addition to code for primary procedure) (Use 34826 in conjunction with code 34825) (For staged procedure, use modifier '–58') (Use code 34825-34826 in addition to codes 34800-34808, as appropriate) (For radiological supervision and interpretation, use 75953)	ZZZ	4.13
●34830	QQ10	Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; tube prosthesis	090	32.59
●34831	QQ11	aorto-bi-iliac prosthesis	090	35.34
●34832	QQ12	aorto-bifemoral prosthesis	090	35.34
●75952	QQ13	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation (For implantation of endovascular grafts, see 34800-34808)	XXX	4.00 (Interim Value)
●75953	QQ14	Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic aneurysm, radiological supervision and interpretation (For implantation of endovascular extension prostheses, see 34825-34826)	XXX	1.36

CPT Code: 34800 **Global Period**: 090 **Recommended RVW**: **20.75**

CPT Descriptor: Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis. (For radiological supervision and interpretation, use 75952)

Typical Patient (*Survey Vignette*):

Typical Patient/Service: A 67-year-old male with COPD and CAD s/p MI has a 5.8 cm. aortic aneurysm. Imaging studies indicate that the aneurysm is infrarenal with an adequate neck to allow successful deployment of an endovascular prosthesis. There is also adequate normal aorta below the aneurysm to allow use of a tube graft. The iliac artery anatomy should accommodate passage of the device.

Physician work for this code includes:

Pre-Service Work begins the day before the operative procedure and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, insure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Intra-Service Work includes
- Device preparation
- Angioplasty of area covered by device (if performed)
- Advancement of device into aorta
- Positioning of device relative to aneurysm
- Deployment of graft
- Fine adjustments to ensure proper seating and hemostatic sealing
- Balloon dilatation and/or intra-device stenting to ensure proper seating, to fully open the graft, and/or to treat endoleak (if present),
- Embolization to treat endoleak (if present) or to prevent endoleak (if needed)

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days.

Not included in this Procedure (Separately Billable)
- Open femoral or iliac artery exposure (codes 34812-34820),
- Catheterization of aorta (codes 36200, or 36245-36248),
- Fluoroscopic guidance of device and catheters (code 75952),
- Angiography and other imaging required for the procedure, including imaging for "mapping" and detection of endoleaks (code 75952), and IVUS if required (code 37250, 37251, 75945, 75946)
- Placement of extensions or cuffs (codes 34825, 34826, and 75953),
- Removal of guidewires and catheters (included in initial 36200 or 362458),
- Closure of arteriotomy and application of sterile dressing (included in codes 34812-34820 or 36200, 36245-36248)

CLINICAL DESCRIPTION OF SERVICE

Description of Pre-Service Work:

Pre-service work begins after the decision to operate is made, from the day before the operation until the skin incision of the operation This activity includes obtaining and reviewing the previous work-up, with special attention to potential cardiovascular risks. In addition, an extensive and detailed review of the preoperative imaging studies (some combination of CT scan, CT angiogram, CT with 3-D reconstructions, MRI, angiograms) is required to determine the exact measurements of the aneurysm. This is necessary because an accurate preoperative choice of component diameters and lengths is one of the primary determinants of whether the endovascular procedure will be successful. In this regard endovascular repair differs substantially from open surgical AAA repair. Although imaging studies are carefully reviewed prior to open repair, the painstaking

diameter and length measurements are uniquely important for the endovascular procedure.

Informed consent is obtained from the patient following a discussion of surgical risks and benefits with the patient and the family. Other pre-service work includes scrubbing, donning lead apparel, supervising patient positioning, waiting for the anesthetic to become effective, prepping and draping the patient. Unique to endovascular AAA repair is the pre-service work of supervision of selection of equipment including guidewires, catheters, sheaths, balloons, stents, contrast material, plus setting up the x-ray equipment and organizing the technologic personnel for appropriate imaging during the procedure. The x-rays and measurements are re-reviewed just before the case to be sure the appropriate grafts are selected and available, and that appropriate extensions are available if needed Before initiation of intra-service work for this code, the typical patient undergoes femoral artery exposure (34812) and introduction of one or two catheter guidewires (36200 or 36245). These are separately reportable under component coding and multiple procedure payment reduction rules.

Description of Intra-Service Work:
Intra-service work for 34800 begins as the endovascular device and introducing sheaths and mechanisms are brought onto the operating table. The device and typically large introducer are threaded onto the guidewire and advanced to the edge of the artery. An arteriotomy is fashioned and the introducer is pushed into the artery. The device is then carefully advanced through the pelvis, into the aorta, and positioned such that the proximal edge is just below the renal artery origins and above the beginning of the aneurysm. Its position is confirmed exactly by fluoroscopy, often with injections of contrast. If a selective second catheter has been placed to mark the lower renal artery it is drawn back into the iliac, and the main endovascular device is deployed under exacting fluoroscopic guidance. Fine adjustments in position are made during the deployment to assure accurate positioning just below the renal artery origins. In some patients the mean arterial pressure is transiently reduced by the anesthesiologist to decrease the chance that pressure from flowing blood will push the endograft distally during deployment. After deployment the arterial pressure is normalized. The introducer portion of the main device is removed over the guidewire, leaving the endograft in position. Some devices require balloon dilatation at the proximal and distal anastomoses to help assure proper seating and hemostatic seal with the arterial wall If this is the case, a large diameter compliant balloon is advanced over the wire to the proximal anastomosis, and under fluoroscopic guidance the balloon is positioned and inflated. This same balloon may be pulled back and used to seat the distal anastomosis.

Once the complete endograft is in place, a pigtail catheter or multi-sidehole catheter is repositioned over one of the guidewires, and placed just above the renal arteries for a final angiographic evaluation. An aortogram is performed and immediately evaluated for graft position, patency of appropriate branches (renals and hypogastrics), presence or absence of endoleaks, and patency of lumbar or inferior mesenteric arteries that may contribute to persistent endoleaks.

If the graft is in good position and free of endoleaks, the intra-service portion of 34800 is complete. Removal of the catheters and guidewires is included in the guidewire catheter introduction codes and the arteriotomy closure is included in the femoral artery exposure code.

Description of Post-Service Work:
Post-service work begins when the patient is transferred to a post-procedure recovery unit. This includes writing orders, dictating the operative note, communicating with the patient's family, communicating with referring and consulting physicians, and participating with the anesthesiologist in the recovery area to insure smooth emergence from anesthesia. Depending on the preexisting comorbidities and operative course the patient may require admission to the intensive care unit. Results of the procedure are discussed with the patient once he or she is fully awake. When stable, the patient is transferred to the floor. The physician makes daily visits and provides appropriate care. Discharge day management includes communicating with all support services such as visiting nurse, meals on wheels, etc., communicating with referring physician, providing activity advice and warnings to patient and family, and arranging office follow-up for wound checks, suture/staple removal, etc. The post-service work of 34800 includes all in-hospital and post-discharge care related to the endovascular AAA repair device for 90 days following the procedure.

SURVEY DATA

Presenter(s): Gary Seabrook, M.D.
Robert Vogelzang, M.D.
James P. Borgstede, M.D.

Specialty(s): Society for Vascular Surgery, ISCVS-NA
Society for Cardiovascular and Interventional Radiology
American College of Radiology

Sample Size: 330 **Response Rate**: 56 (17%):

Type of Sample: random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	10.00	**20.75**	27.00	31.25	70.03
Time (min) and Visits					
24 Hr Preceding Service			60		
Day Of Service					
Pre-Service			70		
Intra-Service	60	109	120	150	240
Immed. Post-Service			40		

Post-Service	**Total Time**	**CPT code / # of visits**
Critical Care		none
Other Hospital	49	99232 x 1; 99231 x1
Discharge Management	36	99238
Office Visits	38	99213 x 1; 99212 x 1

KEY REFERENCE SERVICE(S):

'00 RVW	Global	CPT	Descriptor
28.01	090	35081	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta

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

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

TIME ESTIMATES (MEDIAN)	Survey CPT 34800	Ref CPT 35081
Pre-service time	130	93
Intra-service time	120	150
Immediate Post-service time	40	43
Total critical care time	0	0
Total other hospital visit time	49	125
Discharge management time	36	36
Total office visit time	38	38
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	4.49	3.56
Intra-service	4.56	3.85
Post-service	4.13	3.56
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	4.36	3.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.59	3.44
Urgency of medical decision making	3.46	3.21
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	4.66	4.21
Physical effort required	4.29	4.15
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	4.59	4.26
Outcome depends on the skill and judgement of physician	4.77	4.35
Estimated risk of malpractice suit with poor outcome	4.34	3.88

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

A consensus panel of three specialty societies agreed to request the 25th percentile survey value for this service because two different building block approach calculations justify this level of work.

1. **Related Service Building Block:** Placement of an endovascular stent graft prosthesis requires substantially more pre, intra, and post-service work than transcatheter placement of an intravascular stent (37207, 000 day global, RVW 8.28). The aortic prosthesis is much larger than a typical stent, the delivery device is very much larger and more complex, and placement needs to be more exact. The aorta must be studied and measured by several modalities to choose the correct diameter and length prosthesis. During the procedure the proximal edge of the graft must be placed within millimeters of the renal artery origins, and the distal edge needs to land equally close to the aortic bifurcation. Failure to meet these stringent requirements may result in complications including renal failure from blockage of the renal artery origins, endoleak if the ends of the graft do not land adjacent to normal aorta, or iliac artery occlusion of the graft lands too far distally. For the extra pre, intra, and same-day post work, we believe the tubular aortic stent graft should be twice the RVW of a basic stent, or 8.28 x 2 = 16.56. Since the existing stent code is a 000-day global, we added 4.06 rvus to cover inpatient visits 99232 x 1, 99231 x 1, 99238 x 1, outpatient visit 1 (99213) and outpatient visit 2 (99212). Summing these components results in a total RVW of 20.62, very close to the 25th percentile survey response.

2. **IWPUT Building Block Analysis** also justifies an RVW at the 25th percentile. Deployment of an endovascular aortic stent graft in exactly the correct location is the most intense component of an endovascular AAA repair, and it also represents one of the more intense services performed by interventional radiologists and vascular surgeons. We calculated intra-service work by multiplying intra-service time (120 minutes) by an IWPUT of 0.095 (determined by consensus) for deployment of the endovascular aortic prosthesis, for an intra work of 11.40. Pre-service work was determined as cognitive time multiplied by 0.031, and activities such as change, scrub, prep, etc. were calculated as the product of time and an intensity factor of only 0.008. Pre-service work totals 3.00 rvus by this method. Post-service work was calculated as the sum of in-hospital and post-discharge visits, with outpatient visits discounted according to the HCFA adjustment, for 5.30 rvus. Total RVW by this method is 19.70, again very close the 25th percentile survey value of 20.75.

FREQUENCY INFORMATION

How was this service previously reported?

This service has been recorded using a very wide variety of CPT codes alone or in combination. These codes include but are not limited to 35081, 35452, 36200, 36245, 37205, 37207, and 37799

How often do physicians in your specialty perform this service?

Specialty: SVS	Sometimes
Specialty: SCVIR	Sometimes
Specialty: ACR	Sometimes

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

Specialty: SVS, SCVIR & ACR each: National Frequency: 800 Medicare Frequency: 600

Do many physicians perform this service across the United States? **No**

CPT Code: 34802 **Global Period**: 090 **Recommended RVW**: **23.00**

CPT Descriptor: Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis with one docking limb. (For radiological supervision and interpretation, use 75952)

Typical Patient (*Survey Vignette*):

Typical Patient/Service: A 67-year-old male with COPD and CAD s/p MI has a 5.8 cm. aortic aneurysm. Imaging studies indicate that the aneurysm is infrarenal in nature with an adequate neck of normal aorta below the renal artery origins for deployment of an endovascular prosthesis. Distally the aneurysm extends to the end of the aorta, indicating that a bifurcated prosthesis will be required. Iliac arteries are of appropriate diameter and length to provide landing zones for the iliac limbs of the prosthesis. The iliac artery anatomy should accommodate passage of the device.

Physician work for this code includes:

Pre-Service Work begins the day before the operative procedure and may include the procedural work-up, review of pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, positioning the patient, scrub, gown, wait, prep and drape.

Intra-Service Work includes
- Choice of equipment and materials (balloon size, contrast to be used, etc)
- Device preparation,
- Angioplasty of area covered by device (if performed),
- Advancement of device into aorta,
- Positioning of device relative to aneurysm,
- Main graft deployment
- Advancement of docking limb into main device
- Positioning of docking limb relative to main device
- Fine adjustments to device and docking limb to ensure proper seating and hemostatic seal
- Docking limb deployment
- Balloon dilatation and/or intra-device stenting to ensure proper seating, to fully open the graft, and/or to treat endoleak (if present),
- Embolization to treat endoleak (if present) or to prevent endoleak (if needed)

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days.

Not included in this Procedure (Separately Billable)
- Open femoral artery exposure (codes 34812-34820),
- Catheterization of aorta (codes 36200, or 36245-36248),
- Fluoroscopic guidance of device and catheters (code 75952),
- Angiography and other imaging required for the procedure, including imaging for "mapping" and detection of endoleaks (code 75952), and IVUS if required (code 37250, 37251, 75945, 75946)
- Placement of extensions or cuffs (codes 34825, 34826, and 75953),
- Removal of guidewires and catheters (included in initial 36200 or 362458),
- Closure of arteriotomy and application of sterile dressing (included in codes 34812-34820 or 36200, 36245-36248)

CLINICAL DESCRIPTION OF SERVICE

Description of Pre-Service Work:

Pre-service work begins after the decision to operate is made, from the day before the operation until the skin incision of the operation. This activity includes obtaining and reviewing the previous work-up, with special attention to potential cardiovascular risks. In addition, an extensive and detailed review of the preoperative imaging studies (some combination of CT scan, CT angiogram, CT with 3-D reconstructions, MRI, angiograms) is required to determine the exact measurements of the aneurysm This is necessary because an accurate preoperative choice of component diameters and lengths is one of the primary determinants of whether the endovascular procedure will be successful. In this regard endovascular repair differs substantially from open surgical AAA repair Although imaging studies are carefully reviewed prior to open repair, the painstaking diameter and length measurements are uniquely important for the endovascular procedure.

Informed consent is obtained from the patient following a discussion of surgical risks and benefits with the patient and the family. Other pre-service work includes scrubbing, donning lead apparel, supervising patient positioning, waiting for the anesthetic to become effective, prepping and draping the patient. Unique to endovascular AAA repair is the pre-service work of supervision of selection of equipment including guidewires, catheters, sheaths, balloons, stents, contrast material, plus setting up the x-ray equipment and organizing the technologic personnel for appropriate imaging during the procedure. The x-rays and measurements are re-reviewed just before the case to be sure the appropriate grafts are selected and available, and that appropriate extensions are available if needed. Prior to initiation of the intra-service work of 34802, the typical patient will undergo surgical exposure of one 34812 (or possibly both 34812-50) femoral arteries in addition to introduction of catheters (36200, 36245 where appropriate). These are separately reportable services subject to component coding and multiple procedure payment reduction rules.

Description of Intra-Service Work

Intra-service work begins by loading the endovascular device and its introduction mechanism onto the guidewire and advancing it to the edge of the artery. A large arteriotomy is made, and the introducer is pushed in. This large introducer sheath often fills the entire lumen of the femoral artery. The device is carefully advanced through the pelvis and positioned such that the proximal edge is just below the renal artery origins and above the beginning of the aneurysm. Its position is confirmed exactly by fluoroscopy, often with injections of contrast. If a selective second catheter has been placed to mark the lower renal artery it is drawn back into the iliac, and the main endovascular device is deployed under exacting fluoroscopic guidance. Fine adjustments in position are made during the deployment to assure accurate positioning just below the renal artery origins. In some patients the mean arterial pressure is transiently reduced by the anesthesiologist to decrease the chance that pressure from flowing blood will push the endograft distally during deployment. After deployment the arterial pressure is normalized. The introducer portion of the main device is removed over the guidewire, leaving the endograft in position. Some devices require balloon dilatation at the proximal and distal anastomoses to help assure proper seating and hemostatic seal with the arterial wall (not a separately billable service). If this is the case, a large diameter compliant balloon is advanced over the wire to the proximal anastomosis, and under fluoroscopic guidance the balloon is positioned and inflated. This same balloon may be pulled back and used to seat the iliac anastomosis by using an incomplete inflation (since the iliac diameter is smaller than the aorta). In other cases, a balloon better matched to the iliac diameter is required, entailing an exchange of balloons over the guidewire.

The guidewire on this initial ipsilateral side is left in position within the endograft, and attention is turned to the contralateral side for placement of the docking limb. The guidewire on this side has been left in position within the iliac artery. Using fluoroscopic guidance, this guidewire is advanced into the docking port of the short iliac limb of the main prosthesis. This frequently is a difficult and time-consuming maneuver, since the aneurysm may be large and may divert the catheter or guidewire away from the intended target. If it is not possible to pass the wire from the contralateral groin into the appropriate position, access may be obtained by using the catheter from the ipsilateral groin. With appropriate manipulation this may be hooked over the flow divider of the aortic prosthesis, allowing passage down the short contralateral iliac limb, through the docking port, and down the native contralateral iliac artery. This guidewire may then be grasped by passing a snare device upward from the contralateral groin and pulling the guidewire out through the arteriotomy. Having achieved this 'over the horn" guidewire configuration, a catheter is passed back up the wire, into the contralateral limb docking port, and past the flow divider. If this maneuver is unsuccessful, the contralateral port may also be accessed by means of an axillary or brachial artery puncture (brachial puncture is the only part of this description that would be separately billable). This allows passage of a guidewire from above, maneuvering it

into the contralateral port, and then snaring the wire from the contralateral groin.

Once a guidewire has been successfully advanced from the contralateral groin into the contralateral docking port of the aortic prosthesis, the contralateral docking limb is placed. A sheath is usually passed over the wire. The contralateral limb is advanced through the sheath into docking position, and the exact position of the limb is determined by fluoroscopy The proximal end must be firmly seated within the docking port of the main prosthesis while the distal end must be located within a normal diameter segment of iliac artery, usually proximal to the iliac bifurcation Once correct position is confirmed the sheath is pulled back, and the limb is deployed Accurate deployment is checked with fluoroscopy, using contrast injection. For some devices, the proximal and distal ends of this iliac limb are secured in position and fully opened by dilation using appropriately sized balloons.

Once the complete endograft is in place, a pigtail catheter or multi-sidehole catheter is repositioned over one of the guidewires, and placed just above the renal arteries for a final angiographic evaluation An aortogram is performed and immediately evaluated for graft position, patency of appropriate branches (renals and hypogastrics), presence or absence of endoleaks, and patency of lumbar or inferior mesenteric arteries that may contribute to persistent endoleaks. If the graft is in good position and free of endoleaks, the intra-service portion of 34802 is complete. Removal of the catheters and guidewires is included in the catheter introduction codes (36200-248) and the arteriotomy and skin closure is included in 34812-34820.

Description of Post-Service Work:

Post-service work begins when the patient is transferred to a post-procedure recovery unit. This includes writing orders, reviewing the hardcopy films, dictating the operative note and angiography interpretation, communicating with the patient's family, communicating with referring and consulting physicians, and participating with the anesthesiologist in the recovery area to insure smooth emergence from anesthesia. Depending on the preexisting comorbidities and operative course the patient may require admission to the intensive care unit. Results of the procedure are discussed with the patient once he or she is fully awake. When stable, the patient is transferred to the floor. The physician makes daily visits at appropriate E&M levels as dictated by the patient's condition. Length of hospital stay for the uneventful case may be 2-5 days. Discharge day management includes communicating with all support services such as visiting nurse, meals on wheels, etc., communicating with referring physician, providing activity advice and warnings to patient and family, and arranging office follow-up for wound checks, suture/staple removal, etc. Since this is a 90-day global service all related in-hospital and post-discharge care for 90 days is included in the post-service work of 34802.

SURVEY DATA

Presenter(s): Gary Seabrook, M.D.
Robert Vogelzang, M.D.
James P. Borgstede, M.D.

Specialty(s): Society for Vascular Surgery, ISCVS-NA
Society for Cardiovascular and Interventional Radiology
American College of Radiology

Sample Size: 330 **Response Rate**: 56 (17%):

Type of Sample: random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	9.00	**23.00***	30.00	35.00	76.90
Time (min) and Visits					
24 Hr Preceding Service			60		
Day Of Service					
Pre-Service			75		
Intra-Service	90	**150***	180	200	300
Immed. Post-Service			40		

Post-Service	**Total Time**	**CPT code / # of visits**
Critical Care		None
Other Hospital	49	99232 x 1; 99231 x 1
Discharge Management	36	99238
Office Visits	38	99213 x 1 99212 x 1

Note: The three society consensus panel agreed that the 25th percentile intra-service time of 150 minutes was the most appropriate estimate of intra-time, in parallel to the choice of the 25th percentile RVW.

KEY REFERENCE SERVICE(S):

'00 RVW	Global	CPT	Descriptor
30.76	090	35102	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, external)

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

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

TIME ESTIMATES (MEDIAN)	Survey CPT 34802	Ref CPT 35102
Pre-service time	135	95
Intra-service time	180	180
Immediate Post-service time	40	38
Total critical care time	0	0
Total other hospital visit time	49	136
Discharge management time	36	36
Total office visit time	38	53
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	4.55	3 65
Intra-service	4.66	4.03
Post-service	3.68	3.68
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	4.48	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.66	3.47
Urgency of medical decision making	3.61	3.44
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	4.73	4.35
Physical effort required	4.38	4.35
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	4.64	4.41
Outcome depends on the skill and judgement of physician	4.84	4.47
Estimated risk of malpractice suit with poor outcome	4.38	3.88

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation

A consensus panel of three specialty societies agreed that the 25th percentile survey value is the most appropriate recommended RVW for this service because it is supported by two different building block calculations.

1. **Related Service Building Block:** As noted for 34800, placement of an endovascular stent graft prosthesis requires substantially more pre, intra, and post-service work than transcatheter placement of an intravascular stent (37207, 000 day global, RVW 8.28). Just as with 34800 the prosthesis is very much larger, the introducer much larger and more complex, and the placement must be exact. The bifurcated modular device, however, also adds the highly complex work of deploying the second iliac limb. To extend the building block approach noted for 34800, we estimate placement of the main device to require twice the work of a routine stent (8.28 x 2 = 16.56). In addition we estimate the work of deployment of the iliac docking limb as equivalent to placing an additional stent (37206 or 37208, ZZZ codes with RVW 4.13). Since these reference stent codes are 000 global services we add 4.06 rvus to cover in-hospital visits 99232 x 1, 99231 x 1, discharge day (99238), outpatient visit 1 (99213), and outpatient visit 2 (99212). Summing these components (16.56 + 4.13 + 4.06) results in a total estimated RVW of **24.75**.

2. **IWPUT Building Block Analysis** also justifies an RVW at the 25th percentile. Deployment of an endovascular aortic stent graft in exactly the correct location is the most intense component of an endovascular AAA repair, and it also represents one of the more intense services performed by interventional radiologists and vascular surgeons. Our consensus panel first adjusted the intra-service time downward from the median survey value of 180 minutes to the 25th percentile value of 150 minutes because we believe this to be the more appropriate value. We then calculated intra-service work by multiplying intra-service time (150 minutes) by an IWPUT of 0.095 (determined by consensus) for deployment of the endovascular aortic prosthesis, for an intra work of 14.25 rvus. Pre-service work was determined as cognitive time multiplied by 0.031, and activities such as change, scrub, prep, etc. were calculated as the product of time and an intensity factor of only 0.008. Pre-service work totals 3.15 rvus by this method. Post-service work was calculated as the sum of in-hospital and post-discharge visits, with outpatient visits discounted according to the HCFA adjustment, for 5.30 rvus. Total RVW by this method is then the sum of 14.25 + 3.15 + 5.30 =**22.70**.

FREQUENCY INFORMATION

How was this service previously reported?

This service has been recorded using a very wide variety of CPT codes alone or in combination. These codes include but are not limited to 35102, 35452, 36200, 36245, 37205, 37207, and 37799.

How often do physicians in your specialty perform this service?

Specialty: SVS	Sometimes
Specialty: SCVIR	Sometimes
Specialty: ACR	Sometimes

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

Specialty: SVS	National Frequency: 3,000	Medicare Frequency: 2,000
Specialty: SCVIR	National Frequency: 3,000	Medicare Frequency: 2,000
Specialty: ACR	National Frequency: 3,000	Medicare Frequency: 2,000

Do many physicians perform this service across the United States? **No**

CPT Code: 34804 **Global Period**: 090 **Recommended RVW: 23.00**

CPT Descriptor: Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using unibody bifurcated prosthesis. (For radiological supervision and interpretation, use 75952)

Typical Patient (*Survey Vignette*):

Typical Patient/Service: A 67-year-old male with COPD and CAD s/p MI has a 5.8 cm infrarenal aortic aneurysm Imaging studies indicate that the aneurysm is infrarenal with an adequate neck to allow successful deployment of an endovascular prosthesis Distally the aneurysm extends to the end of the aorta, indicating that a bifurcated prosthesis will be required Iliac arteries are of appropriate diameter and length to provide landing zones for the iliac limbs of the prosthesis. The iliac artery anatomy should accommodate passage of the device.

Physician work for this code starts here:

Pre-Service Work begins the day before the operative procedure and may include the procedural work-up, review of all pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, insure all necessary equipment is present, position the patient, scrub, gown, prep and drape

Intra-Service Work includes
- Device preparation
- Angioplasty of area covered by device (if performed)
- Capture or snare of contralateral limb
- Advancement of device into aorta
- Positioning of device relative to aneurysm
- Fine adjustments to ensure proper seating and hemostatic sealing
- Graft deployment
- Balloon dilatation and/or intra-device stenting to ensure proper seating, to fully open the graft, and/or to treat endoleak if present,
- Embolization to treat endoleak (if present) or to prevent endoleak (if needed)

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days.

Not included in this Procedure (Separately Billable)
- Open surgical arterial exposure (codes 34812-34820),
- Catheterization of aorta (codes 36200, or 36245-36248),
- Fluoroscopic guidance of device and catheters (code 75952),
- Angiography and other imaging required for the procedure, including imaging for "mapping" and detection of endoleaks (code 75952)
- IVUS if required (code 37250, 37251, 75945, 75946)
- Placement of extensions or cuffs (codes 34825, 34826, and 75953),
- Removal of guidewires and catheters (included in initial 36200 or 36245-8),
- Closure of arteriotomy and application of sterile dressing (included in 34812-34820 or 36200, 36245-8)

CLINICAL DESCRIPTION OF SERVICE:

Description of Pre-Service Work:

Pre-service work begins after the decision to operate is made, from the day before the operation until the skin incision of the operation. This activity includes obtaining and reviewing the previous work-up, with special attention to potential cardiovascular risks. In addition, an extensive and detailed review of the preoperative imaging studies (some combination of CT scan, CT angiogram, CT with 3-D reconstructions, MRI, angiograms) is required to determine the exact measurements of the aneurysm. This is necessary because an accurate preoperative choice of component diameters and lengths is one of the primary determinants of whether the

endovascular procedure will be successful. In this regard endovascular repair differs substantially from open surgical AAA repair Although imaging studies are carefully reviewed prior to open repair, the painstaking diameter and length measurements are uniquely important for the endovascular procedure

Informed consent is obtained from the patient following a discussion of surgical risks and benefits with the patient and the family. Other pre-service work includes scrubbing, donning lead apparel, supervising patient positioning, waiting for the anesthetic to become effective, prepping and draping the patient Unique to endovascular AAA repair is the pre-service work of supervision of selection of equipment including guidewires, catheters, sheaths, balloons, stents, contrast material, plus setting up the x-ray equipment and organizing the technologic personnel for appropriate imaging during the procedure The x-rays and measurements are re-reviewed just before the case to be sure the appropriate grafts are selected and available, and that appropriate extensions are available if needed. Prior to initiating endovascular graft deployment, open surgical arterial exposure (34812) will typically be performed. In addition, introduction of appropriate guidewire catheters (36200, 36245 if needed) and a roadmapping aortogram will have been performed. These are separately reportable in conformance with component coding and the multiple procedure payment reduction rules.

Description of Intra-Service Work:

Intra-service work starts when the endovascular device and its introducing mechanism are brought onto the surgical field. Deployment of a unibody bifurcated prosthesis differs from the modular design in that the first steps include passage of the special contralateral iliac limb guidewire into the aorta and capture of this wire by a snare advanced through the arteries from the opposite groin. Once completed, this technically demanding step allows the contralateral graft limb to be pulled downward from the aorta into that opposite iliac artery.

Once this step is completed, the delivery sheath is loaded onto the guidewire and advanced to the edge of the femoral artery This sheath is very large in diameter and typically requires incision of up to ½ of the arterial circumference to allow entry The device is advanced slowly through the femoral and iliac arteries into the aorta. It is carefully positioned such that the proximal edge is just below the renal artery origins and above the beginning of the aneurysm. Exact position is confirmed by fluoroscopy, using injections of contrast. If a selective second catheter has been placed to mark the lower renal artery it is drawn back into the iliac, and the main endovascular device is deployed under fluoroscopic guidance. Fine adjustments in position are made during the deployment to assure accurate positioning just below the renal artery origins. In some patients the mean arterial pressure is transiently reduced by the anesthesiologist to decrease the chance that pressure from flowing blood will push the endograft distally during deployment. After deployment the arterial pressure is normalized. The introducer portion of the main device is removed over the guidewire, leaving the endograft in position. Some devices require balloon dilatation at the aortic and iliac attachment sites to help assure proper seating and hemostatic seal. If this is the case, a large diameter compliant balloon is advanced over the wire to the proximal anastomosis, and under fluoroscopic guidance the balloon is positioned and inflated. This same balloon may be pulled back and used to seat the iliac anastomosis by using an incomplete inflation (since the iliac diameter is smaller than the aorta). In other cases, a balloon better matched to the iliac diameter is required, entailing an exchange of balloons over the guidewire

The next step is deployment of the contralateral iliac limb. The leading guidewire for this limb has already been snared and exits the opposite femoral artery. This wire is carefully retracted, leading the second iliac limb across the aortic bifurcation into the appropriate common iliac artery. Once in correct position this limb is deployed. This second iliac limb is typically dilated with a compliant balloon (all balloon dilations within the body of the device are included in the work of this code).

When the complete endograft is in place, a pigtail catheter or multi-sidehole catheter is repositioned over one of the guidewires, and placed just above the renal arteries for a final angiographic evaluation. An aortogram is performed and immediately evaluated for graft position, patency of appropriate branches (renals and hypogastrics), presence or absence of endoleaks, and patency of lumbar or inferior mesenteric arteries that may contribute to persistent endoleaks. If the graft is in good position and free of endoleaks, the intra-service portion of 34802 is complete. Removal of the catheters and guidewires is included in the catheter introduction codes (36200-248) and the arteriotomy and skin closure is included in the femoral artery exposure codes 34812-34820.

Description of Post-Service Work:
Post-service work begins when the patient is transferred to a post-procedure recovery unit. This includes writing orders, reviewing the hardcopy films, dictating the operative note, communicating with the patient's family, communicating with referring and consulting physicians, and participating with the anesthesiologist in the recovery area to insure smooth emergence from anesthesia Depending on the preexisting comorbidities and operative course the patient may require admission to the intensive care unit. Results of the procedure are discussed with the patient once he or she is fully awake When stable, the patient is transferred to the floor. The physician makes daily visits at appropriate E&M levels as dictated by the patient's condition. Length of hospital stay for the uneventful case may be 2-5 days. Discharge day management includes communicating with all support services such as visiting nurse, meals on wheels, etc., communicating with referring physician, providing activity advice and warnings to patient and family, and arranging office follow-up for wound checks, suture/staple removal, etc. Since this is a 90-day global service all related in-hospital and post-discharge care for 90 days is included in the post-service work of 34804

SURVEY DATA

Presenter(s): Gary Seabrook, M.D.
Robert Vogelzang, M.D.
James P. Borgstede, M.D.

Specialty(s): Society for Vascular Surgery, ISCVS-NA
Society for Cardiovascular and Interventional Radiology
American College of Radiology

Sample Size: 330 **Response Rate:** 56 (17%):

Type of Sample: random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	1.30	**23.00***	30.00	35.50	76.90
Time (min) and Visits					
24 Hr Preceding Service			45		
Day Of Service					
Pre-Service			75		
Intra-Service	90	**150***	180	210	300
Immed. Post-Service			35		

Post-Service	**Total Time**	**CPT code / # of visits**
Critical Care		none
Other Hospital	49	99232 x 1; 99231 x 1
Discharge Management	36	99238
Office Visits	38	99213 x 1; 99212 x 1

***Note:** The three society consensus panel agreed that the 25th percentile RVW of 23.00 and the 25th percentile intra-service time of 150 minutes were the most appropriate estimates of total work and intra-service time. The survey median values for pre-service and post-service time and service levels were deemed appropriate.

KEY REFERENCE SERVICE(S):

'00 RVW	Global	CPT	Descriptor
30.76	090	35102	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, external)

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

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

TIME ESTIMATES (MEDIAN)	Survey CPT 34804	Ref CPT 35102
Pre-service time	120	95
Intra-service time	180	180
Immediate Post-service time	35	38
Total critical care time	0	0
Total other hospital visit time	49	136
Discharge management time	36	36
Total office visit time	38	53
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	4.64	3.65
Intra-service	4.71	4.16
Post-service	3.73	3.77
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	4.48	3.55
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.66	3.45
Urgency of medical decision making	3.59	3.39
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	4.84	4.35
Physical effort required	4.46	4.35
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	4.68	4.45
Outcome depends on the skill and judgement of physician	4.86	4.48
Estimated risk of malpractice suit with poor outcome	4.34	3.90

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

A consensus panel of three specialty societies agreed that the 25th percentile survey value (RVW 23.00) is the most appropriate recommended RVW for this service since it is supported by two different building block calculations.

1. Related Service Building Block: As noted for 34800 and 34802, placement of an endovascular stent graft prosthesis requires substantially more pre, intra, and post-service work than transcatheter placement of an intravascular stent (37205 or 37207, both 000 day globals, both with RVW 8.28). As with prior to endoprostheses, the bifurcated aortic unibody device is extraordinarily large in diameter, the introducing mechanism is very complex, and placement must be exact. The bifurcated unibody device, however, also adds the highly complex work of deploying the contralateral iliac guidewire across the aortic bifurcation, capturing it, from a snare introduced from the opposite groin, and maneuvering it into the contralateral sheath. To extend the "related service" building block approach noted for 34800, we estimate placement of the main device to require twice the work of a routine stent (8.28 x 2 = 16.56). In addition we estimate the work of deployment of the iliac docking limb as equivalent to placing an additional stent (37206 or 37208, ZZZ codes with RVW 4.13). Since these reference stent codes are 000 global services we add 4.06 rvus to cover in-hospital visits 99232 x 1, 99231 x 1, discharge day (99238), outpatient visit 1 (99213), and outpatient visit 2 (99212). Summing these components (16.56 + 4.13 + 4.06) results in a total estimated RVW of **24.75**.

2. IWPUT Building Block Analysis also justifies an RVW at the 25th percentile. Deployment of an endovascular aortic stent graft in exactly the correct location is the most intense component of an endovascular AAA repair, and it also represents one of the more intense services performed by interventional radiologists and vascular surgeons. Our consensus panel first adjusted the intra-service time downward from the median survey value of 180 minutes to the 25th percentile value of 150 minutes because we believe this to be the more appropriate value. We then calculated intra-service work by multiplying intra-service time (150 minutes) by an IWPUT of 0.095 (determined by consensus) for deployment of the endovascular aortic prosthesis, for an intra work of 14.25 rvus. Pre-service work was determined as cognitive time multiplied by 0.031, and activities such as change, scrub, prep, etc. were calculated as the product of time and an intensity factor of only 0.008. Pre-service work totals 2.69 rvus by this method. Post-service work was calculated as the sum of in-hospital and post-discharge visits, with outpatient visits discounted according to the HCFA adjustment, for 5.15 rvus. Total RVW by this method is then the sum of 14.25 + 2.69 + 5.15 = **22.09**.

FREQUENCY INFORMATION

How was this service previously reported?

This service has been recorded using a very wide variety of CPT codes alone or in combination. These codes include but are not limited to 35081, 35452, 36200, 36245, 37205, 37207, and 37799

How often do physicians in your specialty perform this service?

Specialty: SVS, SCVIR, ACR — Sometimes

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

Specialty. SVS	National Frequency: 3,000	Medicare Frequency: 2,000
Specialty: SCVIR	National Frequency: 3,000	Medicare Frequency: 2,000
Specialty: ACR	National Frequency: 3,000	Medicare Frequency: 2,000

Do many physicians perform this service across the United States? No

CPT Code: 34808 Global Period: ~~090~~ ZZZ Recommended RVW: ~~8.95~~ 4.13 (RUC)

CPT Descriptor: Endovascular placement of iliac artery occlusion device (For radiological supervision and interpretation, use 75952)

Typical Patient (*Survey Vignette*):

Typical Patient/Service: A 67-year-old male with COPD and CAD s/p MI has a 5.8 cm infrarenal aortic aneurysm. Imaging studies indicate an adequate proximal aortic neck to allow deployment of an endovascular prosthesis Distally there is an appropriate landing zone in the aorta to allow placement of a tube graft The right iliac artery anatomy will accommodate passage of the main device. However, there is diffuse, severe arterial occlusive disease involving the entire left common and external iliac artery. Thus, it has been decided that the left common iliac will be occluded using endovascular technique, and a right-to-left femoral-femoral bypass graft will be placed to reperfuse the left leg.

Physician work for this code starts here and includes:

Pre-Service Work begins the day before the operative procedure and may include the procedural work-up, review of all pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, insure necessary equipment is present, position patient, scrub, gown, prep, drape.

Intra-Service Work includes
- Advancement of occlusion device into iliac artery
- Ballooning the iliac artery to allow passage of the device, as needed
- Positioning of device
- Deployment of occlusion device(s) to exclude blood flow
- Deployment of other embolization materials needed to complete occlusion of the artery

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days.

Not included in this Procedure (Separately Billable)
- Open surgical arterial exposure (codes 34812-34820),
- Catheterization of aorta (codes 36200, or 36245-36248),
- Fluoroscopic guidance of device and catheters (code 75952),
- Angiography and other imaging required for the procedure, including imaging for "mapping" and detection of endoleaks (code 75952)
- IVUS if required (code 37250, 37251, 75945, 75946)
- Placement of extensions or cuffs (codes 34825, 34826, and 75953),
- Removal of guidewires and catheters (included in initial 36200 or 36245-8),
- Closure of arteriotomy & application of sterile dressing (included in codes 34812-34820 or 36200, 36245-8),

CLINICAL DESCRIPTION OF SERVICE

Description of Pre-Service Work:

Pre-service work begins after the decision to operate is made, from the day before the operation until the skin incision of the operation. This activity includes obtaining and reviewing the previous work-up with special attention to potential cardiovascular risks. In addition, an extensive and detailed review of the preoperative imaging studies (some combination of CT scan, CT angiogram, CT with 3-D reconstructions, MRI, angiograms) is required to determine the exact device required.

Informed consent is obtained from the patient following a discussion of surgical risks and benefits with the patient and the family. Other pre-service work includes scrubbing, donning lead apparel, supervising patient positioning, waiting for the anesthetic to become effective, prepping and draping the patient. Pre-service work includes selection of equipment including guidewires, catheters, sheaths, balloons, stents, contrast material, plus setting up the x-ray equipment and organizing the technologic personnel for appropriate imaging during the procedure. The x-rays and measurements are re-reviewed just before the case to be sure the appropriate device is selected and available

Description of Intra-Service Work:
Intra-service work for 34808 begins with placement of the iliac occluder device and its introducer onto the guidewire. The device is then advanced under fluoroscopic guidance to the exact location where the occlusion is to be performed. Fine adjustments under fluoroscopic guidance are made as necessary The device is deployed and appropriate position is confirmed by hand injection of contrast. If required to achieve complete arterial occlusion, additional embolization of materials is performed and included within the work description of this code The device introducer is removed

Description of Post-Service Work:
Post-service work begins when the patient is transferred to a post-procedure recovery unit. This includes writing orders, reviewing the hardcopy films, dictating the operative note, communicating with the patient's family, communicating with referring and consulting physicians, and participating with the anesthesiologist in the recovery area to insure smooth emergence from anesthesia. The physician makes daily visits as dictated by the patient's condition. Length of hospital stay depends is typically 3-6 days if the iliac occlusion device is placed in concert with an endovascular AAA repair and placement of a fem-fem cross-over graft as described in the vignette. If this code is considered as a stand-alone, length of stay would be less. Since this is a 90-day global service all related in-hospital and post-discharge care for 90 days is included in the post-service work of 34808.

SURVEY DATA

Presenter(s): Gary Seabrook, M.D.
Robert Vogelzang, M.D.
James P. Borgstede, M.D.

Specialty(s): Society for Vascular Surgery, ISCVS-NA
Society for Cardiovascular and Interventional Radiology
American College of Radiology

Sample Size: 330 **Response Rate**: 52 (16%):

Type of Sample: random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	5.00	8.50	10.00	18.00	92.28
Time (min) and Visits					
24 Hr Preceding Service					
Day Of Service					
Pre-Service					
Intra-Service	10	45	60	90	240
Immed. Post-Service					

Post-Service	**Total Time**	**CPT code / # of visits**
Critical Care		None
Other Hospital		
Discharge Management		
Office Visits		

KEY REFERENCE SERVICE(S):

'00 RVW	Global	CPT	Descriptor
8.28	000	37207	Transcatheter placement of an intravascular stent(s), (non-coronary vessel), open; initial vessel

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

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

TIME ESTIMATES (MEDIAN)	Survey CPT 34808	Ref CPT 37207
Pre-service time	90	80
Intra-service time	60	45
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	49	0
Discharge management time	36	0
Total office visit time	38	0
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	3.64	3.27
Intra-service	4.00	3.53
Post-service	3.26	2.87
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.20
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.88	3.13
Urgency of medical decision making	2.94	3.00
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	3.96	3.67
Physical effort required	3.50	3.13
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	3.86	3.33
Outcome depends on the skill and judgement of physician	4.10	3.67
Estimated risk of malpractice suit with poor outcome	3.76	3.60

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

A consensus panel of three specialty societies agreed that the best RVW for this service would be constructed using a related service building block method. The pre and intra-service workof transcatheter placement of an iliac occluding device is essentially equal to transcatheter placement of an intravascular stent (CPT 37205 or 37207, both 000 global services, both have RVW 8.28). However, the occlusion device code has a90 day global. Thus, we would construct the value of 34808 by adding one outpatient level 3 visit (99213, RVW 0.67) to the stent code RVW. Thus, the recommended value is 8.28 + 0.67 =**8.95**.

The recommended RVW of 8.95 value falls within 5% of the 25th percentile survey value of 8.50.

FREQUENCY INFORMATION

How was this service previously reported? This is a new service created as an unusual component of endovascular AAA repair.

How often do physicians in your specialty perform this service?

Specialty: SVS, SCVIR, ACR: Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period?

	National	Medicare
Specialty: SVS, SCVIR, ACR combined	Frequency: <1,000	Frequency: <800

Do many physicians perform this service across the United States? No

CPT Code: 34812 **Global Period**: ~~090~~ 000 **Recommended RVW**. ~~9.55~~ **6.75 (RUC)**

CPT Descriptor: Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision; unilateral (for bilateral procedure, use modifier '50')

Typical Patient (*Survey Vignette*):

Typical Patient/Service: A 67-year-old male with COPD and CAD s/p MI has a 5.8 cm. infrarenal aortic aneurysm. Imaging studies indicate an adequate proximal aortic neck to allow deployment of an endovascular prosthesis Distally there is an appropriate landing zone in the aorta to allow placement of a tube graft The right iliac artery anatomy will accommodate passage of the main device.

Physician work for this code starts here and includes:

Pre-Service Work begins the day before the operative procedure and may include the procedural work-up, review of all pre-operative studies, final discussion with patient and family, obtaining informed consent, discussing patient comorbidities with anesthesia, dress for OR, insure necessary equipment is present, position patient, scrub, gown, prep, drape.

Intra-Service Work includes
- Open surgical dissection of the common femoral artery via groin incision
- Dissection and control of all necessary branches
- Routine surgical closure of the arteriotomy and overlying tissue

Post-service work includes immediate postoperative care starting after skin closure plus all in-hospital and outpatient care related to the femoral exposure during the subsequent 90 days.

Not included in this Procedure (Separately Billable)
- Catheterization of aorta (codes 36200, or 36245-36248),
- Fluoroscopic guidance of device and catheters (code 75952),
- Angiography and other imaging required for the procedure, including imaging for "mapping" and detection of endoleaks (code 75952)
- IVUS if required (code 37250, 37251, 75945, 75946)
- Placement of endovascular device (codes 34800-6)
- Placement of extensions or cuffs (codes 34825, 34826, and 75953),
- Removal of guidewires and catheters (included in initial 36200 or 36245-8),
- Repair, replacement, embolectomy or extensive endarterectomy of the femoral artery (codes 34201, 35226, 35256, 35286, 35355, 35371, 35372)

CLINICAL DESCRIPTION OF SERVICE:

Description of Pre-Service Work:

Pre-service work begins after the decision to operate is made, from the day before the operation until the skin incision of the operation. This activity includes obtaining and reviewing the previous work-up, with special attention to potential cardiovascular risks. Informed consent is obtained from the patient following a discussion of surgical risks and benefits Other pre-service work includes scrubbing, supervising patient positioning, waiting for the anesthetic to become effective, prepping and draping the patient.

Description of Intra-Service Work:

A skin incision is made in the inguinal region The subcutaneous tissue is dissected until the common femoral artery is located Care is taken to avoid injury to the femoral nerve and vein that lie in close proximity. The common, superficial, and deep femoral arteries are dissected and captured in vessel loops. The distal external iliac artery is typically included in the dissection. This exposure is accomplished by retraction and/or division of the inguinal ligament The extra exposure facilitates introduction of the very large diameter sheath required for endovascular AAA repair. It also serves to apply countertraction and temporarily reduce tortuosity of the iliac arteries as the sheath is advanced. Hemostasis in the groin is achieved by ligation or electrocautery of small branch arteries and veins Intravenous heparin is administered before the arteries are clamped. A transverse arteriotomy is made in the anterior surface of the common femoral or distal-most external iliac artery for introduction of the guidewires and sheaths.

Intra-service work of 34812 resumes after deployment of the device has been completed and all sheaths and guidewires have been removed. The arteriotomy is closed with very fine (e.g. 6-0 polypropylene) sutures. Hemostasis is achieved, the wound irrigation, and the soft tissue is reapproximated in several layers Skin closure is performed with staples or sutures.

Description of Post-Service Work:

Post-service work begins when the patient is transferred to a post-procedure recovery unit. This includes writing orders, reviewing the hardcopy films, dictating the operative note, communicating with the patient's family, communicating with referring and consulting physicians, and participating with the anesthesiologist in the recovery area to insure smooth emergence from anesthesia The physician makes daily visits and provides appropriate care. Length of hospital stay for the uneventful endovascular AAA repair case may be 2-5 days Discharge day management includes communicating with all support services such as visiting nurse, meals on wheels, etc., communicating with referring physician, providing activity advice and warnings to patient and family, and arranging office follow-up for wound checks, suture/staple removal, etc Since 34812 is an 090 global service, all in-hospital and post-discharge care related to the femoral artery exposure for 90 days is included in the post-service work

SURVEY DATA

Presenter(s): Gary Seabrook, M.D.

Specialty(s): Society for Vascular Surgery, ISCVS-NA

Sample Size: 110 **Response Rate**: 43 (39%):

Type of Sample: random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	4.00	8.00	10.00	14.00	35.00
Time (min) and Visits					
24 Hr Preceding Service			30		
Day Of Service					
Pre-Service			45		
Intra-Service	15	30	45	60	180
Immed. Post-Service			30		

Post-Service	**Total Time**	**CPT code / # of visits**
Critical Care		None
Other Hospital		
Discharge Management		
Office Visits		

KEY REFERENCE SERVICE(S):

'00 RVW	Global	CPT	Descriptor
19.53	090	35656	Bypass graft, with other than vein; femoral-popliteal

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

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

TIME ESTIMATES (MEDIAN)	Survey CPT 34812	Ref CPT 35656
Pre-service time	75	65
Intra-service time	45	90
Immediate Post-service time	30	20
Total critical care time	0	0
Total other hospital visit time	49	87
Discharge management time	36	36
Total office visit time	38	38
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	2.90	3.13
Intra-service	3.15	3.50
Post-service	2.66	3.00
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	2.98	3.25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.17	3.00
Urgency of medical decision making	2.71	2.88
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	3.22	3.38
Physical effort required	3.00	3.13
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	3.17	3.25
Outcome depends on the skill and judgement of physician	3.29	3.38
Estimated risk of malpractice suit with poor outcome	3.05	3.13

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The society consensus panel agreed that an IWPUT building block value of 9.55 was most appropriate for this service. This value is just below the median survey RVW of 10.00, and a related service building block approach using the value of 9.55 to reconstruct the primary reference code is spot-on.

IWPUT Building Block: In preparation for the upcoming five-year review, the vascular surgery societies carried out an intra-service intensity (IWPUT) survey of 179 vascular surgery operations. The range median IWPUT results was 0.040 – 0.110, based on references of E&M and general surgery services. Further details of this survey are available in our five-year submission and can be obtained from RUC staff. In this survey the median IWPUT for CPT 35721(Exploration without repair, femoral artery) was 0.065. This serves as a reasonably analogous IWPUT for the new code 34812. (Incidentally, we do not believe that the RVW for 35721 is a valid comparison because 35721 was submitted to the 5-year review as an undervalued code.) We multiplied 0.065 by the median intra-service time for 34812 (45 minutes) to generate intra-service work of 2.93. Pre-service work was calculated as 0.031 x cognitive time + 0.008 x non-cognitive time = 1.64 rvus. Post service work included 30 minutes of immediate post-op work (@0.031) + hospital visits 99232 x 1 + 99231 x 1 + 99238(DD) + 99213(OPV1) + 99212(OPV2). Outpatient visits were appropriately discounted per HCFA rules, resulting in total post-service work of 4.99. Total building block work for this service by IWPUT is 1.64 + 2.93 + 4.99 = 9.55.

Related Service Building Block: The most commonly cited reference service was 35656, femoral-popliteal vein bypass using prosthetic graft. RVW for 35656 is 19.53. In most simplified form, performance of a synthetic fem-pop graft consists of two arterial dissections, creation of a tunnel, placing the graft in the tunnel, performing two anastomoses, achieving hemostasis, and closing the wounds. This combination of maneuvers is entirely analogous to performance of two 34812 femoral exposures plus one new code 34813, the ZZZ add-on code for placement of femoral-femoral graft after the arteries have been dissected. Thus, payment for 2x34812 plus one 34813 should equal payment for reference code 35656 because the work is essentially the same. We are recommending an RVW of 4.80 for 34813 (see next application).
Using Medicare coding and payment policy reduction rules, the first 34812 would be paid at full value, 9.55 rvus. The second 34812 would be paid at 50%, therefore 4.78 rvus 34813 is a ZZZ add-on code, therefore paid at full value, 4.80 rvus. Total payment would be 9.55+4.78+4.80 = 19.13. Thus, payment for an equivalent work combination of the new codes equals payment for the reference service, 19.13 compared to 19.53.

Comment on Multiple Payment Reduction Rules: Although the RUC must consider this new service as a stand-alone 90-day global as recommended by the CPT Editorial Panel, the reality is that this code will never be used alone (we requested ZZZ status). It is defined as "Open femoral artery exposure for delivery of endovascular prosthesis", and it will therefore **always** be subject to multiple payment reduction. Thus, when considering the package RVW for an endovascular AAA repair, this new code will be subject to a 50% payment reduction, and will actually be paid at 9.55 x 0.5 = 4.78 rvus.

In some centers and for some devices *bilateral* femoral artery exposure is performed during endo AAA repair. In that circumstance, bilateral femoral exposure will be coded as 34812-50-51. The –50 modifier signifies a bilateral procedure and the –51 indicates multiple payment reduction. We have been informed by Jean Harris of ACS and indirectly by Dr Mangold through Ms. Sherry Smith that the payment rules for this doubly-modified procedure would be the following. First, the payment for –50 bilateral procedures is 1.5 x the single value, or 1.5 x 10rvus = 15rvus. Second, payment reduction of 50% would be applied to this value, or 15rvus x 0.5 = 7.5rvus for *bilateral* femoral artery exposure. Thus, although we have justified the independent value of 10 rvus for a single femoral artery exposure, Medicare payment for *bilateral* exposures during endovascular AAA repair will *total* only 7.5 rvus. This unlikely fact should be additionally considered during consideration of the value for this code.

FREQUENCY INFORMATION

How was this service previously reported? This is a new service. Prior to the creation of these codes endovascular AAA repairs were coded using a wide spectrum of open AAA repair codes and unlisted vascular surgery code 37799.

How often do physicians in your specialty perform this service?

Specialty: SVS: Sometime
Specialty: SCVIR: Rarely
Specialty: ACR: Rarely

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

Specialty	National Frequency	Medicare Frequency
SVS	5,000	4,000
SCVIR	1,000	800
ACR	500	400

Do many physicians perform this service across the United States? No

CPT Code: 34813 **Global Period**: ZZZ **Recommended RVW**: **4.80**

CPT Descriptor: Placement of femoral-femoral prosthetic graft during delivery of endovascular device (List separately in addition to code for primary procedure, 34812-50, bilateral open femoral artery exposure for delivery of endovascular prosthesis)

Typical Patient (*Survey Vignette*):

Typical Patient/Service: A 67-year-old male with COPD and CAD s/p MI has a 5.8 cm. infrarenal aortic aneurysm. Imaging studies indicate an adequate proximal aortic neck to allow deployment of an endovascular prosthesis. Distally there is an appropriate landing zone in the aorta to allow placement of a tube graft. The right iliac artery anatomy will accommodate passage of the main device. However, there is diffuse, severe arterial occlusive disease involving the entire left common and external iliac artery. Thus, it has been decided that the left common iliac will be occluded using endovascular technique, and a right-to-left femoral-femoral bypass graft will be placed to reperfuse the left leg.

Physician work for this code starts here and includes:

Pre-Service Work. There is no pre-service work because this procedure was defined as a "ZZZ" add-on code. Therefore, it contains only intra-service work. Pre and post service work are associated with the femoral exposure code 34812 with the "-50" modifier to indicate bilateral femoral artery exposure.

Intra-Service Work includes
- Creation of a subcutaneous tunnel for the prosthesis
- Bilateral femoral arteriotomies
- Creation of two anastomoses
- Achieve hemostasis

Post-service work: There is no post-service work All post-service care is assigned to the femoral artery exposure code.

Not included in this Procedure (Separately Billable)
- Open surgical exposure of the femoral arteries (code 34812-50)
- Repair, replacement, embolectomy or extensive endarterectomy of the femoral artery (codes 34201, 35226, 35256, 35286, 35355, 35371, 35372)
- Catheterization of aorta (codes 36200, or 36245-36248),
- Fluoroscopic guidance of device and catheters (code 75952),
- Angiography and other imaging required for the procedure, including imaging for "mapping" and detection of endoleaks (code 75952)
- IVUS if required (code 37250, 37251, 75945, 75946)
- Placement of endovascular device (codes 34800-6)
- Placement of extensions or cuffs (codes 34825, 34826, and 75953),
- Removal of guidewires and catheters (included in initial 36200 or 36245-8),

CLINICAL DESCRIPTION OF SERVICE

Description of Intra-Service Work:
Intra-service work begins with creation of an arching, curved subcutaneous tunnel from one femoral artery to the other. A specially designed curved, blunt-nosed tunneling device is used for this purpose. Care is taken not to "button-hole" the skin or enter the abdominal cavity. A synthetic conduit is chosen and pulled gently through the tunnel using care to avoid twisting or kinking. Intravenous heparin anticoagulant is administered and the femoral arteries are clamped with vascular hemostats An appropriate arteriotomy is fashioned in the common femoral and an anastomosis is completed with fine polypropylene sutures. The graft is cut to appropriate length and a similar arteriotomy and anastomosis are performed on the opposite side. Vascular clamps are removed and hemostasis is obtained. The technical adequacy of the reconstruction is typically checked with handheld Doppler The intra-service work of 34813 is complete at this point. Irrigation and closure of the wounds is included in the primary code 34812-50.

SURVEY DATA

Presenter(s): Gary Seabrook, M.D.

Specialty(s): Society for Vascular Surgery, ISCVS-NA

Sample Size: 110 **Response Rate**: 43 (39%):

Type of Sample: random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	1.50	10.00	15.00	19.00	25.00
Intra-Service Time	25	45	60	60	160

KEY REFERENCE SERVICE(S):

'00 RVW	Global	CPT	Descriptor
19.53	090	35656	Bypass graft, with other than vein; femoral-popliteal

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

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

TIME ESTIMATES (MEDIAN)	Survey CPT 34813	Ref CPT 35656
Pre-service time	N/A	65
Intra-service time	60	90
Immediate Post-service time	N/A	20
Total critical care time	N/A	0
Total other hospital visit time	N/A	87
Discharge management time	N/A	36
Total office visit time	N/A	38
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	N/A	3.30
Intra-service	3 26	3.25
Post-service	N/A	3.10
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3.19	3.22
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.26	3.19
Urgency of medical decision making	3.00	2.88
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	3 49	3 47
Physical effort required	3.21	3.22
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	3.47	3.38
Outcome depends on the skill and judgement of physician	3.67	3.63
Estimated risk of malpractice suit with poor outcome	3 42	3.28

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

This is a ZZZ add-on code for placement of a femoral-femoral bypass graft during endovascular AAA repair *after* the femoral arteries have been surgically dissected. There is no pre or post-service work. These add-on codes always present difficulty when RUC survey methodology is applied. Although our survey instructions very clearly and carefully stated that *only* intra-service work should be considered, we believe a substantial number of respondents remained in the "global service" spirit. As a result, we believe a building block method is most appropriate for evaluating the median survey 60 minutes of intra-time. In preparation for the five-year review we recently performed a survey to determine rational IWPUTs for 179 vascular surgery codes. The results ranged from 0.040 (inject veins) to 0.110 (repair thoracoabdominal aortic aneurysm). The IWPUT for synthetic fem-fem bypass in this survey was 0.080. In order to determine the most appropriate value for 34813 we multiplied 60 minutes of survey intra-time by an IWPUT of 0.080 to reach a value of **4.80 rvus**.

As noted in the 'Additional Rationale' for 34812, the combination of two artery exposures (2 x 34812) plus one fem-fem graft (34813) has very close work equivalent to the reference code 35656 (fem-pop bypass using synthetic conduit). Using Medicare multiple procedure payment reduction rules, the first 34812 would be paid at full value of 9.55 rvus, the second would be reduced by 50% to 4.78 rvus, and a full 4.80 rvus would be applied for the ZZZ code 34813. This totals 19.13 rvus, an excellent match for the reference code value of 19.53.

FREQUENCY INFORMATION

How was this service previously reported?

This is a new code created to capture the additional work of fem-fem graft placement that is occasionally performed during endovascular AAA repair.

How often do physicians in your specialty perform this service?

Specialty: SVS Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period?

	National	Medicare
Specialty: SVS	Frequency: 1,000	Frequency: 800

Do many physicians perform this service across the United States? No

CPT Code: 34820 **Global Period:** ~~090~~ **000** **Recommended RVW:** ~~14.25~~ **9.75 (RUC)**

CPT Descriptor: Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision; unilateral (for bilateral procedure, use modifier '-50')

Typical Patient (*Survey Vignette*):

Typical Patient/Service: A 67-year-old female with COPD and CAD s/p MI has a 5.8 cm. infrarenal aortic aneurysm Imaging studies indicate an adequate proximal aortic neck to allow deployment of an endovascular prosthesis. Distally there is an appropriate landing zone in the aorta to allow placement of a tube graft. Bilateral distal external iliac and common femoral arteries are too small in diameter to accommodate passage of the endovascular device. The decision has been made to perform surgical exposure of a more proximal segment of iliac artery, where the diameter is larger, to provide a suitable entry site for placement of the device.

Physician work for this code starts here and includes:

Pre-Service Work begins the day before the operative procedure and may include the procedural work-up, review of all pre-operative studies, final discussion with patient and family, obtain informed consent, discuss patient comorbidities with anesthesia, dress for OR, insure necessary equipment is present, position patient, scrub, gown, prep, drape.

Intra-Service Work includes
- Open surgical dissection of the iliac artery via abdominal or retroperitoneal incision
- Dissection and control of all necessary branches
- Routine surgical closure of the arteriotomy and overlying tissue

Post-service work includes immediate postoperative care starting after skin closure plus all in-hospital and outpatient care related to the iliac exposure during the subsequent 90 days.

Not included in this Procedure (Separately Billable)
- Catheterization of aorta (codes 36200, or 36245-36248),
- Fluoroscopic guidance of device and catheters (code 75952),
- Angiography and other imaging required for the procedure, including imaging for "mapping" and detection of endoleaks (code 75952)
- IVUS if required (code 37250, 37251, 75945, 75946)
- Placement of endovascular device (codes 34800-6)
- Placement of extensions or cuffs (codes 34825, 34826, and 75953),
- Removal of guidewires and catheters (included in initial 36200 or 36245-8),
- Repair, replacement, bypass, embolectomy or extensive endarterectomy of the iliac or femoral arteries (codes 34201, 35221, 35226, 35251, 35256, 35281, 35286, 35351, 35355, 35371, 35372, 35563, 35565, 35663, 35665)

CLINICAL DESCRIPTION OF SERVICE

Description of Pre-Service Work:

Pre-service work begins after the decision to operate is made, from the day before the operation until the skin incision of the operation. This activity includes obtaining and reviewing the previous work-up, with special attention to potential cardiovascular risks. In addition, an extensive and detailed review of the preoperative imaging studies (some combination of CT scan, CT angiogram, CT with 3-D reconstructions, MRI, angiograms) is required to determine the exact measurements of the aneurysm.

Informed consent is obtained from the patient following a discussion of surgical risks and benefits with the patient and the family. Other pre-service work includes scrubbing, supervising patient positioning, waiting for the anesthetic to become effective, prepping and draping the patient.

Description of Intra-Service Work:
A skin incision is made in the lower abdomen or retroperitoneum The tissue is dissected deep into the pelvis until the iliac artery is located. Care is taken to avoid injury to the nerves, veins, and ureter that lie in close proximity. The arteries are dissected and isolated in vessel loops Hemostasis is achieved by ligation or electrocautery Intravenous heparin is administered before the arteries are clamped. A transverse arteriotomy is made in the anterior surface of the iliac artery for introduction of the guidewires and sheaths.

The intra-service work of 34820 is interrupted until placement of the endovascular device has been completed Once the device is successfully deployed 34820 resumes with closure of the arteriotomy using fine vascular suture, achievement of hemostasis, wound irrigation, and soft tissue reapproximation. Skin is closed with sutures or staples

Description of Post-Service Work:
Post-service work begins when a dressing is applied, and the patient is transferred to a post-procedure recovery unit. Post-service work includes writing orders, dictating the operative note, communicating with the patient's family, communicating with referring and consulting physicians, and participating with the anesthesiologist in the recovery area to insure smooth emergence from anesthesia. Depending on the preexisting comorbidities and operative course the patient may require admission to the intensive care unit. Results of the procedure are discussed with the patient once he or she is fully awake. When stable, the patient is transferred to the floor. The physician makes daily visits and provides appropriate care. Length of hospital stay for the uneventful endovascular aneurysm repair may be 2-5 days. Discharge day management includes communicating with all support services such as visiting nurse, meals on wheels, etc., communicating with referring physician, providing activity advice and warnings to patient and family, and arranging office follow-up for wound checks, suture/staple removal, etc. Since 34820 is a 090 global service, post-service work includes all related in-hospital and post-discharge care for 90-days.

SURVEY DATA

Presenter(s): Gary Seabrook, M.D.
Specialty(s): Society for Vascular Surgery, ISCVS-NA

Sample Size: 110 **Response Rate**: 39 (35%):
Type of Sample: random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	6.50	**14.25**	18.00	20.00	45.00
Time (min) and Visits					
24 Hr Preceding Service			30		
Day Of Service					
Pre-Service			50		
Intra-Service	30	45	75	100	180
Immed. Post-Service			30		

Post-Service	**Total Time**	**CPT code / # of visits**
Critical Care		none
Other Hospital	68	99232 x 1; 99231 x 2
Discharge Management	36	99238
Office Visits	38	99213 x 1; 99212 x 1

000 Global

KEY REFERENCE SERVICE(S):

'00 RVW	Global	CPT	Descriptor
19 53	090	35656	Bypass graft, with other than vein, femoral-popliteal

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

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

TIME ESTIMATES (MEDIAN)	Survey CPT 34820	Ref CPT 35656
Pre-service time	80	65
Intra-service time	75	90
Immediate Post-service time	30	20
Total critical care time	0	0
Total other hospital visit time	68	87
Discharge management time	36	36
Total office visit time	38	38
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	3.70	3.30
Intra-service	3.97	3.50
Post-service	3.39	3.10
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3 73	3.20
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.63	3.40
Urgency of medical decision making	3.21	2.90
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	3.92	3.50
Physical effort required	3.89	3.30
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	3.82	3.40
Outcome depends on the skill and judgement of physician	4.08	3.80
Estimated risk of malpractice suit with poor outcome	3.68	3.40

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation

We recommend the 25th percentile value of 14.25 rvus because it is justified by an IWPUT building block approach.

Median survey intra time of 75 minutes is very reasonable to dissect out this deep pelvic artery, perform the arterial closure once the graft has been inserted, and close the abdomen and skin. We applied an IWPUT of 0.080 to this service based on our recent IWPUT described earlier in this application. The value of 0.080 was the median level for several intra-abdominal vascular services including CPT 35840 Explore abdominal artery. Applying 0.080 IWPUT to 75 minutes derives an intra-service work of 6.00 rvus. Pre-service work of 1.79 rvus was determined as the product of cognitive time x 0.031 and non-cognitive time x 0.008 Post-service work of 5.63 was the sum of 30 minutes of immediate post-service care at 0.031 + inpatient visits 99232 x 1 + 99231 x 1 + 99238(DD) and outpatient visits 99213 x 1 + 99212 x 1 (with appropriate HCFA global surgical service reductions). Total value is 1.79 (pre) + 6.00 (intra) + 5.63 (post) = 13.42

FREQUENCY INFORMATION

How was this service previously reported? This is a new service created to widen the scope of patients suitable for endovascular AAA repair. It has been and will be a rarely used code. We doubt that it has been previously reported by any code other than the unlisted vascular surgery service 37799.

How often do physicians in your specialty perform this service?

Specialty: SVS Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period?

	National	Medicare
Specialty: SVS	Frequency: 200	Frequency: 150

Do many physicians perform this service across the United States? No

CPT Code: 34825 **Global Period**: 090 **Recommended RVW**: **12.00**

CPT Descriptor: Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic aneurysm; initial vessel

(Use code 34825 in addition to codes 34800-34808, as appropriate)

(For radiological supervision and interpretation, use 75953)

(For staged procedure, use modifier '-58')

Typical Patient (*Survey Vignette*):

Typical Patient/Service: A 67-year-old male with COPD and CAD s/p MI underwent endovascular repair of a 5 8 cm diameter abdominal aortic aneurysm (AAA) A distal anastomotic endoleak is discovered by follow-up CT scan, and its exact nature is confirmed with angiography (separately reportable) during post-operative follow-up. A distal endovascular extension will be placed to correct the endoleak. (For radiological supervision and interpretation use 7592X2)

Note: This code may also be used if an extension is required at the time of the original endovascular repair to fully cover the lesion. The code is used once per vessel and not per cuff/extension.

Physician work for this code includes:

Pre-Service Work begins the day before the procedure and may include the procedural work-up, review of all pre-operative studies, final discussion with patient and family, obtain informed consent, discuss patient comorbidities with anesthesia, insure necessary equipment is present, don scrub attire, position patient, scrub hands, gown, prep, drape.

Intra-Service Work includes
- Angioplasty of area covered by extension(s) (if performed)
- Advancement of extension(s) to treatment site
- Positioning of extension(s) relative to landing zone
- Fine adjustments to extension(s) to ensure proper seating and hemostatic seal
- Cuff/Extension deployment
- Balloon dilatation and/or intra-device stenting to ensure proper seating
- Embolization to treat endoleak (if present)

Post-service work includes immediate post-procedure care plus all in-hospital and outpatient care related to the cuff/extension placement during the subsequent 90 days.

Not included in this Procedure (Separately Billable)
- Catheterization of aorta (codes 36200, or 36245)
- Fluoroscopic guidance of device and catheters (code 75953),
- Aortography for "mapping" and detection of endoleaks (code 75953)
- Removal of guidewires and catheters (included in initial 36200 or 36245)
- Arteriotomy, if performed (included in codes 34812-34820)
- Closure of arteriotomy and application of sterile dressing (included in codes 34812-10)
- IVUS to confirm extension(s) positioning, if performed

CLINICAL DESCRIPTION OF SERVICE

Description of Pre-Service Work:

Pre-service work begins after the decision to operate is made, from the day before the operation until the skin incision of the operation. This activity includes obtaining and reviewing the previous work-up, with special attention to potential cardiovascular risks. In addition, an extensive and detailed review of the preoperative imaging studies (some combination of CT scan, CT angiogram, CT with 3-D reconstructions, MRI, angiograms) is required to determine the exact site of the endoleak This is necessary because an accurate preoperative choice of component diameters and lengths is one of the primary determinants of whether the endovascular procedure will be successful.

Informed consent is obtained from the patient following a discussion of risks and benefits with the patient and the family. Other pre-service work includes scrubbing, donning lead apparel, supervising patient positioning, waiting for the anesthetic to become effective, prepping and draping the patient. Unique to endoleak repair is the pre-service work of supervision of selection of equipment including guidewires, catheters, sheaths, balloons, stents, contrast material, plus setting up the x-ray equipment and organizing the technologic personnel for appropriate imaging during the procedure. The x-rays and measurements are re-reviewed just before the case to be sure the appropriate grafts are selected and available, and that appropriate extensions are available if needed. Prior to initiation of the intra-service work for this code, catheters are introduced in the aorta or appropriate branches (36200 or 36245). Depending on the diameter of the extension cuff and the size of the patient's arteries, open surgical exposure may be required (34812). These are separately reportable under the component and multiple procedure rules.

Description of Intra-Service Work:

Intra-service work typically begins by passing an adequately large diameter sheath along the guidewire. The endovascular extension prosthesis is then advanced over the guidewire within the sheath. The device is carefully advanced through the pelvis and positioned such that the proximal and distal edges bridge the endoleak. Position is confirmed exactly by fluoroscopy, often with injections of contrast. Fine adjustments in position are made as needed. When in exactly the right position the extension cuff is deployed. Some devices require balloon dilatation to help assure proper seating and hemostatic seal (included in service). If this is the case, a large diameter compliant balloon is advanced over the wire, and under fluoroscopic guidance the balloon is positioned and inflated. An injection is performed to determine whether the endoleak has been sealed.

Description of Post-Service Work:

Post-service work begins when the patient is transferred to a post-procedure recovery unit. This includes writing orders, reviewing the hardcopy films, dictating the operative note and angiography interpretation, communicating with the patient's family, communicating with referring and consulting physicians, and participating with the anesthesiologist in the recovery area to insure smooth emergence from anesthesia. Depending on the preexisting comorbidities and operative course the patient may require admission to the intensive care unit. Results of the procedure are discussed with the patient once he or she is fully awake. When stable, the patient is transferred to the floor. The physician makes daily visits and provides appropriate care. Length of hospital stay for the uneventful case may be 1-5 days. Discharge day management includes communicating with all support services such as visiting nurse, meals on wheels, etc., communicating with referring physician, providing activity advice and warnings to patient and family, and arranging office follow-up for wound checks, suture/staple removal, etc. Since 34825 is a 090 global service code, all related in-hospital and post-discharge care for 90 days is included in the post-service work.

SURVEY DATA

Presenter(s): Gary Seabrook, M.D.
Robert Vogelzang, M.D.
James P. Borgstede, M.D.

Specialty(s): Society for Vascular Surgery, ISCVS-NA
Society for Cardiovascular and Interventional Radiology
American College of Radiology

Sample Size: 330 **Response Rate**: 54 (16%):

Type of Sample: random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	5.00	9.00	**12.00**	15.75	61.52
Time (min) and Visits					
24 Hr Preceding Service			30		
Day Of Service					
Pre-Service			50		
Intra-Service	10	30	60	90	150
Immed. Post-Service			30		

Post-Service	**Total Time**	**CPT code / # of visits**
Critical Care		none
Other Hospital	49	99232 x 1, 99231 x 1
Discharge Management	36	99238
Office Visits	38	99213 x 1; 99212 x 1

KEY REFERENCE SERVICE(S):

'00 RVW	Global	CPT	Descriptor
8.28	000	37207	Transcatheter placement of an intravascular stent(s), (non-coronary vessel), open; initial vessel

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

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

TIME ESTIMATES (MEDIAN)	Survey CPT 34825	Ref CPT 37207
Pre-service time	80	88
Intra-service time	60	45
Immediate Post-service time	30	25
Total critical care time	0	0
Total other hospital visit time	49	0
Discharge management time	36	0
Total office visit time	38	0
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	3.88	3.25
Intra-service	4 10	3.50
Post-service	3.33	2.94
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3.98	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.85	3.38
Urgency of medical decision making	3.65	2.75
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	4.21	3.75
Physical effort required	3.61	3.44
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	4.25	3.50
Outcome depends on the skill and judgement of physician	4.37	3.69
Estimated risk of malpractice suit with poor outcome	3.90	3.50

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

A consensus panel of the three specialties that surveyed this service agreed that the most appropriate RVW is the survey median, **12.00**. This is justified both by a related service building block approach and also by an IWPUT building block approach.

Related Service Building Block: The closest clinically related service is placement of a transcatheter intravascular stent There are two of these CPT codes 37205 (percutaneous, initial vessel) and 37207 (open artery, initial vessel) Both are 000-day globals and both have an RVW of 8.28 Pre-service work is more than that of a routine stent in that CT, arteriogram, and/or ultrasound studies need to be examined in detail to determine the site of the endoleak. The exact diameter *and* length of cuff must be determined beforehand. Patient counseling also requires more time for explanation of risks and benefits Placement of the endovascular extension cuff involves using a covered stent rather than a bare one, thereby requiring use of a much larger diameter introducing mechanism. The larger size mandates a larger hole at the arterial introduction site, more difficulty passing the device through the pelvis with increased attendant risk. Finally, positioning of the cuff must be more exact than placement of the typical stent Oftentimes the endoleak may be very close to the renal artery origins, requiring deployment accuracy within just a few millimeters Since the cuff is covered with fabric, deployment of the device in the wrong spot may have catastrophic results if vessels such as the renal artery origins are covered For all the above reasons, we believe the physician work of this new service in the pre and intra-service elements is at least 25% greater than the RVW for a stent We therefore estimate the pre and intra-service work as 8.28 x 1 25 = 10 35.

Since 34825 is a 90-day global service, post-service work must be estimated and added to the pre and intra work We assumed the initial 99232 in the post-procedure survey data should be included as part of the 000-day care, that is performed on the same day as the procedure We then assigned the 99231 and the Discharge Day service (99238) to subsequent hospital days plus two OPV (99213 + 99212) for a total post-service value of 3.00 rvus. Thus, total RVW for this service by a related service building block approach is 10.35 + 3.00 = **13.35.**

IWPUT Building Block: Pre-service work was estimated as a survey median total of 50 minutes of cognitive time at 0.031 plus 30 minutes of non-cognitive time (scrub, prep, drape,position etc) at 0.008 for a total pre-service work of 1.79 rvus. Intra-service work was calculated as the survey median intra time of 60 minutes at an IWPUT of 0.095. This IWPUT was agreed upon by the consensus panel based on the high intensity, high risk nature of deploying at extension cuff under such exacting circumstances. Intra-service work calculates as 60 x 0.095 = 5.70 rvus Post-service work is the sum of the survey respondents data: 99232 x 1 + 99231 x 1 + 99238 + 99213 + 99212 = 4.08 rvus. Thus, by IWPUT building block, the RVW for this service is 1.79 + 5.70 + 4.08 = **11.57**.

FREQUENCY INFORMATION

How was this service previously reported? This is a new code created to report adjunctive measures related to endovascular AAA repair

How often do physicians in your specialty perform this service?

Specialty: SVS	Rarely
Specialty. SCVIR & ACR	Sometimes

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

Specialty: SVS	National Frequency: 500	Medicare Frequency: 400
Specialty: SCVIR & ACR	National Frequency: 3000	Medicare Frequency: 2000

Do many physicians perform this service across the United States? No

CPT Code: 34826 **Global Period.** ZZZ **Recommended RVW: 4.13**

CPT Descriptor: Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic aneurysm; each additional vessel
(List separately in addition to code for primary procedure)
(Use code 34826 in conjunction with code 34825)
(For staged procedure, use modifier '-58')
(Use code 34825-34826 in addition to codes 34800-34808, as appropriate)
(For radiological supervision and interpretation, use 75953)

Typical Patient (*Survey Vignette*):

Typical Patient/Service: A 67-year-old male with COPD and CAD s/p MI underwent endovascular repair of a 5 8cm diameter abdominal aortic aneurysm (AAA). An endoleak is discovered by follow-up CT scan one year after the procedure, and angiography (separately reportable) confirms leaks from one iliac anastomosis as well as from the proximal anastomosis. Endovascular extensions will be placed to correct endoleaks in both vessels

Note: This code may also be used if extensions are required at the time of the original endovascular repair to fully cover all lesions. This code is used for the second vessel and not for a second cuff/extension placed in the initial vessel.

Physician work for this code includes:

Pre-Service Work: This is no pre-service work because this is a "ZZZ" add-on code. All pre-service work is included in 34825.

Intra-Service Work includes
- Physician supervision of extension(s) preparation
- Angioplasty of area covered by extension(s) (if performed)
- Advancement of extension(s) to endoleak
- Positioning of extension(s) relative to endoleak
- Fine adjustments to extension(s) to ensure proper seating and hemostatic seal
- Cuff/Extension deployment
- Balloon dilatation and/or intra-device stenting to ensure proper seating
- Embolization to treat endoleak (if present)

Post-service work: There is no post-service work in this code since it is an "add-on". All post-service work is included in 34825.

Not included in this Procedure (Separately Billable)
- Catheterization of aorta (codes 36200, or 36245)
- Fluoroscopic guidance of device and catheters (code 75953),
- Aortography for "mapping" and detection of endoleaks (code 75953)
- Removal of guidewires and catheters (included in initial 36200 or 36245)
- Arteriotomy, if performed (included in codes 34812-34820)
- Closure of arteriotomy and application of sterile dressing (included in codes 34812-10)
- IVUS to confirm extension(s) positioning, if performed

CLINICAL DESCRIPTION OF SERVICE

Description of Pre-Service Work:
None – ZZZ add-on code

Description of Intra-Service Work:

Intra-service work typically begins by passing an adequately large diameter sheath along the guidewire. The endovascular extension prosthesis is then advanced over the guidewire within the sheath. The device is carefully positioned such that the proximal and distal edges bridge the endoleak Position is confirmed exactly by fluoroscopy, often with injections of contrast. Fine adjustments in position are made to assure exact positioning The extension cuff is deployed. Some devices require balloon dilatation to help assure proper seating and hemostatic seal. If this is the case, a large diameter compliant balloon is advanced over the wire, and under fluoroscopic guidance the balloon is positioned and inflated. An injection is performed to determine whether the endoleak has been sealed.

Description of Post-Service Work:
None – ZZZ add-on code

SURVEY DATA

Presenter(s): Gary Seabrook, M.D.
Robert Vogelzang, M.D.
James P. Borgstede, M.D.

Specialty(s): Society for Vascular Surgery, ISCVS-NA
Society for Cardiovascular and Interventional Radiology
American College of Radiology

Sample Size: 330 **Response Rate**: 50 (15%):

Type of Sample: random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	2.00	6.00	8.13	12.00	33.00
Intra-Service Time	15	30	30	60	420

KEY REFERENCE SERVICE(S):

'00 RVW	Global	CPT	Descriptor
4.13	000	37208	Transcatheter placement of an intravascular stent(s), (non-coronary vessel), open; each additional vessel (List separately in addition to code for primary procedure)

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

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

TIME ESTIMATES (MEDIAN)	Survey CPT 34826	Ref CPT 37208
Pre-service time	N/A	not surveyed
Intra-service time	30	30
Immediate Post-service time	N/A	not surveyed
Total critical care time	N/A	0
Total other hospital visit time	N/A	0
Discharge management time	N/A	0
Total office visit time	N/A	0
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	N/A	not surveyed
Intra-service	4 06	3.00
Post-service	N/A	not surveyed
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3.88	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.62	2.90
Urgency of medical decision making	3.44	2.50
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	4.14	3.10
Physical effort required	3 63	3.00
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	4.14	3.00
Outcome depends on the skill and judgement of physician	4.26	3.20
Estimated risk of malpractice suit with poor outcome	3.96	3.10

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The best clinical reference for this ZZZ add-on code for additional extension cuffs is the add-on code for additional stents, 37208. Code 37208 is valued at 4.13 rvus. In the typical situation where a patient needs more than one extension cuff, the first one will likely be the most complex, placed in the aorta adjacent to the renal origins. The second extension cuff is likely to be placed in the iliac arteries, a less stressful and less demanding location. **We recommend an RVW of 4.13 which is equivalent to the reference code.**

FREQUENCY INFORMATION

How was this service previously reported? _This is an entirely new service created as an adjunct to endovascular AAA repair.

How often do physicians in your specialty perform this service?

Specialty: SVS: Rarely
Specialty: SCVIR and ACR: sometimes

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

Specialty: SVS:	National Frequency: 200	Medicare Frequency: 150
Specialty: SCVIR & ACR combined	National Frequency: 2000	Medicare Frequency: 1500

Do many physicians perform this service across the United States? No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION (April 2000)

CPT Code: 34830 **Global Period**: 090 **Recommended RVW**: **32.59**

CPT Descriptor: Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; tube prosthesis

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Typical Patient (*Survey Vignette*).

Typical Patient/Service: A 67-year-old male with COPD and CAD s/p MI has a 5.8 cm. infrarenal aortic aneurysm. He undergoes attempted endovascular repair, but after the procedure has been underway for 5 hours it is determined that the endoprosthesis cannot be completed successfully. The main body of the device is lodged in the distal infrarenal aorta. You perform an intraoperative consultation and recommend operative repair. **The work of this new code starts here:** Pre-service work includes immediate review of preoperative studies, brief discussion with anesthesia, nursing, and the patient's family, plus prepare equipment, scrub, gown, re-prep and re-drape the patient. Open repair of the aneurysm is performed, including removal of any lodged endoprosthesis components plus repair of intra-abdominal arterial trauma. Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in -hospital and outpatient care for 90 days.

CLINICAL DESCRIPTION OF SERVICE

Description of Pre-Service Work:

Pre-service work begins when the when it is decided that the endovascular approach is unsuccessful since the surgeons involved in open repair may not be those involved in the endovascular repair. The patient's preoperative evaluation is reviewed in detail Abbreviated discussion is held with the family regarding risks and benefits of open surgery in this urgent circumstance. Discussions are held with the anesthesiologist regarding any additional maneuvers necessary for open surgery, and if the surgeon was not part of the prior endovascular team, discussions are help with that team regarding procedures performed to this point. Other pre-service work includes scrubbing, supervising positioning, waiting for additional anesthetic maneuvers, prepping, and redraping the patient.

Description of Intra-Service Work:

Intra-service work includes dissection of the abdomen contents and exposure of the aorta. Proximal and distal exposure of the aorta above and below the aneurysm are accomplished. This exposure is typically more extensive than during routine elective AAA repair due to malpositioned or traumatized vessels. Intravenous heparin is administered for anticoagulation, and the blood flow in the aneurysm is stopped by application of large vascular hemostats. The aneurysm is opened, bleeding lumbar arteries are suture ligated, and thrombus is removed. Any lodged pieces of endograft are removed. The proximal anastomosis of the prosthesis is sutured to normal, healthy, untraumatized aorta above the aneurysm. The proximal clamp is removed and the anastomosis tested for hemostasis. Additional sutures are placed as required. The distal anastomosis is carried out in a similar manner at the distal-most infrarenal aorta. Following completion of all anastomoses, the vascular clamps are removed and blood flow is restored. Anticoagulation is reversed and hemostasis achieved. All wounds are irrigated and closed in layers

Description of Post-Service Work:

The patient is transported to the intensive care unit. Operative notes are dictated, orders written, and communication with family and referring doctors accomplished. Extensive post-operative care is the rule rather than the exception in this situation. Patients often spend many days in the ICU and in the hospital. Discharge day service often includes extensive communication with patient, family, and visiting nurses. Patients oftentimes require transfer to rehabilitation or skilled nursing facilities. Post-discharge outpatient care and follow-up is typically extensive.

SURVEY DATA

Presenter(s): Gary Seabrook, M.D.

Specialty(s): Society for Vascular Surgery, ISCVS-NA

Sample Size: 90 **Response Rate**: 35 (39%):

Type of Sample: random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	28.01	31.00	33.25	36.60	50.00
Time (min) and Visits					
24 Hr Preceding Service			**0**		
Day Of Service					
Pre-Service			**60**		
Intra-Service	150	180	**210**	240	360
Immed. Post-Service			**45**		

Post-Service	**Total Time**	**CPT code / # of visits**
Critical Care		none
Other Hospital	199	99233 x 2; 99232 x 2; 99231 x 3
Discharge Management	36	99238
Office Visits	61	99213 x 2, 99212 x 1

KEY REFERENCE SERVICE(S):

'00 RVW	Global	CPT	Descriptor
28.01	090	35081	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft, for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta

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

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

TIME ESTIMATES (MEDIAN)	Survey CPT 34830	Ref CPT 35081
Pre-service time	60	105
Intra-service time	210	210
Immediate Post-service time	45	45
Total critical care time	0	0
Total other hospital visit time	199	133
Discharge management time	36	36
Total office visit time	61	38
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	4.22	4.00
Intra-service	4.81	4.20
Post-service	3.97	3.60
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3.97	3.80
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.91	4.00
Urgency of medical decision making	4.76	3.60
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	4.82	4.20
Physical effort required	4.44	4.00
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	4.82	4.40
Outcome depends on the skill and judgement of physician	4.82	4.80
Estimated risk of malpractice suit with poor outcome	4.56	4.60

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

We recommend an IWPUT Building Block value of **32.59**, just less than the median survey value of 33.25.

IWPUT Building Block: Based on our recent IWPUT survey, open elective infrarenal AAA repair with a tube graft had a median IWPUT of 0.090 while emergent repair of a ruptured infrarenal AAA with a tube graft had an IWPUT of 0.100. We believe this rescue code merits an IWPUT midway between those benchmarks, and we assigned 0.095. Median survey intra-time was 210 minutes, calculating to an intra-service work of 19.95. Cognitive pre-time (30 mintues) was calculated at 0.031 while less cognitive time (30 mintues) was calculated at 0.008, for a total pre-work of 1.17 rvus. Post-work was calculated by visit at 11.47. Total work by IWPUT was 32.59 rvus.

FREQUENCY INFORMATION

How was this service previously reported? This is an entirely new code created to deal with rare complications of endovascular AAA repair. CPT 37799 was probably used in the few instances this procedure has been carried out.

How often do physicians in your specialty perform this service?

Specialty: SVS Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period?

	National	Medicare
Specialty: SVS	Frequency: 50	Frequency: 40

Do many physicians perform this service across the United States? No

CPT Code: 34831 **Global Period**: 090 **Recommended RVW**: ~~36.46~~ **35.34 (RUC)**

CPT Descriptor: Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; aorto-biiliac prosthesis

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Typical Patient (*Survey Vignette*):

Typical Patient/Service: A 67-year-old male with COPD and CAD s/p MI has a 5.8 cm. infrarenal aortic aneurysm He undergoes attempted endovascular repair, but after the procedure has been underway for 5 hours it is determined that the endoprosthesis cannot be completed successfully. The main body of the device is lodged in the distal infrarenal aorta. You perform an intraoperative consultation and recommend operative repair **The work of this new code starts here:** Pre-service work includes immediate review of preoperative studies, brief discussion with anesthesia, nursing, and the patient's family, plus prepare equipment, scrub, gown, re-prep and re-drape the patient. Open repair of the aneurysm is performed, including removal of any lodged endoprosthesis components plus repair of intra-abdominal arterial trauma. Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days.

CLINICAL DESCRIPTION OF SERVICE

Description of Pre-Service Work:

Pre-service work begins when the when it is decided that the endovascular approach is unsuccessful since the surgeons involved in open repair may not be those involved in the endovascular repair. The patient's preoperative evaluation is reviewed in detail. Abbreviated discussion is held with the family regarding risks and benefits of open surgery in this urgent circumstance. Discussions are held with the anesthesiologist regarding any additional maneuvers necessary for open surgery, and if the surgeon was not part of the prior endovascular team, discussions are help with that team regarding procedures performed to this point. Other pre-service work includes scrubbing, supervising positioning, waiting for additional anesthetic maneuvers, prepping, and redraping the patient.

Description of Intra-Service Work:

Intra-service work includes dissection of the abdomen contents and exposure of the aorta. Proximal and distal exposure of the aorta above and below the aneurysm are accomplished. This exposure is typically more extensive than during routine elective AAA repair due to malpositioned or traumatized vessels. Intravenous heparin is administered for anticoagulation, and the blood flow in the aneurysm is stopped by application of large vascular hemostats. The aneurysm is opened, bleeding lumbar arteries are suture ligated, and thrombus is removed. Any lodged pieces of endograft are removed. The proximal anastomosis of a bifurcated prosthesis is sutured to normal, healthy, untraumatized aorta above the aneurysm. The proximal clamp is removed and the anastomosis tested for hemostasis. Additional sutures are placed as required. The distal anastomoses are carried out in a similar manner to the iliac arteries. Following completion of all anastomoses, the vascular clamps are removed and blood flow is restored. Anticoagulation is reversed and hemostasis achieved. All wounds are irrigated and closed in layers.

Description of Post-Service Work:

The patient is transported to the intensive care unit. Operative notes are dictated, orders written, and communication with family and referring doctors accomplished. Extensive post-operative care is the rule rather than the exception in this situation. Patients often spend many days in the ICU and in the hospital. Discharge day service often includes extensive communication with patient, family, and visiting nurses. Patients oftentimes require transfer to rehabilitation or skilled nursing facilities. Post-discharge outpatient care and follow-up is typically extensive.

SURVEY DATA

Presenter(s): Gary Seabrook, M.D.

Specialty(s): Society for Vascular Surgery, ISCVS-NA

Sample Size: 90 **Response Rate**: 36 (40%):

Type of Sample: random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	30.54	32.88	**34.50**	37.75	50.00
Time (min) and Visits					
24 Hr Preceding Service			**0**		
Day Of Service					
Pre-Service			**60**		
Intra-Service	180	210	**240**	270	360
Immed. Post-Service			**40**		

Post-Service	**Total Time**	**CPT code / # of visits**
Critical Care		None
Other Hospital	199	99233 x 2; 99232 x 2; 99231 x 3
Discharge Management	36	99238
Office Visits	61	99213 x 2; 99212 x 1

KEY REFERENCE SERVICE(S):

'00 RVW	Global	CPT	Descriptor
30.76	090	35102	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft, for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, external)

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

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

TIME ESTIMATES (MEDIAN)	Survey CPT 351X15	Ref CPT 35102
Pre-service time	60	95
Intra-service time	240	180
Immediate Post-service time	40	45
Total critical care time	0	0
Total other hospital visit time	199	136
Discharge management time	36	36
Total office visit time	61	53
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	4.38	4.25
Intra-service	4 91	4.50
Post-service	4.18	3.88
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	4.22	4.31
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.14	4.38
Urgency of medical decision making	4.97	3.63
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	4.67	4.56
Physical effort required	4.78	4.38
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	4.94	4.44
Outcome depends on the skill and judgement of physician	4.81	4.56
Estimated risk of malpractice suit with poor outcome	4.75	4.00

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

We recommend the IWPUT Building Block RVW of 36.46 because we believe its relation to the other two codes in this family is more realistic than using the median survey value of 34.50.

IWPUT Building Block: Based on our recent IWPUT survey, open elective infrarenal AAA repair with a bifurcated graft had a median IWPUT of 0.095 while emergent repair of a ruptured infrarenal AAA with a bifurcated graft had an IWPUT of 0.104. We believe this rescue code merits an IWPUT midway between those benchmarks, and we assigned 0.100. Median survey intra-time was 240 minutes, calculating to an intra-service work of 24.00 rvus. Cognitive pre-time (30 mintues) was calculated at 0.031 while less cognitive time (scrub, gown, position, drape, 28 mintues) was calculated at 0.008, for a total pre-work of 1.15 rvus. Post-work was calculated by visit at 11.31. Total work by IWPUT was 36.46 rvus.

FREQUENCY INFORMATION

How was this service previously reported?

This is an entirely new code that has probably been performed <1,000 in the country to date. Most likely they have been reported as a mix between 35102,35103, and 37799.

How often do physicians in your specialty perform this service?

Specialty: SVS: Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period?

	National	Medicare
Specialty: SVS	Frequency: 100	Frequency: 80

Do many physicians perform this service across the United States? No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION (April 2000)

CPT Code: 34832 **Global Period**: 090 **Recommended RVW**: ~~37.10~~ **35.34 (RUC)**

CPT Descriptor: Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; aorto-bifemoral prosthesis

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Typical Patient (*Survey Vignette*):

Typical Patient/Service: A 67-year-old male with COPD and CAD s/p MI has a 5.8 cm. infrarenal aortic aneurysm. He undergoes attempted endovascular repair, but after the procedure has been underway for 5 hours it is determined that the endoprosthesis cannot be completed successfully. The main body of the device is lodged in the distal infrarenal aorta. You perform an intraoperative consultation and recommend operative repair. **The work of this new code starts here:** Pre-service work includes immediate review of preoperative studies, brief discussion with anesthesia, nursing, and the patient's family, plus prepare equipment, scrub, gown, re-prep and re-drape the patient. Open repair of the aneurysm is performed, including removal of any lodged endoprosthesis components plus repair of intra-abdominal arterial trauma. Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days.

CLINICAL DESCRIPTION OF SERVICE

Description of Pre-Service Work:

Pre-service work begins when the when it is decided that the endovascular approach is unsuccessful since the surgeons involved in open repair may not be those involved in the endovascular repair. The patient's preoperative evaluation is reviewed in detail. Abbreviated discussion is held with the family regarding risks and benefits of open surgery in this urgent circumstance. Discussions are held with the anesthesiologist regarding any additional maneuvers necessary for open surgery, and if the surgeon was not part of the prior endovascular team, discussions are help with that team regarding procedures performed to this point. Other pre-service work includes scrubbing, supervising positioning, waiting for additional anesthetic maneuvers, prepping, and redraping the patient.

Description of Intra-Service Work:

Intra-service work includes dissection of the abdomen contents and exposure of the aorta. Proximal and distal exposure of the aorta above and below the aneurysm are accomplished. This exposure is typically more extensive than during routine elective AAA repair due to malpositioned or traumatized vessels. Intravenous heparin is administered for anticoagulation, and the blood flow in the aneurysm is stopped by application of large vascular hemostats. The aneurysm is opened, bleeding lumbar arteries are suture ligated, and thrombus is removed. Any lodged pieces of endograft are removed. The proximal anastomosis of a bifurcated prosthesis is sutured to normal, healthy, untraumatized aorta above the aneurysm. The proximal clamp is removed and the anastomosis tested for hemostasis. Additional sutures are placed as required. Since the distal common iliac arteries or external iliacs are involved with the aneurysm or have been traumatized during the endovascular procedure, the prosthetic limbs are tunneled through the pelvis with anastomoses performed at the femoral artery level. Following completion of all anastomoses, the vascular clamps are removed and blood flow is restored. Anticoagulation is reversed and hemostasis achieved. All wounds are irrigated and closed in layers.

Description of Post-Service Work:

The patient is transported to the intensive care unit. Operative notes are dictated, orders written, and communication with family and referring doctors accomplished. Extensive post-operative care is the rule rather than the exception in this situation. Patients often spend many days in the ICU and in the hospital. Discharge day service often includes extensive communication with patient, family, and visiting nurses. Patients oftentimes require transfer to rehabilitation or skilled nursing facilities. Post-discharge outpatient care and follow-up is typically extensive.

SURVEY DATA

Presenter(s): Gary Seabrook, M.D.

Specialty(s): Society for Vascular Surgery, ISCVS-NA

Sample Size: 90 **Response Rate**: 33 (37%):

Type of Sample: random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	31.00	34.00	35.00	38.10	58.00
Time (min) and Visits					
24 Hr Preceding Service			**0**		
Day Of Service					
Pre-Service			60		
Intra-Service	150	210	**240**	300	360
Immed. Post-Service			**60**		

Post-Service	**Total Time**	**CPT code / # of visits**
Critical Care		none
Other Hospital	199	99233 x 2; 99232 x 2; 99231 x 3
Discharge Management	36	99238
Office Visits	61	99213 x 2; 99212 x 1

KEY REFERENCE SERVICE(S):

'00 RVW	Global	CPT	Descriptor
30.76	090	35102	Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, external)

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

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

TIME ESTIMATES (MEDIAN)	Survey CPT 34832	Ref CPT 35102
Pre-service time	60	95
Intra-service time	240	230
Immediate Post-service time	60	43
Total critical care time	0	0
Total other hospital visit time	199	136
Discharge management time	36	36
Total office visit time	61	53
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	4.37	3.60
Intra-service	4.87	4.30
Post-service	4.37	3.60
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	4.23	3.80
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.63	4.00
Urgency of medical decision making	4.93	3.30
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	4.84	4.30
Physical effort required	4.71	4.20
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	4.94	4.10
Outcome depends on the skill and judgement of physician	4.94	4.30
Estimated risk of malpractice suit with poor outcome	4.52	3.40

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation

We recommend the IWPUT Building Block RVW of 37.10 because we believe its relation to the other two codes in this family is more realistic than using the median survey value of 35.00.

IWPUT Building Block: Based on our recent IWPUT survey, open elective infrarenal AAA repair with a bifurcated graft had a median IWPUT of 0.095 while emergent repair of a ruptured infrarenal AAA with a bifurcated graft had an IWPUT of 0.104. We believe this rescue code merits an IWPUT midway between those benchmarks, and we assigned 0.100. Median survey intra-time was 240 minutes, calculating to an intra-service work of 24.00 rvus. Cognitive pre-time (30 minutes) was calculated at 0.031 while less cognitive time (scrub, gown, position, drape, 30 minutes) was calculated at 0.008, for a total pre-work of 1.17 rvus. Post-work was calculated by visit at 11.93. Total work by IWPUT was 37.10 rvus.

FREQUENCY INFORMATION

How was this service previously reported?

This is an entirely new code that has probably been performed <1,000 in the country to date. Most likely they have been reported as a mix between 35102,35103, and 37799.

How often do physicians in your specialty perform this service?

Specialty: SVS: Rarely

Do many physicians perform this service across the United States? No

	National	Medicare
Specialty: SVS	Frequency: 50	Frequency: 40

Do many physicians perform this service across the United States? No

CPT Code: 75952 **Global Period**: XXX **Recommended RVW**: ~~4.50~~ **4.00 (RUC)**

CPT Descriptor: Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation

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Typical Patient (*Survey Vignette*):

Typical Patient/Service: A 67-year-old male with COPD and CAD s/p MI has a 5 8 cm aortic aneurysm Imaging studies (typically a combination of CT scan, MRI, IVUS, and/or angiography) indicate that the aneurysm is infrarenal and has an adequate neck to allow successful deployment of an endovascular prosthesis. Other anatomic considerations such as size, tortuosity, and calcification of the iliac arteries and presence of thrombus, plaque, and/or heavy calcification in the landing zones has also been evaluated.

Physician work for this code begins here and includes:

Pre-Service Work
- Donning lead apparel
- Supervision patient positioning
- Supervision of selection of equipment including guidewires, catheters, sheaths, balloons, stents, contrast material, as well as confirmation that all needed equipment is available
- Setting up the x-ray equipment and organizing the technologic personnel for appropriate imaging during the procedure

Intra-Service Work
- Angiographic "road-mapping" of aortic anatomy
- Fluoroscopic guidance of guidewires, catheters, endovascular prosthesis, and docking limbs (if utilized)
- Fluoroscopic confirmation of appropriate placement of prosthesis and docking limbs, with or without contrast.
- Fluoroscopic guidance of intra-prosthesis balloon dilatation, if necessary
- Supervision and interpretation of post-deployment aortogram for graft position, patency of appropriate branches (renals and hypogastrics), presence or absence of endoleaks, and patency of lumbar, hypogastric or inferior mesenteric arteries that may contribute to persistent endoleaks
- Interpretation of films and fluoroscopic imaging.
- Balloon dilatation and/or intra-device stenting to ensure proper seating, to fully open the graft, and/or to treat endoleak (if present),
- Embolization to treat endoleak (if present) or to prevent endoleak (if needed)

Post-service work Dictation of permanent report.

Not included in this Procedure (Separately Billable)
- Deployment of endovascular prosthesis (codes 34800-34804) and/or occlusion device(s) (code 34808)
- Open artery exposure (codes 34812-34820)
- Catheterization of aorta (codes 36200-36245)
- Closure of arteriotomy and application of sterile dressing (included in codes 34812-34820)
- IVUS, if performed

SURVEY DATA

Presenter(s): Gary Seabrook, M.D.
Robert Vogelzang, M.D.
James P. Borgstede, M.D.

Specialty(s): Society for Vascular Surgery, ISCVS-NA
Society for Cardiovascular and Interventional Radiology
American College of Radiology

Sample Size: 330 **Response Rate**: 56 (17%):

Type of Sample: random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	0.82	2.00	**3.50**	8.13	40.00
Pre-Service			**20**		
Intra-Service	15	30	**60**	119	180
Post-Service			**30**		

KEY REFERENCE SERVICE(S):

'00 RVW	Global	CPT	Descriptor
1.79	000	75630	Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation

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

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

TIME ESTIMATES (MEDIAN)	Survey CPT 75952	Ref CPT 75630
Pre-service time	20	20
Intra-service time	60	30
Immediate Post-service time (or total post-service)	30	30
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	3.29	2.58
Intra-service	3.89	2.68
Post-service	3.02	2.37
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	4.04	2.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.85	2.67
Urgency of medical decision making	3.59	2.22
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	4.15	2.94
Physical effort required	3.48	2.50
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	4.15	2.89
Outcome depends on the skill and judgement of physician	4.13	2.78
Estimated risk of malpractice suit with poor outcome	3.74	2.67

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

Unlike many of the other radiological S&I codes, 75952 includes all the supervision and interpretation of an entire endovascular aortic aneurysm repair. As such, we recommend a relative service building block approach and applying a reduction factor to account for economy of scale. Although the most commonly cited reference service by survey respondents was 75630 (S&I aortogram and iliofemoral outflow with RVW 1.79) we believe the more clinically relevant reference code for the aortogram portion is 75625 (S&I aorta with an RVW of 1.14). Every endovascular AAA repair includes at least 2 aortograms, therefore the first building block should be 1.14 x 2 = 2.28 to represent the aortograms. The next clinically realistic building block would be 75960 (S&I for stent placement, each vessel, with RVW = 0.82). As noted in our rationale for 34800-X4, every aortic endoprosthesis placement is equivalent to the work of at least two stents. Thus, the next building block is 0.82 x 2 = 1.64. Finally, virtually every aortic endograft repair involves much more than 2 balloon inflations to properly seat and seal the graft, and we therefore recommend the RVW for 75962 (transluminal balloon angioplasty at 0.54 rvus) be applied twice, for 1.08 rvus. The total is 2.28 for aortography + 1.64 for stent placement + 1.08 for balloon angioplasty = 5.00 rvus total.

Application of an economy of scale factor admittedly is subjective. Certain aspects of the interpretation may hold economy of scale while the elements of supervision do not. Endovascular AAA repairs have total intra-service times of 120 – 150 minutes just for the graft deployment. The supervising radiologist must be present for that entire duration since injections are occur intermittently throughout that entire time. In addition the radiologist must be present for introduction of the catheters etc. that extends the total time beyond the intra-service time of the primary codes. Thus, we recommend an economy of scale factor of 0.9 applied to the cumulative rvus mentioned above. **We recommend 5.00x 0.9 = 4.50 rvus.**

Although this value is 1.00 rvus greater than the survey median we would point out that for 8 codes in this family we have recommended RVWs 1.5 – 7.0 rvus **less than** survey medians. This is the only code that, on a percentage basis, is somewhat above survey median. We believe this is a very reasonable recommendation.

FREQUENCY INFORMATION

How was this service previously reported? This is an entirely new code representing a new service. If these services were reported previously they may have been included in the surgical coding or as some combination of 75625, 75960, and 75962.

How often do physicians in your specialty perform this service?

Specialty: SVS	rarely
Specialty: SCVIR & ACR	Sometimes

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

Specialty	National Frequency	Medicare Frequency
SVS	1,000	800
SCVIR	10,000	8,000
ACR		

Do many physicians perform this service across the United States? No

CPT Code: 75953 **Global Period**: XXX **Recommended RVW**: **1.36**

CPT Descriptor: Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic aneurysm, radiological supervision and interpretation

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Typical Patient (*Survey Vignette*):

Typical Patient/Service: A 67-year-old male with COPD and CAD s/p MI underwent endovascular repair of a 5.8 cm. diameter abdominal aortic aneurysm A distal anastomotic endoleak was discovered by CT scan one year later, and its exact nature is confirmed with angiography (separately billable) A distal endovascular extension will be placed to correct the endoleak.

Physician work for this code begins here and includes:

Pre-Service Work
- Donning lead apparel
- Supervision patient positioning
- Supervision of selection of equipment including guidewires, catheters, sheaths, balloons, stents, contrast material, as well as confirmation that all needed equipment is available
- Setting up the x-ray equipment and organizing the technologic personnel for appropriate imaging during the procedure

Intra-Service Work
- Angiographic "road-mapping" of aortic anatomy
- Fluoroscopic guidance of guidewires, catheters, endovascular extension(s)
- Fluoroscopic guidance of deployment of endovascular extension(s), with or without contrast.
- Fluoroscopic guidance of intra-extension balloon dilatation, and/or stent placement, if necessary
- Supervision and interpretation of post-deployment aortogram for extension position, patency of appropriate branches (renals and hypogastrics), presence or absence of endoleaks, and patency of lumbar, hypogastric or inferior mesenteric arteries that may contribute to persistent endoleaks
- Interpretation of films and fluoroscopic imaging.

Post-service work:
- Dictation of permanent report.
- Communication with referring and consulting physicians

Not included in this Procedure (Separately Billable)
- Deployment of endovascular extensions(s) (codes 34826)
- Open artery exposure (codes 34812-34820)
- Catheterization of aorta (codes 36200-36245)
- Removal of guidewires and catheters (included in initial 36200 or 36245)
- Closure of arteriotomy and application of sterile dressing (included in codes 34812-34820)
- IVUS to confirm extension(s) positioning, if performed

SURVEY DATA

Presenter(s): Gary Seabrook, M.D.
Robert Vogelzang, M.D.
James P. Borgestede, M.D.

Specialty(s): Society for Vascular Surgery, ISCVS-NA
Society for Cardiovascular and Interventional Radiology
American College of Radiology

Sample Size: 330 **Response Rate**: 53 (16%):

Type of Sample: random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	0.54	1.85	2.50	5.00	25.00
Pre-Service			20		
Intra-Service	15	30	45	70	180
Post-Service			30		

KEY REFERENCE SERVICE(S):

'00 RVW	Global	CPT	Descriptor
1.79	000	75630	Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation

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

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

TIME ESTIMATES (MEDIAN)	Survey CPT 75953	Ref CPT 75630
Pre-service time	20	15
Intra-service time	45	30
Immediate Post-service time (or total post-service)	30	30
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	3.27	2.47
Intra-service	3.77	2.59
Post-service	3.00	2.29
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3.75	2.84
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.73	2.79
Urgency of medical decision making	3.42	2 47
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	4.13	3.00
Physical effort required	3.40	2.58
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	4.06	2.89
Outcome depends on the skill and judgement of physician	4.04	2.68
Estimated risk of malpractice suit with poor outcome	3.75	2.58

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

Our three specialty consensus panel felt the most commonly cited reference service, 75630 (S&I aortogram + iliofemoral run-off) is not the best clinical reference. We suggest this code be valued as the building block combination of one stent placement S&I (75960, RVW = 0.82) plus one balloon angioplasty S&I (75962, RVW = 0.54). **Thus, we recommend a total of 0.82 + 0.54 = 1.36 rvus for 75953.**

Our recommended value of 1.36 is 1.14 rvus less than the survey median In fact, it is less than the 25th percentile survey value of 1.85.

FREQUENCY INFORMATION

How was this service previously reported? This is a new code representing a new service. It may have been coded in the past as some combination of 75625, 75960, and 76962, but it is simply impossible to tell for sure.

How often do physicians in your specialty perform this service?

Specialty: SVS	Rarely
Specialty: SCVIR & ACR	Sometimes

For your specialty, estimate the number of times this service might be provided nationally in a one-year period?

Specialty	National Frequency	Medicare Frequency
SVS	500	400
SCVIR & ACR combined	3,000	2,000

Do many physicians perform this service across the United States? No

Codes 34800-34832, 75952, 75953 (QQ1-QQ14)
AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

CPT Code:_QQ1-QQ14

34800-34832, 75952, 75953(QQ1-QQ14) Practice Expense Inputs

Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)*	Number of Office Visits	Total Time of Office Visits
All RN/LPN/MA					
34800, 34802, 34804, 34825 (090)	45	0	0	1-99213 @ 36 1-99212 @ 27	63
34808, 34813, 34826 (ZZZ)	0	0	0	0	0
34812, 34820 (000)	0	0	0	0	0
34830, 34831, 34832 (090)	45	0	0	2-99213 @ 36 1-99212 @ 27	99
75952, 75953	0	0	0	0	0

*Excluding Time of Office Visits

Medical Supplies	34800, 34802, 34804, 34825	34830, 34831, 34832
Basic Post-op Incision Care Kit includes	1	1
1 pair sterile gloves 2 alcohol swabs 2 packs steristrips 12 inches tape (2 increments at 6 inches) 1 staple remover 10 ml betadine (20 units) 2 gauze packages 1 Tincture benzoin swabs		
Multi-specialty minimum supply pack for visit	2	3
One patient gown 7 feet exam paper 1 pillow case 2 pairs nonsterile gloves 1 temperature probe cover		

No Procedure Specific Equipment

Overhead Equipment assumed to be standard E/M standard overhead, which includes the following:
Exam Table
Crash cart, no defibrillator
Otoscope-Opthalmoscope

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
February 2000

Harvest of Upper Extremity Artery for CABG

Work Relative Value Recommendations

A new CPT code 35600 was added to describe the harvesting of one segment of an upper extremity artery for coronary artery bypass procedures. Currently, procurement of an artery is included in the Coronary Artery Bypass procedure codes and is not separately reported. However, the procurement of an upper extremity artery (e.g., radial artery) requires a separate operative field and there is an increased risk associated with the use of an upper extremity artery. There is also increased work in procuring an upper extremity artery, medical management of the graft and care of the extremity.

The specialty society recommended work value for code 35600 of 9.50 was decreased by the RUC. The RUC considers the work in the procedure (35600) to be comparable to vein harvesting, CPT code ***35500 Harvest of upper extremity vein, one segment, for lower extremity or coronary artery bypass procedure (List separately in addition to code for primary procedure)***. CPT code 35500 has a work value of 6.45. However, the CABG codes inherently include harvesting and anastomosis of the vessel, with an increment of 3.00 for each additional coronary arterial graft. Therefore, the RUC reduced the value by deducting ½ of this increment 3.00 (1.50) to account for the harvesting that is already an inherent part of the CABG codes. **Therefore, the RUC recommends a work value of 4.95 for CPT code 35600.**

In the CPT proposal form, the society noted that 10% of the population who receive CABG may be eligible for this type of grafting. However, the specialty society clarified that at their recent annual meeting, updated data was presented that .25% - 2.5% of the CABG patient population are eligible. The use of the radial artery is used most often in younger patients.

Practice Expense Recommendations

There are no direct practice expense inputs for this service, as this service is an add-on code performed in a facility.

CPT Code (•New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Arterial Grafting for Coronary Artery Bypass *The following codes are used to report coronary artery bypass procedures using either arterial grafts only or a combination of arterial-venous grafts. The codes include the use of the internal mammary artery, gastroepiploic artery, epigastric artery, radial artery, and arterial conduits procured from other sites.* *To report combined arterial-venous grafts it is necessary to report two codes: 1) the appropriate arterial graft code (33533-33536); and 2) the appropriate combined arterial-venous graft code (33517-33523).* Procurement of the artery for grafting is included in the description of the work for 33533-33536 and should not be reported as a separate service or co-surgery, except when an upper extremity artery (eg, radial artery) is procured. To report harvesting of an upper extremity artery, use 35600 in addition to the bypass procedure. Procurement of the saphenous vein graft is included in the description of the work for 33517-33523 and should not be reported as a separate service or co-surgery. When arterial and/or venous graft procurement is performed by surgical assistant, add modifier '-80' to 33517-33523, 33533-33536, as appropriate.				
●35600	B1	Harvest of upper extremity artery, one segment, for coronary artery bypass procedure.	ZZZ	4.95
33533	B2	Coronary artery bypass, using arterial graft(s); single arterial graft	090	25.83 (no change)

CPT Code (•New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
33534	B3	two coronary arterial grafts	090	28.82 (no change)
33535	B4	three coronary arterial grafts	090	31.81 (no change)
33536	B5	four or more coronary arterial grafts	090	34.79 (no change)

CPT Code: 35600 Tracking Number: B1 Global Period: ZZZ **Recommended RVW: ~~9.50~~ 4.95 (RUC)**

CPT Descriptor:: Harvest of upper extremity artery, one segment, for coronary artery bypass procedure (List separately in addition to code for primary procedure.)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey/Typical Patient/Service:

A 58-year-old man presented to the emergency room with unstable angina. His past medical history included a five-vessel coronary bypass eight years prior to his admission. Four of his bypass grafts were created using saphenous veins removed from his left leg. His entire right saphenous system had been removed because of severe varicosities. The patient had been involved in an automobile accident as a teenager with extensive deep vein thrombosis of right leg which ultimately led to the varicosities and venous insufficiency. In his initial CABG operation, the left internal mammary artery was used as a bypass conduit to his left anterior descending coronary artery.

Once the patient was stabilized, he underwent cardiac catheterization. Three of the four saphenous vein bypass grafts were occluded. The left internal mammary artery was patent and filled the left anterior descending coronary artery nicely. The fourth saphenous vein graft was diffusely diseased and had a severe stenosis with an unstable ulcerated plaque in its midportion. This bypass graft led to the right coronary artery which was relatively large. The right coronary system filled a large system via collaterals. The was no antegrade arterial inflow to the circumflex system because of the patient's native disease.

The patient was felt to be a candidate for reoperative coronary bypass surgery. At the time of his procedure, the right internal mammary was removed and used as a free graft to revascularize the circumflex system. His left radial artery was removed for use as a bypass conduit. The radial artery was used as a free graft to the right coronary system. There were two separate distal sites that the radial artery was used to revascularize using a sequential technique.

Description of Pre-Service Work: **N/A**

Description of Intra-Service Work: The radial artery was harvested by making a curvalinear incision at the edge of the hairline of the left forearm following the brachioradialis muscle laterla to the biceps tendon and down to a midway point between the tendon of the flexor carpi radialis muscle and the radial styloid at the wrist crease. Hemostasis was obtained using a Bovie needle coagulator. The fascia between the bellies of the brachioradialis and flexor carpi radialis muscle was then divided. A bolus dose of diltiazem hydrochloride was administered and a continuous intravenous infusion of the drug was begun. The radial artery was visualized and beginning at the middle of the forearm was dissected proximally with the venous vascular pedicle kept intact. The vasa vasorum of the radial artery were then divided posteriorly using silk sutures proximally and metallic clips distally.

As the dissection approached the wrist, there were numerous small vessels that required meticulous identification and separation. Before dividing the radial artery, a soft non-occuding clamp was placed across the vessel and palpation of the ulnar artery was performed to be certain that there was adequate blood supply to the hand and fingers. The radial artery was then divided proximally and distally and the ends remaining in the forearm were were oversewn with a running 4-0 Prolene suture.

A methylene blue marking pencil was then used to score the vein on its anterior surface which was 180 degrees opposite to the origin of the branches of the radial artery. The radial artery was gently dilated with a papaverine solution and placed in a cold papaverine Ringer's solution.

Description of Post-Service Work: N/A

SURVEY DATA:

Presenter(s) Sidney Levitsky, M.D..

Specialty(s): Society of Thoracic Surgeons/American Association for Thoracic Surgery

Sample Size: 50 Response Rate: (%): 48% (24) Final Median RVW: 9..50

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: Cardiothoracic surgeons specializing in this type of procedure

25th Percentile RVW: 7.00 75th Percentile RVW: 13.20 Low: 3.1 High: 34

Median Pre-Service Time: N/A Median Intra-Service Time: 40 min

25th Percentile Intra-Svc Time: 30 min 75th Percentile Intra-Svc Time: 50 min Low: 20 min High: 240 min

Median Post-Service Time: N/A

	Total Time	Level of Service by CPT Code (List # of Visits)
Day of Procedure:		
Critical care:		
Other Hospital Visit:		
Discharge Day Mgmt:		
Office:		

CPT Code: 35600

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
33530	Reoperation, coronary artery bypass or valve procedure more than one month after original operation (List separately in addition to primary procedure)	5.86
33971	Removal of intraaortic balloon assist device, including repair of femoral artery, with or without graft	9.69

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

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

TIME ESTIMATES (Median)	CPT Code 35600	Reference Service 1 33530	Reference Service 2 33971
Median Pre-Time (day of procedure) N/A			
Median Intra-Time	40 min	30 min	30 min
Median Post-Time (day of procedure) N/A			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3	3	4
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3	3	3
Urgency of medical decision making	2.5	3	4

Technical Skill/Physical Effort (Mean)

Technical skill required	4	4	3
Physical effort required	3	4	3

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3	4	4
Outcome depends on the skill and judgement of physician	3.5	4	4
Estimated risk of malpractice suit with poor outcome	3.5	3	4

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1	Reference Service 2
Time Segments (Mean)			
Pre-Service intensity/complexity N/A			
Intra-Service intensity/complexity	4	4	3
Post-Service intensity/complexity N/A			

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The consensus committee felt that the data were well distributed between the 25th, 50th, and 75th percentile, and chose the 50th percentile median RVW. In addition, although it was not used as a reference code, we felt that 35500, harvest of upper extremity vein for CABG or lower extremity bypass, with a RUC recommended value of 6.54 was a good standard of comparison because the work is similar, although lesser in time, intensity, and risk. We believe harvesting the artery carries a higher degree of difficulty, higher risk to the patient, and higher risk of malpractice, so we stood by the median survey recommended work value of 9.50.

FREQUENCY INFORMATION

How was this service previously reported? It was not being reported. It was seen as bundled with CABG arterial grafting.

How often do physicians in your specialty perform this service? _Commonly __Sometimes _Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 5000 cases/year

Do many physicians perform this service across the United States? __Yes _x_No

AMA SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Venous Access For Specimen Collection Implantable Venous Access Port

Work Relative Value Recommendations
New code 36540 *Collection of blood specimen from a partially or completely implantable venous access device* was created to describe the collection of blood specimens from an implantable venous access port. Venous access ports are implanted in patients who require recurrent venous access for therapeutic intervention; however, these access ports may also be used to draw blood for laboratory testing. Currently, CPT does not contain an existing code that describes venous access for collection of a blood specimen from an implantable access port.

The RUC agreed with the specialty society that there is no physician work involved in the new code 36540 *Collection of blood specimen from a partially or completely implantable venous access device.*

Practice Expense Recommendations
The RUC recommends that the practice expense inputs for new code 36540 be forwarded to HCFA with no clinical time. The RUC agreed that for this new code to be performed in a non-facility setting, the attached medical supplies and equipment were necessary.

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 36540	II1	Collection of blood specimen from a partially or completely implantable venous access device	XXX	0.00

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 36540 Tracking Number: II1 Global Period: XXX **Recommended RVW:** 0

CPT Descriptor: Collection of blood specimen from a partially or completely implantable venous access device

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient with breast cancer receiving repeated IV antineoplastic drugs presents for evaluation of potential cytopenias associated with her therapy. The patient has inadequate peripheral veins and has an intravenous access port. The clinician requests the staff use the access port for the blood draw.

Description of Pre-Service Work: N/A

Description of Intra-Service Work: There is no physician work associated with this code.

Description of Post-Service Work: N/A

SURVEY DATA:

Presenter(s) John Pippen, M.D.

Specialty(s): American Society of Clinical Oncology

Sample Size: 30 Response Rate: (%): 100% Median RVW: 0

Type of Sample (Circle One): **random**, panel, convenience. Explanation of sample size: _____

25th Percentile RVW: 0 75th Percentile RVW: 0 Low: 0 High: 0

Median Pre-Service Time: 0 Median Intra-Service Time: 0

25th Percentile Intra-Svc Time: 0 75th Percentile Intra-Svc Time: 0 Low: 0 High: 0

Median Post-Service Time:	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	0	
Critical Care:	0	
Other Hospital Visits:	0	
Discharge Day Mgmt.:	0	
Office Visits:	0	

NOTE: There is no physician work associated with the code being surveyed.

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time		
Median Intra-Time		
Median Immediate Post-service Time		
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

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

Technical Skill/Physical Effort (Mean)

Technical skill required		
Physical effort required		

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality		
Outcome depends on the skill and judgement of physician		

Estimated risk of malpractice suit with poor outcome		

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

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

ASCO is recommending a relative work value of zero, because collection of a blood specimen from a venous access device is most commonly performed by clinical staff

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FREQUENCY INFORMATION

How was this service previously reported? **According to the AMA's CPT staff, this procedure is currently "not separately reportable."**

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

Specialty Oncology ___X___ Commonly _____ Sometimes _____ Rarely

Specialty _____ _____ Commonly _____ Sometimes _____ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Oncology Frequency **

**Frequency is unknown. No code previously existed to capture data on the frequency of the service.

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Oncology Frequency ** (see above note)

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? __X__ Yes _____ No

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CPT Code: 36540

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

AMA/Specialty Society Update Process
Summary of Recommendation
XXX Global Period

In Office Direct Inputs

Sample Size: 30 Response Rate: (%): 100% Global Period: XXX

Tracking Number: II1 Reference Code 1 96530 Reference Code 2 _____

Geographic Practice Setting %: Rural 6.7% Suburban 63.3% Urban 30.0%

Type of Practice %:
0% Solo Practice
66.7% Single Specialty Group
23.3% Multispecialty Group
10.0% Medical School Faculty Practice Plan

Please describe the clinical activities of your staff:

Pre-Service ~~Clinical Labor Activities: N/A~~

Intra-Service ~~Clinical Labor Activities: The patient is greeted, escorted to room, and asked to remove appropriate piece of clothing to allow access to device. After gathering all of the needed supplies, staff, usually an RN, must fill and label an average of two saline syringes and one heparin syringe to flush the port before and after drawing the specimen. The patient's site is then prepped with Betadine and alcohol and the port is accessed. Frequently no blood is returned and the patient must be repositioned for another try. When blood is returned, the port is flushed with saline. An initial sample of blood is drawn and discarded before the collection of the specimen begins. The specimen is collected and transferred into specimen tubes. The device is then flushed with saline by syringe, followed by a heparin flush injected by syringe. The needle is than removed from the port. The site must then be cleaned of betadine and/or blood and bandaged. The specimen is then labeled with the patient's name and date of birth. The contaminated supplies are properly discarded, and the nurse must make a record of the procedure in the patient's medical record.~~

Post-Service ~~Clinical Labor Activities: N/A~~

Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)
~~RN~~	~~N/A~~	~~17.45~~	~~N/A~~

CPT Code: 36540

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

Medical Supplies **NOTE: 5 cc of heparin is not listed since it should be separately reimbursed as a drug. However, many carriers do not separately reimburse for the heparin.**	**Quantity of Supplies**	**Units Used for Purchase**
Huber needle	1	Unit
10 cc sterile syringe (3 to flush, 2 for specimen)	5	Unit
Saline	20	CC
18 gauge 1" needle	3	Unit
~~Syringe labels~~	~~3~~	~~Unit~~
Alcohol swabs (to cleanse site, vials, and clean-up)	7	Unit
Sterile gloves	1	Pair
Betadine swabs	3	Unit
2x2 8-ply sterile gauze sponge	2	Unit
Polytissue 3-ply to protect clothing	1	Unit
~~Blood sample tubes~~	~~2~~	~~Unit~~
Bandaid	1	Unit

Procedure Specific Medical Equipment	**No. of units in practice**	**Minutes of use per procedure**	**Hours per week in use for all services**	**Equipment Cost**
~~Chemotherapy recliner~~	~~4 per MD~~	~~17.5~~	~~40~~	~~895~~

Overhead Medical Equipment	**No. of units in practice**	**Equipment Cost**
Chemotherapy Couch	1	895

AMA SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Percutaneous Management of Dialysis Graft/Fistula

New code 36870 *Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)* was created to describe percutaneous treatment of a thrombosed hemodialysis graft or fistula. Currently, CPT does not contain a code that accurately describes this service; therefore the unlisted code 37799 *Unlisted procedure, vascular surgery* was reported.

The RUC did not accept the initial specialty society work relative value recommendation. Facilitation Committee Three reviewed this issue and presented the following information.

The RUC evaluated new code 36870 *Thrombectomy, percutaneous arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)* which had a recommended work RVU of 6.85. This recommended value is also the survey median work value.

The RUC identified that there are three services that will always be provided together; new code 36870 (Societies' recommended work RVU of 6.85; 090 global), 36145 *Introduction of needle or intracatheter; arteriovenous shunt created for dialysis (cannula, fistula, or graft)* (work RVU = 2.01), and 75790 *Angiography, arteriovenous shunt (eg, dialysis patient), radiological supervision and interpretation* (work RVU = 1.84).

36870	6.85
36145 (2.01 * .5)	
(50% reduction)	1.00
75790	1.84
	9.69

The RUC agreed that the complete service should be directly comparable to the open code. The RUC evaluated code 36831 *Thrombectomy, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft* (work RVU = 8.00; 090 global). The RUC; therefore, reduced the open code's total work RVU of 8.00 by 1.00 (50% of 36145) and 1.84 (75790), with the resulting work RVU = 5.16.

The RUC also reviewed code 36860 *External cannula declotting; without balloon catheter* (work RVU = 2.01; 000 global) and 35473 *Transluminal balloon angioplasty, percutaneous; iliac* (work RVU = 6.04; 000 global) and determined that this 36870 was roughly in this range. The Societies' agreed to a value of 5.16, recognizing that it also incorporated a 090 global. **The RUC recommends a work relative value of 5.16 for code 36870.**

Practice Expense Recommendations

The RUC approved a Facilitation Committee report that reviewed the direct inputs for Percutaneous Management of Dialysis Graft/Fistula when performed in a non-facility setting. The RUC agreed with the facilitation committee that a pre-service time of 15 minutes, a service period time of 115 minutes, and post service time of 5 minutes, was appropriate for this procedure. One physician 99212 office visit is included in the global period, with the specialty noting that this visit would require less time than the standard 99212 and recommends 16 minutes of clinical staff time. Revised medical supplies and equipment were also submitted by the facilitation committee and approved by the RUC.

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲36831(e)		Thrombectomy, open, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure)	090	8.00 (no change)
▲36832(e)		Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)	090	10.50 (no change)
●36870	JJ1	Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis) (Do not report 36550 in conjunction with 36870) (For catheterization, use 36145) (For radiological supervision and interpretation, use 75790)	090	5.16

CPT Code: 36870 (JJ1) **Global Period**: 090 **Recommended RVW**: ~~6.85~~ **5.16 (RUC)**

CPT Descriptor:

Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)

(Do not report 36550 in conjunction with 36870)

(For catheterization, use 36145)

(For radiologic supervision and interpretation, use 75790)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A male patient on chronic hemodialysis presents for dialysis and is noted to have no flow in his forearm dialysis graft. He is referred to interventional radiology for restoration of flow through his graft. This is done as an emergency, to allow him to return to the dialysis center for dialysis later the same day, so no treatment is missed.

Description of Pre-Service Work:

The pre-service period includes physician services provided from the day before the operative procedure until the time of the operative procedure and may include the following:

- Hospital admission work-up.
- The pre-operative evaluation may include the procedural work-up, review of records, communicating with other professionals, patient and family, and obtaining consent.
- Other pre-operative work may include dressing, scrubbing, and waiting before the operative procedure, preparing patient and needed equipment for the operative procedure, positioning the patient and other non "skin-to-skin" work in the OR.

The following services are not included:

- Consultation or evaluation at which the decision to provide the procedure was made (reported with modifier -57).
- Distinct evaluation and management services provided in addition to the procedure (reported with modifier -25).
- Mandated services (reported with modifier –32).

Description of Intra-Service Work:

The intra-service period includes all "skin-to-skin" work that is a necessary part of the procedure.

Included in Procedure

- Systemic sedation and local anesthetic,
- Intra-graft thrombolysis either by bolus injection, infusion, "pulse-spray" techniques, or "lyse-and-wait",
- Maceration of thrombus and shunt clearance using thrombectomy device, angioplasty balloons, and/or Fogarty-type catheters,
- Removal of guidewires and catheters with manual compression to achieve hemostasis, and
- Hemostasis monitoring

Excluded from Procedure (Separately Billable)

- Access to graft/fistula (code 36145),
- Injection of contrast for fistulagram (included in first 36145),
- Second access to graft/fistula if needed (code 36145),
- Diagnostic fistulagram (code 75790),
- Venous percutaneous angioplasty (codes 35476 and 75978),
- Thrombolytic infusion in site other than graft (codes 37201 and 75986),
- Repeat fistulagram to verify the site of lesion (included in initial 75790), and
- Completion fistulagram of inflow/outflow vessels (included in initial 75790)

Description of Post-Service Work:

The post-service period includes services provided on the day of the procedure, within 90 days of the procedure (for a global period of 090), and may include the following:

- Day of Procedure: Post-operative care on day of the procedure is divided into "Immediate Post-Service Time" (Question 2b), and any subsequent visit on the day of the operative procedure (Question 2c)., Immediate Post-Service Time includes non "skin-to-skin" work in the OR, patient stabilization in the recovery room or special unit, communicating with the patient and other professionals (including written and telephone reports and orders).

- Other follow-up care before the patient is discharged: Post-operative visits in ICU, other in-hospital visits, and discharge day management services.

- Office visits within the assigned global period of 90 days.

The following services are not included:

- Unrelated evaluation and management service provided during the postoperative period (reported with modifier -24)
- Return to the operating room for a related procedure during the postoperative period (reported with modifier -78)
- Unrelated procedure or service performed by the same physician during the postoperative period (reported with modifier -79)

SURVEY DATA

Presenter(s): James Borgstede, M.D.
Robert L. Vogelzang, M.D.

Specialty(s): American College of Radiology
Society of Cardiovascular & Interventional Radiology

Sample Size: **Response Rate**: 48 (%):

Type of Sample: ACR, panel SCVIR, panel and convenience (SCVIR Committees and Workshop Attendees)

	Low	25th pctl	Median	75th pctl	High
Survey RVW	1.20	6.03	**6.85**	8.50	17.50
Time (min) and Visits					
24 Hr Preceding Service			**5**		
Day Of Service					
Pre-Service			**15**		
Intra-Service	15	45	**60**	90	180
Immed. Post-Service			**15**		

Post-Service	**Total Time**	**CPT code / # of visits**
Critical Care		none
Other Hospital		none
Discharge Management	36	99238
Office Visits	15	99212 x 1

KEY REFERENCE SERVICE(S):

'00 RVW	Global	CPT	Descriptor
6.04	000	35473	Percutaneous transluminal angioplasty, iliac

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

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

TIME ESTIMATES (MEDIAN)	Survey CPT 36870	Ref CPT 35473
Pre-service time	20	35
Intra-service time	60	60
Immediate Post-service time	15	20
Total critical care time	0	0
Total other hospital visit time	0	0
Discharge management time	36	36
Total office visit time	19	19
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	2.78	3.14
Intra-service	3.93	3.79
Post-service	2.35	2 79
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3.15	3.20
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.91	3.33
Urgency of medical decision making	3.45	3.07
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	3.96	3.60
Physical effort required	3.94	3.33
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	3.28	3.80
Outcome depends on the skill and judgement of physician	3.96	3 80
Estimated risk of malpractice suit with poor outcome	2.83	3.60

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The recommended RVW (6.85) is the median of the pooled RVW estimates from ACR's and SCVIR's respective surveys (N=48). The difference in work between iliac angioplasty (code 35473) and code 36870 reflects: (1) 36870 is usually performed on an emergent basis, (2) the physician is treating thrombus in a longer segment of vessel with 36870 than that for iliac angioplasty, which tends to be a focal lesion, and (3) there is frequently direct radiation exposure to the physician with code 36870.

FREQUENCY INFORMATION

How was this service previously reported?

37799 (CY1999)
G0159 (CY2000)

How often do physicians in your specialty perform this service?

Specialty ACR	~~Commonly~~	**Sometimes**	~~Rarely~~
Specialty: SCVIR	**Commonly**	~~Sometimes~~	~~Rarely~~

For your specialty, estimate the number of times this service might be provided nationally in a one-year period?

There are approximately 250,000 patients who undergo hemodialysis in the U.S. each year. Of these, 85% will have grafts which thrombose, an average of 1.2 times annually. The total number of thrombectomy procedures annually is about 250,000, of which 60,000 to 125,000 are percutaneous.

Nearly 100% of percutaneous thrombectomies will be provided to Medicare patients as it is part of Medicare's coverage of dialysis treatments.

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

CPT Code 36870: Percutaneous Management of Dialysis Graft/Fistula
AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

AMA/Specialty Society Update Process
Summary of Recommendation
010 or 090 Day Global Periods

In Office Direct Inputs

Estimates developed by consensus panel

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Complete forms, coordinate surgical services, and schedule space

Intra-Service Clinical Labor Activities:

Review charts and obtain vital signs, greet patient and provide gowning, provide pre-service education and informed consent, prepare room, etc., sedation, position patient, and assist with procedure.

Post-Service Clinical Labor Activities:

Monitor patient, clean room, complete f orms, provide discharge services, and coordinate care.

Clinical Labor	**Pre-Service Time**	**Service Period (Day of service)**	**Post-Service Time After Day of Service)***	**Number of Office Visits**	**Total Time of Office Visits**
RN/LPN/MA	~~37~~ 15 minutes	~~69~~ 115 minutes	~~26~~ 5 minutes	1 x 99212**	16
~~LPN~~					
~~MA~~					
~~Radiology Technologist~~		~~65 minutes~~	~~22 minutes~~		

*Excluding Time of Office Visits
** This 99212 is less time than the standard 99212.

Medical Supplies*	**Quantity of Supplies**	**Units Used for Purchase**	
Thrombectomy device	1	1	

CPT Code 36870: Percutaneous Management of Dialysis Graft/Fistula
AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

~~Angioplasty balloon~~	~~1.5~~	~~1~~		
Fogarty thrombectomy balloon	1	1	$100	
Guidewire 93129	2	1		
Vascular sheaths 93815	2	1		
~~Contrast agent~~	~~1-100cc vial~~	~~1~~		
~~Sterile tray~~	~~1~~	~~1~~		
Sterile gloves 14005	~~5~~ 3 pair	5		
Disposable syringes 91406 & 91409 One 10 cc and one 20 cc	~~4~~ one of each	~~4~~		
Heparin 53007	5000 units	1 bottle		
~~Lidocaine~~ Saline (flush) 53015	~~1 vial~~ 500cc	~~1~~ 1 Bottle		
~~Band-aids~~ Steri-strips 31513	~~2~~ 1	~~2~~ 6-Strip package		
~~Drug for Sedation/pain~~	~~0-2~~			
~~Antibiotic ointment~~ Saline (flush) 53015	~~1 packet~~ 500cc	1 Bottle		
Disposable Thrombectomy ballowin	1	1	$300 ie. Arrow Trerotola Device	
~~Suture~~Nylon suture 4.0 31704	~~4.0~~ 1 packet	Item		
Drape, sheet	1 item			
Exam table paper	7 feet			
Pillow case	1 item			
Gloves, non-sterile	2 pair			
Otoscope speculum disposable	1 item			
Patient education booklet	1 item			
Patient gown, disposable	1 item			
Swab, alcohol	2 items			
Thermometer probe cover, disposable	1 item			
Tongue depressor	1 item			

* Items have been added to reflect the inclusion of a standard supply package for E/M.

Procedure Specific Medical Equipment	**No. of units in practice**	**Minutes of use per procedure**	**Hours per week in use for all services**	**Equipment Cost**
~~Angiography suite~~	~~1~~	~~90~~	~~20~~	
Cardiac monitor	1	90	20	
Blood/Pressure monitor	1	90	20	

CPT Code 36870: Percutaneous Management of Dialysis Graft/Fistula
AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

Overhead Medical Equipment*	**No. of units in practice**	**Equipment Cost**		
Crash cart	1			
~~Oxygen tank~~	1		~~Oxygen is used because intravenous sedation is given and oxygen may be administered as well.~~	
Exam Table	1			
~~Otoscope-opthalmoscope~~	1			

* Items have been added to reflect the inclusion of a standard supply package for E/M

Standby

Per HCFA.

CPT Code 36870: Percutaneous Management of Dialysis Graft/Fistula
AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

TYPE OF SERVICE: Surgical Procedures
010 and 090 Global Periods

SITE OF SERVICE: In-OFFICE

Clinical Services	Minutes	Staff Type – Circle
Pre-Service Period		
Start. Following visit when decision for surgery or procedure made		
Complete pre-service diagnostic & referral forms	~~11~~	RN, LPN, MA, Other
Coordinate pre-surgery services	10	RN, LPN, MA, Other
Office visit before surgery/procedure Review test and exam results	~~8~~	RN, LPN, MA, Other
Provide pre-service education/obtain consent	5	RN, LPN, MA, Other
Follow-up phone calls & prescriptions	~~7.5~~	RN, LPN, MA, Other
Other Activity (please specify)		
		RN, LPN, MA, Other
End: When patient enters office for surgery/procedure		
Service Period		
Start· When patient enters office for surgery/procedure		
Pre-service services		
Review charts	~~7.5~~ 5	RN, LPN, MA, Other
Greet patient and provide gowning	~~6~~ 3	RN, LPN, MA, Other
Obtain vital signs	~~8~~ 5	RN, LPN, MA, Other
Provide pre-service education/obtain consent	~~10~~	RN, LPN, MA, Other
Prepare room, equipment, supplies	~~15~~ 5	RN, LPN, MA, Other
Prepare and position patient/ monitor patient/ set up IV	~~10~~ 5	RN, LPN, MA, Other
Sedate/apply anesthesia	~~12~~ 5	RN, LPN, MA, Other
Intra-service		
Assist physician in performing procedure	~~65~~ 60	RN, LPN, MA, ~~Other~~ ~~Tech~~

CPT Code 36870: Percutaneous Management of Dialysis Graft/Fistula
AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

Post-service

Monitor pt. following service/check tubes, monitors, drains	16	**RN**, LPN, MA, Other
Clean room/equipment	~~12~~	RN, LPN, MA, **Other** Tech
Complete diagnostic forms, lab & X-ray requisitions	~~10~~5	RN, LPN, MA, **Other** Tech
Review/read X-ray, lab, and pathology reports		RN, LPN, MA, Other
Check dressings & wound/ home care instructions/coordinate office visits/prescriptions	~~10~~ 5	**RN, LPN, MA,** Other
Other Activity (please specify)		
		RN, LPN, MA, Other
End: Patient leaves office	115 minutes	

Post-Service Period
Start: Patient leaves office

Conduct phone calls/call in prescriptions	5	**RN, LPN, MA,** Other
Office visits		
Greet patient, escort to room		
Provide gowning		
Interval history & vital signs & chart		
Assemble previous test reports/results		
Assist physician during exam		
Assist with dressings, wound care, suture removal		
Prepare Dx test, prescription forms		
Post service education, instruction, counseling		
Clean room/equip, check supplies		
Coordinate home or outpatient care	16=99211	RN, LPN, MA, Other
List total number of office visits	**A 1**	
Total office visit time (A * B)	**B 16 minutes**	
Conduct phone calls between office visits		RN, LPN, MA, Other
Other Activity (please specify)		
	21 minutes	RN, LPN, MA, Other
End: With last office visit before end of global period		

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Lymph Node Biopsy

Through the CPT Process (CPT/HCPAC Advisory Committee review), The CPT Editorial Panel will be implementing a CPT-5 recommendation to delete the "separate procedure" designation from the code descriptor nomenclature and replace this designation with cross-references identifying specific services for which the code should not be separately reported. The two services listed below are the first to undergo this revision and have a corresponding cross-reference included. As the CPT Editorial Panel proceeds with this project, it is the intention that the RUC will review these changes to recommend to HCFA that they are indeed editorial or if the change (via inclusion or exclusion of certain codes in the cross-reference) is not editorial.

The RUC recommends that the replacement of "separate procedure" in the descriptor of codes 38500 and 38530 with the addition of new explanatory notes is editorial and not a change in the service. The RUC recommends no change in the current work relative values for these services.

Code (●New) (▲Revised) (D Deletion) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommenda-tion
▲38500	C1	Biopsy or excision of lymph node(s); open, superficial ~~(separate procedure)~~ (Do not report 38500 with 38700-38780)	010	2.88 (no change)
▲38530	C2	Open, internal mammary node(s) (~~separate procedure~~)	090	6.13 (no change)

AMA SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

GI Endoscopy Procedures

The specialty societies presenting relative value recommendations for Gastrointestinal Endoscopy Procedures at the RUC recognized that their survey data was insufficient and requested the RUC to develop interim recommendations for these new CPT codes. This issue will be reviewed again by the specialty societies and any new recommendations will be presented at the February 2001 RUC meeting. The RUC will reconsider this issue and will forward any recommendations to HCFA at that time.

In developing interim recommendations for these new endoscopy procedures, the RUC reviewed the current relationships within existing codes and determined an appropriate increment for both the transendoscopic ultrasound and the needle/aspiration/biopsy. The RUC recommends the following interim work RVUs:

43200	*Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*	*1.59*
43202	*with biopsy, single or multiple*	*1.89*
43231 (Y1)	**Esophagoscopy, rigid or flexible; with endoscopic ultrasound examination**	**4.09**
43232 (Y2)	**with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)**	**4.71**
43235	*Upper gastrointestinal endoscopy including esophagus, stomach and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*	*2.39*
43259	*with endoscopic ultrasound examination*	*4.89*

43242 (Y3)	**with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)**	**5.51**
43240 (Y4)	**with transmural drainage of pseudocyst**	**7.39**
45330	*Sigmoidoscopy, flexible; diagnostic, with or without collection of of specimen(s) by brushing or washing (separate procedure)*	*.96*
45341 (Y5)	**with endoscopic ultrasound examination**	**3.46**
45342 (Y6)	**with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)**	**4.08**

The rationale for each is as follows:

Y1 = 43200 (1.59) + 2.50 (ultrasound increment)* = 4.09

Y2 = Y1 (4.09) + .62 (biopsy increment)** = 4.71

Y3 = 43259 (4.89) + .62 (biopsy increment)** = 5.51

Y4 = The RUC recommends that this service is equivalent to code 43262 *Endoscopic retrograde cholangio-pancreatography (ERCP); with sphincterotomy/papilotomy* (work RVU = 7.39*). The specialty's survey data indicated that the total time for this new CPT code is 130 minutes, which is directly comparable to the Harvard total time of 137 minutes for 43262.*

Y5 = 45330 (.96) + 2.50 (ultrasound increment)* = 3.46

Y6= Y5 + .62 (biopsy increment)** = 4.08

*Ultrasound increment = 43259 (4.89) – 43235 (2.39) = 2.50

**Biopsy increment = Blend between 19291 *Preoperative placement of needle localization wire, breast; each additional lesion* (0.63) and the increment between 31629 *Bronchoscopy, (rigid or flexible), with transbronchial needle aspiration biopsy* (work RVU = 3.37) and 31622 *Bronchoscopy (rigid or flexible); diagnostic with or without cell washing (separate procedure)* (work RVU = 2.78) of .59.

Practice Expense Recommendation
The following applies to codes 43231, 43232, 43242, 43240, 45341, 45342 (Y1-Y6).
Practice Expense inputs agreed upon at the pre-facilitation meeting were as follows

35 minutes pre-service time RN/MA/LPN
10 minutes coordination of care RN/MA/LPN
10 minutes post-telephone calls RN/MA/LPN

No Medical Supplies
No Equipment

These services are performed in a facility setting.

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●43231	Y1	Esophagoscopy, rigid or flexible; with endoscopic ultrasound examination	000	4.09 (Interim)
●43232	Y2	with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (Do not report 76975 in conjunction with 43231, 43232) (For interpretation of specimen, see 88172-88173)	000	4.71 (Interim)
43235		*Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection specimen(s) by brushing or washing (separate procedure)*		
●43240	Y4	with transmural drainage of pseudocyst	000	7.39 (Interim)
▲43241(e)		with transendoscopic intraluminal tube or catheter placement	000	2.59 (no change)
●43242	Y3	with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) Do not report 76975 in conjunction with 43242) (For interpretation of specimen, see 88172-88173)	000	5.51 (Interim)

●45341	Y5	Sigmoidoscopy, flexible; with endoscopic ultrasound examination	000	3.46 (Interim)
●45342	Y6	with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) Do not report 76975 in conjunction with 45341, 45342) (For interpretation of specimen, see 88172-88173) (For transrectal ultrasound utilizing rigid probe device, use 76872)	000	4.08 (Interim)
▲76975		Gastrointestinal endoscopic ultrasound, ~~radiological~~ supervision and interpretation ~~(For procedure, use 43259)~~	XXX	0.81 (No change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 43231 Tracking Number: Y1 Global Period: 000 **Recommended RVW: ~~5.96~~ 4.09 (RUC)**

CPT Descriptor: Esophagoscopy, rigid or flexible; with endoscopic ultrasound examination

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
A 53-year-old gentleman with recent onset dysphagia is thought to have a submucosal mass on barium upper GI x-ray series. A CT scan has been performed and suggests that a primary esophageal mass or periesophageal lymph node may be present. The patient is sent for endoscopic ultrasound evaluation.

Description of Pre-Service Work:
On the day of the procedure you review with the patient his symptoms and ascertain the severity of his dysphagia to identify if technical problems may arise when using the larger caliber echoendoscope to traverse the esophagus. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. Available laboratory studies which may indicate a risk for bleeding are reviewed. A pre-anesthetic exam with airway assessment and cardiopulmonary evaluation is performed. You are provided with the patient's x-rays and have an opportunity to review these imaging studies. The characteristics of the mass are noted including its relationship to the esophageal wall, vital mediastinal vascular and non-vascular structures and the appearance pre and post intravenous contrast enhancement. You discuss the risks of the procedure with the patient including bleeding, perforation, infection and medication reaction including cardiopulmonary compromise. You indicate that these risks are higher with an endoscopic ultrasound procedure than standard endoscopy due to the longer exam duration, the increased caliber of the instruments as well as the possibility that the lesion may require transmural biopsy. In the latter case, you explain to the patient that if the lesion appears cystic and undergoes a fine needle aspiration biopsy that intravenous antibiotics will be administered during the exam and oral antibiotics will need to be continued for 48 hours after the exam.

Description of Intra-Service Work:
Conscious sedation is provided to the patient by you while continuously monitoring pulse oximetry and sequential non-invasive blood pressure measurements. A standard video gastroscope is advanced into the esophagus to allow an endoscopic assessment of the lesion. This is necessary since the oblique forward viewing optics available with the echoendoscopes are not adequate to allow complete circumferential visualization of the esophagus lumen. A smooth subepithelial mass is identified in the mid esophagus. The distance from the incisors is noted and the instrument is withdrawn. A dedicated echoendoscope is then prepared with a balloon placed over the transducer housing. Since the dedicated instrument cannot be attached to the endoscope processor until the initial endoscopy is completed, you proceed to purge the air from the balloon chamber by repetitively inflating and deflating the channel. The level of sedation of the patient is reassessed and additional medication is administered as needed. The echoendoscope is then introduced into the oropharynx and advanced to the level of the identified abnormality under direct endoscopic visualization. While slowly withdrawing the echoendoscope, ultrasound imaging commences which includes visualization of the abnormality, recognizing whether the lesion arises from the esophageal wall or mediastinal space, assessing for invasion of the mediastinum or adjacent vital structures and determining if regional lymphadenopathy is present. If the lesion arises from the esophageal wall higher frequency ultrasound imaging is performed to determine which layer the lesion arises from (deep mucosa, submucosa or muscularis propria). Occasionally, you advance the echoendoscope under direct endoscopic visualization to permit reassessment of the abnormalities. Documentation of the exam findings including measurements of the lesion, labeling of the identified structures and magnified images of the abnormality are obtained and sent to a hard copy device. A determination is made on the risk/benefit of biopsying the lesion. If no biopsies are contemplated, the procedure is then terminated.

Description of Post-Service Work:
The radiographs generated during the exam are reviewed and a report is dictated. After the patient has recovered from the procedure and prior to departure, the patient is assessed by you to determine if any complications have occurred. The findings of the exam are reviewed with the patient and their family.

SURVEY DATA:

Presenter(s) Joel Brill, MD (AGA)

Specialty(s): AGA/ASGE/ACG - Gastroenterology

Sample Size: 20 Response Rate: (%): 38 Median RVW: 5.96

Type of Sample: panel
Explanation of sample size: This service has become performed with increasing frequency over the past 6 years, concomitant with advances in technology. The ASGE surveyed their EUS Committee and received 80% response rate from that group. The AGA and ACG surveyed additional physicians who perform this service on a frequent basis and received about 50% response rate to the survey.

25th Percentile RVW: 5.8 75th Percentile RVW: 6.5 Low: 4.78 High: 10

Median Pre-Service Time: 20 Median Intra-Service Time: 40

25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 30 Low: 10 High: 40

Median Post-Service Time: 20

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
43260	ERCP	5.96

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	20	15
Median Intra-Time	40	30
Median Immediate Post-service Time	20	15
Median of Aggregate Critical Care Times	NA	NA
Median of Aggregate Other Hospital Visit Times	NA	NA
Median Discharge Day Management Time	NA	NA
Median of Aggregate Office Visit Times	NA	NA

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.16	3.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.0	3.22
Urgency of medical decision making	3.67	3.33

Technical Skill/Physical Effort (Mean)

Technical skill required	4.61	3.72
Physical effort required	3.88	3.27

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.78	3.72
Outcome depends on the skill and judgement of physician	4.61	3.77
Estimated risk of malpractice suit with poor outcome	3.83	3.56

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.61	3.22
Intra-Service intensity/complexity	4.16	3.5
Post-Service intensity/complexity	3.77	3.22

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The process used consisted of a survey of 20 physicians (panel sample) who typically perform this service. Final recommendations and work values were reviewed by 3 physicians representing the AGA, ACG, ASGE. These physicians reviewed all components of work and practice expense for newly proposed CPT codes as well as the information provided for the reference procedures

FREQUENCY INFORMATION

How was this service previously reported? 43299

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

Specialty_Gastroenterology_____ ___X__Commonly _____Sometimes _____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty _Gastroenterology_____ Frequency: 25,000

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty _Gastroenterology_____ Frequency__80%_____

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 43232 Tracking Number: Y2 Global Period: 000 **Recommended RVW: ~~8.00~~ 4.71 (RUC)**

CPT Descriptor: Esophagoscopy, rigid or flexible; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)

(do not report 76975 in conjunction with 43232)
(for interpretation of specimen, see 88172-88173)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
A 57-year-old woman with a long history of tobacco use presents with a central lung nodule and evidence of mediastinal enlargement on chest CT scan. Sputum cytology has demonstrated that she has a non-small cell lung cancer. A bronchoscopy is performed and the pulmonologist performs transtracheal Wang needle biopsy of presumed metastatic subcarinal lymphadenopathy. The cytology demonstrates no evidence for malignancy. Prior to consideration of operative intervention, assessment for malignant mediastinal lymphadenopathy is requested by endoscopic ultrasound guided biopsy.

Description of Pre-Service Work:
You review with the patient her symptoms and ascertain if dysphagia has been a problem in order to identify if technical problems may arise when using the larger caliber echoendoscopes to traverse the esophagus. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment and cardiopulmonary evaluation is performed. The patient's laboratory studies as they relate to coagulation status and platelet count are reviewed. You are provided with the patient's x-rays and have an opportunity to review these imaging studies. The characteristics of the mediastinal lymphadenopathy are noted including the relationship to the esophageal wall, vital mediastinal vascular and non-vascular structures and the appearance pre and post intravenous contrast enhancement. You discuss the risks of the procedure with the patient including bleeding, perforation, infection and medication reaction including cardiopulmonary compromise. You indicate that these risks are higher with an endoscopic ultrasound procedure than standard endoscopy due to the longer exam time, the increased caliber of the instruments as well as the possibility that the lesion may require transmural biopsy. In the latter case, you explain to the patient that if the lesion appears cystic and undergoes a fine needle aspiration biopsy that intravenous antibiotics will be administered during the exam and oral antibiotics will need to be continued for 48 hours after the exam. Additionally, you explain that the exam will require passage of two consecutive echoendoscopes the first of which will allow localization of the most distant or advanced lymphadenopathy and the second will be used to perform the biopsy procedure. You explain that two echoendoscopes are typically required since the biopsy instrument does not provide a complete circumferential image of the mediastinal structures which is necessary to determine the extent of abnormalities.

Description of Intra-Service Work:
Conscious sedation is provided to the patient by you while continuously monitoring pulse oximetry and sequential non-invasive blood pressure measurements. A dedicated echoendoscope is then prepared with a balloon placed over the transducer housing. The equipment is rechecked to make sure that air has been fully purged from the balloon covering the transducer. The echoendoscope is then introduced into the oropharynx and advanced to the distal esophagus under direct endoscopic visualization. Ultrasound imaging commences which includes a search for any abnormalities including mediastinal lymphadenopathy, recognizing whether abnormal lesions arise from the esophageal wall or mediastinal space, and assessing for invasion of the mediastinum or adjacent vital structures. A search for mediastinal involvement by the primary tumor is made as well. The presence or absence of pleural effusions is noted. For each lymph node identified, the location is noted as described by the American Thoracic Society lymph node staging map. A determination of the lymph node size and echo characteristics are made as well. Occasionally, you advance the echoendoscope under direct endoscopic visualization to permit reassessment of abnormalities. Documentation of the exam findings includes measurement of the lesions and labeling of the identified structures. Magnified images of abnormalities are obtained to assist with interpretation.

All recorded images are then sent to a hard copy device. A determination is made on the risk/benefit of biopsying any lesions. If a mediastinal lymph node(s) which can be safely biopsied from the esophagus is identified and the biopsy results may impact on a decision to operate on the patient, then the biopsy is undertaken. A linear scanning echoendoscope is prepared for the exam. Since this instrument cannot be attached to the endoscope processor until the radial scanning echoendoscopy is completed, you proceed to purge the air from the balloon chamber by repetitively inflating and deflating the channel. The level of sedation of the patient is reassessed and additional medication is administered as needed. The echoendoscope is then introduced into the oropharynx and advanced into the distal esophagus under direct endoscopic visualization. Sagittal imaging requires spatial reorientation of structures previously examined in a transverse plane. Integrating these imaging aspects, the lymph node(s) is identified. A decision with respect to the most advanced lymph node site is made (e.g. contralateral as opposed to ipsilateral: N3 versus N2). A needle biopsy catheter device is prepared. The needle biopsy device is advanced through the biopsy channel of the ultrasound endoscope. Doppler imaging is performed to insure that any vascular structures or areas within the lymph node are recognized prior to biopsy. Under direct ultrasound visualization, the needle is advanced through the esophageal wall into the lymph node. The central stylet is removed from the needle by the nurse, negative pressure is applied to the hub of the device and to and fro movements are made with the needle in the lymph node. After 1 – 2 minutes, the needle is removed from the echoendoscope and the material is sprayed onto glass slides for cytologic examination. An attendant cytotechnologist will provide an adequacy assessment on the collected material which requires 15 – 30 minutes. Typically, 5 needle passes will be made for each biopsy site. For each biopsy, the needle and stylet assembly will be rinsed to remove any blood and then reassembled for use. If an adequate specimen is not obtained after five passes, then a new biopsy site will be selected when available. Otherwise the procedure will be terminated. Throughout the biopsy component of the exam, documentation of the exam findings including measurements of the lesion, labeling of the identified structures, recording of the needle position within the lesion and magnified images of the abnormality are obtained and sent to a hard copy device. Doppler findings are annotated with labeling performed by you.

Description of Post-Service Work:
The radiographs generated during the exam are reviewed and a report is dictated. After the patient has recovered from the procedure and prior to departure, the patient is assessed by you to determine if any complications have occurred including pneumothorax, hemothorax or pneumomediastinum. Instructions are reviewed with the patient and family with respect to delayed infectious complications including mediastinitis. If a cystic lesion was biopsied, the prescribed antibiotic is reviewed with the patient and their family. The findings of the exam are reviewed with the patient and their family.

SURVEY DATA:

Presenter(s) Joel Brill, MD (AGA)

Specialty(s): AGA/ASGE/ACG - Gastroenterology

Sample Size: 19 Response Rate: (%): 36 Median RVW: 8.0

Type of Sample: panel.
Explanation of sample size: This service has become performed with increasing frequency over the past 6 years, concomitant with advances in technology. The ASGE surveyed their EUS Committee and received 80% response rate from that group. The AGA and ACG surveyed additional physicians who perform this service on a frequent basis and received about 50% response rate to the survey.

25th Percentile RVW: 7.2 75th Percentile RVW: 9.5 Low: 1.7 High: 16

Median Pre-Service Time: 20 Median Intra-Service Time: 60

25th Percentile Intra-Svc Time: 50 75th Percentile Intra-Svc Time: 75 Low: 15 High: 100

Median Post-Service Time: 20

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
43262	ERCP with speincterotomy/papillotomy	7.39

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	20	15
Median Intra-Time	60	30
Median Immediate Post-service Time	20	15
Median of Aggregate Critical Care Times	NA	NA
Median of Aggregate Other Hospital Visit Times	NA	NA
Median Discharge Day Management Time	NA	NA
Median of Aggregate Office Visit Times	NA	NA

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.31	3.21
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.31	3.15
Urgency of medical decision making	4.15	3.63

Technical Skill/Physical Effort (Mean)

Technical skill required	4.73	3.57
Physical effort required	4.26	3.26

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.42	3.89
Outcome depends on the skill and judgement of physician	4.78	3.84
Estimated risk of malpractice suit with poor outcome	4.31	3.63

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.89	3.26
Intra-Service intensity/complexity	4.73	3.68
Post-Service intensity/complexity	4.21	3.47

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The process used consisted of a survey of 19 physicians (panel sample) who typically perform this service. Final recommendations and work values were reviewed by 3 physicians representing the AGA, ACG, ASGE. These physicians reviewed all components of work and practice expense for newly proposed CPT codes as well as the information provided for the reference procedures

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FREQUENCY INFORMATION

How was this service previously reported? ___43299_____

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

Specialty_Gastroenterology_____ ___X__Commonly _____Sometimes _____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty _Gastroenterology_____ Frequency__4000-6000

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty _Gastroenterology_____ Frequency__80%_____

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

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 43242 Tracking Number: Y3 Global Period: 000 **Recommended RVW: ~~9.53~~ 5.51 (RUC)**

CPT Descriptor: Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or the jejunem as appropriate; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)

(do not report 76975 in conjunction with 43242)
(for interpretation of specimen, see 88172-88173)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
A 67-year-old woman who develops painless jaundice is identified to have dilation of her bile duct and pancreatic duct on CT scan. A discrete mass lesion is not identified. The patient is referred for an endoscopic ultrasound to identify if a mass lesion is present and if so then proceed with a biopsy of the lesion to confirm the diagnosis.

Description of Pre-service work:
You review with the patient her symptoms and ascertain if dysphagia has been a problem to identify if technical problems may arise when using the larger caliber echoendoscopes to traverse the esophagus. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment and cardiopulmonary evaluation is performed. The patient's laboratory studies as they relate to coagulation status and platelet count are reviewed in light of the jaundice and potential risk for disordered hemostasis. You are provided with the patient's x-rays and have an opportunity to review these imaging studies. The characteristics of the biliary ductal dilation are reviewed and a reassessment is made to ascertain the presence or absence of a pancreatic mass lesion. The CT technique and level of resolution are reviewed to determine the adequacy of the exam for identifying a neoplastic process. You discuss the risks of the procedure with the patient including bleeding, perforation, infection, pancreatitis and medication reaction including cardiopulmonary compromise. You indicate that these risks are higher with an endoscopic ultrasound procedure than standard endoscopy due to the longer exam duration, the increased caliber of the instruments as well as the possibility that the lesion may require transmural biopsy. In the latter case, you explain to the patient that if the lesion appears cystic and undergoes a fine needle aspiration biopsy than intravenous antibiotics will be administered during the exam and oral antibiotics will need to be continued for 48 hours after the exam. Additionally, you explain that the exam will require passage of two consecutive echoendoscopes the first of which will allow localization of the lesion and identification of lymphadenopathy and the second will be used to perform the biopsy procedure. You explain that two echoendoscopes are typically required since the biopsy instrument does not provide a complete circumferential image of the abdominal structures which is necessary to determine the extent of abnormalities.

Description of Intra-service work:
Conscious sedation is provided to the patient by you while continuously monitoring pulse oximetry and sequential non-invasive blood pressure measurements. A dedicated echoendoscope is then prepared with a balloon placed over the transducer housing. Air is been fully purged from the balloon covering the transducer. The echoendoscope is then introduced into the oropharynx and advanced into the esophagus, stomach and subsequently distal duodenum under direct endoscopic visualization. The periampullary region is visualized endoscopically to ascertain for the presence or absence of a mass. Employing the ultrasound component of the equipment, images are obtained of the periduodenal space with special attention made to the pancreatic head region. A mass is searched for and the relationship to vital mesenteric vascular structures is noted as well as adjacent organs. Biliary and pancreatic ductal structures are identified with displacement or compression by the mass characterized. Regional lymph nodes are searched for. The instrument is withdrawn into the duodenal bulb and a search is made for lymph nodes arising in the hilum of the liver. The acoustic coupling balloon is deflated and the instrument is then withdrawn into the stomach. Under direct endoscopic visualization, the echoendoscope is advanced into the prepyloric region. The acoustic coupling balloon is reinflated and the pancreas body and tail are examined to assess the extent of the tumor in the head of the pancreas as well as ascertain indirect findings of malignancy including main pancreatic duct dilation and pancreas atrophy. A search is made for perigastric and celiac lymph nodes. Survey views of the left lobe of the liver are made as well to assess for small hepatic metastases. Frequently, you readvance the

echoendoscope under direct endoscopic visualization into the distal duodenum to permit reassessment of abnormalities. Throughout the exam, you record images with appropriate annotation and measurements. Magnified images of abnormalities are obtained to assist with interpretation. All recorded images are then sent to a hard copy device. A determination is made on the risk/benefit of biopsying any lesions as well as the potential resectability of the identified mass. If suspicious lymphadenopathy is identified, this is selected for biopsy if it can be reached safely and the result will impact on a decision to operate on the patient. In the absence of malignant lymphadenopathy, consideration of biopsy of the primary mass in the pancreas head is made if a tissue diagnosis is requested prior to operative intervention or for treatment planning purposes. A linear scanning echoendoscope is prepared for the exam Since the this instrument cannot be attached to the endoscope processor until the radial scanning echoendoscopy is completed, you proceed to purge the air from the balloon chamber by repetitively inflating and deflating the channel. The level of sedation of the patient is reassessed and additional medication is administered as needed. The echoendoscope is then introduced into the oropharynx and advanced through the esophagus, stomach and into the distal duodenum under direct endoscopic visualization. Sagittal imaging requires spatial reorientation of structures previously examined in a transverse plane. Integrating these imaging aspects, the abnormal lesion(s) selected for biopsy is identified. A needle biopsy catheter device is prepared. The needle biopsy device is advanced through the biopsy channel of the ultrasound endoscope. Doppler imaging is performed to insure that any vascular structures or areas within the lesion are recognized prior to biopsy. Under direct ultrasound visualization, the needle is traversed across the gastrointestinal wall into the lesion. The central stylet is removed from the needle by the nurse, negative pressure is applied to the hub of the device and to and fro movements are made with the needle in the lesion. After 1 – 2 minutes, the needle is removed from the echoendoscope and the material is sprayed onto glass slides for cytologic examination. An attendant cytotechnologist provides an adequacy assessment on the collected material which requires 15 – 30 minutes. Typically, 5 needle passes will be made for each biopsy site. For each biopsy, the needle and stylet assembly will be rinsed to remove any blood and then reassembled for use. If an adequate specimen is not obtained after five passes, then a new biopsy site will be selected when available. Otherwise the procedure will be terminated. Throughout the biopsy component of the exam, documentation of the exam findings including measurements of the lesion, labeling of the identified structures, recording of the needle position within the lesion and magnified images of the abnormality are obtained and sent to a hard copy device. Doppler findings are annotated with labeling performed by you.

Description of Post-service work:
The radiographs generated during the exam are reviewed and a report is dictated. After the patient has recovered from the procedure and prior to departure, the patient is assessed by you to determine if any complications have occurred including perforation and intra-abdominal hemorrhage. Instructions are reviewed with the patient and family with respect to delayed hemorrhage, infection or pancreatitis. If a cystic lesion was biopsied, the prescribed antibiotic is reviewed with the patient and their family. The findings of the exam are reviewed with the patient and their family.

SURVEY DATA:

Presenter(s) Joel Brill, MD (AGA)

Specialty(s): AGA/ASGE/ACG - Gastroenterology

Sample Size: 20 Response Rate: (%): 38 Median RVW: 9.53

Type of Sample: panel
Explanation of sample size: This service has become performed with increasing frequency over the past 6 years, concomitant with advances in technology. The ASGE surveyed their EUS Committee and received 80% response rate from that group. The AGA and ACG surveyed additional physicians who perform this service on a frequent basis and received about 50% response rate to the survey.

25th Percentile RVW: 8.9 75th Percentile RVW: 11.9 Low: 2 High: 17

Median Pre-Service Time: 20 Median Intra-Service Time: 90

25th Percentile Intra-Svc Time: 67.5 75th Percentile Intra-Svc Time: 90 Low: 45 High: 120

Median Post-Service Time: 20

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
43264	ERCP with retrograde removal of stones from biliary/pancreatic ducts	8.90

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	20	15
Median Intra-Time	90	45
Median Immediate Post-service Time	20	15
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.55	3.66
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.44	3.44
Urgency of medical decision making	4.44	3.94

Technical Skill/Physical Effort (Mean)

Technical skill required	5.0	4.0
Physical effort required	4.56	3.66

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.28	4.11
Outcome depends on the skill and judgement of physician	4.94	3.89
Estimated risk of malpractice suit with poor outcome	4.11	3.94

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.10	3.31
Intra-Service intensity/complexity	4.94	4.15
Post-Service intensity/complexity	4.15	3.42

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The process used consisted of a survey of X physicians (panel sample) who typically perform this service. Final recommendations and work values were reviewed by X physicians representing the AGA, ACG, ASGE. These physicians reviewed all components of work and practice expense for newly proposed CPT codes as well as the information provided for the reference procedures

FREQUENCY INFORMATION

How was this service previously reported? 43299

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

Specialty Gastroenterology ___X__Commonly _____Sometimes _____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology Frequency: 4000-6000

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Gastroenterology Frequency 80%

Do many physicians perform this service across the United States? Yes, within gastroenterology/GI endoscopy

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 43240 Tracking Number: Y4 Global Period: 000 **Recommended RVW: ~~10.50~~ 7.39 (RUC)**

CPT Descriptor: Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or the jejunem as appropriate; with transmural drainage of pseudocyst.

CLINICAL DESCRIPTION OF SERVICE:

Vignette used in survey:

A 68 year-old gentleman with chronic alcoholism and an episode of acute pancreatitis eight weeks ago has developed a pancreatic pseudocyst with symptoms of early satiety and abdominal pain. Conservative measures have failed to result in resolution of the pseudocyst. A CT scan demonstrates that the pseudocyst is in close proximity to the stomach and duodenum and therefore may be amenable to endoscopic drainage.

Description of Pre-service work:
You review with the patient his symptoms and ascertain if these are truly attributable to the pseudocyst. Presence of risk factors for progression of the pancreatitis are assimilated including continued alcohol use, a prior evaluation for cholelithiasis and the potential for an underlying malignancy. Risk factors for underlying chronic liver disease are explored with the patient and an assessment of nutrition is made. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment and cardiopulmonary evaluation is performed. The abdomen is examined to obtain a baseline evaluation for comparison purposes after the procedure is completed. The patient's laboratory studies as they relate to coagulation status and platelet count are reviewed. Liver chemistries are reviewed to assess for any potential complicating factors including biliary obstruction. You are provided with the patient's x-rays and have an opportunity to review these imaging studies. The characteristics of the pseudocyst and its relationship to the gastrointestinal tract are closely scrutinized. The presence or absence of septation and internal debris is searched for. The maturity of the pseudocyst wall is assessed. A search for perigastric or periduodenal venous collaterals is made to determine the potential for bleeding. Evidence for ongoing inflammation and pancreatic necrosis is determined. The CT technique and level of resolution are reviewed to determine the adequacy of the exam for identifying a neoplastic process. You discuss the risks of the procedure with the patient including bleeding, perforation, infection, pancreatitis, prolonged hospitalization, disability, death (up to 10%) and medication reaction including cardiopulmonary compromise. You indicate that the risk of death with the procedure is most often due to immediate complications with uncontrollable hemorrhage or delayed infection. The alternatives (with their disadvantages and advantages relative to endoscopic pseudocyst drainage) including surgical intervention and percuaneous drainage are discussed. You explain that intravenous antibiotics will be administered before the exam. In most patients, you explain that they will require hospitalization after the procedure to insure the absence of immediate complications and allow for the continuation of intravenous antibiotics.

Description of Intra-service work:
Conscious sedation is provided to the patient by you while continuously monitoring pulse oximetry and sequential non-invasive blood pressure measurements. The patient is in an examining room with fluoroscopy and hard copy image ability. A side viewing endoscope (duodenoscope) is introduced into the oropharynx and advanced into the esophagus, stomach and subsequently distal duodenum under direct endoscopic visualization. The periampullary region is visualized endoscopically to ascertain for the presence or absence of a mass. Esophageal, gastric and duodenal varices are carefully searched for to assess for evidence of mesenteric venous thrombosis or portal hypertension which may increase the risk bleeding. The intestinal mucosa is carefully evaluated to assess for evidence of an extrinsic compression whereby the pseudocyst might be identified. Preferably, you wish to drain the lesion through the duodenum rather than the stomach since patency of the drainage site is better maintained. However, most often surrounding edema makes this approach more difficult and therefore a site is selected based on optimal drainage and technical feasibility. If an adequate extrinsic press is not seen, then consideration for blindly advancing a needle into the fluid collection is posed based on the anatomic information provided by the CT. Otherwise, one can remove the duodenoscope and employ an echoendoscope to gain access to the pseudocyst. Once a suitable site has been selected, a needle knife is used to burn through the gastrointestinal wall and enter the pseudocyst cavity. If after advancing the device for several millimeters a fluid return is not seen, a new site is selected or the procedure is terminated. Once the pseudocyst has been entered, an assessment for hemorrhage is

made by observing the fluid withdrawn from the catheter. Barring any bleeding, fluid samples are collected for amylase, culture, gram stain and cytology. Under combined fluoroscopic and endoscopic visualization, a guidewire is advanced through the needle knife catheter and coiled into the pseudocyst cavity. The catheter is withdrawn leaving the wire in place. A biliary dilation balloon is then advanced over the guidewire and the tract between the gastrointestinal lumen and pseudocyst cavity is dilated (usually 6 - 10 mm at pressures up to 10 atmospheres). Degree of dilation is monitored by fluoroscopy. The balloon is deflated and then withdrawn leaving the guidewire in place. A stiffener tube is then advanced over the guidewire into the pseudocyst cavity. Under fluoroscopic and endoscopic guidance, a 10 French double pigtail stent is then placed across the gastrointestinal wall into the pseudocyst cavity carefully insuring that the stent does not migrate completely into the pseudocyst when released. To allow insertion of the stent the guidewire and catheter must be removed. The catheter is then flushed with contrast material and the pseudocyst cavity is recannulated. Entry is confirmed by monitoring of contrast injection under fluoroscopy. When this is confirmed, a decision is made regarding placement of a second 10 French double pigtail stent or insertion of a nasocystic lavaging catheter. In most cases, the latter will be performed. This is accomplished placing a guidewire through the catheter into the pseudocyst and then removing the catheter while maintaining guidewire position. The nasocystic tube is then advanced over the guidewire and coiled within the pseudocyst. While monitoring the position of the irrigation tube on fluoroscopy, the endoscope is slowly withdrawn from the patient while advancing this catheter. Once the endoscope has exited the patient's mouth, the nasocystic catheter is grasped (the guidewire is still within it). A nasogastric tube is then inserted into the patients nose and exits through his mouth. The nasocystic catheter is then back threaded through the nasogastric tube and withdrawn through the nose. Contrast is injected into the tube to insure its position on fluoroscopy and then it is flushed. Throughout the procedure, radiographic images are obtained to confirm placement of drainage tubes and entry site.

Description of Post-service work:
The radiographs generated during the exam are reviewed and a report is dictated. After the patient has recovered from the procedure, the patient is assessed by you to determine if any complications have occurred including perforation and intra-abdominal hemorrhage. Arrangements are reviewed for hospital admission. Admission orders for care of the irrigation catheter, diet, activity, laboratory evaluation to assess for bleeding/infection and antibiotic therapy are written. Instructions are reviewed with the patient and family with respect to delayed hemorrhage, infection or pancreatitis. The findings of the exam are reviewed with the patient and his family.

SURVEY DATA:

Presenter(s) Joel Brill, MD (AGA)

Specialty(s): AGA/ASGE/ACG - Gastroenterology

Sample Size: 19 Response Rate: (%): 33 Median RVW: 10.5

Type of Sample: panel
Explanation of sample size: This service has become performed with increasing frequency over the past 6 years, concomitant with advances in technology. The ASGE surveyed their EUS Committee and received 80% response rate from that group. The AGA and ACG surveyed additional physicians who perform this service on a frequent basis and received about 50% response rate to the survey.

25th Percentile RVW: 9.78 75th Percentile RVW: 12 Low: 7.39 High: 17.0

Median Pre-Service Time: 20 Median Intra-Service Time: 90

25th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 90 Low: 40 High: 120

Median Post-Service Time: 20

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
43264	ERCP with removal of stones from biliary/pancreatic ducts	8.90

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	20	25
Median Intra-Time	90	60
Median Immediate Post-service Time	20	20
Median of Aggregate Critical Care Times	NA	NA
Median of Aggregate Other Hospital Visit Times	NA	NA
Median Discharge Day Management Time	NA	NA
Median of Aggregate Office Visit Times	NA	NA

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.57	3.57
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.73	3.57
Urgency of medical decision making	4.52	3.94

Technical Skill/Physical Effort (Mean)

Technical skill required	4.89	4.05
Physical effort required	4.68	3.89

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.89	3.84
Outcome depends on the skill and judgement of physician	4.89	4.10
Estimated risk of malpractice suit with poor outcome	4.73	3.89

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.57	3.42
Intra-Service intensity/complexity	4.89	4.05
Post-Service intensity/complexity	4.47	3.36

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The process used consisted of a survey of 19 physicians (panel sample) who typically perform this service. Final recommendations and work values were reviewed by 3 physicians representing the AGA, ACG, ASGE. These physicians reviewed all components of work and practice expense for newly proposed CPT codes as well as the information provided for the reference procedures

FREQUENCY INFORMATION

How was this service previously reported? 43299

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

Specialty_Gastroenterology_____ ___X__Commonly _____Sometimes _____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty _Gastroenterology_____ Frequency: 4000-6000

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty _Gastroenterology_____ Frequency__80%_____

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 45341 Tracking Number: Y5 Global Period: 000 **Recommended RVW: ~~5.00~~ 3.46 (RUC)**

CPT Descriptor: Sigmoidoscopy, flexible; with endoscopic ultrasound examination

(for radiolocial supervision and interpretation, use 76975)

CLINICAL DESCRIPTION OF SERVICE:

Vignette used in survey:

A 59-year-old gentleman with hematochezia is identified to have an adenocarcinoma of the rectum. Sigmoidoscopy with endoscopic ultrasound is requested to assess the depth of tumor invasion and assess for the presence of regional lymph nodes. An abdominal and pelvic CT scan have been preformed and reveal rectal wall thickening and no evidence of metastatic disease.

Description of Pre-service work:

On the day of the procedure you review with the patient his symptoms. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment and cardiopulmonary evaluation is performed. Available laboratory studies which may indicate a risk for bleeding are reviewed. You are provided with the patient's x-rays and have an opportunity to review these imaging studies. The characteristics of the rectal mass are noted. You discuss the risks of the procedure with the patient including bleeding, perforation, infection and cardiopulmonary compromise. You indicate that these risks are higher with an endoscopic ultrasound procedure than standard sigmoidoscopy due to the longer exam duration, the need for sedation, the increased caliber of the instruments as well as the possibility that the lesion may require transmural biopsy. In the latter case, you explain to the patient that when a fine needle aspiration biopsy is performed that intravenous antibiotics will be administered during the exam and oral antibiotics will need to be continued for 48 hours after the exam.

Description of Intra-service work:

Conscious sedation is provided to the patient by you while continuously monitoring pulse oximetry and sequential non-invasive blood pressure measurements. Sedation is needed due to the length of the exam, the need to have the patient in a quite restful state for precise imaging and the discomfort associated with expansion of the rectum and sigmoid colon caused by insufflation of water to allow for acoustic coupling. Digital rectal exam is performed to characterize the location and degree of infiltration of the tumor. A standard flexible sigmoidoscope is advanced into the rectum and then sigmoid colon to allow an endoscopic assessment of the lesion. This is necessary since the oblique forward viewing optics available with the echoendoscopes are not adequate to allow complete circumferential visualization of the rectal lumen. The proximal and distal distance of the rectal mass from the anus is noted. A retroflex view is performed in the rectum to evaluate the relationship of the mass to the anal verge. The instrument is then withdrawn. A dedicated echoendoscope is then prepared with a balloon placed over the transducer housing. Since the dedicated instrument cannot be attached to the endoscope processor until the initial endoscopy is completed, you proceed to purge the air from the balloon chamber by repetitively inflating and deflating the channel. The echoendoscope is then introduced into the anus and advanced into the sigmoid colon under direct endoscopic visualization. The acoustic coupling balloon is inflated with water. Continuous imaging with ultrasound is performed on withdrawal of the echoendoscope. Visualization of the iliac vessels and regional lymphadenopathy is procured. The primary tumor is assessed with an analysis of depth of invasion (mucosa, submucosa, muscularis propria, perirectal space, adjacent organs such as prostate, bladder, vagina) and circumferential extent are made. Involvement of the internal and/or external anal sphincter are searched for. Frequently, imaging will be done at a low and high frequency to allow assessment of near and distant structures. Regional lymph node involvement in the peritumoral and proximal and distal rectal regions are identified. Frequently, you advance the echoendoscope under direct endoscopic visualization to permit reassessment of abnormalities. Documentation of the exam findings including measurements of the lesion(s), labeling of the identified structures and magnified images of the abnormality are obtained and sent to a hard copy device. A determination is made on the risk/benefit of biopsying the lesion. If no biopsies are contemplated, the procedure is then terminated.

Description of Post -service work:
The radiographs generated during the exam are reviewed and a report is dictated. After the patient has recovered from the procedure and prior to departure, the patient is assessed by you to determine if any complications have occurred including perforation. The findings of the exam are reviewed with the patient and their family.

SURVEY DATA:

Presenter(s): Joel Brill, MD (AGA)

Specialty(s): AGA/ASGE/ACG - Gastroenterology

Sample Size: 16 Response Rate: (%): 30 Median RVW: 5.0

Type of Sample: panel
Explanation of sample size: This service has become performed with increasing frequency over the past 6 years, concomitant with advances in technology. The ASGE surveyed their EUS Committee and received 80% response rate from that group. The AGA and ACG surveyed additional physicians who perform this service on a frequent basis and received about 50% response rate to the survey.

25th Percentile RVW: 4.15 75th Percentile RVW: 5.96 Low: 1.4 High: 10

Median Pre-Service Time: 10 Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 10 75th Percentile Intra-Svc Time: 20 Low: 5 High: 40

Median Post-Service Time: 15

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
45383	Colonoscopy, flexible, with ablation of tumors	5.87

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	10	10
Median Intra-Time	30	25
Median Immediate Post-service Time	15	10
Median of Aggregate Critical Care Times	NA	NA
Median of Aggregate Other Hospital Visit Times	NA	NA
Median Discharge Day Management Time	NA	NA
Median of Aggregate Office Visit Times	NA	NA

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.93	2.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.0	2.5
Urgency of medical decision making	3.75	2.93

Technical Skill/Physical Effort (Mean)

Technical skill required	4.12	3.06
Physical effort required	3.56	2.93

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.94	2.93
Outcome depends on the skill and judgement of physician	4.18	3.18
Estimated risk of malpractice suit with poor outcome	3.31	3.27

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.25	2.62
Intra-Service intensity/complexity	3.87	3
Post-Service intensity/complexity	3.25	2.56

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The process used consisted of a survey of 16 physicians (panel sample) who typically perform this service. Final recommendations and work values were reviewed by 3 physicians representing the AGA, ACG, ASGE. These physicians reviewed all components of work and practice expense for newly proposed CPT codes as well as the information provided for the reference procedures

FREQUENCY INFORMATION

How was this service previously reported? 43299

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

Specialty_Gastroenterology_____ ___X__Commonly _____Sometimes _____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty _Gastroenterology_____ Frequency : 4000-6000

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty _Gastroenterology_____ Frequency__80%_____

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 45342 Tracking Number: Y6 Global Period: 000 **Recommended RVW: ~~6.20~~ 4.08 (RUC)**

CPT Descriptor: Sigmoidoscopy, flexible; with transendoscopic ultrasound- guided intramural or transmural fine needle aspiration/biopsy(s)

(do not report 76975 in conjunction with 45342)
(for interpretation of specimen, see 88172-88173)

CLINICAL DESCRIPTION OF SERVICE:

Vignette used in survey:

A 59-year-old gentleman with hematochezia is identified to have an adenocarcinoma of the rectum. Rectal ultrasound is requested to assess the depth of tumor invasion and the presence of regional lymph nodes. An abdominal and pelvic CT scan have been preformed and reveal rectal wall thickening and no evidence of metastatic disease.

Description of Pre-service work:
On the day of the procedure you review with the patient his symptoms. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment and cardiopulmonary evaluation is performed. Available laboratory studies which may indicate a risk for bleeding are reviewed. You are provided with the patient's x-rays and have an opportunity to review these imaging studies. The characteristics of the rectal mass are noted. You discuss the risks of the procedure with the patient including bleeding, perforation, infection and cardiopulmonary compromise. You indicate that these risks are higher with an endoscopic ultrasound procedure than standard sigmoidoscopy due to the longer exam duration, the need for sedation, the increased caliber of the instruments as well as the possibility that the lesion may require transmural biopsy. In the latter case, you explain to the patient that when a fine needle aspiration biopsy is performed that intravenous antibiotics will be administered during the exam and oral antibiotics will need to be continued for 48 hours after the exam.

Description of Intra-service work:
Conscious sedation is provided to the patient by you while continuously monitoring pulse oximetry and sequential non-invasive blood pressure measurements. Sedation is needed due to the length of the exam, the need to have the patient in a quite restful state for precise imaging and the discomfort associated with expansion of the rectum and sigmoid colon caused by insufflation of water to allow for acoustic coupling. Digital rectal exam is performed to characterize the location and degree of infiltration of the tumor. A standard flexible sigmoidoscope is advanced into the rectum and then sigmoid colon to allow an endoscopic assessment of the lesion. This is necessary since the oblique forward viewing optics available with the echoendoscopes are not adequate to allow complete circumferential visualization of the rectal lumen. The proximal and distal distance of the rectal mass from the anus is noted. A retroflex view is performed in the rectum to evaluate the relationship of the mass to the anal verge. The instrument is then withdrawn. A dedicated echoendoscope is then prepared with a balloon placed over the transducer housing. Since the dedicated instrument cannot be attached to the endoscope processor until the initial endoscopy is completed, you proceed to purge the air from the balloon chamber by repetitively inflating and deflating the channel. The echoendoscope is then introduced into the anus and advanced into the sigmoid colon under direct endoscopic visualization. The acoustic coupling balloon is inflated with water. Continuous imaging with ultrasound is performed on withdrawal of the echoendoscope. Visualization of the iliac vessels and regional lymphadenopathy is procured. The primary tumor is assessed with an analysis of depth of invasion (mucosa, submucosa, muscularis propria, perirectal space, adjacent organs such as prostate, bladder, vagina) and circumferential extent are made. Involvement of the internal and/or external anal sphincter are searched for. Frequently, imaging will be done at a low and high frequency to allow assessment of near and distant structures. Regional lymph node involvement in the peritumoral and proximal and distal rectal regions are identified. Frequently, you advance the echoendoscope under direct endoscopic visualization to permit reassessment of abnormalities. Documentation of the exam findings including measurements of the lesion(s), labeling of the identified structures and magnified images of the abnormality are obtained and sent to a hard copy device. A determination is made on the risk/benefit of biopsying a regional or distant lymph node. If a lymph node(s) that can be safely biopsied is identified and the biopsy results may impact on the patient's therapy, then the biopsy is undertaken. Intravenous antibiotics are administered to the patient. A linear scanning echoendoscope is prepared for the exam. Since this instrument cannot be attached to the endoscope processor until the radial scanning echoendoscopy is completed, you proceed to purge the air from the balloon chamber by repetitively inflating and deflating

the channel. The level of sedation of the patient is reassessed and additional medication is administered as needed. The echoendoscope is then introduced into the rectum and advanced into the sigmoid colon under direct endoscopic visualization. Sagittal imaging requires spatial reorientation of structures previously examined in a transverse plane. Integrating these imaging aspects, the lymph node(s) is identified. A decision with respect to the most advanced lymph node site is made (e.g. peri-iliac versus perirectal). A needle biopsy catheter device is prepared. The needle biopsy device is advanced through the biopsy channel of the ultrasound endoscope. Doppler imaging is performed to insure that any vascular structures or areas within the lymph node are recognized prior to biopsy. Under direct ultrasound visualization, the needle is advanced through the gastrointestinal wall into the lymph node. The central stylet is removed from the needle by the nurse, negative pressure is applied to the hub of the device and to and fro movements are made with the needle in the lymph node. After 1 - 2 minutes, the needle is removed from the echoendoscope and the material is sprayed onto glass slides for cytologic examination. An attendant cytotechnologist will provide an adequacy assessment on the collected material which requires 15 - 30 minutes. Typically, 5 needle passes will be made for each biopsy site. For each biopsy, the needle and stylet assembly will be rinsed to remove any blood and then reassembled for use. If an adequate specimen is not obtained after five passes, then a new biopsy site will be selected when available. Otherwise the procedure will be terminated. Throughout the biopsy component of the exam, documentation of the exam findings including measurements of the lesion, labeling of the identified structures, recording of the needle position within the lesion and magnified images of the abnormality are obtained and sent to a hard copy device. Doppler findings are annotated with labeling performed by you.

Description of Post -service work:
The radiographs generated during the exam are reviewed and a report is dictated. After the patient has recovered from the procedure and prior to departure, the patient is assessed by you to determine if any complications have occurred including perforation and intra-abdominal hemorrhage. Instructions are reviewed with the patient and family with respect to delayed hemorrhage and infection. The prescribed antibiotic is reviewed with the patient and their family. The findings of the exam are reviewed with the patient and their family.

SURVEY DATA:

Presenter(s): Joel Brill, MD (AGA)

Specialty(s): AGA/ASGE/ACG - Gastroenterology

Sample Size: 16 Response Rate: (%): 30 Median RVW: 6.2

Type of Sample: panel
Explanation of sample size: This service has become performed with increasing frequency over the past 6 years, concomitant with advances in technology. The ASGE surveyed their EUS Committee and received 80% response rate from that group. The AGA and ACG surveyed additional physicians who perform this service on a frequent basis and received about 50% response rate to the survey.

25th Percentile RVW: 5.79 75th Percentile RVW: 9.0 Low: 1.5 High: 13.0

Median Pre-Service Time: 15 Median Intra-Service Time: 50

25th Percentile Intra-Svc Time: 10 75th Percentile Intra-Svc Time: 20 Low: 5 High: 40

Median Post-Service Time: 12.5

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
45383	Colonoscopy, flexible, with ablation of tumors	5.87

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	15	15
Median Intra-Time	50	42.5
Median Immediate Post-service Time	15	12.5
Median of Aggregate Critical Care Times	NA	NA
Median of Aggregate Other Hospital Visit Times	NA	NA
Median Discharge Day Management Time	NA	NA
Median of Aggregate Office Visit Times	NA	NA

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4	3.07
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.18	3.21
Urgency of medical decision making	4.12	3.5

Technical Skill/Physical Effort (Mean)

Technical skill required	4.5	3.35
Physical effort required	4.06	3.35

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.69	3.46
Outcome depends on the skill and judgement of physician	4.37	3.66
Estimated risk of malpractice suit with poor outcome	3.68	3.47

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.43	3.06

Intra-Service intensity/complexity	4.5	3.66
Post-Service intensity/complexity	3.62	3.06

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The process used consisted of a survey of 16 physicians (panel sample) who typically perform this service. Final recommendations and work values were reviewed by 3 physicians representing the AGA, ACG, ASGE. These physicians reviewed all components of work and practice expense for newly proposed CPT codes as well as the information provided for the reference procedures

FREQUENCY INFORMATION

How was this service previously reported? ___43299_____

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

Specialty_Gastroenterology_____ ___X__Commonly _____Sometimes _____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty _Gastroenterology_____ Frequency: 4000-6000

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty _Gastroenterology_____ Frequency__80%_____

Do many physicians perform this service across the United States? Yes, within gastroenterology/GI endoscopy

Practice Expense Inputs for Tabs 29 and 30

Tab 29-30
The following apply to Y1-Y6: Codes 43231, 43232, 43242, 43240, 45341, 45342; KK1-KK4: Codes 44397, 45327, 45345, 45387.
Practice Expense inputs agreed upon at the pre-facilitation meeting were as follows

35 minutes pre-service time RN/MA/LPN
10 minutes coordination of care RN/MA/LPN
10 minutes post-telephone calls RN/MA/LPN

No Medical Supplies

No Equipment

** Since these procedures are only performed in the facility setting, supplies & equipment are not physician costs, however, there are clinical staff activities related to the procedure

AMA SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000
Naso- or Oro-gastric tube placement

Work Relative Value Recommendation
New code 43752 *Naso- or oro-gastric tube placement, necessitating physician skill* was created to describe the instance wherein naso-gastric tube placement required additional skill or involved additional risk in which a physician's skill is required. Generally, these services are performed by non-physician clinical staff; however, if multiple attempts taken by non-physician personnel to place the tube were unsuccessful, this would then require a physician's skill to place the tube in which CPT currently does not contain a code.

The RUC has not developed a specific work relative value recommendation for new CPT code 43752 *Naso- or oro-gastric tube placement, necessitating physician skill* and had requested that the CPT Editorial Panel reconsider the nomenclature for this service. The Editorial Panel did add the note under CPT 44500 *Introduction of long gastrointestinal tube (eg, Miller-Abbott) (separate procedure)* to specify that NG tube placement be reported utilizing the new code 43752; however, the CPT Editorial Panel did not revise the nomenclature for 43752. **The RUC will reconsider this issue at the February 2001 meeting and will forward any recommendations to HCFA at that time.**

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	**Tracking Number**	**CPT Descriptor**	**Global Period**	**Work RVU Recommendation**
●43752	RR1	Naso- or oro-gastric tube placement, necessitating physician's skill (For enteric tube placement, see 44500, 74340) (If imaging guidance is performed, use 76000) (Do not report 43752 in conjunction with critical care codes 99291-99292, or neonatal intensive care codes, 99295-99298)	000	No RUC recommendation at this time
▲44500		**Introduction of long gastrointestinal tube (eg, Miller-Abbott) (separate procedure)** **(For naso- or oro-gastric tube placement, use 43752)**	000	0 49 (No Change)

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Small Bowel Transplantation

The RUC requests that these services be carrier priced for one year to allow the specialty society to present survey data to the RUC in February 2001. The RUC will forward recommended relative values to HCFA for consideration for the 2002 Medicare Physician Payment Schedule.

Code (●New) (▲Revised) (D Deletion) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
●44132	D1	Donor enterectomy, open, with preparation and maintenance of allograft; from cadaver donor	YYY	N/A	Carrier Price
●44133	D2	partial, from living donor	YYY	N/A	Carrier Price
●44135	D3	Intestinal allotransplantation; from cadaver donor	YYY	N/A	Carrier Price
●44136	D4	from living donor	YYY	N/A	Carrier Price

American Society of Transplant Surgeons

March 1, 2000

Dr. James G. Hoehn, MD
Chair, RVS Update Committee
American Medical Association
515 North State Street
Chicago, IL 60610

Dr. Dr Hoenn:

The American Society of Transplant Surgeons would like to suggest deferring RUC review of the recent CPT codes for small bowel transplantation (4413X1, -X2, -X3, and -X4). This field has just begun to develop. The number of surgeons doing these procedures is increasing, but at present the are relatively few centers and surgeons from whom to collect data.

At present the procedure is not reimbursed by HCFA. We anticipate that this valuable new technology will be accepted and reimbursement by HCFA approved soon. In that instance, we ask that carrier pricing be used until RUC assessment of the procedures.

The ASTS proposes to gather data to bring to the RUC for your meeting in either February or April, 2001, with recommendations for appropriate values

We hope this will be acceptable to the Committee.

Sincerely,

Ronald W. Busuttil, MD, PhD
President

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AMA SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Endoscopic Enteral Stenting

Work Relative Value Recommendation

The specialty societies presenting relative value recommendations for Endoscopic Enteral Stenting at the RUC recognized that their survey data was insufficient and requested the RUC to develop interim recommendations for these new CPT codes. This issue will be reviewed again by the specialty societies and any new recommendations will be presented at the February 2001 RUC meeting. The RUC will reconsider this issue and will forward any recommendations to HCFA at that time.

In developing interim RUC recommendations for these codes, the committee established an increment that could be applied to each base code for the "transendoscopic stent placement (includes predilation)" component. The RUC determined this increment by adding a component for placement of stent with a component to represent the work inherent in utilizing a guidewire, as follows:

43219	*Esophagoscopy, rigid or flexible; with insertion of plastic tube or stent*	2.80	
43200	*Esophagoscopy, rigid or flexible; diagnostic, with or without collection* of specimen(s) by brushing or washing (separate procedure)	1.59	
	Increment for Placement of Stent		**1.21**
43226	*Esophagoscopy, rigid or flexible; with insertion of guide wire followed by dilation over guide wire*	2.34	

43200 *Esophagoscopy, rigid or flexible; diagnostic, with or without collection* of specimen(s) by brushing or washing (separate procedure)	1.59	
Increment for Guidewire		**0.75**
Increment for "transendoscopic stent placement (includes predilation)"		**1.96**

Based on this increment, the RUC recommends the following interim work relative value recommendations:

44397

New code 44397 *Colonoscopy through stoma; with transendoscopic stent placement (includes predilation)* was created to describe stent placement via colonoscopy through a stoma, for duodenal and colonic obstructions or with gastric outlet strictures caused by malignant neoplasms. Stent placement also provides a solution for relieving large bowel obstruction prior to colectomy. Currently, CPT does not contain an existing CPT code that accurately describes placement of an enteral stent; therefore, the unlisted code 45999 *Unlisted procedure, rectum* was reported.

Colonoscopy through stoma; with transendoscopic stent placement (includes predilation) = 44388 *Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* 2.82 + 1.96 = **4.78**.

45327

New code 45327 *Proctosigmoidoscopy, rigid; with transendoscopic stent placement (includes predilation)* was created to describe stent placement during a rigid proctosigmoidoscopy. Currently, CPT does not contain an existing CPT code that accurately describes placement of an enteral stent; therefore, the unlisted code 45999 *Unlisted procedure, rectum* was reported.

Proctosigmoidoscopy, rigid; with transendoscopic stent placement (includes predilation) = 45300 *Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* 0.70 + 1.96 = **2.66**.

45345
New code 45345 *Sigmoidoscopy, flexible; with transendoscopic stent placement (includes predilation)* was created to describe stent placement during a flexible sigmoidoscopy. Currently, CPT does not contain an existing CPT code that accurately describes placement of an enteral stent; therefore, the unlisted code 45999 *Unlisted procedure, rectum* was reported.

Sigmoidoscopy, flexible; with transendoscopic stent placement (includes predilation) = 45330 *Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* 0.96 + 1.96 = **2.92**.

45387
New code 45387 *Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement (includes predilation)* was created stent placement during a flexible colonoscopy. Currently, CPT does not contain an existing CPT code that accurately describes placement of an enteral stent; therefore, the unlisted code 45999 *Unlisted procedure, rectum* was reported.

Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement (includes predilation) = 45378 *Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon depression (separate procedure)* 3.70 +1.96 = **5.66**.

Other New Codes:
The CPT Editorial Panel approved new codes (43256, 44370, 44379 and 44383) at the May 2000 meeting. The RUC; therefore, did not have the opportunity to review these services. The RUC will forward recommendations after February 2001.

Practice Expense Recommendation
The following applies to codes 44397, 45327, 45345, and 45387.
Practice Expense inputs agreed upon at the pre-facilitation meeting were as follows:

35 minutes pre-service time RN/MA/LPN
10 minutes coordination of care RN/MA/LPN
10 minutes post-telephone calls RN/MA/LPN
No Medical Supplies
No Equipment
These services are performed in the facility setting.

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
43235		*Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*	000	2.39 (No Change)
●43256		with transendoscopic stent placement (includes predilation)	000	No RUC recommendation at this time
44360		*Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ilium; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*	000	2.92 (No Change)
●44370		with transendoscopic stent placement (includes predilation)	000	No RUC recommendation at this time
44376		*Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ilium; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*	000	5.69 (No Change)
●44379		with transendoscopic stent placement (includes predilation)	000	No RUC recommendation at this time

44380		*Ileoscopy, through stoma, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)t*	000	1.51 (No Change)
●44383		with transendoscopic stent placement (includes predilation)	000	No RUC recommendation at this time
44388		*Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*	000	2.82 (no change)
●44397	KK1	with transendoscopic stent placement (includes predilation)	000	4.78 (Interim)
45300		*Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*	000	0.70 (no change)
●45327	KK2	with transendoscopic stent placement (includes predilation)	000	2.66 (Interim)
45330		*Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*	000	0.96 (no change)
●45345	KK3	with transendoscopic stent placement (includes predilation)	000	2.92 (Interim)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 44397 Tracking Number: KK1 Global Period: 000 **Recommended RVW: ~~7.53~~ 4.78 (RUC)**

CPT Descriptor: Colonoscopy through stoma; with transendoscopic stent placement (includes predialation)

CLINICAL DESCRIPTION OF SERVICE:

Vignette used in survey:

A 70-year-old man underwent diverting colostomy for an obstructing sigmoid carcinoma. At the time of initial presentation the patient was extremely ill with complete colonic obstruction. The primary tumor was found to be a colorectal neoplasm with extensive nodal metastases. The colostomy was never taken down and the patient now presents with CT findings of a progressive mass in the mid-transverse colon. There is some suggestion by the CT scan that there is near-complete obstruction of the lumen to the mid-transverse colon. The patient now has malignant ascites and is considered a non-resectable candidate. Endoscopy is now done to palliate his impending colonic obstruction.

Descripton of Pre-Service Work
None

Description of Intra-Service Work
The patient is sedated with intravenous Demerol, versed, or Valium. An adult colonoscope introduced through the patient's colostomy site and passed to the mid-transverse colon where there is an obstructing neoplasm. The endoscope can not be advanced through the lesion. The procedure is performed using fluoroscopic guidance. Using a standard 5 Fr biliary catheter and a 0.035" guidewire, the catheter is advanced beyond the stricture. The guidewire is removed and water soluble contrast is injected through the catheter to the delineate the length of the stricture. The guidewire is reinserted and the catheter is withdrawn. Over the guidewire and through the endoscope, a 20 mm internal diameter by 90 mm long expandable metal stent is deployed across the stricture using both endoscopic and fluoroscopic guidance. The endoscope is then withdrawn. With sedation and manipulation, the treatment session takes approximately 40 minutes.

Description of Post Service Work
The patient is re-examined 2-3 days after the procedure. The patient is counseled to remain on a low-residue diet to prevent obstruction of the stent. Dictate and check procedure report.

SURVEY DATA:

Presenter(s): Joel Brill, MD (AGA)

Specialty(s): AGA/ASGE/ACG - Gastroenterology

Sample Size: 22 Response Rate: (%): 29 Median RVW: 7.53

Type of Sample: panel
Explanation of sample size: This procedure is being performed with increasing frequency, concomitant with advances in technology. AGA, ASGE, ACG and ASCRS surveyed physicians who perform this service and received approximately a 26% response rate.

25th Percentile RVW: 6.025 75th Percentile RVW: 8.6 Low:3.0 High: 12.12

Median Pre-Service Time:30 Median Intra-Service Time: 42.5

25th Percentile Intra-Svc Time:40 75th Percentile Intra-Svc Time: 50 Low: 30 High: 120

Median Post-Service Time: 25

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
45383	Colonoscopy, flexible, with ablation of tumors	5.87

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	30	17.5
Median Intra-Time	42.5	45
Median Immediate Post-service Time	25	17.5
Median of Aggregate Critical Care Times	NA	NA
Median of Aggregate Other Hospital Visit Times	NA	NA
Median Discharge Day Management Time	NA	NA
Median of Aggregate Office Visit Times	NA	NA

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.75	3.4
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.2	3.35
Urgency of medical decision making	4.3	3.35

Technical Skill/Physical Effort (Mean)

Technical skill required	4.7	3.8
Physical effort required	4.3	3.35

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.55	3.55
Outcome depends on the skill and judgement of physician	4.6	3.7

Estimated risk of malpractice suit with poor outcome	3.75	3.6

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.2	3.25
Intra-Service intensity/complexity	4.76	3.65
Post-Service intensity/complexity	4.0	2.95

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The process used consisted of a survey of 22 physicians (panel sample) who typically perform this service. Final recommendations and work values were reviewed by 62 physicians representing the AGA, ACG, ASGE. These physicians reviewed all components of work and practice expense for newly proposed CPT codes as well as the information provided for the reference procedures

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FREQUENCY INFORMATION

How was this service previously reported? ___44799_____

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

Specialty_Gastroenterology_____ ___X__Commonly _____Sometimes _____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty _Gastroenterology_____ Frequency____5,000_____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty _Gastroenterology_____ Frequency__80%_____

Do many physicians perform this service across the United States? Yes, within gastroenterology/GI endoscopy

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 45327 Tracking Number: KK2 Global Period: 000 **Recommended RVW: ~~7.2~~ 2.66 (RUC)**

CPT Descriptor: Proctosigmoidoscopy, rigid; with transendoscopic stent placement (includes predialation)

CLINICAL DESCRIPTION OF SERVICE:

Vignette used in survey:

A 70-year-old man with a history of extensive gastric carcinoma underwent palliative subtotal gastrectomy. Six months later the patient develops obstipation. A CT scan of the abdomen reveals extensive metastasis into the pelvis with encasement of the rectum. A barium enema revealed near-complete obstruction at the level of the mid-rectum from an extrinsic mass. The patient undergoes proctosigmoidoscopy with stent placement to palliate obstruction

Description of Pre-Service Work
None

Intra-Service Work
The patient is sedated with intravenous Demerol, versed, or Valium. A rigid proctosigmoidoscope is advanced into the rectum to the level of the extrinsically compressing lesion. Through the proctosigmoidoscope, a guidewire can be advanced across the lesion without the need for fluoroscopy. Through the proctosigmoidoscope an 18 mm internal diameter by 10 cm long expandable metal stent is advanced over the guidewire across the stricture. The stent is deployed under endoscopic vision. The proctosigmoidoscope is then removed. With sedation the treatment session takes 30 minutes.

Post Service Work
The patient is re-examined 2-3 days after the procedure The patient is counseled to maintain a low-residue diet and daily laxatives to prevent compaction within the stent. Dictate and check procedure report.

SURVEY DATA:

Presenter(s): Joel Brill, MD (AGA)

Specialty(s): AGA/ASGE/ACG - Gastroenterology

Sample Size: 19 Response Rate: (%): 25 Median RVW: 7.2

Type of Sample: panel.
Explanation of sample size: This procedure is being performed with increasing frequency, concomitant with advances in technology. AGA, ASGE, ACG and ASCRS surveyed physicians who perform this service and received approximately a 26% response rate.

25th Percentile RVW: 5.95 75th Percentile RVW: 8.40 Low: 2.0 High: 9.0

Median Pre-Service Time: 30 Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 30 75th Percentile Intra-Svc Time: 45 Low: 20 High: 100

Median Post-Service Time: 30

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
45383	Colonoscopy, flexible, with ablation of tumors	5.87

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	31.05	16.27
Median Intra-Time	40.52	36.94
Median Immediate Post-service Time	32.63	23.22
Median of Aggregate Critical Care Times	NA	NA
Median of Aggregate Other Hospital Visit Times	NA	NA
Median Discharge Day Management Time	NA	NA
Median of Aggregate Office Visit Times	NA	NA

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.84	3.16
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.05	2.88
Urgency of medical decision making	3.94	2.66

Technical Skill/Physical Effort (Mean)

Technical skill required	4.31	3.22
Physical effort required	3.94	2.94

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.21	3.16
Outcome depends on the skill and judgement of physician	4.31	3.38
Estimated risk of malpractice suit with poor outcome	3.42	3.33

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.72	2.72
Intra-Service intensity/complexity	4.31	3.33
Post-Service intensity/complexity	3.73	2.77

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The process used consisted of a survey of 19 physicians (panel sample) who typically perform this service. Final recommendations and work values were reviewed by 3 physicians representing the AGA, ACG, ASGE. These physicians reviewed all components of work and practice expense for newly proposed CPT codes as well as the information provided for the reference procedures

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FREQUENCY INFORMATION

How was this service previously reported? 44799

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

Specialty Gastroenterology ___X__Commonly _____Sometimes _____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology Frequency 20,000

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Gastroenterology Frequency 80%

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 45345 Tracking Number: KK3 Global Period: 000 **Recommended RVW: ~~6.65~~ 2.92 (RUC)**

CPT Descriptor: Sigmoidoscopy, flexible; with transendoscopic stent placement (includes predialation)

CLINICAL DESCRIPTION OF SERVICE:

Vignette used in survey:
A 65-year-old woman with a history of endometrial carcinoma presents for evaluation of recurrent sigmoid obstruction. The patient had previously undergone total hysterectomy and received radiation therapy. Five months prior she developed complete sigmoid obstruction. Biopsies of an obstructing mass confirmed uterine carcinoma. At that time a stent was placed at the sigmoid with relief of obstruction. She returns for follow-up complaining of some rectal bleeding and intermittent constipation. A limited barium enema of the left colon reveals tumor ingrowth with significant reduction in the luminal diameter of the previously placed stents The patient is to undergo recurrent stent placement.

Description of Pre-Service Work
None

Description of Intra-service work
The patient is sedated with intravenous Demerol, versed, or Valium An adult flexible sigmoidoscope is passed to the sigmoid where the previous stent is encountered. The scope can be passed completely through the stent with some resistance. A savory guidewire is passed endoscopically to the point of the splenic flexure The endoscopic is removed leaving the guidewire in place. The endoscope is reinserted along side the guidewire to the distal portion of the previously placed stent. A new 18 mm internal diameter by 10 mm long covered esophageal stent is back-loaded over the guidewire and advanced through the previous stent under endoscopic visualization. The stent is then deployed under endoscopic visualization without the use of fluoroscopy at any time during the procedure. The guidewire is then removed. With sedation and pauses to deploy the stent, the treatment session takes approximately 30 minutes.

Description of Post Service Work
The patient is re-examined 2 to 3 days following the procedure. The patient is counseled to remain on a low-residue diet, and to take a mild laxative daily to prevent stool impaction within the stent. Dictate and check procedure report.

SURVEY DATA:

Presenter(s): Joel Brill, MD (AGA)

Specialty(s): AGA/ASGE/ACG - Gastroenterology

Sample Size: 20 Response Rate: (%): 26 Median RVW: 6.65

Type of Sample: panel.
Explanation of sample size: This procedure is being performed with increasing frequency, concomitant with advances in technology. AGA, ASGE, ACG and ASCRS surveyed physicians who perform this service and received approximately a 26% response rate.

25th Percentile RVW: 5.125 75th Percentile RVW: 8.0 Low:2.25 High: 10.98

Median Pre-Service Time: 30 Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 30 75th Percentile Intra-Svc Time: 42.5 Low: 15 High: 60

Median Post-Service Time: 30

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	30	

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
45383	Colonoscopy, flexible, with ablation of tumors	5.87

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	30	15
Median Intra-Time	30	40
Median Immediate Post-service Time	30	17.5
Median of Aggregate Critical Care Times	NA	NA
Median of Aggregate Other Hospital Visit Times	NA	NA
Median Discharge Day Management Time	NA	NA
Median of Aggregate Office Visit Times	NA	NA

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.78	3.05
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.10	2.89
Urgency of medical decision making	4.16	2.94

Technical Skill/Physical Effort (Mean)

Technical skill required	4.53	3.5
Physical effort required	4.05	3.11

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.32	3.80

Outcome depends on the skill and judgement of physician	4.37	3.50
Estimated risk of malpractice suit with poor outcome	3.79	3.50

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.79	3.0
Intra-Service intensity/complexity	4.37	3.33
Post-Service intensity/complexity	3.68	2.61

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The process used consisted of a survey of 20 physicians (panel sample) who typically perform this service. Final recommendations and work values were reviewed by 3 physicians representing the AGA, ACG, ASGE. These physicians reviewed all components of work and practice expense for newly proposed CPT codes as well as the information provided for the reference procedures

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FREQUENCY INFORMATION

How was this service previously reported? 44799

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

Specialty Gastroenterology ___X__Commonly _____Sometimes _____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology Frequency 35,000

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Gastroenterology Frequency 80%

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 45387 Tracking Number: KK4 Global Period: 000 **Recommended RVW: ~~8.05~~ 8.05 (RUC)**

CPT Descriptor: Colonoscopy, flexible proximal to splenic flexure; with transendoscopic stent placement (includes predialation)

CLINICAL DESCRIPTION OF SERVICE:

Vignette used in survey:

An 82-year-old man presents with a history of right upper quadrant abdominal pain and progressive weight loss with hem-positive stool. A CT scan of the abdomen reveals extensive liver metastasis and an enlarged mass originating from the hepatic flexure consistent with primary colorectal carcinoma There is extensive invasion of the mesentry. A water soluble enema x-ray examination reveals near complete obstruction of the hepatic flexure. Palliative therapy using stent placement has been purposed.

Description of Pre-Service Work
None

Description of Intra-Service Work
The patient is sedated with intravenous Demerol, versed, or Valium. A standard adult colonoscope is passed to the hepatic flexure and the tumor is localized. A 5 Fr biliary catheter preloaded with a 0.035" angled hydrophilic guidewire is used to traverse the malignant stricture. The guidewire is removed and contrast is injected to confirm the length of the stricture. A stiffer 0.035" guidewire is advanced across the stricture through the previous catheter. The catheter is removed Over the guidewire and through the endoscope a 22 mm diameter by 60 mm long expandable metal stent is deployed under endoscopic and fluoroscopic guidance. With the sedation and pauses during the procedure, the session takes approximately 30 to 45 minutes.

Description of Post service work
The patient is re-examined later that afternoon and daily. The patient is counseled to eat a low-residue diet to prevent stent obstruction. Dictate and check procedure report.

SURVEY DATA:

Presenter(s): Joel Brill, MD (AGA)

Specialty(s): AGA/ASGE/ACG - Gastroenterology

Sample Size: 20 Response Rate: (%): 26 Median RVW: 8.05

Type of Sample: panel
Explanation of sample size: This procedure is being performed with increasing frequency, concomitant with advances in technology. AGA, ASGE, ACG and ASCRS surveyed physicians who perform this service and received approximately a 26% response rate.

25th Percentile RVW: 6.9 75th Percentile RVW: 8.65 Low: 5.8 High: 12.12

Median Pre-Service Time: 30 Median Intra-Service Time: 45

25th Percentile Intra-Svc Time: 20 75th Percentile Intra-Svc Time: 45 Low: 10 High: 120

Median Post-Service Time: 30

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
43268	ERCP with retrograde insertion of tube/stent into bile/pancreatic duct	7.39

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	30	15
Median Intra-Time	45	45
Median Immediate Post-service Time	30	20
Median of Aggregate Critical Care Times	NA	NA
Median of Aggregate Other Hospital Visit Times	NA	NA
Median Discharge Day Management Time	NA	NA
Median of Aggregate Office Visit Times	NA	NA

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.66
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.21	3.44
Urgency of medical decision making	4.36	3.53

Technical Skill/Physical Effort (Mean)

Technical skill required	4.84	4.11
Physical effort required	4.74	3.77

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.63	3.83
Outcome depends on the skill and judgement of physician	4.73	4.11
Estimated risk of malpractice suit with poor outcome	4.00	3.94

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4	3.5
Intra-Service intensity/complexity	5	4
Post-Service intensity/complexity	4	3

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The process used consisted of a survey of 20 physicians (panel sample) who typically perform this service. Final recommendations and work values were reviewed by 3 physicians representing the AGA, ACG, ASGE. These physicians reviewed all components of work and practice expense for newly proposed CPT codes as well as the information provided for the reference procedures

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FREQUENCY INFORMATION

How was this service previously reported? ___47999_____

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

Specialty_Gastroenterology_____ ___X__Commonly _____Sometimes _____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty _Gastroenterology_____ Frequency__40,000_____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty _Gastroenterology_____ Frequency__80%_____

Do many physicians perform this service across the United States? Yes, within gastroenterology/GI endoscopy

Practice Expense Inputs for Tabs 29 and 30

Tab 29-30
The following apply to Y1-Y6: Codes 43231, 43232, 43242, 43240, 45341, 45342; KK1-KK4: Codes 44397, 45327, 45345, 45387.
Practice Expense inputs agreed upon at the pre-facilitation meeting were as follows

35 minutes pre-service time RN/MA/LPN
10 minutes coordination of care RN/MA/LPN
10 minutes post-telephone calls RN/MA/LPN

No Medical Supplies

No Equipment

** Since these procedures are only performed in the facility setting, supplies & equipment are not physician costs, however, there are clinical staff activities related to the procedure

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
February 2000

Laparoscopic Radical Nephrectomy

Work Relative Value Recommendations

A new code 50545 *Laparoscopy, surgical; radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy)* was added to describe a laparoscopic radical nephrectomy. Currently, there is not an existing CPT code that accurately describes this service and is therefore reported using the unlisted code *53899 Unlisted procedure, urinary system*. There are CPT codes that describe open radical nephrectomies; however, the laparoscopic procedure requires different instrumentation and procedural steps to safely remove the kidney.

The RUC considered the results from the work survey, which provided a median work relative value of 24.00. When evaluating the physician work, RUC members agreed that the physician work is similar to code *50547 Laparoscopy, surgical; donor nephrectomy from living donor (excluding preparation and maintenance of allograft)* (work RVU = 25.50). The time and intensity of these services are comparable. It was the consensus of the RUC that this is an appropriate value. **Therefore, the RUC recommends a work relative value unit of 24.00 for CPT code 50545.**

CPT codes 50546 and 50548 were revised; however, the RUC does not recommend a change in the work relative value recommendation, as the RUC views these changes as editorial.

Practice Expense Recommendations

The direct practice expense inputs for code 50545 were crosswalked from existing inputs for code *50546 Laparoscopy, surgical; nephrectomy*. The RUC recommendations are attached and reflect the clinical staff pre-time and two post operative office visits. This service is always performed in a facility.

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

CPT Code (●New) (▲Revised) (D Deleted)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommen-dation
● 50545	P1	Laparoscopy, surgical; radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy) (For open procedure, use 50230)	090	24.00
▲50546	P2	nephrectomy, including partial ureterectomy ~~(includes removal of kidney and portion of ureter only)~~	090	20.48 (No Change)
▲50548	P3	~~Laparoscopically assisted~~ nephr~~oureter~~ectomy with total ureterectomy (For open procedure, see 50234, 50236)	090	24.40 (No Change)

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 50545 Tracking Number P1 Global Period: 090 **Recommended RVW: 24.00**

CPT Descriptor: Laparoscopy surgical; radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 32-year old woman is found to have a 3 cm renal cell carcinoma in the lower pole of the left kidney discovered on CT scan for suspected gallbladder disease. The gallbladder was found to be normal. The patient wishes if at all possible to avoid a large scar and elects a laparoscopic radical nephrectomy.

Description of Pre-Service Work:

Appropriate preoperative studies are obtained and reviewed. The patient is seen by the operating surgeon before being given an anesthetic. Procedure specific equipment is checked. The patient is taken to the operating room and given either general or spinal anesthesia, appropriately positioned for the procedure, prepped and draped.

Description of Intra-Service Work:

Either an intra or extra peritoneal approach is used. The abdomen is insufflated with CO2, four operating ports are placed. The left colon is taken down at the white line and reflected medially, the kidney is mobilized without opening Gerota's fascia (leaving a layer of fat over the kidney). The ureter and renal vessels are identified and ligated. Lymph node bearing tissue along the aorta may be removed as a separate specimen. The upper pole of the kidney is carefully dissected off of the spleen and the Kidney is now entirely free within the abdomen. Two of the laparoscopic ports are connected by a 5 cm incision and the kidney is removed. The wound is closed, the laparoscopic incisions are closed.

Description of Post-Service Work:

The surgeon waits in the operating room and assists the anesthesiologist in transferring the patient to a recovery room stretcher. The patient is transferred to the recovery room. Post-operative orders are written. A detailed operative report is dictated. The surgeon talks with the patient's family about the procedure, diagnosis, and postoperative care. The patient is admitted to the hospital from the recovery room. Post operative care for the global period is included.

Hospital by-laws require that a detailed discharge summary must be dictated.

SURVEY DATA:

Presenter(s) Thomas P. Cooper, M.D.

Specialty(s): Urology

Sample Size: 50 Response Rate: (%): 39/50 (78%) Median RVW: 24.00

Type of Sample: panel plus mail survey

25th Percentile RVW: 23.00 75th Percentile RVW: 26.00 Low: 17.15 High: 30.65

Median Pre-Service Time: 60 min Median Intra-Service Time: 240 min

25th Percentile Intra-Svc Time: 210 min 75th Percentile Intra-Svc Time: 300 min Low: 60 min High: 500 min

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	30	
Critical Care:	0	0
Other Hospital Visits:	57	3 - 99231
Discharge Day Mgmt.:	36	1 - 99238
Office Visits:	61	1 – 99213 & 1 - 99214

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
50547	Laparoscopy, surgical; donor nephrectomy from living donor (excluding preparation and maintenance of allograft)	25.50

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

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

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	60	60
Median Intra-Time	240	220
Median Immediate Post-service Time	30	30
Median of Aggregate Critical Care Times	0	0
Median of Aggregate Other Hospital Visit Times	50	45
Median Discharge Day Management Time	25	25
Median of Aggregate Office Visit Times	40	30

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.4	4.1
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4 4	4.2
Urgency of medical decision making	4.2	4 1

Technical Skill/Physical Effort (Mean)

Technical skill required	4.9	4.6
Physical effort required	4.7	4 5

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.7	4.5
Outcome depends on the skill and judgement of physician	4.7	4.4
Estimated risk of malpractice suit with poor outcome	4 3	4.1

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4 1	3 9
Intra-Service intensity/complexity	4.8	4 4
Post-Service intensity/complexity	3 9	3 8

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The AUA panel that reviewed this issue consisted of 39 urologists (both men and women) from solo, single specialty, multi-specialty and academic practices. These physicians represent 17 states across the United States and all of the subspecialites of urology. Additionally, 11urologists were queried by mail survey.

FREQUENCY INFORMATION

How was this service previously reported? Either 53899, Unlisted procedure, urinary system or 50230, Nephrectomy, including partial ureterectomy, any approach including rib section; radical, with regional lymphadenectomy and/or vena caval thrombectomy.

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

Specialty Urology ____Commonly X Sometimes ____Rarely

Specialty ____Commonly ____Sometimes ____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Urology Frequency 2000

Specialty ____ Frequency ____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Urology Frequency 1500

Specialty ____ Frequency ____

Do many physicians perform this service across the United States? ____Yes X No

AMA/Specialty Society Update Process
Summary of Recommendation
010 or 090 Day Global Periods
Out-Of-Office Direct Inputs

Sample Size:_____ Response Rate: (%):_____ Global Period: 090

Tracking Number: P1 Reference Code 1 50546* Reference Code 2_____

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

***The inputs for 50545 were crosswalked from existing inputs for CPT code 50546 (Laparoscopy, surgical; nephrectomy), with additions shown in bold.**

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
Complete pre-service diagnostic & referral forms

ordinate pre-surgery services

Schedule space and equipment in facility

Office visit before surgery/procedure

Review test and exam results

Provide pre-service education/obtain consent

Intra-Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: RN time for two office visits

Clinical Labor	Pre-Service Time Prior to Admission	Service Period (Admission to Discharge)	Coordianation of Care*	Post-Service Time After Discharge **	Number of Office Visits	Total Time of Office Visits
RN	60				2	45

staff in the physician's office during the service period.
Excluding Time of Office Visits

Medical Supplies	Quantity of Supplies	Units Used for Purchase
pillow case, disposable	2	item
hydrogen peroxide	20	ml
Betadine	10	ml
suture removal kit	1	item
tape	6	inch
steri-strips	6	strip
Gauze,Sterile 4 x 4	1	item
cotton tipped applicators	8	item
swab, alcohol	4	item
gloves, sterile	1	pair
gloves, non-sterile	4	pair
exam table paper	14	foot
patient gown, disposable	2	item
thermometer probe cover, disposable	2	item
patient education booklet	**1**	**item**

Procedure Specific Medical Equipment	**No. of units in practice**	**Minutes of use per procedure**	**Hours per week in use for all services**	**Equipment Cost**
A				

Overhead Medical Equipment	**No. of units in practice**	**Equipment Cost**
exam table		**1360**
exam lamp		1850
crash cart, no defibrilator		**1135.81**

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
February 2000

Laparoscopic Ureterneocystostomy

Work Relative Value Recommendation

CPT Code 50947

CPT Code *50947 Laparoscopy, surgical; ureteroneocystostomy with cystoscopy and ureteral stent placements* was created to describe ureteroneocystostomy with cystoscopy and ureteral stent placements performed laparoscopically. Currently, there is not an existing CPT code that describes a laparoscopic technique for ureteroneocystostomy with cystoscopy and ureteral stent placements and the unlisted code *53899 Unlisted procedure, urinary system* is reported. With the advent of better laparoscopic techniques, ureteroneocystostomy can be performed in a less invasive manner with equally satisfying results. This procedure is performed generally in children and the procedure is more difficult than when performed through an open approach.

When evaluating the physician work, RUC members agreed the physician work is similar to code *50547 Laparoscopy, surgical; donor nephrectomy from living donor (excluding preparation and maintenance of allograft)* (work RVU = 25.50) and used this as a reference service. The median intra-service time for new code 50947 is higher than the comparison code (50547). Additionally, the intensity and complexity measures are higher for new code 50947 than the comparison code. **Therefore, the RUC recommends the survey median work RVU of 24.50 for code 50947.**

CPT Code 50948

CPT code *50948 Laparoscopy, surgical; ureteroneocystostomy without cystoscopy and ureteral stent placement* was created to describe ureteroneocystostomy performed laparoscopically without cystoscopy and ureteral stent placement. Currently, there is not an existing CPT code that describes a laparoscopic technique for ureteroneocystostomy performed without cystoscopy and ureteral stent placements. Therefore, the unlisted code *53899 Unlisted procedure, urinary system* is reported.

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When evaluating the physician work, RUC members agreed the physician work is similar to code *50547 Laparoscopy, surgical; donor nephrectomy from living donor (excluding preparation and maintenance of allograft)* (work RVU = 25.50) and used this as a reference service. The median intra-service time is higher for new code 50948 than the comparison code (50547). The intensity and complexity factors for the new code are higher than the comparison code 50574. **Therefore, the RUC recommends the survey median work RVU of 22.50 for code 50948.**

The RUC agreed that an increment of 2.00 for the cystoscopy was appropriate and compares to code *52000 Cystourethroscopy (separate procedure).*

Practice Expense Recommendations

The direct expense inputs were crosswalked from existing inputs for *50546 Laparoscopy, surgical; nephrectomy* with the addition of one additional office visit. The RUC recommendations are attached and reflect the clinical staff pre-time and three post operative office visits for code 50947. These services are always performed in a facility.

CPT Code (●New) (▲Revised) (D Deleted)	**Track-ing Num-ber**	**CPT Descriptor**	**Global Period**	**Work RVU Recommendation**
●50947	Q1	Laparoscopy, surgical; ureteroneocystostomy with cystoscopy and ureteral stent placement	090	24.50
●50948	Q2	ureteroneocystostomy without cystoscopy and ureteral stent placement (For open ureteroneocystostomy, see 50780-50785)	090	22.50
●50949		Unlisted laparoscopy procedure, ureter	YYY	N/A

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

SUMMARY OF RECOMMENDATION

CPT Code: 50947 Tracking Number: Q1 Global Period: 090 **Recommended RVW: 24.50**

CPT Descriptor: Laparoscopy, surgical; ureteroneocystostomy with cystoscopy and ureteral stent placements

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A ten-year-old girl with recurrent UTIs is found to have grade III left sided vesicoureteral reflux. Because of breakthrough UTIs and recurrent left pyelonephritis, ureteral implant is recommended. The parents have elected for a laparoscopic left ureteral reimplant rather than an open procedure.

Description of Pre-Service Work:

Appropriate preoperative studies are obtained and reviewed. The patient is seen by the operating surgeon before being given an anesthetic. Procedure specific equipment is checked. The patient is taken to the operating room and given general anesthesia, appropriately positioned for the procedure, prepped and draped.

Description of Intra-Service Work:

A periumbilical incision is made in a circumferential direction inferior to the umbilicus. Dissection is carried down just inferior to the umbilicus to enter the peritoneal cavity. A disposable trocar and laparoscope are introduced and the abdomen insufflated. Next, three 5 mm instrument ports are introduced. Once these ports are placed, dissection is carried out to mobilize the ureter just proximal to the broad ligament and down to the ureterovesicle junction. A detrusor incision is made along the left lateral aspect of the bladder in a direction such that the ureter could lie in a nonkinking position into the trough. Toward the latter part of the dissection, a small opening is made into the bladder mucosa. The ureter is laid in the detrusor trough. At the most distal port of the dissection, the ureter is anastomosed to the detrusor edges. Once this is done, the detrusor trough is sequentially closed from distal to proximal until the hiatus is closed.

A cystoscope is inserted into the bladder and a 4 French ureteral stent is advanced up the left ureter to the kidney. Under laparascopic vision, the stent is seen to slide up the ureter with ease. A urethral catheter is placed and all scopes are removed. All abdominal wounds are closed and the patient is taken to the recovery room.

Description of Post-Service Work:

The surgeon waits in the operating room and assists the anesthesiologist in transferring the patient to a recovery room stretcher. The patient is transferred to the recovery room. Post-operative orders are written. A detailed operative report is dictated. The surgeon talks with the patient's family about the procedure, diagnosis, and postoperative care. The patient is admitted to the hospital from the recovery room. Post operative care for the global period is included. Hospital by-laws require that a detailed discharge summary must be dictated.

SURVEY DATA:

Presenter(s) Thomas P. Cooper, M.D.

Specialty(s): Urology

Sample Size: 50 Response Rate: (%): 40/50 (80%) Median RVW: 24.50

Type of Sample: panel plus mail survey

25th Percentile RVW: 20.08 75th Percentile RVW: 28.00 Low: 16.00 High: 33.50

Median Pre-Service Time: 60 min Median Intra-Service Time: 255 min

25th Percentile Intra-Svc Time: 180 min 75th Percentile Intra-Svc Time: 300 min Low: 90 min High: 360 min

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	30	
Critical Care:	0	0
Other Hospital Visits:	57	3 - 99231
Discharge Day Mgmt.:	36	1 - 99238
Office Visits:	69	3 - 99213

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
50547	Laparoscopy, surgical; donor nephrectomy from living donor (excluding preparation and maintenance of allograft)	25.50

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	60	60
Median Intra-Time	255	180
Median Immediate Post-service Time	30	30
Median of Aggregate Critical Care Times	0	0
Median of Aggregate Other Hospital Visit Times	45	45
Median Discharge Day Management Time	22 5	20
Median of Aggregate Office Visit Times	45	30

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4 1	3 9
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.1	4 0
Urgency of medical decision making	3.6	3.5

Technical Skill/Physical Effort (Mean)

Technical skill required	4 8	4 4
Physical effort required	4.5	4.3

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4 4	4.3
Outcome depends on the skill and judgement of physician	4.8	4 6
Estimated risk of malpractice suit with poor outcome	4.4	4.2

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.0	3 9
Intra-Service intensity/complexity	4.6	4 3
Post-Service intensity/complexity	3 8	3 7

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The AUA panel that reviewed this issue consisted of 39 urologists (both men and women) from solo, single specialty, multi-specialty and academic practices. These physicians represent 17 states across the United States and all of the subspecialites of urology. Additionally, 11 urologists were queried by mail survey.

FREQUENCY INFORMATION

How was this service previously reported? 53899, Unlisted procedure, urinary system

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

Specialty Urology _____ Commonly _____ Sometimes X Rarely

Specialty _____ Commonly _____ Sometimes _____ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Urology _____ Frequency 500

Specialty _____ Frequency _____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Urology _____ Frequency 0

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? _____ Yes X No

SUMMARY OF RECOMMENDATION

CPT Code: 50948 Tracking Number: Q2 Global Period: 090 **Recommended RVW: 22.50**

CPT Descriptor: Laparoscopy, surgical; ureteroneocystostomy without cystoscopy and ureteral stent placements

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A ten-year-old girl with recurrent UTIs is found to have grade III left sided vesicoureteral reflux. Because of breakthrough UTIs and recurrent left pyelonephritis, ureteral reimplant is recommended. The parents have elected for a laparoscopic rather than an open procedure.

Description of Pre-Service Work:

Appropriate preoperative studies are obtained and reviewed. The patient is seen by the operating surgeon before being given an anesthetic. Procedure specific equipment is checked. The patient is taken to the operating room and given general anesthesia, appropriately positioned for the procedure, prepped and draped.

Description of Intra-Service Work:

A periumbilical incision is made in a circumferential direction inferior to the umbilicus. Dissection is carried down just inferior to the umbilicus to enter the peritoneal cavity. A disposable trocar and laparoscope are introduced and the abdomen insufflated. Next, three 5 mm instrument ports are introduced. Once these ports are placed, dissection is carried out to mobilize the ureter just proximal to the broad ligament and down to the ureterovesicle junction. A detrusor incision is made along the left lateral aspect of the bladder in a direction such that the ureter could lie in a nonkinking position into the trough. Toward the latter part of the dissection, a small opening is made into the bladder mucosa. The ureter is laid in the detrusor trough. At the most distal port of the dissection, the ureter is anastomosed to the detrusor edges. Once this is done, the detrusor trough is sequentially closed from distal to proximal until the hiatus is closed.

Description of Post-Service Work:

The surgeon waits in the operating room and assists the anesthesiologist in transferring the patient to a recovery room stretcher. The patient is transferred to the recovery room. Post-operative orders are written. A detailed operative report is dictated. The surgeon talks with the patient's family about the procedure, diagnosis, and postoperative care. The patient is admitted to the hospital from the recovery room. Post operative care for the global period is included. Hospital by-laws require that a detailed discharge summary must be dictated.

SURVEY DATA:

Presenter(s) Thomas P. Cooper, M.D.

Specialty(s): Urology

Sample Size: 50 Response Rate: (%):40/50 (80%) Median RVW: 22.50

Type of Sample: panel plus mail survey,

25th Percentile RVW: 19.75 75th Percentile RVW: 26.28 Low: 15.50 High: 30.00

Median Pre-Service Time: 60 min Median Intra-Service Time: 240 min

25th Percentile Intra-Svc Time: 180 min 75th Percentile Intra-Svc Time: 270 min Low: 90 min High: 360 min

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	30	
Critical Care:	0	0
Other Hospital Visits:	60	1 – 99231 1 - 99233
Discharge Day Mgmt.:	36	1 - 99238
Office Visits:	61	1 – 99214 1 - 99213

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
50547	Laparoscopy, surgical; donor nephrectomy from living donor (excluding preparation and maintenance of allograft)	25.50

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	60	60
Median Intra-Time	240	180
Median Immediate Post-service Time	30	30
Median of Aggregate Critical Care Times	0	0
Median of Aggregate Other Hospital Visit Times	50	50
Median Discharge Day Management Time	22.5	22.5
Median of Aggregate Office Visit Times	40	30

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.1	3.8
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.1	4.0
Urgency of medical decision making	3.6	3.5

Technical Skill/Physical Effort (Mean)

Technical skill required	4.6	4 3
Physical effort required	4.3	4.2

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.3	4.2
Outcome depends on the skill and judgement of physician	4.6	4.4
Estimated risk of malpractice suit with poor outcome	4.3	4.1

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3 9	3 7
Intra-Service intensity/complexity	4 5	4 2
Post-Service intensity/complexity	3 8	3.6

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The AUA panel that reviewed this issue consisted of 39 urologists (both men and women) from solo, single specialty, multi-specialty and academic practices. These physicians represent 17 states across the United States and all of the subspecialites of urology. Additionally, 11 urologists were queried by mail survey.

FREQUENCY INFORMATION

How was this service previously reported? 53899, Unlisted procedure, urinary system

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

Specialty Urology _____ Commonly _____ Sometimes X Rarely

Specialty _____ Commonly _____ Sometimes _____ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Urology _____ Frequency 500

Specialty _____ Frequency _____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Urology _____ Frequency 0

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? _____ Yes X No

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AMA/Specialty Society Update Process
Summary of Recommendation
010 or 090 Day Global Periods
Out-Of-Office Direct Inputs

Sample Size:_____ Response Rate: (%):_____ Global Period:__090___

Tracking Number: Q1 Reference Code 1 50546* Reference Code 2_____

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

***The inputs for 50947 were crosswalked from existing inputs for CPT code 50546 (Laparoscopy, surgical; nephrectomy), with additions shown in bold.**

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

›mplete pre-service diagnostic & referral forms
›oordinate pre-surgery services
Schedule space and equipment in facility
Office visit before surgery/procedure
Review test and exam results
Provide pre-service education/obtain consent

Intra-Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: RN time for 3 office visits.

Clinical Labor	Pre-Service Time Prior to Admission	Service Period (Admission to Discharge)	Coordianation of Care*	Post-Service Time After Discharge **	Number of Office Visits	Total Time of Office Visits
RN	60				3	67.5

*By staff in the physician's office during the service period.
**Excluding Time of Office Visits

Medical Supplies	Quantity of Supplies	Units Used for Purchase
pillow case, disposable	3	item
hydrogen peroxide	20	ml
Betadine	10	ml
suture removal kit	1	item
tape	6	inch
steri-strips	6	strip
Gauze,Sterile 4 x 4	1	item
cotton tipped applicators	8	item
swab, alcohol	4	item
gloves, sterile	1	pair
gloves, non-sterile	6	pair
exam table paper	21	foot
patient gown, disposable	3	item
thermometer probe cover, disposable	3	item
patient education booklet	**1**	**item**

Procedure Specific Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Equipment Cost
N/A				

Overhead Medical Equipment	No. of units in practice	Equipment Cost
exam table		**1360**
exam lamp		1850
crash cart, no defibrilator		**1135.81**

AMA/Specialty Society Update Process
Summary of Recommendation
010 or 090 Day Global Periods
Out-Of-Office Direct Inputs

Sample Size:_____ Response Rate: (%):_____ Global Period:__090___

Tracking Number: Q2 Reference Code 1 50546* Reference Code 2_____

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

***The inputs for 50948 were crosswalked from existing inputs for CPT code 50546 (Laparoscopy, surgical; nephrectomy), with additions shown in bold.**

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

`omplete pre-service diagnostic & referral forms
oordinate pre-surgery services
Schedule space and equipment in facility
Office visit before surgery/procedure
Review test and exam results
Provide pre-service education/obtain consent

Intra-Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: RN time for 2 office visits

Clinical Labor	Pre-Service Time Prior to Admission	Service Period (Admission to Discharge)	Coordianation of Care*	Post-Service Time After Discharge **	Number of Office Visits	Total Time of Office Visits
RN	60				2	45

*By staff in the physician's office during the service period.
**Excluding Time of Office Visits

Medical Supplies	Quantity of Supplies	Units Used for Purchase
pillow case, disposable	2	item
hydrogen peroxide	20	ml
Betadine	10	ml
suture removal kit	1	item
tape	6	inch
steri-strips	6	strip
Gauze,Sterile 4 x 4	1	item
cotton tipped applicators	8	item
swab, alcohol	4	item
gloves, sterile	1	pair
gloves, non-sterile	6	pair
exam table paper	14	foot
patient gown, disposable	2	item
thermometer probe cover, disposable	2	item
patient education booklet	**1**	**item**

Procedure Specific Medical Equipment	**No. of units in practice**	**Minutes of use per procedure**	**Hours per week in use for all services**	**Equipment Cost**

Overhead Medical Equipment	**No. of units in practice**	**Equipment Cost**
Exam Table		**1360**
exam lamp		1850
crash cart, no defibrilator		**1135.81**

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
February 2000

Endoscopic Urinary System Procedures

Work Relative Value Recommendations

CPT Code 52341

New CPT code *52341 Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)* was created. Cystoscopy with treatment of ureteral stricture has been performed for years. However, over the past 10 years, this procedure has become more commonplace due to improved ureteroscopic techniques and new technology.

The RUC considered work survey results, which provided a median work value of 6.00. It was the consensus of the RUC that this value was appropriate. Additionally, when evaluating the physician work, RUC members agreed that the physician work was similar to CPT code *52330 Cystourethroscopy (including ureteral catheterization); with manipulation, without removal or ureteral calculus* (work RVU = 5.04) and used this as a reference. The physician time is comparable to code 52330. The mental effort and judgement for new code 52341 is generally higher than the comparison code (52330). **Therefore, the RUC recommends a work relative value of 6.00 for CPT code 52341**.

CPT Code 52342

New CPT code *52342 Cystourethroscopy; with treatment of ureteropelvic juncture stricture (eg, balloon dilation, laser, electrocautery, and incision)* was created as CPT did not contain an existing code which accurately described this procedure.

The RUC considered work survey results, which provided a median work value of 6.50. It was the consensus of the RUC that this value was appropriate. Additionally, the RUC agreed that the physician work for new code 52342 was similar to code *52325 Cystourethroscopy (including ureteral catheterization); with fragmentation of ureteral calculus (eg, ultrasonic or electro-*

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hydraulic technique) (work RVU = 6.16). The median intra-service time and intensity/complexity measures are greater for new code 52342 than the comparison code 52325. **Therefore, the RUC recommends a work relative value of 6.50 for CPT code 52342.**

CPT Code 52343

New CPT code *52343 Cystourethroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)* was created as CPT did not contain an existing code which accurately described this procedure.

The RUC considered work survey results, which provided a median work value of 7.20. It was the consensus of the RUC that this value was appropriate. Additionally, the RUC agreed that the physician work for new code 52343 was similar to code *52330 Cystourethroscopy (including ureteral catheterization); with manipulation, without removal of ureteral calculus* (work RVU = 5.04) and used this as a reference. The median pre and intra-service time for new code 52343 are significantly higher than the comparison code 52330. Additionally, the intensity and complexity measures are higher for new code 52343. **Therefore, the RUC recommends a work relative value of 7.20 for CPT code 52343.**

CPT Code 52344

New CPT code *52344 Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)* was created as CPT did not contain an existing code which accurately described this procedure.

The RUC considered work survey results, which provided a median work value of 7.70. It was the consensus of the RUC that this value was appropriate. Additionally, the RUC agreed that the physician work for new code 52344 was similar to code *52335 Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter and/or pyeloureteral junction by any method)* (work RVU = 5.86) and used this as a reference. The median intra-service time is comparable between the new code 52344 and the comparison code 52335. Additionally, the intensity and complexity measures are generally higher for the new code 52344. **Therefore, the RUC recommends a work relative value of 7.70 for CPT code 52344.**

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CPT Code 52345

New CPT code *52345 Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)* was created as CPT did not contain an existing code which accurately described this procedure.

The RUC considered work survey results, which provided a median work value of 8.20. It was the consensus of the RUC that this value was appropriate. Additionally, the RUC agreed that the physician work for new code 52345 was similar to code 52339 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter and/or pyeloureteral junction by any method), with resection of tumor* (work RVU = 8.82). The median intra-service time and intensity/complexity measures for this new code are comparable to the reference code 52339. **Therefore, the RUC recommends a work relative value of 8.20 for CPT code 52345**.

CPT Code 52346

New CPT code *52346 Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)* was created as CPT did not contain an existing CPT code which accurately described this procedure.

The RUC considered work survey results, which provided a median work value of 9.23. It was the consensus of the RUC that this value was appropriate. Additionally, the RUC agreed that the physician work for new code 52346 was similar to code 52339 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter and/or pyeloureteral junction by any method), with resection of tumor* (work RVU = 8.82). The median intra-service time for new code 52346 is 30 minutes longer than the comparison code 52339. Additionally, the intensity and complexity measures are generally higher for new code 52345 than the comparison code. **Therefore, the RUC recommends a work relative value of 9.23 for CPT code 52346**.

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CPT Code 52351-52355

CPT codes 52351 – 52355 have been renumbered from codes 52335-52339. CPT code 52400 was renumbered from code 52340. The work RVUs should be crosswalked from the deleted codes to the new codes. The RUC did discuss the nomenclature changes for code 52351 (R7). The society clarified that the procedure still includes "dilation of the ureter and/or pyeloureteral junction by any method." However, this language was deleted so that users would not confuse this code with codes 52341-52346. The change is considered editorial. Urologists understand that it is necessary to dilate to perform the diagnostic service; however, any dilation used in treatment is not included in these codes.

Practice Expense Recommendations

These services are performed in the facility setting only, with a global period of 000. Therefore, there is no practice expense related to post-procedure office visits. However, the specialty recommended that there was pre-time associated with clinical staff activities. The PEAC is currently developing standard packages of pre-time. Therefore, the RUC has tabled action on the pre-time for these codes until after these standardized packages are developed.

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CPT Code (●New) (▲Revised) (D Deleted)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgical cystourethroscopy always includes diagnostic cystourethroscopy. To report a diagnostic cystourethroscopy, use 52351. (Do not report 52351, in conjunction with 52341-52346, 52352-52355)				
CPT Code	**Tracking Number**	**CPT Descriptor**	**Global Period**	**Work RVU Recommendation**
52334		*Cystourethroscopy with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde* *(For percutaneous nephrostolithotomy, see 50080, 50081; for establishment of nephrostomy tract only, see 50395)*	000	4.83 (No Change)
52335		~~Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter and/or pyeloureteral junction by any method);~~ ~~(For radiological supervision and interpretation, see 74485)~~ (52335 has been deleted. To report, use 52351)	000	**Deleted Code**

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CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
52336		~~with removal or manipulation of calculus (ureteral catheterization is included)~~ (52336 has been deleted. To report, use 52352)	000	**Deleted Code**
52337		~~with lithotripsy (ureteral cathererization is included)~~ (52337 has been deleted. To report, use 52353)	000	**Deleted Code**
52338		~~with biopsy and/or fulguration of lesion~~ (52338 has been deleted. To report, use 52354)	000	**Deleted Code**
52339		~~with resection of tumor~~ (52339 has been deleted. To report, use 52355)	000	**Deleted Code**
52340		~~Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds~~ (52340 has been deleted. To report, use 52400)	090	**Deleted Code**
●52341	R1	Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)	000	6.00
●52342	R2	with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)	000	6.50

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CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●52343	R3	with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)	000	7.20
●52344	R4	Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)	000	7.70
●52345	R5	with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)	000	8.20
●52346	R6	with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)	000	9.23
●52351	R7	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic ~~(includes dilation of the ureter and/or pyeloureteral junction by any method)~~ radiological supervision and interpretation, see 74485) (Do not report 52351, in conjunction with 52341-52346, 52352-52355)	000	5.86 (code renumbered from 52335)
●52352	R8	with removal or manipulation of calculus (ureteral catheterization is included)	000	6.88 (code renumbered from 52336)

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CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●52353	R9	with lithotripsy (ureteral catheterization is included)	000	7.97 (code renumbered from 52337)
●52354	R10	with biopsy and/or fulguration of lesion	000	7.34 (code renumbered from 52338)
●52355	R11	with resection of tumor	000	8.82 (code renumbered from 52339)
52400	R12	Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds	090	9.68 (code renumbered from 52340)

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SUMMARY OF RECOMMENDATION

CPT Code: 52341 Tracking Number: R1 Global Period: 000 **Recommended RVW:** 6.00

CPT Descriptor: Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 58-year-old man with left flank pain. Studies demonstrate a left hydronephrosis with a lower ureteral stricture. The patient elects endoscopic rather than open surgical treatment.

Description of Pre-Service Work:

Appropriate preoperative studies are obtained and reviewed. The patient is seen by the operating surgeon before being given an anesthetic. Procedure specific equipment is checked. The patient is taken to the operating room and given either general or spinal anesthesia, appropriately positioned for the procedure, prepped and draped.

Description of Intra-Service Work:

The patient is in the dorsal lithotomy position. The cystoscope is introduced through the urethra into the bladder. The ureteral orifice is visualized. A guide wire is passed up the ureter. A high pressure balloon is passed over the guidewire to the strictured area and inflated. After an appropriate length of time, the balloon is deflated and removed. A Foley catheter is placed.

Description of Post-Service Work:

The surgeon waits in the operating room and assists the anesthesiologist in transferring the patient to a recovery room stretcher. The patient is transferred to the recovery room. Post-operative orders are written. Prescriptions are written. A detailed operative report is dictated. The surgeon talks with the patient's family about the procedure, diagnosis, and postoperative care. The patient is seen by the surgeon later that day and if feeling well is dismissed home. Follow up appointment is arranged. Hospital by-laws require that a detailed discharge summary must be dictated.

SURVEY DATA:

Presenter(s) Thomas P. Cooper, M.D.

Specialty(s): Urology

Sample Size: 47 Response Rate: (%): 38/47 (81%) Median RVW: 6.00

Type of Sample: panel plus mail survey

25th Percentile RVW: 5.06 75th Percentile RVW: 6.69 Low: 4.00 High: 10.00

Median Pre-Service Time: 47.5 min Median Intra-Service Time: 60 min

25th Percentile Intra-Svc Time: 45 min 75th Percentile Intra-Svc Time: 78.75 min Low: 30 min High: 150 min

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	30	
Critical Care:	0	0
Other Hospital Visits:	19	1- 99231
Discharge Day Mgmt.:	0	0
Office Visits:	0	0

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
52330	Cystourethroscopy (including ureteral catheterization); with manipulation, without removal of ureteral calculus	5.04

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	47.5	45
Median Intra-Time	60	60
Median Immediate Post-service Time	30	30
Median of Aggregate Critical Care Times	0	0
Median of Aggregate Other Hospital Visit Times	15	15
Median Discharge Day Management Time	0	0
Median of Aggregate Office Visit Times	0	0

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.4	3.3
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3 4	3.3
Urgency of medical decision making	3.4	3.4

Technical Skill/Physical Effort (Mean)

Technical skill required	3.8	3.9
Physical effort required	3.3	3.5

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.6	3 7
Outcome depends on the skill and judgement of physician	3.7	3.9
Estimated risk of malpractice suit with poor outcome	3.7	3.8

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.3	3.3
Intra-Service intensity/complexity	3.6	3.7
Post-Service intensity/complexity	3.2	3 3

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The AUA panel that reviewed this issue consisted of 39 urologists (both men and women) from solo, single specialty, multi-specialty and academic practices. These physicians represent 17 states across the United States and all of the subspecialites of urology. Additionally, 8 urologists were queried by mail survey.

FREQUENCY INFORMATION

How was this service previously reported? 53899, Unlisted procedure, urinary system

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

Specialty Urology _____ Commonly X Sometimes _____ Rarely

Specialty _____ Commonly _____ Sometimes _____ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Urology Frequency 3000

Specialty _____ Frequency _____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Urology Frequency 1000

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? X Yes _____ No

SUMMARY OF RECOMMENDATION

CPT Code: 52342 Tracking Number: R2 Global Period: 000 **Recommended RVW: 6. 50**

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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 58-year-old man with left flank pain. Studies demonstrate a left hydronephrosis with a ureteral pelvic junction obstruction. The patient elects endoscopic rather than open surgical treatment.

Description of Pre-Service Work:

Appropriate preoperative studies are obtained and reviewed. The patient is seen by the operating surgeon before being given an anesthetic. Procedure specific equipment is checked. The patient is taken to the operating room and given either general or spinal anesthesia, appropriately positioned for the procedure, prepped and draped.

Description of Intra-Service Work:

The patient is in the dorsal lithotomy position. The cystoscope is introduced through the urethra into the bladder. The ureteral orifice is visualized. A guide wire is passed up the ureter. A high-pressure balloon is passed over the guidewire through the ureteral pelvic junction obstruction and inflated. After an appropriate length of time the balloon is deflated and removed. A Foley catheter is placed.

Description of Post-Service Work:

The surgeon waits in the operating room and assists the anesthesiologist in transferring the patient to a recovery room stretcher. The patient is transferred to the recovery room. Post-operative orders are written. Prescriptions are written. A detailed operative report is dictated. The surgeon talks with the patient's family about the procedure, diagnosis, and postoperative care. The patient is seen by the surgeon later that day and if feeling well is dismissed home. Follow up appointment is arranged. Hospital by-laws require that a detailed discharge summary must be dictated.

SURVEY DATA:

Presenter(s) Thomas P. Cooper, M.D.

Specialty(s): Urology

Sample Size: 47 Response Rate: (%): 37/47 (79%) Median RVW: 6.50

Type of Sample: panel plus mail survey _____

25th Percentile RVW: 6.00 75th Percentile RVW: 7.92 Low: 5.00 High: 12.00

Median Pre-Service Time: 60 min Median Intra-Service Time: 65 min _____

25th Percentile Intra-Svc Time: 60 min 75th Percentile Intra-Svc Time: 90 min Low: 30 min High: 150 min

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	30	
Critical Care:	0	0
Other Hospital Visits:	19	1 - 99231
Discharge Day Mgmt.:	0	0
Office Visits:	0	0

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
52325	Cystourethroscopy (including ureteral catheterization); with fragmentation of ureteral calculus (eg, ultrasonic or electro-hydraulic technique)	6.16

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	60	60
Median Intra-Time	65	60
Median Immediate Post-service Time	30	30
Median of Aggregate Critical Care Times	0	0
Median of Aggregate Other Hospital Visit Times	15	20
Median Discharge Day Management Time	0	0
Median of Aggregate Office Visit Times	0	0

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.7	3.4
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.7	3 4
Urgency of medical decision making	3.5	3.5

Technical Skill/Physical Effort (Mean)

Technical skill required	4.0	3.9
Physical effort required	3.6	3.6

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.9	3.6
Outcome depends on the skill and judgement of physician	4.0	3.8
Estimated risk of malpractice suit with poor outcome	4.0	3.8

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.6	3.5
Intra-Service intensity/complexity	3.8	3.7
Post-Service intensity/complexity	3 4	3.3

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The AUA panel that reviewed this issue consisted of 39 urologists (both men and women) from solo, single specialty, multi-specialty and academic practices. These physicians represent 17 states across the United States and all of the subspecialites of urology. Additionally, 8 urologists were queried by mail survey.

FREQUENCY INFORMATION

How was this service previously reported? 53899, Unlisted procedure, urinary system

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialti please provide information for each specialty.

Specialty Urology ____Commonly __X__Sometimes ____Rarely

Specialty ____ ____Commonly ____Sometimes ____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Urology Frequency 3000

Specialty ____ Frequency ____

For your specialty, estimate the number of times this service might be**provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Urology Frequency 1000

Specialty ____ Frequency ____

Do many physicians perform this service across the United States? __X__Yes ____No

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SUMMARY OF RECOMMENDATION

CPT Code: 52343_ Tracking Number: R3__ Global Period: 000___ **Recommended RVW: 7.20**

CPT Descriptor: Cystourethroscopy with treatment of intra-renal obstruction (eg, balloon dilation, laser, electrocautery, and incision)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 56-year-old man has intermittent severe left flank pain. Studies demonstrate a dilated upper pole calyx with stenosis of the infundibulum. He elects endoscopic rather than open surgical treatment.

Description of Pre-Service Work:

Appropriate preoperative studies are obtained and reviewed. The patient is seen by the operating surgeon before being given an anesthetic. Procedure specific equipment is checked. The patient is taken to the operating room and given either general or spinal anesthesia, appropriately positioned for the procedure, prepped and draped.

Description of Intra-Service Work:

The patient is in the dorsal lithotomy position. The cystoscope is introduced through the urethra into the bladder. The ureteral orifice is visualized. A guide wire is passed up the ureter and into the dilated upper pole calyx. A high-pressure balloon is passed over the guidewire through the stenosed infundibulum and inflated. After an appropriate length of time the balloon is deflated and removed. A Foley catheter is placed.

Description of Post-Service Work:

The surgeon waits in the operating room and assists the anesthesiologist in transferring the patient to a recovery room stretcher. The patient is transferred to the recovery room. Post-operative orders are written. Prescriptions are written. A detailed operative report is dictated. The surgeon talks with the patient's family about the procedure, diagnosis, and postoperative care. The patient is seen by the surgeon later that day and if feeling well is dismissed home. Follow up appointment is arranged. Hospital by-laws require that a detailed discharge summary must be dictated.

SURVEY DATA:

Presenter(s) Thomas P. Cooper, M.D.

Specialty(s): Urology

Sample Size: 47 Response Rate: (%): 37/47 (79%) Median RVW: 7.20

Type of Sample: panel plus mail survey _____

25th Percentile RVW: 6.25 75th Percentile RVW: 8.82 Low: 5.04 High: 21.50

Median Pre-Service Time: 60 min Median Intra-Service Time: 90 min

25th Percentile Intra-Svc Time: 60 min 75th Percentile Intra-Svc Time: 120 min Low: 30 min High: 180 min

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	30	
Critical Care:	0	0
Other Hospital Visits:	19	1 - 99231
Discharge Day Mgmt.:	0	0
Office Visits:	0	0

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
52330	Cystourethroscopy (including ureteral catheterization); with manipulation, without removal of ureteral calculus	5.04

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	60	45
Median Intra-Time	90	60
Median Immediate Post-service Time	30	30
Median of Aggregate Critical Care Times	0	0
Median of Aggregate Other Hospital Visit Times	15	15
Median Discharge Day Management Time	0	0
Median of Aggregate Office Visit Times	0	0

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.8	3.5
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.6	3.2
Urgency of medical decision making	3.6	3.5

Technical Skill/Physical Effort (Mean)

Technical skill required	4.0	3.8
Physical effort required	3.8	3.6

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.0	3.6
Outcome depends on the skill and judgement of physician	4 0	3.7
Estimated risk of malpractice suit with poor outcome	3.9	3 7

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.6	3 4
Intra-Service intensity/complexity	3 9	3 6
Post-Service intensity/complexity	3 5	3 4

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The AUA panel that reviewed this issue consisted of 39 urologists (both men and women) from solo, single specialty, multi-specialty and academic practices. These physicians represent 17 states across the United States and all of the subspecialites of urology. Additionally, 8 urologists were queried by mail survey.

FREQUENCY INFORMATION

How was this service previously reported? 53899, Unlisted procedure, urinary system

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialt please provide information for each specialty.

Specialty Urology _____Commonly X Sometimes _____Rarely

Specialty _____ _____Commonly _____Sometimes _____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Urology Frequency 500

Specialty _____ Frequency _____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Urology Frequency 100

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? _____Yes X No

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SUMMARY OF RECOMMENDATION

CPT Code: 52344 Tracking Number: R4 Global Period: 000 **Recommended RVW: 7.70**

CPT Descriptor: Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture, (eg, balloon dilation, laser, electrocautery, and incision)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 58-year-old man with left flank pain. Studies demonstrate a left hydronephrosis with a lower ureteral stricture. The patient elects endoscopic rather than open surgical treatment.

Description of Pre-Service Work:

Appropriate preoperative studies are obtained and reviewed. The patient is seen by the operating surgeon before being given an anesthetic. Procedure specific equipment is checked. The patient is taken to the operating room and given either general or spinal anesthesia, appropriately positioned for the procedure, prepped and draped.

Description of Intra-Service Work:

The patient is in the dorsal lithotomy position. The ureteroscope is passed through the urethra to the bladder and then into the ureter. The stricture is visualized and a guide wire is passed through the lumen of the stricture. The laser is used to incise the narrowed area. There is no bleeding. The instruments are removed and a Foley catheter is placed.

Description of Post-Service Work:

The surgeon waits in the operating room and assists the anesthesiologist in transferring the patient to a recovery room stretcher. The patient is transferred to the recovery room. Post-operative orders are written. Prescriptions are written. A detailed operative report is dictated. The surgeon talks with the patient's family about the procedure, diagnosis, and postoperative care. The patient is seen by the surgeon later that day and, if feeling well, is dismissed home. Follow up appointment is arranged. Hospital by-laws require that a detailed discharge summary must be dictated.

SURVEY DATA:

Presenter(s) Thomas P. Cooper, M.D.

Specialty(s): Urology

Sample Size: 47 Response Rate: 36/47 (77%) Median RVW: 7.70

Type of Sample : panel plus mail survey

25th Percentile RVW: 6.95 75th Percentile RVW: 8.78 Low: 5.86 High: 15.00

Median Pre-Service Time: 60 min Median Intra-Service Time: 77.5 min

25th Percentile Intra-Svc Time: 60 min 75th Percentile Intra-Svc Time: 101.25 min Low: 45 min High: 180 min

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	30	
Critical Care:	0	0
Other Hospital Visits:	19	1 - 99231
Discharge Day Mgmt.:	0	0
Office Visits:	0	0

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
52335	Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter and/or pyeloureteral junction by any method)	5.86

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	60	60
Median Intra-Time	77.5	75
Median Immediate Post-service Time	30	30
Median of Aggregate Critical Care Times	0	0
Median of Aggregate Other Hospital Visit Times	15	15
Median Discharge Day Management Time	0	0
Median of Aggregate Office Visit Times	0	0

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.9	3 8
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3 7	3 7
Urgency of medical decision making	3.6	3.7

Technical Skill/Physical Effort (Mean)

Technical skill required	4 3	4.1
Physical effort required	3.9	3.8

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.2	3.9
Outcome depends on the skill and judgement of physician	4.2	4.1
Estimated risk of malpractice suit with poor outcome	4.0	3.9

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3 6	3 6
Intra-Service intensity/complexity	4 0	3 9
Post-Service intensity/complexity	3 5	3.5

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The AUA panel that reviewed this issue consisted of 39 urologists (both men and women) from solo, single specialty, multi-specialty and academic practices. These physicians represent 17 states across the United States and all of the subspecialites of urology. Additionally, 8 urologists were queried by mail survey.

FREQUENCY INFORMATION

How was this service previously reported? 53899, Unlisted procedure, urinary system

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

Specialty Urology X Commonly ____ Sometimes ____ Rarely

Specialty ____ Commonly ____ Sometimes ____ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Urology Frequency 5000

Specialty ____ Frequency ____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Urology Frequency 2000

Specialty ____ Frequency ____

Do many physicians perform this service across the United States? X Yes ____ No

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SUMMARY OF RECOMMENDATION

CPT Code: 52345 Tracking Number: R5 Global Period: 000 **Recommended RVW: 8.20**

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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 21-year-old woman has a history of increasing left flank pain, noted especially after drinking several beers. Studies demonstrate a left UPJ obstruction. The patient elects ureteroscopic treatment of the obstruction instead of an open pyeloplasty.

Description of Pre-Service Work:

Appropriate preoperative studies are obtained and reviewed. The patient is seen by the operating surgeon before being given an anesthetic. Procedure specific equipment is checked. The patient is taken to the operating room and given either general or spinal anesthesia, appropriately positioned for the procedure, prepped and draped.

Description of Intra-Service Work:

The patient is placed in the dorsal lithotomy position. The ureteroscope is passed through the urethra to the bladder and then into the ureter. The ureteroscope is gradually passed up the ureter, over the iliac vessels and into the upper ureter. The pinpoint opening of the UPJ is visualized. A guide wire is placed. The electrocautery balloon is positioned and the strictured area is treated successfully. The area is carefully inspected, there is no bleeding. The instruments are removed.

Description of Post-Service Work:

The surgeon waits in the operating room and assists the anesthesiologist in transferring the patient to a recovery room stretcher. The patient is transferred to the recovery room. Post-operative orders are written. Prescriptions are written. A detailed operative report is dictated. The surgeon talks with the patient's family about the procedure, diagnosis, and postoperative care. The patient is seen by the surgeon later that day and if feeling well is dismissed home. Follow up appointment is arranged. Hospital by-laws require that a detailed discharge summary must be dictated.

SURVEY DATA:

Presenter(s) Thomas P. Cooper, M.D.

Specialty(s): Urology

Sample Size: 47 Response Rate: 37/47 (79%) Median RVW: 8.20

Type of Sample: panel plus mail survey _____

25th Percentile RVW: 7.86 75th Percentile RVW: 9.50 Low: 6.00 High: 18.00

Median Pre-Service Time: 50 min Median Intra-Service Time: 90 min

25th Percentile Intra-Svc Time: 75 min 75th Percentile Intra-Svc Time: 120 min Low: 45 min High: 200 min

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	30	
Critical Care:	0	0
Other Hospital Visits:	19	1 - 99231
Discharge Day Mgmt.:	0	0
Office Visits:	0	0

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
52339	Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter and/or pyeloureteral junction by any method), with resection of tumor	8.82

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	50	60
Median Intra-Time	90	80
Median Immediate Post-service Time	30	30
Median of Aggregate Critical Care Times	0	0
Median of Aggregate Other Hospital Visit Times	15	15
Median Discharge Day Management Time	0	0
Median of Aggregate Office Visit Times	0	0

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4 0	3.9
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3 9	3.9
Urgency of medical decision making	3 8	3 9

Technical Skill/Physical Effort (Mean)

Technical skill required	4.5	4.1
Physical effort required	4 1	3.9

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.4	4.1
Outcome depends on the skill and judgement of physician	4.3	4.1
Estimated risk of malpractice suit with poor outcome	4.3	4.1

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3 6	3 7
Intra-Service intensity/complexity	4 2	4 0
Post-Service intensity/complexity	3 7	3.6

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The AUA panel that reviewed this issue consisted of 39 urologists (both men and women) from solo, single specialty, multi-specialty and academic practices. These physicians represent 17 states across the United States and all of the subspecialites of urology. Additionally, 8 urologists were queried by mail survey.

FREQUENCY INFORMATION

How was this service previously reported? 53899, Unlisted procedure, urinary system

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

Specialty Urology ____Commonly X Sometimes ____Rarely

Specialty ____ ____Commonly ____Sometimes ____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Urology Frequency 3000

Specialty ____ Frequency ____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Urology Frequency 500

Specialty ____ Frequency ____

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

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SUMMARY OF RECOMMENDATION

CPT Code: 52346 Tracking Number: R6 Global Period: 000 **Recommended RVW: 9.23** __

CPT Descriptor: Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture, (eg, balloon dilation, laser, electrocautery, and incision)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 56-year-old man has intermittent severe left flank pain. Studies demonstrate a dilated upper pole calyx with stenosis of the infundibulum. He elects endoscopic rather than open surgical treatment.

Description of Pre-Service Work:

Appropriate preoperative studies are obtained and reviewed. The patient is seen by the operating surgeon before being given an anesthetic. Procedure specific equipment is checked. The patient is taken to the operating room and given either general or spinal anesthesia, appropriately positioned for the procedure, prepped and draped.

Description of Intra-Service Work:

The patient is in the dorsal lithotomy position. The ureteroscope is inserted through the urethra, into the bladder and then into the ureter. The ureteroscope is then passed slowly up the ureter, over the iliac vessels and into the renal pelvis. The obstructing infundibulum is identified and a guide wire is passed through the small opening and coiled into the dilated calyx. A laser fiber is introduced and the opening is carefully enlarged. Bleeding is minimal. The instruments are removed.

Description of Post-Service Work:

The surgeon waits in the operating room and assists the anesthesiologist in transferring the patient to a recovery room stretcher. The patient is transferred to the recovery room. Post-operative orders are written. Prescriptions are written. A detailed operative report is dictated. The surgeon talks with the patient's family about the procedure, diagnosis, and postoperative care. The patient is seen by the surgeon later that day and if feeling well is dismissed home. Follow up appointment is arranged. Hospital by-laws require that a detailed discharge summary must be dictated.

SURVEY DATA:

Presenter(s) Thomas P. Cooper, M.D.

Specialty(s): Urology

Sample Size: 47 Response Rate: 36/47 (77%) Median RVW: 9.23

Type of Sample: panel plus mail survey

25th Percentile RVW: 8.50 75th Percentile RVW: 12.00 Low: 6.30 High: 19.50

Median Pre-Service Time: 45 min Median Intra-Service Time: 120 min

25th Percentile Intra-Svc Time: 80 min 75th Percentile Intra-Svc Time: 127.5 min Low: 60 min High: 200 min

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	30	
Critical Care:	0	0
Other Hospital Visits:	19	1 - 99231
Discharge Day Mgmt.:	0	0
Office Visits:	0	0

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
52339	Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter and/or pyeloureteral junction by any method), with resection of tumor	8.82

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	45	45
Median Intra-Time	120	90
Median Immediate Post-service Time	30	30
Median of Aggregate Critical Care Times	0	0
Median of Aggregate Other Hospital Visit Times	15	15
Median Discharge Day Management Time	0	0
Median of Aggregate Office Visit Times	0	0

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4 2	3.9
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.1	3.8
Urgency of medical decision making	3.7	3.6

Technical Skill/Physical Effort (Mean)

Technical skill required	4 7	4 3
Physical effort required	4 2	3.9

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.3	4.0
Outcome depends on the skill and judgement of physician	4.6	4.1
Estimated risk of malpractice suit with poor outcome	4.2	4 0

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3 8	3.7
Intra-Service intensity/complexity	4.3	4 0
Post-Service intensity/complexity	4.2	3.5

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The AUA panel that reviewed this issue consisted of 39 urologists (both men and women) from solo, single specialty, multi-specialty and academic practices. These physicians represent 17 states across the United States and all of the subspecialites of urology. Additionally, 8 urologists were queried by mail survey.

FREQUENCY INFORMATION

How was this service previously reported? 53899, Unlisted procedure, urinary system

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialt please provide information for each specialty.

Specialty Urology ____Commonly ____Sometimes X Rarely

Specialty ____Commonly ____Sometimes ____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Urology Frequency Less than 500

Specialty ____ Frequency ____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Urology Frequency Less than 100

Specialty ____ Frequency ____

Do many physicians perform this service across the United States? ____Yes X No

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AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
February 2000

Partial Orchiectomy

Work Relative Value Recommendation

CPT Code 54512
New code *54512 Excision of extraparenchymal lesion of testis* was created as CPT does not contain an existing code that accurately described an excision of an extraparenchymal lesion of the testis. Therefore, the unlisted code *55899 Unlisted procedure, male genital system* was used to report this procedure.

When evaluating the physician work, RUC members agreed the physician work is similar to code *54530 Orchiectomy, radical, for tumor; inguinal approach* (work RVU = 8.58) and used this as a reference service. The physician time and intensity/complexity measures of new code 54512 are comparable to the reference code (54530). **Therefore, the RUC recommends the survey median work RVU of 8.58 for code 54512**.

CPT Code 54522
New code *54522 Orchiectomy, partial* was created, as CPT did not contain an existing code that accurately described this service. Therefore, the unlisted code *55899 Unlisted procedure, male genital system* was used to report this procedure.

When evaluating the physician work, RUC members agreed the physician work is similar to code *54530 Orchiectomy, radical, for tumor; inguinal approach* (work RVU = 8.58) and used this as a reference service. The median intra-service time for new code 54522 is higher than the comparison code 54530. Additionally, the intensity and complexity measures for new code 54522 are generally higher than the comparison code. **Therefore, the RUC recommends the survey median work RVU of 9.50 for code 54522.**

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

Practice Expense Recommendations

The direct practice expense inputs are included in the attached summary forms. Code 54512 was crosswalked to code *54530 Orchiectomy, radical, for tumor; inguinal approach.* The RUC agreed that 69 minutes of a RN for pre-time was appropriate as the procedure is performed the same day the physician initially sees the patient and finds the mass. The schedule is disrupted for the entire day as this patient must be scheduled for emergent surgery and the rest of the schedule is interrupted. The RN must obtain approval for surgery.

The RUC also recommended that the inputs for the post-operative office visits be modified as code 54530 includes four visits and these new codes only include two office visits.

These services are only performed in the facility setting.

CPT Code (●New) (▲Revised) (D Deleted)	**Tracking Number**	**CPT Descriptor**	**Global Period**	**Work RVU Recommen-dation**
●54512	SI	Excision of extraparenchymal lesion of testis	090	8.58
●54522	S2	Orchiectomy, partial	090	9.50

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: 54512 Tracking Number: S1 Global Period: 090 **Recommended RVW: 8.58**

CPT Descriptor: : Excision of extraparenchymal lesion of testis

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 32-year-old man has a firm, painless 2 cm mass palpable in the right scrotum. The history is unremarkable. Tumor markers are negative. Ultrasound is inconclusive, but does show a solid mass adjacent to the testicle. Scrotal exploration through a groin incision is planned with frozen section and possible orchiectomy or excision of extraparenchymal lesion as may be indicated.

Description of Pre-Service Work:

Appropriate preoperative studies are obtained and reviewed. The patient is seen by the operating surgeon before being given an anesthetic. Procedure specific equipment is checked. The patient is taken to the operating room and given either general or spinal anesthesia, appropriately positioned for the procedure, prepped and draped.

Description of Intra-Service Work:

Local anesthesia with 0.25% Marcaine is instilled along the intended incision line. A right groin incision is made, the external oblique fascia is opened, the ileoinguinal nerve is preserved, the cord is mobilized and a Penrose drain tourniquet is placed around the cord; more 0.25% Marcaine is instilled into the cord. The testicle is the delivered out of the scrotum and into the wound, still attached to the cord. Towels are used to isolate the testis. The tunica vaginalis is opened and the testis and epididymus are palpated and visually inspected. A 2 cm firm, fleshy mass is adjacent to the epididymus. Biopsies are taken for frozen section. The frozen section returns as a "benign adenomatoid tumor." The mass is then totally excised. Hemostasis is achieved. The testis is replaced in normal position. The tourniquet is removed and the wound is irrigated and closed. A sterile dressing is applied.

Description of Post-Service Work:

The surgeon waits in the operating room and assists the anesthesiologist in transferring the patient to a recovery room stretcher. The patient is transferred to the recovery room. Post-operative orders are written. Prescriptions are written. A detailed operative report is dictated. The surgeon talks with the patient's family about the procedure, diagnosis, and postoperative care. The patient is seen by the surgeon later that day and if feeling well enough is dismissed home. Follow up appointment is arranged. Post operative care for the global period is included. Hospital by-laws require that a detailed discharge summary must be dictated.

SURVEY DATA:

Presenter(s) Thomas P. Cooper, M.D.

Specialty(s): Urology

Sample Size: 39 Response Rate: 36/39 (92%) Median RVW: 8.58

Type of Sample: panel _____

25th Percentile RVW: 8.00 75th Percentile RVW: 9.38 Low: 5.23 High: 12.00

Median Pre-Service Time: 50 min Median Intra-Service Time: 70 min

25th Percentile Intra-Svc Time: 60 min 75th Percentile Intra-Svc Time: 90 min Low: 30 min High: 125 min

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	30	
Critical Care:	0	0
Other Hospital Visits:	19	1 - 99231
Discharge Day Mgmt.:	0	0
Office Visits:	46	2 - 99213

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
54530	Orchiectomy, radical, for tumor; inguinal approach	8.58

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	50	50
Median Intra-Time	70	60
Median Immediate Post-service Time	30	30
Median of Aggregate Critical Care Times	0	0
Median of Aggregate Other Hospital Visit Times	15	15
Median Discharge Day Management Time	0	0
Median of Aggregate Office Visit Times	30	30

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3 6	3.5
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.6	3.6
Urgency of medical decision making	3.6	3.7

Technical Skill/Physical Effort (Mean)

Technical skill required	3.6	3.3
Physical effort required	3.2	3.1

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3 7	3.6
Outcome depends on the skill and judgement of physician	3 9	3.6
Estimated risk of malpractice suit with poor outcome	4.1	4 0

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.4	3.4
Intra-Service intensity/complexity	3 7	3.4
Post-Service intensity/complexity	3 1	3 3

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The AUA panel that reviewed this issue consisted of 39 urologists (both men and women) from solo, single specialty, multi-specialty and academic practices. These physicians represent 17 states across the United States and all of the subspecialites of urology.

FREQUENCY INFORMATION

How was this service previously reported? 55899, Unlisted procedure, male genital system

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

Specialty Urology _____ Commonly _____ Sometimes X Rarely

Specialty _____ Commonly _____ Sometimes _____ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Urology Frequency 500

Specialty _____ Frequency _____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Urology Frequency 100

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? X Yes _____ No

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 54522 Tracking Number: S2 Global Period: 090 **Recommended RVW: 9.50**

CPT Descriptor: Orchiectomy, partial

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 28-year-old man has a firm painful 2 cm mass palpable in the right testicle. There is a history of an athletic injury to the right testicle several years ago. Tumor markers are negative. Ultrasound is inconclusive, but does show a mass on the anterior surface of the testicle with calcification. Scrotal exploration through a groin incision is planned with frozen section and possible orchiectomy or partial orchiectomy as may be indicated.

Description of Pre-Service Work:

Appropriate preoperative studies are obtained and reviewed. The patient is seen by the operating surgeon before being given an anesthetic. Procedure specific equipment is checked. The patient is taken to the operating room and given either general or spinal anesthesia, appropriately positioned for the procedure, prepped and draped.

Description of Intra-Service Work:

Local anesthesia with 0.25% Marcaine is instilled along the intended incision line. A right groin incision is made, the external oblique fascia is opened, the ileoinguinal nerve is preserved, the cord is mobilized and a Penrose drain tourniquet is placed around the cord; more 0.25% Marcaine is instilled into the cord. The testicle is then delivered out of the scrotum and into the wound, still attached to the cord. Towels are used to isolate the testis. The tunica vaginalis is opened and the testis and epididymus are palpated and visually inspected. A 2 cm gritty plaque-like area is noted. Biopsies are taken for frozen section. The frozen section returns as a "benign calcified pseudotumor of the tunica albuginea." The abnormal area is then totally excised. Hemostasis is achieved; the tunica albuginea (testicular capsule) is closed with multiple interrupted vertical mattress sutures. The testis is replaced in normal position. The tourniquet is removed and the wound is irrigated and closed. A sterile dressing is applied.

Description of Post-Service Work:

The surgeon waits in the operating room and assists the anesthesiologist in transferring the patient to a recovery room stretcher. The patient is transferred to the recovery room. Post-operative orders are written. Prescriptions are written. A detailed operative report is dictated. The surgeon talks with the patient's family about the procedure, diagnosis, and postoperative care. The patient is seen by the surgeon later that day and if feeling well enough is dismissed home. Follow up appointment is arranged. Post operative care for the global period is included. Hospital by-laws require that a detailed discharge summary must be dictated.

SURVEY DATA:

Presenter(s) Thomas P. Cooper, M.D.

Specialty(s): Urology

Sample Size: 39 Response Rate: 36/39 (92%) Median RVW: 9.50

Type of Sample: panel _____

25th Percentile RVW: 8.38 75th Percentile RVW: 10.00 Low: 5.23 High: 15.00

Median Pre-Service Time: 45 min Median Intra-Service Time: 75 min _____

25th Percentile Intra-Svc Time: 60 min 75th Percentile Intra-Svc Time: 90 min Low: 40 min High: 180 min

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	25	
Critical Care:	0	0
Other Hospital Visits:	19	1 - 99231
Discharge Day Mgmt.:	0	0
Office Visits:	46	2 - 99213

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
54530	Orchiectomy, radical, for tumor, inguinal approach	8.58

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	45	45
Median Intra-Time	75	60
Median Immediate Post-service Time	25	25
Median of Aggregate Critical Care Times	0	0
Median of Aggregate Other Hospital Visit Times	15	15
Median Discharge Day Management Time	0	0
Median of Aggregate Office Visit Times	30	30

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.9	3 4
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.8	3.6
Urgency of medical decision making	4 0	3.9

Technical Skill/Physical Effort (Mean)

Technical skill required	3.6	3.4
Physical effort required	3.1	3.1

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3 7	3.4
Outcome depends on the skill and judgement of physician	3.9	3.5
Estimated risk of malpractice suit with poor outcome	4.3	4.1

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3 7	3 5
Intra-Service intensity/complexity	3.8	3 5
Post-Service intensity/complexity	3 3	3 4

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The AUA panel that reviewed this issue consisted of 39 urologists (both men and women) from solo, single specialty, multi-specialty and academic practices. These physicians represent 17 states across the United States and all of the subspecialites of urology.

FREQUENCY INFORMATION

How was this service previously reported? 55899, Unlisted procedure, male genital system

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

Specialty Urology _____Commonly _____Sometimes X Rarely

Specialty _____ _____Commonly _____Sometimes _____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Urology Frequency Less than 100

Specialty _____ Frequency_____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Urology Frequency Less than 100

Specialty _____ Frequency_____

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

AMA/Specialty Society Update Process
Summary of Recommendation
010 or 090 Day Global Periods
Out-Of-Office Direct Inputs

Sample Size:_____ Response Rate: (%):_____ Global Period: 090

Tracking Number: S1 Reference Code 1 54530* Reference Code 2_____

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

***The inputs for 54512 were crosswalked from existing inputs for CPT code 54530.**

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Complete pre-service diagnostic & referral forms
`ordinate pre-surgery services
hedule space and equipment in facility
Office visit before surgery/procedure
Review test and exam results
Provide pre-service education/obtain consent

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities: RN time for 2 office visits

Clinical Labor	Pre-Service Time Prior to Admission	Service Period (Admission to Discharge)	Coordianation of Care*	Post-Service Time After Discharge **	Number of Office Visits	Total Time of Office Visits
RN	69				2	64

*By staff in the physician's office during the service period.
xcluding Time of Office Visits

Medical Supplies	Quantity of Supplies	Units Used for Purchase
patient gown, disposable	2	item
exam table paper	14	foot
pillow case, disposable	2	item
Sani-wipe	10	item
Depends	1	item
patient education booklet	1	item
gloves, non-sterile	4	pair
thermometer probe cover, disposable	2	item
gloves, sterile	1	pair
swab, alcohol	1	item
Gauze,Sterile 4 x 4	2	item
steri-strips	12	strip
tape	6	inch
staple removal kit	1	item
Betadine	10	ml
tincture benzoin swab	1	item

Procedure Specific Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Equipment Cost

Overhead Medical Equipment	No. of units in practice	Equipment Cost
exam table		**1360**
Crash cart, no defibrilator		1135.81

AMA/Specialty Society Update Process
Summary of Recommendation
010 or 090 Day Global Periods
Out-Of-Office Direct Inputs

Sample Size:_____ Response Rate: (%):_____ Global Period: 090

Tracking Number: S2 Reference Code 1 54530* Reference Code 2_____

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

***The inputs for 54522 were crosswalked from existing inputs for CPT code 54530, with additions shown in bold and deletions shown with strikethrough.**

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Complete pre-service diagnostic & referral forms
Coordinate pre-surgery services
Schedule space and equipment in facility
Office visit before surgery/procedure
Review test and exam results
Provide pre-service education/obtain consent

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities: RN time for 2 office visits

Clinical Labor	Pre-Service Time Prior to Admission	Service Period (Admission to Discharge)	Coordianation of Care*	Post-Service Time After Discharge **	Number of Office Visits	Total Time of Office Visits
RN	69				2	64

*By staff in the physician's office during the service period.
**Excluding Time of Office Visits

Medical Supplies	Quantity of Supplies	Units Used for Purchase
patient gown, disposable	2	item
exam table paper	14	foot
pillow case, disposable	2	item
Sani-wipe	10	item
~~Depends~~	~~1~~	~~item~~
patient education booklet	1	item
gloves, non-sterile	4	pair
thermometer probe cover, disposable	2	item
gloves, sterile	1	pair
swab, alcohol	1	item
Gauze,Sterile 4 x 4	2	item
steri-strips	12	strip
tape	6	inch
staple removal kit	1	item
Betadine	10	ml
tincture benzoin swab	1	item
suture removal kit	**1**	**item**
scrotal support	**1**	**item** Need Price
`bdominal body dressing	**1**	**item**

Procedure Specific Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Equipment Cost

Overhead Medical Equipment	No. of units in practice	Equipment Cost
Exam table		1360
Crash cart, no defibrilator		1135.81

AMA SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Cryosurgical Ablation of the Prostate

55873
Work Relative Value Recommendation

New CPT code 55873 *Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement)* describes cryosurgical ablation of the prostate due to prostate cancer. Cryosurgical ablation of the prostate consists of freezing a cancerous prostate causing cell destruction and death. New code 55873 includes placement of a suprapubic tube, which is included in the work of 55873 and not separately reported. Currently, this procedure is reported using the unlisted code 55899 *Unlisted procedure, male genital system*, as CPT does not contain a code that accurately describes this service.

The RUC did not accept the initial specialty society work value recommendation for new code 55873. A Facilitation Committee reviewed this issue and presented the following recommendation to the RUC.

The time and intensity and complexity measures for new code 55873 were compared to the original reference service code 55845 *Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes* (work RVU = 28.55). However, the RUC agreed the work of new code 55873 was more comparable to the work and time described by code 55801 *Prostatectomy, perineal, subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy)* (work RVU = 17.80) with the ultrasonic guidance component included in code 55873. The total physician time of 395 minutes for code 55873 is comparable to the total physician for 55801 of 461 minutes. **The RUC recommends a work relative value of 17.80 for code 55873.**

Practice Expense Recommendations
The RUC recommends that the pre-service clinical staff time be reduced from 89 minutes to 45 minutes (for RN/LPN) to be consistent with other codes in the family. The RUC recommends approval of all other practice expense inputs for this service as presented. This service is performed in a facility setting.

76967
The RUC recommended that the CPT Editorial Panel reconsider its action to create a separate code for ultrasonic guidance for interstitial cryosurgical probe placement, as this service is an inherent component of the cryosurgical ablation of the prostate, code 55873.

The CPT Editorial Panel subsequently rescinded its earlier action to create this code and bundled this service into the primary procedure.

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●55873	O1	Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement)	090	17.80

SUMMARY OF RECOMMENDATION

CPT Code: 55873 Tracking Number: 01 Global Period: 90 Days **Recommended RVW: ~~26.50~~ 17.80 (RUC)**

CPT Descriptor: Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 62 year-old man with clinically localized prostate cancer, having considered all available treatment options, has elected to have cryosurgical ablation of the prostate. *NOTE:* 1. Placement of a suprapubic tube (trocar technique) is included in the work of this procedure; 2. Ultrasonic guidance for interstitial cryosurgical probe placement is not included and may be billed separately. All postoperative care for 90 days is included.

Description of Pre-Service Work:

Appropriate preoperative studies are obtained and reviewed. The patient is seen by the operating surgeon before being given an anesthetic. Procedure specific equipment is checked. The patient is taken to the operating room and given either general or spinal anesthesia, appropriately positioned for the procedure, prepped and draped.

Description of Intra-Service Work:

The patient is in the dorsal lithotomy position. The skin of the perineum and suprapubic area is prepped and draped and the bladder palpated.

The bladder is filled in a retrograde fashion using a syringe or catheter. A trocar puncture is made into the bladder. A guidewire is introduced into the bladder through the sheath once the trocar itself is removed. A skin incision is made to facilitate catheter advancement over the guidewire. A suprapubic tube is placed. This accomplished, the guidewire is removed, the balloon inflated, return checked through the catheter port, and the catheter sutured to the skin. A guidewire is then placed into the bladder through the urethra and a urethral warming device is advanced into the bladder over the guidewire. The guidewire is then removed. The transrectal ultrasound probe is positioned in the rectum. *(Note: see separate CPT descriptor "Ultrasonic guidance for interstitial cryosurgical probe placement").*

Multiple needle passes are made into the prostate through the perineum. The stylet of each needle is removed and an angle tipped wire advanced through the needle into the prostate. The needle sheath is then removed. The process is repeated multiple times until all needles have been replaced with angle tipped wires. A small incision is made on the perineum where each guidewire enters the skin to facilitate passage of a series of sequential dilators. Using these dilators, a tract is made through the perineum and pelvic floor into the prostate. Finally, multiple cryosurgical probes are placed over the guidewires and into the prostate under ultrasonic guidance.

The cryoprobes are cooled to the appropriate setting. The iceball's growth and regression is monitored with ultrasound. A second freeze is routinely done. A third freeze may be done in the area of the urethral diaphragm and prostatic apex by withdrawing the posterior probes. After all areas are treated, the cryoprobes are thawed and removed. The cryoprobe sheath sites in the perineum may be closed with sutures. A compression dressing applied.

Description of Post-Service Work:

The surgeon waits in the operating room and assists the anesthesiologist in transferring the patient to a recovery room stretcher. The patient is transferred to the recovery room. Post-operative orders are written. A detailed operative report is dictated. The surgeon talks with the patient's family about the procedure, diagnosis and post-operative care. The patient is either admitted to the hospital or dismissed home later that day after being assessed by the surgeon. Hospital by-laws require that a detailed discharge summary must be dictated. All postoperative care for 90 days is included.

SURVEY DATA:

Presenter(s) James B. Regan, M.D.

Specialty(s): Urology

Sample Size: 69 Response Rate: (%): 56/69 (81%) Median RVW: 26.50

Type of Sample: Panel

25th Percentile RVW: 24.25 75th Percentile RVW: 28.50 Low: 18.5 High: 35.75
Median Pre-Service Time: 60 Median Intra-Service Time: 200

25th Percentile Intra-Svc Time: 180 75th Percentile Intra-Svc Time: 240 Low: 150 High: 290

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	30	
Critical Care:	0	
Other Hospital Visits:	0	
Discharge Day Mgmt.:	36	1 - 99238
Office Visits:	69	3 - 99213

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
55845	Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	**28.55**

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service CPT 55845
Median Pre-Time	60	45
Median Intra-Time	200	194
Median Immediate Post-service Time	30	30
Median of Aggregate Critical Care Times	0	15
Median of Aggregate Other Hospital Visit Times	0	15
Median Discharge Day Management Time	20	20
Median of Aggregate Office Visit Times	45	45

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4 11	3.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4 31	4.0
Urgency of medical decision making	3.65	3 57

Technical Skill/Physical Effort (Mean)

Technical skill required	4.76	4.31
Physical effort required	4.07	4.07

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.70	4.39

Outcome depends on the skill and judgement of physician	4.78	4 46
Estimated risk of malpractice suit with poor outcome	4 59	3.81

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3 54	3.28
Intra-Service intensity/complexity	4.74	4 17
Post-Service intensity/complexity	3.54	3 52

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

Sixty-nine urologists from solo, single specialty, multi-specialty and academic practices, representing 20 states across the United States, were queried by mail survey.

FREQUENCY INFORMATION

How was this service previously reported? 55899, Unlisted procedure, urinary system

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

Specialty Urology _____ Commonly X Sometimes _____ Rarely

Specialty _____ Commonly _____ Sometimes _____ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Urology _____ Frequency 3,400 _____

Specialty _____ Frequency _____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Urology _____ Frequency 1,000 _____

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? _____ Yes X No

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

CPT Code: 55873, Cryosurgical ablation of the prostate

AMA/Specialty Society Update Process
Summary of Recommendation
010 or 090 Day Global Periods
Out-Of-Office Direct Inputs

Sample Size:_____ Response Rate: (%):_____ Global Period:_____

Tracking Number: __01_____ Reference Code 1 *55810 Reference Code 2_____

*** The inputs for 55873 were crosswalked from existing inputs for CPT code 55810, *Prostatectomy, perineal radical.* For supplies, additions are shown in bold and deletions are indicated by strikethrough.**

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
Pre-service screening
Test and examination results
Informed consent
Assure proper authorization
Organize all necessary personnel for procedure
Organize all necessary personnel and services for the intra-service period
Answer questions from patient and family (face to face and telephone)

Intra-Service Clinical Labor Activities:

none

Post-Service Clinical Labor Activities:

Phone calls to and from patient and family
Put patient in room
Help patient disrobe
Examination of perineum and suprapubic area
Cleaning wound and apply new dressing
Patient education
Calling in prescriptions
Preparing and cleaning room
Sterilizing instruments

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

CPT Code: 55873, Cryosurgical ablation of the prostate

Clinical Labor	Pre-Service Time Prior to Admission	Service Period (Admission to Discharge)	Coordianation of Care*	Post-Service Time After Discharge**	Number of Office Visits	Total Time of Office Visits
RN/LPN	~~89~~ 45			36	3	78

*By staff in the physician's office during the service period.
**Excluding Time of Office Visits

Medical Supplies	Quantity of Supplies	Units Used for Purchase
patient gown, disposable	3	item
exam table paper	21	foot
pillow case, disposable	3	item
Sani-wipe	15	item
~~depends~~	~~1~~	~~item~~
patient education booklet	1	item
gloves, non-sterile	6	pair
thermometer probe cover, disposable	3	item
gloves, sterile	1	pair
swab, alcohol	1	item
Gauze, sterile 4x4	**8**	item
~~steri-strips~~	~~9~~	~~strip~~
tape	6	inch
~~staple removal kit~~	~~1~~	~~item~~
Betadine	10	ml
tincture benzoin swab	1	item
~~syringe, 10 cc or 12 cc~~	~~1~~	~~item~~
suture removal kit	**1**	**item**
foley catheter 93101	**1**	**item**
catheter insertion kit 93102	**1**	**item**
leg bag 93107	**1**	**item**

Procedure Specific Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Equipment Cost
None				

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

CPT Code: 55873, Cryosurgical ablation of the prostate

Overhead Medical Equipment	No. of units in practice	Equipment Cost
exam table		1360
exam lamp		1850
crash cart, no defibrillator		1,135.81
defibrillator with a cardiac monitor		5995

AMA SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Incision and Drainage of Vaginal Hematoma

Work Relative Value Recommendation

New CPT code 57022 *Incision and drainage of vaginal hematoma; post-obstetrical* describes the procedure of incising and draining a vaginal hematoma. Vaginal hematomas may occur as a complication of delivery, vaginal surgery and as a result of accidents. Typically, this procedure is performed on obstetrical patients in the global obstetrical period; however, this procedure requires a return trip to the operating room and therefore, is not considered to be included in the global obstetrical package. This service is also typically performed on an urgent basis. Currently, CPT does not contain an existing code that accurately describes this service; therefore, the unlisted codes 58999 *Unlisted procedure, female genital system (nonobstetrical)* or 59899 *Unlisted procedure, maternity care and delivery* were reported.

The RUC compared new code 57022 to the reference service code 56405 *Incision and drainage of vulva or perineal abscess* (work RVU = 1.43). When evaluating the pre and intra-service times and intensity and complexity measures for new code 57022, these measures were greater than the reference service code 56405 due to the technical difficulty of the procedure and the need to stabilize the patient and arrange for operating room time, as this procedure is often performed on an emergent basis. Based upon the greater intensity and complexity measures for new code 57022, the RUC agreed that this procedure was more comparable to the reference service code 59160 *Curettage, postpartum,* which has a work RVU of 2.71. The RUC agreed that the recommended work value of 2.56, which was also the survey median work relative value, was appropriate. **The RUC recommends a work relative value of 2.56 for code 57022.**

The RUC noted that this recommendation is appropriate for obstetrical patients; however, incision and drainage of vaginal hematomas for sexual abuse cases represents more physician work. The RUC recommends that the specialty society pursue a new code to report this service. A new code was subsequently added by the CPT Editorial Panel. The RUC did not have an opportunity to review this service. A recommendation will be reviewed by the RUC in February 2001, and the RUC will forward the recommendation to HCFA at this time.

Practice Expense Recommendation
The direct inputs for this code were developed by a specialty consensus panel. The specialty's standard supply packages were approved by the RUC with the deletion of the autoclave from the overhead equipment category. This service is performed in a facility setting.

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	**Tracking Number**	**CPT Descriptor**	**Global Period**	**Work RVU Recommendation**
●57022	LL1	Incision and drainage of vaginal hematoma; post-obstetrical	010	2.56
●57023		Incision and drainage of vaginal hematoma; non-obstetrical (eg, post-trauma, spontaneous bleeding)	010	No RUC recommendation at this time

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 57022 Tracking Number: LL1 Global Period: 010 **Recommended RVW:** 2.56

CPT Descriptor: Incision and drainage of vaginal hematoma; post-obstetrical

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 25-year old who recently delivered vaginally has begun complaining of vaginal pain. An examination reveals a large hematoma in the vaginal canal. The patient is taken to the operating room and the vaginal wall is incised and the hematoma evacuated under anesthesia.

Description of Pre-Service Work:

An explanation of the procedure is provided and informed consent is obtained. The patient is positioned and draped. An intravenous line is established.

Description of Intra-Service Work:

The perineal and vaginal areas are prepped with Betadine. A general anesthetic is administered. The vaginal mucosa overlying the hematoma is incised and the hematoma is drained. Bleeding vessels are ligated with suture and the cavity is irrigated. A Penrose drain is placed in the defect and the vaginal mucosa is repaired. The vagina is packed with gauze. A Foley catheter is placed in the bladder.

Description of Post-Service Work:

The patient is observed for 24 hours. The packing and drain are removed before discharge. The Foley catheter is removed. The medical chart is completed and a follow-up visit is scheduled for one week.

SURVEY DATA:

Presenter(s) George Hill, MD and Sandra Reed, MD

Specialty(s): American College of Obstetricians and Gynecologists

Sample Size: 81 Response Rate: (%): 24 (30%) Median RVW: 2.56

Type of Sample (Circle One): random, **panel,** convenience. Explanation of sample size: _____

25th Percentile RVW: 1.8 75th Percentile RVW: 4 Low: 1.3 High: 10

Median Pre-Service Time: 30 Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 20 75th Percentile Intra-Svc Time: 40 Low: 10 High: 60

Median Post-Service Time:	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	20	
Critical Care:		
Other Hospital Visits:	19	99231
Discharge Day Mgmt.:		
Office Visits:	23	99213

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
56405	Incision and drainage of vulva or perineal abscess	1.43
59160	Curettage, postpartum	2.71

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT 56405
Median Pre-Time	30	20
Median Intra-Time	30	20
Median Immediate Post-service Time	20	15
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times	15	0
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times	10	10

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3	2.6
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.6	2.4
Urgency of medical decision making	3.95	2.8

Technical Skill/Physical Effort (Mean)

Technical skill required	3.35	3.00
Physical effort required	3.10	2.4

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.85	3.2
Outcome depends on the skill and judgement of physician	3.81	2 8
Estimated risk of malpractice suit with poor outcome	3.9	3.0

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.38	2.8
Intra-Service intensity/complexity	3.52	3.0
Post-Service intensity/complexity	2.57	2.4

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

57022 represents significantly more work than 56405 due to the greater technical difficulty of the procedure itself (a vaginal hematoma is more difficult to visualize and access). In addition, 57022 is typically performed on an urgent basis – for example, a patient who recently delivered complains of intense pain or experiences a sudden drop in blood pressure. Pre-service work is thus greater due to the need to stabilize the patient, arrange for the operating room, and communicate with the patient's family. Because of these aspects of the procedure, 57022 is similar to 59160 (Postpartum curettage – 2.71 RVUs). ACOG therefore recommends the survey median of 2.56.

FREQUENCY INFORMATION

How was this service previously reported? 58999 or 59899

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

Specialty Ob/Gyn _____ X Commonly ____ Sometimes ____ Rarely

Specialty_____ _____Commonly _____Sometimes _____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty __unknown_____ Frequency_____unknown_____

Specialty _____ Frequency_____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty _____ Frequency_____

Specialty _____ Frequency_____

Do many physicians perform this service across the United States? __X__Yes _____No

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AMA/Specialty Society Update Process
Summary of Recommendation
010 or 090 Day Global Periods
Out-Of-Office Direct Inputs

Sample Size:__6__ Response Rate: (%):_N/A__ Global Period:_010__

Tracking Number:__LL1___ Reference Code 1_56405__ Reference Code 2_____

A consensus panel of 6 ACOG Fellows representing the range of ob-gyn specialists from various geographic locations met to determine the direct practice inputs for a number of ob-gyn procedures.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

None.

Intra-Service Clinical Labor Activities:

None.

ɔst-Service Clinical Labor Activities:

Conduct two follow-up phone calls with the patient, assist with post-operative office visit.

Clinical Labor	Pre-Service Time Prior to Admission	Service Period (Admission to Discharge)	Coordianation of Care*	Post-Service Time After Discharge **	Number of Office Visits	Total Time of Office Visits
RN/LPN/MA	0	0	0	10	1	~~52~~ 43

*By staff in the physician's office during the service period.
**Excluding Time of Office Visits

Medical Supplies	Quantity of Supplies	Units Used for Purchase
ɪadine	10 ml	1500 ml

CPT Code: 57022

~~Disinfectant solution~~	~~0.2 oz~~	~~14 oz. can~~
~~Drape, sheet~~	~~1 item~~	~~100/case~~
~~Exam table paper~~	~~7 foot~~	~~125 ft/roll, 12 rolls/case~~
~~Gloves, non-sterile~~	~~2 pair~~	~~100/box~~
~~Gloves, sterile~~	~~1 pair~~	~~100/box~~
~~KY jelly, single use pack, 5 grams~~	~~1 item~~	~~72/box~~
~~Maxi pad~~	~~1 item~~	~~72/box~~
~~Paper towel~~	~~6 item~~	~~400 sheets/roll~~
~~Patient gown, disposable~~	~~1 item~~	~~50/case~~
~~Pillow case, disposable~~	~~1 item~~	~~100/case~~
~~Soap, antibacterial~~	~~3 ml~~	~~1500 ml~~
~~Speculum, disposable~~	~~1 item~~	~~1 item~~

Supplies include the ACOG approved standard supply packages A and B plus drape sheet (code 11106) and the Betadine listed above. See attached standard supply packages for ACOG.

Procedure Specific Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Equipment Cost
None				

Overhead Medical Equipment	No. of units in practice	Equipment Cost
Power table	1	
~~Autoclave~~	~~1~~	
Fiberoptic exam light	1	
Crash cart, no defibrillator	1	

ACOG
Medical Supply Packages for Ob-Gyn Services

A. Minimum Supply Package for Office Visits

Supply Code Number	Description	Quantity
Multi-specialty minimum supply package for visits (developed by PEAC 2/00):		
11107	Patient gown, disposable	1 item
11111	Exam table paper	7 foot
11112	Pillowcase, disposable	1 item
11302	Gloves, non-sterile	2 pair
11509	Thermometer probe cover, disposable	1 item
ACOG Addition:		
52314	Disinfectant solution	0.2 oz

B. Minimum Supply Package for Pelvic Exam

Supply Code Number	Description	Quantity
31105	KY jelly, single use pack, 5 grams	1 item
31511	Mini pad	1 item
11507	Speculum, disposable	1 item
11513	Swabs, procto	2 item

C. Basic Post-Operative Incision Care Kit for Ob-Gyn Services

Supply Code Number	Description	Quantity
Basic Post-Operative Incision Care Kit (developed by PEAC 2/00):		
14005	Gloves, sterile	1 pair
~~31101~~	~~Swabs, alcohol~~	2 item
31513	Steri-strips	2 package
31514	Tape	12 inch
31702	Staple removal kit	1 item
52301	Betadine	10 ml
31505	Gauze, sterile 4 x 4	1 item
52308	Swab, tincture benzoin	1 item
ACOG Addition:		
11106	Drape, sheet	1 item

Type of Visit	Basic Supply Package
Ob-gyn office visit with pelvic exam	**A + B + drape sheet (1 item, supply code 11106)**
Ob-gyn in-office procedure	**A + B + sterile gloves (1 pair, supply code 14005) + drape sheet (1 item, supply code 11106)**
Ob-gyn post-operative incision care visit	**A + C**
Ob-gyn post-operative incision care visit with pelvic exam	**A + B + C**

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

CPT Code: 57022

TYPE OF SERVICE: Surgical Procedures
010 and 090 Global Periods

SITE OF SERVICE: OUT-OF-OFFICE

Clinical Services	Minutes	Staff Type – Circle
Pre-Service Period *Start. Following visit when decision for surgery or procedure made*		
Complete pre-service diagnostic & referral forms	0	RN, LPN, MA, Other _____
Coordinate pre-surgery services	0	RN, LPN, MA, Other _____
Schedule space and equipment in facility	0	RN, LPN, MA, Other _____
Office visit before surgery/procedure Review test and exam results	0	RN, LPN, MA, Other _____
Provide pre-service education/obtain consent	0	RN, LPN, MA, Other _____
Follow-up phone calls & prescriptions	0	RN, LPN, MA, Other _____
Other Activity (please specify) _____	0	RN, LPN, MA, Other _____
End· When patient enters hospital for surgery/procedure		
Service Period *Start· Patient admitted to hospital for surgery/procedure* *Pre-service services*		
Review charts	0	RN, LPN, MA, Other _____
Greet patient and provide gowning	0	RN, LPN, MA, Other _____
Obtain vital signs	0	RN, LPN, MA, Other _____
Provide pre-service education/obtain consent	0	RN, LPN, MA, Other _____
Prepare room, equipment, supplies	0	RN, LPN, MA, Other _____
Prepare and position patient/ monitor patient/ set up IV	0	RN, LPN, MA, Other _____
Sedate/apply anesthesia	0	RN, LPN, MA, Other _____
Intra-service		
Assist physician in performing surgery/procedure	0	RN, LPN, MA, Other _____

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs
CPT Code: 57022

Post-service

Monitor pt. following service/check tubes, monitors, drains	0	RN, LPN, MA, Other _____
Clean room/equipment by physician staff	0	RN, LPN, MA, Other _____
Assist with ICU or hospital visits	0	RN, LPN, MA, Other _____
Total Number of ICU visits	0	
Total Number of hospital visits	0	
Complete diagnostic forms, lab & X-ray requisitions	0	RN, LPN, MA, Other _____
Review/read X-ray, lab, and pathology reports	0	RN, LPN, MA, Other _____
Discharge day management services, check dressings & wound/ home care instructions/coordinate office visits/prescriptions	0	RN, LPN, MA, Other _____
Coordination of care by staff in office	0	RN, LPN, MA, Other _____
Other Activity (please specify)		
_____	0	RN, LPN, MA, Other _____

End: Patient discharge from hospital

Post-Service Period
Start: Patient discharge from hospital

Conduct phone calls/call in prescriptions	10	RN, LPN, MA, Other _____
Office visits Greet patient, escort to room Provide gowning Interval history & vital signs & chart Assemble previous test reports/results Assist physician during exam Assist with dressings, wound care, suture removal Prepare Dx test, prescription forms Post service education, instruction, counseling Clean room/equip, check supplies Coordinate home or outpatient care	~~52~~ 43	RN, LPN, MA, Other _____
List total number of office visits	A 1	
Total office visit time (A * B)	B ~~52~~ 43	
Conduct phone calls between office visits	0	RN, LPN, MA, Other _____
Other Activity (please specify)		
	0	RN, LPN, MA, Other _____

End: With last office visit before end of global period

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Reversal of Sling Operation for Stress Incontinence

Work Relative Value Recommendation
New CPT code 57287 *Removal or revision of sling for stress incontinence (eg, fascia or synthetic)* describes the removal or revision of a sling due to infection, graft erosion or persistent urinary retention. Currently, CPT does not contain an existing code that accurately describes this service; therefore, this service was reported using the unlisted code 58999 *Unlisted procedure, female genital system (nonobstetrical).*

The RUC did not accept the initial specialty society work value recommendation. Facilitation Committee Two reviewed this issue and presented the following information.

New code 57287 was originally compared to the reference service code 57288 *Sling operation for stress incontinence (eg, fascia or synthetic)* (work RVU = 13.02); however the RUC determined the work to be more comparable to code 51840 *Anterior vesicourethropexy, or urethropexy (Marshall-Marchetti-Krantz, Burch); simple* (work RVU = 10.71) and accordingly recommends a work relative value of 10.71. The RUC noted that the Harvard intra-service time for code 51840 is 74 minutes, which the RUC agreed to be more comparable to the 70 minutes of intra-service time for new code 57287. **The RUC recommends a work relative value of 10.71 for code 57287.**

Practice Expense Recommendation

The practice expense inputs for 57287 were crosswalked from existing inputs for CPT code 51845 *Abdomino-vaginal vesical neck suspension, with or without endoscopic control (eg, Stamey, Raz, modified Pereyra)*. The RUC approved the practice expense inputs for 57287 with the following recommended changes:

- Syringe with water be modified to be supply code 91407 Syringe, 10cc – 12cc.
- The staff type was changed from RN only to RN/LPN
- Staple removal kit removed from medical supplies
- Ultrasound removed from overhead medical equipment

This service is provided in a facility setting.

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	**Tracking Number**	**CPT Descriptor**	**Global Period**	**Work RVU Recommendation**
●57287	T1	Removal or revision of sling for stress incontinence (eg, fascia or synthetic)	090	10.71

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 57287 Tracking Number: T1 Global Period: 090 **Recommended RVW:** ~~12.25~~ **10.71 (RUC)**

CPT Descriptor: Removal or revision of sling for stress incontinence (eg, fascia or synthetic)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 58-year old female with stress urinary incontinence had undergone a transvaginal sling procedure utilizing synthetic material. One year postoperatively, she develops urinary retention and sling removal is recommended.

Description of Pre-Service Work:

Appropriate preoperative studies are obtained and reviewed. The patient is seen by the operating surgeon before being given an anesthetic. Procedure specific equipment is checked. The patient is taken to the operating room and given either general or spinal anesthesia, appropriately positioned for the procedure, prepped and draped.

Description of Intra-Service Work:

A left vaginal incision is performed in the anterior vaginal vault lateral to the urethra and carried down to the graft material. The graft material is mobilized from the surrounding tissue to the level of the endopelvic fascia. The same dissection is carried out on the contralateral side. The graft material is then mobilized underneath the urethra and the graft removed.

Description of Post-Service Work:

The surgeon waits in the operating room and assists the anesthesiologist in transferring the patient to a recovery room stretcher. The patient is transferred to the recovery room. Postoperative orders are written. Prescriptions are written. A detailed operative report is dictated. The surgeon talks with the patient's family about the procedure, diagnosis, and postoperative care. The patient is admitted to the hospital or dismissed home. Postoperative care for the global period is included. Drains are removed when appropriate, either in the hospital or after discharge in the office. Follow up care is arranged and the patient is discharged. Hospital by-laws require that a detailed discharge summary must be dictated.

SURVEY DATA:

Presenter(s) James B. Regan, M.D.

Specialty(s): Urology and Gynecology

Sample Size: 99 Response Rate: 50/99 (51%) Median RVW: 12.25

Type of Sample: panel

25th Percentile RVW: 10.04 75th Percentile RVW: 14.19 Low: 4.00 High: 24.00

Median Pre-Service Time: 45 min Median Intra-Service Time: 70 min

25th Percentile Intra-Svc Time: 60 min 75th Percentile Intra-Svc Time: 120 min Low: 40 min High: 180 min

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	30 min	
Critical Care:	0 min	0
Other Hospital Visits:	38 min	2 - 99231
Discharge Day Mgmt.:	36 min	1 - 99238
Office Visits:	61 min	1- 99212 2- 99213

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
57288	Sling operation for stress incontinence (eg, fascia or synthetic)	13.02

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT 57288
Median Pre-Time	45	47.5
Median Intra-Time	70	90
Median Immediate Post-service Time	30	30
Median of Aggregate Critical Care Times	0	0
Median of Aggregate Other Hospital Visit Times	30	17.5
Median Discharge Day Management Time	15	15
Median of Aggregate Office Visit Times	40	40

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3 66	4.27
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.68	3.68
Urgency of medical decision making	3 64	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	3.94	3.98
Physical effort required	3.74	3.65

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.28	3.79
Outcome depends on the skill and judgement of physician	4 08	4.23

Estimated risk of malpractice suit with poor outcome	4 44	3.90

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.88	3 66
Intra-Service intensity/complexity	4 02	3 81
Post-Service intensity/complexity	3.78	3.47

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The AUA conducted a mail survey of 69 urologists from solo, single specialty, multi-specialty and academic practices. These physicians represent 20 states across the United States. Additionally, 30 urogynecologists were queried by mail survey in cooperation with the American College of Obstetricians and Gynecologists.

FREQUENCY INFORMATION

How was this service previously reported? Unlisted procedure code, 58999.

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

Specialty ____Urology_____ _____Commonly _____Sometimes __X_Rarely

Specialty ____OB/GYN_____ _____Commonly _____Sometimes __X__ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty _____Urology_____ Frequency____Approximately 1,041_____

Specialty _____OB/GYN_____ Frequency____Less than 100_____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty _____Urology_____ Frequency____Less than 100_____

Specialty _____OB/GYN_____ Frequency____Less than 100_____

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

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

CPT Code: 57287, Removal or revision of sling for stress incontinence

AMA/Specialty Society Update Process
Summary of Recommendation
010 or 090 Day Global Periods
Out-Of-Office Direct Inputs

Sample Size:_____ Response Rate: (%):_____ Global Period: 090

Tracking Number: T1 Reference Code 1 51845* Reference Code 2_____

***The inputs for 57287 were crosswalked from existing inputs for CPT code 51845, Abdomino-vaginal vesical neck suspension, with or without endoscopic control (eg, Stamey, Raz, modified Pereyra). For supplies, additions are shown in bold.**

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Pre-service screening
Test and examination results
Informed consent
Assure proper authorization
rganize all necessary personnel for procedure
rganize all necessary personnel and services for the intra-service period
Answer questions from patient and family (face to face and telephone)

Intra-Service Clinical Labor Activities:
none

Post-Service Clinical Labor Activities:
Change drains
Check wounds
Change dressing
Phone calls to and from patient and family
Put patient in room
Examination of perineum
Calling in prescriptions
Prepare and clean room
Sterilizing instruments
Removal of catheter and possible replacement

Clinical Labor	Pre-Service Time Prior to Admission	Service Period (Admission to Discharge)	Coordianation of Care*	Post-Service Time After Discharge **	Number of Office Visits	Total Time of Office Visits
RN/LPN	45			45	3	45

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

CPT Code: 57287, Removal or revision of sling for stress incontinence

'y staff in the physician's office during the service period.
Excluding Time of Office Visits

Medical Supplies	Quantity of Supplies	Units Used for Purchase
patient gown, disposable	3	item
exam table paper	21	foot
pillow case, disposable	3	item
Sani-wipe	15	item
Depends	1	item
patient education booklet	1	item
gloves, non-sterile	8	pair
thermometer probe cover, disposable	3	item
gloves, sterile	1	pair
swab, alcohol	1	item
Gauze,Sterile 4 x 4	2	item
steri-strips	12	strip
tape	6	inch
~~staple removal kit~~	~~1~~	~~item~~
Betadine	10	ml
ıcture benzoin swab	1	item
ıture removal kit	**1**	**item**
Foley catheter 93101	**1**	**item**
~~**vaginal pack**~~	~~**1**~~	~~**item**~~
catheter insertion kit 93102	**1**	**item**
syringe , 10cc-12cc 91407	**1**	**item**

Procedure Specific Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Equipment Cost
none				

Overhead Medical Equipment	No. of units in practice	Equipment Cost
exam table		1360
exam lamp		1850
crash cart, no defibrillator		1135.81
defibrillator with a cardiac ɔnitor		**5995**
~~**.trasound, shimatsu**~~		~~**35000**~~

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

CPT Code: 57287, Removal or revision of sling for stress incontinence

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Endometrial Ablation

Work Relative Value Recommendation
New CPT code 58353 *Endometrial ablation, thermal, without hysteroscopic guidance* was created to describe the use of thermal energy to ablate uterine tissue. Currently, this procedure is reported using code 58563 *Hysteroscopy, surgical; with endometrial ablation (any method)* (work RVU = 6.17) with the modifier –52 (Reduced Services) appended. However, the existing code 58563 describes the procedure performed via a hysteroscope whereas the service described by new code 58353 is performed without using a hysteroscope.

The RUC agreed the physician work for new code 58353 (work RVU = 3.56) was not comparable to the original reference service code 58563 *Hysteroscopy, surgical; with endometrial ablation (any method)* (work RVU = 6.17). The RUC determined that it would be appropriate to subtract the work of a diagnostic hysteroscopy, code 58555 *Hysteroscopy, diagnostic (separate procedure)* (work RVU = 3.33) from the hysteroscopic endometrial ablation code 58563 (work RVU = 6.17), to yield a work relative value of 2.84. However, this value did not reflect the work inherent in dilating the cervix, sounding the uterus and inserting the balloon device. The RUC determined this work to be comparable to that of inserting an intrauterine device, code 58300 *Insertion of intrauterine device (IUD)* (work RVU = 1.01). The RUC added in the work of 58300 (work RVU = 1.01) to 2.84 to obtain a total work relative value of 3.85. This was similar to the survey 25th percentile work RVU = 3.56, which was also the recommended specialty society work value; therefore, the RUC agreed that 3.56 was an acceptable work value. **The RUC recommends a work relative value of 3.56 for code 58353.**

Practice Expense Recommendations
The RUC approved the attached direct practice expense inputs. These inputs were originally developed by the specialty's consensus Panel and standard supply packages were applied to this code. The RUC removed the autoclave from the overhead equipment category. This service is performed in a facility setting.

Code (●New) (▲Revised) (D Deletion) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●58353	E1	Endometrial ablation, thermal, ~~any method~~, without hysteroscopic guidance (For hysteroscopic procedure, use 58563)	010	3.56

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 58353 Tracking Number: E1 Global Period: 010 **Recommended RVW:** 3.56

CPT Descriptor: Endometrial ablation, thermal, without hysteroscopic guidance

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 42 year old premenopausal woman who has completed childbearing was diagnosed with menorrhagia. Pap smear and endometrial biopsy were normal. Standard sonography and hysteroscopy indicated that anatomy of the uterine cavity was normal (depth, 8 cm), and ruled out submucous fibroids, large polyps, and congenital anomalies. Drug therapy was the initial course of action, but multiple courses of hormone replacement therapy proved inadequate. The patient was advised to undergo thermal endometrial ablation.

Description of Pre-Service Work:

A non-steroidal anti-inflammatory drug (NSAID) is given one hour prior to treatment and continued post-operatively as necessary to reduce intra-operative and post-operative uterine cramping. The patient is positioned and anesthetized appropriately. System is visually inspected for defects and signs of wear. Balloon is pre-filled with 5-10cc of D_5W.

Description of Intra-Service Work:

Suction curettage is performed for 3 min. Fluid and air are evacuated from the balloon to a negative pressure of -150 to -200 mmHg. Negative pressure is maintained for 10 seconds. The cervix is dilated to 5 mm, if necessary. Depth of uterus is measured. A balloon catheter is inserted ensuring that the depth indicated is consistent with the previous sound measurement. The balloon catheter is filled to pressure of 160-180 mm Hg and held at stable pressure for a minimum of 30 seconds. The controller is activated to achieve treatment temperature. This cycle may require as much as 4 minutes. The therapy cycle is 8 min. following achievement of 87°C. At completion of the treatment cycle, the fluid is allowed to cool for 30 sec. Fluid is removed from balloon and balloon is removed from uterus.

Description of Post-Service Work:

In the operating room, postoperative services include completing the operative record. In the recovery setting, the patient is typically monitored for approximately one to two hours and given discharge instructions about follow-up care.

SURVEY DATA:

Presenter(s) George Hill, MD and Sandra Reed, MD

Specialty(s): American College of Obstetricians and Gynecologists

Sample Size: 97 Response Rate: (%): 21 (22%) Median RVW: 4.37

Type of Sample (Circle One): random, **panel**, convenience. Explanation of sample size: New procedure not widely performed

25th Percentile RVW: 3.56 75th Percentile RVW: 5.28 Low: 1.79 High: 7.5

Median Pre-Service Time: 52.5 Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 20 75th Percentile Intra-Svc Time: 30 Low: 15 High: 70

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	15	
Critical Care:		
Other Hospital Visits:	15	99231
Discharge Day Mgmt.:		
Office Visits:	15	99213

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
58563	Hysteroscopy, surgical; with endometrial ablation	6.17
58555	Hysteroscopy, diagnostic (separate procedure)	3.33

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	52.5	55
Median Intra-Time	30	40
Median Immediate Post-service Time	15	18
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times	15	NA

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.80	3.89
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.31	3.60
Urgency of medical decision making	2.81	3.10

Technical Skill/Physical Effort (Mean)

Technical skill required	3.13	4.10
Physical effort required	2.88	3.80

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.81	3.90
Outcome depends on the skill and judgement of physician	2.69	4.20
Estimated risk of malpractice suit with poor outcome	2.69	3.40

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.31	3.30
Intra-Service intensity/complexity	3.19	4.50
Post-Service intensity/complexity	2.88	3.20

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

Survey respondents overestimated physician work for 58353. ACOG's RUC committee felt that a reasonable approach to assigning a value for 58353 was to first subtract the work of a diagnostic hysteroscopy (58555 - 3.33 RVUs) from the hysteroscopic endometrial ablation (6.17 RVUs). This yields 2.84 for the endometrial ablation itself . However, this does not account for the work of dilating the cervix, sounding the uterus, and inserting the balloon (thermal device) which the

committee felt was approximately equivalent to the work of inserting an IUD (58300 -- 1.01 RVUs). Therefore, the 25th percentile of 3.56 seems reasonable.

FREQUENCY INFORMATION

How was this service previously reported? 56356-52

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

Specialty_Ob/Gyn_____ _____Commonly __X__Sometimes _____Rarely

Specialty_____ _____Commonly _____Sometimes _____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty __Ob-gyn_____ Frequency__Unknown_____

Specialty _____ Frequency_____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Ob-Gyn_____ Frequency__58353 is not indicated for post-menopausal women

Specialty _____ Frequency_____

Do many physicians perform this service across the United States? _____Yes __X__No

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AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs
CPT Code: 58353

AMA/Specialty Society Update Process
Summary of Recommendation
010 or 090 Day Global Periods
Out-Of-Office Direct Inputs

Sample Size:__6____ Response Rate: (%):_N/A__ Global Period:__010___

Tracking Number:__E1__ Reference Code 1_58563__ Reference Code 2_____

A consensus panel of 6 ACOG Fellows from various geographic locations and representing the range of ob-gyn specialties met to determine the direct practice inputs for a number of ob-gyn procedures.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Review test and exam results, provide pre-service education about the procedure and answer patient's questions.

Intra-Service Clinical Labor Activities:

none

Post-Service Clinical Labor Activities:

Conduct two follow-up phone calls with patient and/or pharmacy. Provide assistance during one post-operative office visit.

Clinical Labor	Pre-Service Time Prior to Admission	Service Period (Admission to Discharge)	Coordination of Care*	Post-Service Time After Discharge **	Number of Office Visits	Total Time of Office Visits
RN/LPN/MA	11	0	0	10	1	52

*By staff in the physician's office during the service period.
**Excluding Time of Office Visits

Medical Supplies	Quantity of Supplies	Units Used for Purchase
Betadine	10 ml	1500 ml
~~Disinfectant solution~~	~~0.2 oz~~	~~14 oz. can~~
~~Drape, sheet~~	~~1 item~~	~~100/case~~
~~Exam table paper~~	~~7 foot~~	~~125 ft/roll, 12 rolls/case~~
~~Gloves, non-sterile~~	~~2 pair~~	~~100/box~~

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

CPT Code: 58353

~~Gloves, sterile~~	~~1 pair~~	~~100/box~~
~~K-Y jelly, single use pack, 5 grams~~	~~1 item~~	~~72/box~~
~~Maxi pad~~	~~1 item~~	~~72/box~~
~~Paper towel~~	~~6 item~~	~~400 sheets/roll~~
~~Patient gown, disposable~~	~~1 item~~	~~50/case~~
~~Pillow case, disposable~~	~~1 item~~	~~100/case~~
~~Soap, antibacterial~~	~~3 ml~~	~~1500 ml~~
~~Speculum, disposable~~	~~1 item~~	~~1 item~~

Medical supplies include the standard ACOG packages A and B plus a drape sheet (code 11106) plus the Betadine listed above. See attached package listing.

Procedure Specific Medical Equipment	**No. of units in practice**	**Minutes of use per procedure**	**Hours per week in use for all services**	**Equipment Cost**
None				

Overhead Medical Equipment	**No. of units in practice**	**Equipment Cost**
Power table	1	
~~Autoclave~~	~~1~~	
Fiberoptic exam light	1	
Crash cart, no defibrillator	1	

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs
CPT Code: 58353

TYPE OF SERVICE: Surgical Procedures
010 and 090 Global Periods

SITE OF SERVICE: OUT-OF-OFFICE

Clinical Services	Minutes	Staff Type – Circle
Pre-Service Period *Start: Following visit when decision for surgery or procedure made*		
Complete pre-service diagnostic & referral forms	0	RN, LPN, MA, Other _____
Coordinate pre-surgery services	0	RN, LPN, MA, Other _____
Schedule space and equipment in facility	0	RN, LPN, MA, Other _____
Office visit before surgery/procedure Review test and exam results	4	RN, LPN, MA, Other _____
Provide pre-service education/obtain consent	7	RN, LPN, MA, Other _____
Follow-up phone calls & prescriptions	0	RN, LPN, MA, Other _____
Other Activity (please specify) _____	0	RN, LPN, MA, Other _____
End: When patient enters hospital for surgery/procedure		
Service Period *Start: Patient admitted to hospital for surgery/procedure* *Pre-service services*		
Review charts	0	RN, LPN, MA, Other _____
Greet patient and provide gowning	0	RN, LPN, MA, Other _____
Obtain vital signs	0	RN, LPN, MA, Other _____
Provide pre-service education/obtain consent	0	RN, LPN, MA, Other _____
Prepare room, equipment, supplies	0	RN, LPN, MA, Other _____
Prepare and position patient/ monitor patient/ set up IV	0	RN, LPN, MA, Other _____
Sedate/apply anesthesia	0	RN, LPN, MA, Other _____
Intra-service		
Assist physician in performing surgery/procedure	0	RN, LPN, MA, Other _____

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs
CPT Code: 58353

Post-service

Monitor pt following service/check tubes, monitors, drains	0	RN, LPN, MA, Other _____
Clean room/equipment by physician staff	0	RN, LPN, MA, Other _____
Assist with ICU or hospital visits	0	RN, LPN, MA, Other _____
Total Number of ICU visits	0	
Total Number of hospital visits	0	
Complete diagnostic forms, lab & X-ray requisitions	0	RN, LPN, MA, Other _____
Review/read X-ray, lab, and pathology reports	0	RN, LPN, MA, Other _____
Discharge day management services, check dressings & wound/ home care instructions/coordinate office visits/prescriptions	0	RN, LPN, MA, Other _____
Coordination of care by staff in office	0	RN, LPN, MA, Other _____
Other Activity (please specify)		
_____	0	RN, LPN, MA, Other _____

End: Patient discharge from hospital

Post-Service Period
Start Patient discharge from hospital

Conduct phone calls/call in prescriptions	10	RN, LPN, MA, Other _____
Office visits Greet patient, escort to room Provide gowning Interval history & vital signs & chart Assemble previous test reports/results Assist physician during exam Assist with dressings, wound care, suture removal Prepare Dx test, prescription forms Post service education, instruction, counseling Clean room/equip, check supplies Coordinate home or outpatient care	52	RN, LPN, MA, Other _____
List total number of office visits	**A 1**	
Total office visit time (A * B)	**B 52**	
Conduct phone calls between office visits	0	RN, LPN, MA, Other _____
Other Activity (please specify)		
	0	RN, LPN, MA, Other _____

End: With last office visit before end of global period

AMA SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Repair of Intracranial Aneurysm

61700

Work Relative Value Recommendation

The RUC recommends that existing code 61700 *Surgery of simple intracranial aneurysm, intracranial approach; carotid circulation* (work RVU = 50.50) be an interim RUC recommendation until such time that the neurosurgeons have time to gather further specific data regarding the difference between a complex intracranial aneurysm versus a simple intracranial aneurysm.

61697

Work Relative Value Recommendation

The RUC recommends that new code 61697 *Surgery of complex intracranial aneurysm, intracranial approach; carotid circulation* be an interim RUC recommendation until such time that the neurosurgeons have time to gather further specific data regarding the difference between a complex intracranial aneurysm versus a simple intracranial aneurysm.

Practice Expense Recommendation

The RUC recommends a crosswalk of the PE inputs for 61697 from 61700.

61702

Work Relative Value Recommendation

The RUC recommends that existing code 61702 *Surgery of simple intracranial aneurysm, intracranial approach; vertebrobasilar circulation* (work RVU = 48.41) be an interim RUC recommendation until such time that the neurosurgeons have time to gather further specific data regarding the difference between a complex intracranial aneurysm versus a simple intracranial aneurysm.

61698

Work Relative Value Recommendation

The RUC recommends that new code 61698 *Surgery of complex intracranial aneurysm, intracranial approach; vertebrobasilar circulation* be an interim RUC recommendation until such time that the neurosurgeons have time to gather further specific data regarding the difference between a complex intracranial aneurysm versus a simple intracranial aneurysm.

Practice Expense Recommendations

The RUC recommends a crosswalk of the PE inputs for 61698 from 61702.

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●61697	NN1	Surgery of complex intracranial aneurysm, intracranial approach; carotid circulation	090	50.52 (Interim)
●61698	NN2	Surgery of complex intracranial aneurysm, intracranial approach; vertebrobasilar circulation (Complex involves aneurysms that are larger than 15mm or with calcification of the aneurysm neck, or with incorporation of normal vessels into the aneurysm neck, or a procedure requiring temporary vessel occlusion, trapping or cardiopulmonary bypass to successfully treat the aneurysm.)	090	48.41 (Interim)
▲61700	NN3	Surgery of simple intracranial aneurysm, intracranial approach; carotid circulation	090	50.52 (Interim)
▲61702	NN4	Surgery of simple intracranial aneurysm, intracranial approach; vertebrobasilar circulation	090	48.41 (Interim)

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April 4, 2000

Patrick Gallagher
Director, Physician Payment Systems
515 N. State St.
Chicago, IL 60610

Subject: Work RVU Recommendations for 6169X1-X2 (NN1-NN2)

Dear Mr. Gallagher:

Recommendations for the proposed new codes and work RVUs for surgical treatment of complex intracranial aneurysms (NN1 and NN2) that are scheduled for the April 2000 RUC meeting are included in this submission. This recommendation is provided in conjunction with the Cerebrovascular Section of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons. All are in agreement that the work values for the two current codes (61700 and 61702) would be appropriate work RVUs to use for the corresponding new "complex" aneurysm codes (6170X and 6170Y).

These two new codes for complex aneurysms are:

6169X1 (NN1) Surgery of complex intracranial aneurysm, intracranial approach; carotid circulation

6169X2 (NN2) Surgery of complex intracranial aneurysm, intracranial approach, vertebrobasilar circulation

Currently, there are two codes for treatment of intracranial aneurysms, one for aneurysms on the carotid artery and it's branches above the tentorium (61700), and the other for aneurysms on vessels of the vertebrobasilar circulation in the posterior cranial fossa (61702). At present, these two codes are used to describe the surgical treatment of any and all intracranial aneurysms.

There are a group of aneurysms that have come to be classed as "complex", in contrast to "simple" aneurysms, and the surgical treatment of such complex aneurysms will generally reflect differences in operative time and adjunctive intraoperative techniques necessary to safely control these aneurysms. This complexity of surgical management usually exceeds that of routine or simple aneurysms. The two new codes for complex aneurysm treatment allow for inclusion of these significant differences and services required in complex aneurysm surgery.

Complex aneurysms are defined as having one or more of the following features:

- larger than 15 mm or
- with calcification in the aneurysmal neck, or
- with incorporation of normal vessels into the aneurysm neck, or
- requiring temporary interruption of circulation to the aneurysm before clipping such as
  -with proximal vessel temporary clipping, or
  -temporary trapping of the vascular segment containing the aneurysm, or
  -circulatory arrest with cardiopulmonary bypass.
- aneurysm puncture to decompress the size of the sac, or
- endaneurysmorrhaphy (surgical excision of the aneurysm sac)

The simple aneurysm surgical codes have been modified to specify the fact that they do not include the above defined features of a complex aneurysm or the adjunctive measures used for their control. The code changes are:

6169X1 (NN1) Surgery of simple intracranial aneurysm, intracranial approach; carotid circulation

6169X2 (NN2) Surgery of simple intracranial aneurysm, intracranial approach, vertebrobasilar circulation

We have requested that these changes be made for ***Tracking Purposes Only.*** We are not proposing a change in valuation of the original aneurysm codes, 61700 or 61702. We are proposing that the work values assigned to the new complex aneurysm codes be valued the same as for the corresponding simple aneurysm codes. The current values and proposed values are as follows:

CPT Code	Current Work RVU	Recommended Work RVU
61700 (simple carotid)	**50.52**	
6169X1 (complex carotid)		**50.52**
61702 (simple vertebrobasilar)	**48.41**	
6169X2 (complex vertebrobasilar)		**48.41**

At present, there is no way to track the patients who have complex aneurysms and operative treatment as distinguished from the entire population of approximately 25,000 patient who annually suffer an aneurysmal subarachnoid hemorrhage. The percentage of this group that meet the criteria for complex intracranial aneurysms is unknown, and without this information, we cannot recommend estimates for work RVUs that – in the end – would be budget neutral. These two new codes will permit tracking the number of such complex aneurysms treated annually to provide data on the actual frequency of complex versus simple aneurysm surgery for their respective intracranial circulation.

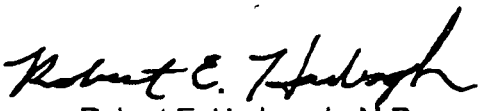
Our recommendation to maintain work-RVUs for the new codes will have no impact on the total amount expended by Medicare on surgical treatment of intracranial aneurysms, since both types of aneurysms are presently combined under the old aneurysm codes. By separating out the patients with complex aneurysm operations, there will be no change in the charges since the RVUs will be the same for both simple and complex aneurysms.

We recommend a work RVU of 50.50 for 6169X1 and a work RVU of 48.41 for 6169X2.

Thank you for your assistance in this process.

Sincerely,

Robert E. Florin, M.D.
AANS Member of the RUC



Robert E. Harbaugh, M.D.,
AANS-CNS Cerebral Vascular Section Liaison

AMA SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Reprogramming of Programmable CSF Shunt

Work Relative Value Recommendations

New code 62252 *Reprogramming of programmable CSF shunt* was created to describe non-invasive changes in the pressure settings of programmable cerebrospinal fluid (CSF) shunts. The shunt is typically programmed through the skin using an electromagnetic current. Currently, CPT does not contain an existing CPT code that accurately identifies this service; therefore the unlisted code 95999, *Unlisted neurological or neuromuscular diagnostic procedure* was reported.

The RUC did not accept the initial specialty society work value recommendation. Facilitation Committee 1 reviewed this issue and presented the following information.

The physician work involved in new code 62252 involves the reading of the setting of a CSF shunt valve implanted beneath the scalp. To ensure exact adjustment of the shunt valve, the physician performs specific patient positioning and x-rays before and after adjustment of the shunt valve in which the radiological services are not separately reportable.

The intra-service work for new code 62252 involves the reprogramming of the CSF shunt valve by using a hand-held electronic transmitter, as well as positioning and x-raying the patient in order to ensure the valve has been set correctly. The associated risk is high, as sudden death may occur and the setting of the valve correctly is very important to assure there is the desired pressure. The RUC adjusted the intra-service time from 15 minutes to 20 minutes to reflect the work involved for the patient positioning and x-ray time before and after shunt programming and to ensure correct valve setting.

The RUC adjusted the pre-service time from 10 minutes to 15 minutes, with the understanding that the reference code 93735 *Electronic analysis of single chamber pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); with reprogramming* (work RVU = 0.74) has similar physician work involved.

The RUC agreed the post-service time was appropriate at 10 minutes for dictation, documentation, phone calls, and discussion with the family.

The RUC came to a consensus that new code 62252 most closely resembles reference service code 93735 *Electronic analysis of single chamber pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); with reprogramming* (work RVU = 0.74) instead of 93738 *Electronic analysis of single or dual chamber pacing cardioverter-defibrillator only (interrogation, evaluation of pulse generator status); with reprogramming* and because of this change, it was agreed that a work RVU of 0.74, rather than the specialty society recommended value of 0.92, was appropriate. **The RUC recommends a work relative value of 0.74 for code 62252.**

Practice Expense Recommendation

The RUC recommends direct inputs for services performed in the non-facility setting. The RUC increased the pre-service clinical staff time from 28 to 35 minutes and approved the standard list of supplies and equipment.

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	**Tracking Number**	**CPT Descriptor**	**Global Period**	**Work RVU Recommendation**
●62252	J1	Reprogramming of programmable CSF shunt	XXX	0.74

CPT Code: 62252 (J1) **Global Period.** XXX **Recommended RVW:** ~~0.92~~ **0.74 (RUC)**

CPT Descriptor: Reprogramming of programmable CSF shunt

Typical Patient (*Survey Vignette*):
A 5-year-old boy with an implanted programmable CSF valve and shunt system is referred by a pediatrician for recent onset of constant complaints of headache. His history includes implantation of the shunt three years prior for hydrocephalus After reviewing the patient chart and previous films, and evaluating the patient in the office, the surgeon decides to decrease the shunt pressure. The surgeon orders a radiograph to determine the current setting of the shunt valve. The surgeon accompanies the patient for the radiograph to supervise "positioning" of the patient. [*Note that the radiographic work is separately reportable by the physician taking the radiograph and that the surgeon is only supervising positioning of the patient, which is critical to correctly visualizing the valve position of the shunt on film.*] After reviewing the results of the radiograph, the physician reprograms the shunt from 120 mmH2O to 80 mmH2O. [*This is done either in the radiology department or back in the surgeon's office, depending on practice location and policy.*] An immediate follow-up radiograph is ordered by the surgeon to confirm that the valve has been set to the desired pressure. The surgeon will supervise "positioning" of the patient for the radiograph. [*As before, the radiographic work is separately reportable by the physician taking the radiograph*]. After confirming the pressure setting, the patient is released from the office/radiology department. A follow-up phone call to the boy's family several days later finds that a headache has not occurred since the reprogramming. A written report is sent to the referring pediatrician [*NOTE. When completing this survey, **ONLY** consider the work that you perform and do not include the work of the separately reportable imaging service.*]

CLINICAL DESCRIPTION OF SERVICE

Description of Pre-Service Work:
- Review patient history and previous films
- Examine and talk with patient
- Order radiograph and supervise patient positioning for film
- Review film with radiologist and ascertain pressure setting

Description of Intra-Service Work:
- Palpate implanted valve through skin posterior to the ear
- Place transmitter head of programmer unit over valve, setting unit to desired pressure

Description of Post-Service Work:
- Order radiograph and supervise patient positioning for film
- Review film with radiologist to confirm pressure setting
- Dictate procedure report
- Discuss procedure outcome with patient and family
- Discuss procedure outcome with referring physician
- Dictate procedure outcome letter for referring physician and/or insurance company

SURVEY DATA

Presenter(s): Richard Boop, MD
Gregory Przybylski, MD

Specialty(s): American Association of Neurological Surgeons

Sample Size: 70 **Response Rate**: 19* (27%)
*it was difficult to find pediatric neurosurgeons familiar with this service

Type of Sample: Random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	0.50	0.78	**0.92**	1.05	4.30
Pre-Service			**15**		
Intra-Service	5	10	**20**	20	60
Post-Service			**10**		

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2000 work RVU	global	Previous survey data for Ref Codes					
				pre min	intra min	post min	ICU visits	ACU visits	Office visits
95971	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple brain, spinal cord, or peripheral (ie, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming	**0.78**	XXX	3	20	3	n/a	n/a	n/a
93738	Electronic analysis of single or dual chamber pacing cardioverter-defibrillator only (interrogation, evaluation of pulse generator status); with reprogramming	**0.92**	XXX	10	20	10	n/a	n/a	n/a

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

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

TIME ESTIMATES (MEDIAN)	Survey CPT 62252	Ref CPT 93738	Ref CPT 95971
Pre-service time	15	See previous survey data shown on table presented above.	
Intra-service time	15		
Post-service time	10		
INTENSITY/COMPLEXITY MEASURES (mean)			
TIME SEGMENTS			
Pre-service	2.53	2.75	2.33
Intra-service	2.22	2.00	2 33
Post-service	2.36	2.25	2.50
MENTAL EFFORT AND JUDGMENT			
The number of possible diagnosis and/or the number of management options that must be considered	2.98	3 33	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.85	3.67	2.50
Urgency of medical decision making	2.34	3.67	2 17
TECHNICAL SKILL/PHYSICAL EFFORT			
Technical skill required	2.34	2.67	2.33
Physical effort required	1.68	2.00	1.67
PSYCHOLOGICAL STRESS			
The risk of significant complications, morbidity and/or mortality	2.45	3.33	2.17
Outcome depends on the skill and judgement of physician	2.91	3.00	3.00
Estimated risk of malpractice suit with poor outcome	2.57	4.00	2.17

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The physician work for this code is limited to the time and work for reading the setting of a CSF shunt valve implanted beneath the scalp, and reprogramming that valve setting by use of a hand held electronic transmitter placed over the valve after entering the desired settings for the valve. This is reported as having a median survey time of 15 minutes. The preservice time is also 15 minutes and the post service, 10 minutes.

The survey respondents equally cited two reference services, 93738 and 95971. Both of these services involve electronic analysis and reprogramming of implanted stimulator devices, one for the spinal cord and the other for the heart Current time data base information indicates that they both have 20 min of intraservice time and both have lesser amounts of pre/post service time compared to 62252. The intensity comparisons mostly fall between the two reference codes, with several components less then either reference. **We recommend the median survey RVW of 0.92 for 62252.** This value is the same as the RVW for 93738.

FREQUENCY INFORMATION

How was this service previously reported?

64999 Unlisted procedure, nervous system
95999 Unlisted neurological or neuromuscular diagnostic procedure

How often do physicians in your specialty perform this service?

Specialty: pediatric neurosurgery	~~Commonly~~	**Sometimes**	~~Rarely~~
Specialty: general neurosurgery	~~Commonly~~	~~Sometimes~~	**Rarely**

For your specialty, estimate the number of times this service might be provided nationally in a one-year period?

The majority of reprogramming services will be provided to the pediatric population with hydrocephalus. It is estimated that about 5000 reprogramming procedures will be performed in CY2000.

Do many physicians perform this service across the United States? ~~Yes~~ **No**

AMA/Specialty Society Update Process
Summary of Recommendation
XXX Global Period

In Office Direct Inputs

CPT Code: 62252 (J1) **Global Period**: XXX

CPT Descriptor: Reprogramming of programmable CSF shunt

Please describe the clinical activities of your staff:

Total service

Complete pre-service diagnostic and referral forms; schedule and coordinate imaging service; provide pre-service education; prepare exam room; greet patient; obtain vitals; assist physician with exam; follow-up phone calls

Clinical Labor	Total service time
RN/LPN/MA	~~28~~ 35 min

Pre-service

1. Schedule skull x-ray 2 minutes
2. Nurse escorts/monitors pt for x-ray(s) 20 minutes

Intra-Service

1. Set-up computer 3 minutes
2. Assist w/ reprogramming 3 minutes
3. Take patient back to exam room 2 minutes

Post-service

1. Call family w/ follow-up 5 additional minutes beyond 99213

Medical Supplies	Quantity of Supplies	Units Used for Purchase
~~Please use standard office visit supplies (e.g., exam table paper, etc.)~~.		
Patient Gown	1 item	
Exam table paper	7 feet	
Pillow case	1 item	
Gloves non-sterile	2 pair	
Temperature probe cover	1 item	

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

CPT Code: 62252

Procedure Specific Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Equipment Cost
Hand help reprogramming device*				

*Additional cost information to be provided at RUC meeting.

Valve Programmer

Catalog Number	Description
82-3121	Programmer, complete 100/120 and 220/240 VAC, IEC, supplied with transmitter head and cord, and carrying case, not sterile
82-3126	Programmer, complete 220/240 VAC supplied with transmitter head and cord, and carrying case, not sterile
82-3130	Transmitter and cord, not sterile

$1,500 cost

These numbers are from the Codman catalog, Codman, a Johnson & Johnson Company Richard Powers 508-828-3179 Dpowers@dpyus.jnj.com

Overhead Medical Equipment	No. of units in practice	Equipment Cost
Please assign standard neurosurgical equipment as indicated in HCFA files. Power table E11001 Crash cart E91002		

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000
Laminotomy Re-Exploration

Work Relative Value Recommendations

The RUC did not have the opportunity to review this issue and will request the specialty societies to present to the RUC at the February 2001 meeting. The RUC will forward any recommendations to HCFA at this time.

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲63040		Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk, reexploration, single interspace; cervical	090	No recommendation at this time.
▲63042		Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk, reexploration, single interspace, lumbar	090	No recommendation at this time
●63043	YY1	each additional cervical interspace (List separately in addition to code for primary procedure) (Use 63043 in conjunction with code 63040)	ZZZ	No recommendation at this time.
●63044	YY2	each additional lumbar interspace (List separately in addition to code for primary procedure) (Use 63044 in conjunction with code 63042) (Codes 63040-63042 are unilateral procedures For bilateral procedures, use modifier '-50')	ZZZ	No recommendation at this time.

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

April 2000

Chemodenervation of Muscles of the Trunk and the Limbs

Work Relative Value Recommendation:
New CPT code 64614 *Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)* was created to describe injection of botulinum toxin into the limb and trunk muscle(s) for treatment of dystonia, spasticity, cerebral palsy, multiple sclerosis and muscle spasms. Botox is a neurotoxin that irreversibly blocks acetocholine, which results in partial paralysis of the muscles. Typically, for vocal dystonia, the physician targets two muscles for injection in which EMG localization is used to identify the muscles. The physician typically targets four to eight muscles for injection in a limb. CPT currently contains codes for chemodenervation for muscles of the face and neck; however, CPT does not contain a code that accurately describes chemodenervation of the trunk and/or limb muscles.

The RUC did not accept the initial specialty society work value recommendation for new code 64614. Facilitation Committee One reviewed this issue and presented the following recommendation to the RUC.

The intensity of work for new code 64614 is greater than the reference service code 64613 *Destruction by neurolytic agent (chemodenervation of muscle endplate); cervical spinal muscles (eg, for spasmodic torticollis)* (work RVU = 1.96), as the muscles to be injected are not easily determinable and there are a greater number of injections performed in the trunk and/or limb muscles. Also, the dosage of botox given is substantially higher in new code 64614 than compared to the reference service code. The RUC noted that this procedure is more difficult and involves more work, as the typical patient is either a stroke or cerebral palsy patient. Additionally, this procedure involves injections into 4-8 muscles whereas the reference service code typically involves injections into less than 4 muscles. The RUC also compared code 64614 to 67345 *Chemodenervation of extraocular muscle* (work RVU = 2.96). The RUC agreed that 2.20 is appropriate as it reflects increased work over codes 64612 and 64613. **The RUC recommends a work relative value of 2.20 for CPT code 64614.**

CPT codes 64612 *Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (eg, for blepharospasm, hemifacial spasm)* and 64613 *Chemodenervation of muscle(s); cervical spinal muscle(s) (eg, for spasmodic torticollis)* were revised; however, the RUC does not recommend a change in the work relative values.

Practice Expense Recommendations

The RUC agreed that the attached list of practice expenses accurately reflected the resources required to perform the procedure in the non-facility setting. There are no direct practice expense inputs when performed in a facility setting.

Code (●New) (▲Revised)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲64612	F1	~~Destruction by neurolytic agent~~ ~~(c~~Chemodenervation of muscle(s); ~~endplate);~~ muscle(s) innervated by facial nerve (eg, for blepharospasm, hemifacial spasm)	010	1.96 (No change)
▲64613	F2	cervical spinal muscle(s) (eg, for spasmodic torticollis)	010	1.96 (No change)
●64614	F3	extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis) (For chemodenervation for strabismus involving the extraocular muscles, use 67345)	010	2.20

0

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 64614 Tracking Number: __ Global Period: 010 **Recommended RVW: ~~2.2~~ 2.20 (RUC)**

CPT Descriptor: Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
A 36-year old, right-handed man complained of severe cramping of his right hand when trying to write or print. This began several years ago but has worsened considerably to the point where his writing is now illegible. Examination shows flexion of the fingers. Based on available clinical and electrodiagnostic information, involuntary overactivity at the flexor digitorum sublimis, flexor carpi ulnaris and flexor digitorum profundus was identified. The specific muscles were identified, and targeted injections using optimal doses of botulinum toxin were administered. The cramping was relieved and the patient could subsequently write legibly for long periods of time.

Description of Pre-Service Work: Pre-procedure work includes the work to confirm whether botulinum toxin would be of benefit and identify the appropriate sites, as well as the discussion with the patient of the procedure, its rationale and risks.

Description of Intra-Service Work: Intra-service work includes preparation of the region for injections, precise localization of each appropriate muscle, and actual botulinum toxin injection at multiple sites along the muscle. Several muscles are usually injected.

Description of Post-Service Work: Post-service work is the dictated report and other communication with the referring MD. Also, the physician reviews the potential complications and again gives the patient guidelines for calling or returning. Further, the value of repeat injection, the timing of that injection and the long-term prognosis are reviewed.

SURVEY DATA:

Presenter(s): James Anthony, MD, Neil Spiegel, DO

Specialty(s): Neurology, Electrodiagnostic Medicine, Physical Medicine and Rehabilitation

Sample Size: ____ **Response Rate: (%):**_____ Median RVW: 2.00

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: Members of AAEM, AAN, and AAPM&R who perform Botox injections and have listed e-mail addresses

25th Percentile RVW: 1.96 75th Percentile RVW: 2.25 Low:1.95 High: 2.96

Median Pre-Service Time: 15 Median Intra-Service Time: 20

25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 30 Low: 10 High: 60

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
64613	Destruction by neurolytic agent (chemodenervation of muscle endplate), cervical spinal muscles (eg, for spasmodic torticollis)	1 96

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

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

TIME ESTIMATES (Median)	CPT Code 64614	Reference Service: 64613
Median Pre-Time	15	15
Median Intra-Time	20	20
Median Immediate Post-service Time	15	10

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.59	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.24	3.19
Urgency of medical decision making	2.24	2.31

Technical Skill/Physical Effort (Mean)

Technical skill required	4.12	4.00
Physical effort required	2.53	2.47

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.06	3.18
Outcome depends on the skill and judgement of physician	4.12	4.00
Estimated risk of malpractice suit with poor outcome	2.94	2.88

INTENSITY/COMPLEXITY MEASURES	CPT Code 64614	Reference Service: 64613
Time Segments (Mean)		
Pre-Service intensity/complexity	2.76	2.82
Intra-Service intensity/complexity	3.76	3.65
Post-Service intensity/complexity	2.65	2.59

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The surveyed code is fundamentally the same as the key reference code with the exceptions that: 1) The appropriate muscles to inject are not as easily determined. 2) The dose of Botox (which correlates with complications) is substantially higher in the surveyed code as compared to the reference codes. 3) The patient population is one that requires more time to understand the implications of the treatment and greater time for review of complications. The patients often have impairment of cognitive function. These factors justify a modest increase in physician work as compared to the reference code.

FREQUENCY INFORMATION

How was this service previously reported?
The CPT codes previously used for reporting this procedure are:

64640 Destruction by neurolytic agent, other peripheral nerve or branch

90782 Therapeutic or diagnostic injection, subcutaneous or intramuscular

90799 Unlisted therapeutic or diagnostic injection

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

Specialty Neurology ____Commonly _X_Sometimes _____Rarely

Specialty Physical Medicine and Rehabilitation ____Commonly _X_Sometimes _____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology Frequency 16,000

Specialty Physical Medicine and Rehabilitation Frequency 16,000

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Neurology Frequency 4,000

Specialty Physical Medicine and Rehabilitation Frequency 4,000

Do many physicians perform this service across the United States? X Yes ___ No

CPT Code: 64614

Specialty Society(s): *American Academy of Neurology*

CPT CODE: *64614* Global Period *010*

CPT Description: *Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)*

Brief Description of Process used to Develop Recommendation and the Composition of Specialty Society Practice Expense Committee:

A Consensus Panel of 30 physicians who participated in the work value survey reviewed and refined data developed by a small group of experts. The consensus panel consists of 30 physicians who have been in practice for between two and twenty-five years, with 50% specializing in physical medicine and rehabilitation and 50% in neurology. Ten percent of our panelists practice in rural areas, 37% in suburban areas, and 43% in urban areas. 49% are in Medical School Faculty Practice Plans, while 17% are in Multispecialty Practices, 27% in Single Specialty Practices, and 7% are Solo Practitioners.

CLINICAL LABOR:

Non-Facility - Pre-Service Clinical Labor Activities:	*Complete pre-service diagnostic & referral forms; Follow-up phone calls and prescriptions*
Non-Facility - Intra-Service Clinical Labor Activities:	*Review charts; Greet patient and provide gowning. This activity is more time consuming than standard "meet and greet" as the patient has suffered a stroke or has cerebral palsy; Obtain vital signs; Provide pre-service education/obtain consent; Prepare room, supplies, and equipment. Prepare and position patient/monitor patient/set up IV. Assist physician in performing procedure; Clean Room and Equipment.*
Non-Facility - Post-Service Clinical Labor Activities:	*Conduct phone calls/call in prescriptions; Conduct phone calls between office visits.*

CLINICAL LABOR - Continued

Total Clinical Staff Time in office: *63 minutes* Total Clinical Staff Time out office: 0

Estimate # of Physician Office Visits in Global Period: *1*

Staff Type	Pre In Office	Intra In Office	Post In Office	Pre Out Office	Intra Out Office	Post Out Office
~~*Registered Nurse*~~ *RN/MA/LPN*	12	41	10			

MEDICAL SUPPLIES:

Supply Code	Description	In Office		Out of Office		Estimated Supplies Cost
20039	30% Myoject disp, hypo, needle electro	1	item	0	item	
11106	drape, sheet	1	item	0	item	
51304	emla topical anesthetic	1	item	0	item	
11111	exam table paper	7	foot	0	foot	
31505	Gauze,Sterile 4 x 4	2	item	0	item	
11302	gloves, non-sterile	2	pair	0	pair	
31713	grounding pad	1	foot	0	foot	
91427	needle, 30g	1	item	0	item	
75045	nerve stimulator	1	item	0	item	
11107	patient gown, disposable	1	item	0	item	
91408	sodium chloride injection, 30 ml	1	item	0	item	
31101	swab, alcohol	2	item	0	item	
91408	syringe, 1ml	1	foot	0	item	

CPT Code: 64614

PROCEDURE SPECIFIC EQUIPMENT

Equipment Code	Description	Minutes of Use Per Procedure In Office	Out of Office	Estimated Total Equipment Cost

none

OVERHEAD EQUIPMENT

Description	Equipment Code	Estimated Total Equipment Cost
exam table	*E11001*	*0*
crash cart , no defibrilator	*E91002*	*0*

CPT Code: 64614

TYPE OF SERVICE: Surgical Procedures
010 and 090 Global Periods

SITE OF SERVICE: In-OFFICE

Clinical Services	Minutes	Staff Type – Circle
Pre-Service Period *Start: Following visit when decision for surgery or procedure made*		
Complete pre-service diagnostic & referral forms	6	**RN, LPN, MA,** Other _____
Coordinate pre-surgery services	_____	RN, LPN, MA, Other _____
Office visit before surgery/procedure Review test and exam results	_____	RN, LPN, MA, Other _____
Provide pre-service education/obtain consent	_____	RN, LPN, MA, Other _____
Follow-up phone calls & prescriptions	6	**RN, LPN, MA,** Other _____
Other Activity (please specify)		
_____	_____	RN, LPN, MA, Other _____
End: When patient enters office for surgery/procedure		
rvice Period *rt: When patient enters office for surgery/procedure* *re-service services*		
Review charts	2	**RN, LPN, MA,**, Other _____
Greet patient and provide gowning	4	**RN, LPN, MA,**, Other _____
Obtain vital signs	2	**RN, LPN, MA,** Other _____
Provide pre-service education/obtain consent	13	**RN, LPN, MA,** Other _____
Prepare room, equipment, supplies	3	**RN, LPN, MA,**, Other _____
Prepare and position patient/ monitor patient/ set up IV	6	**RN, LPN, MA,**
Sedate/apply anesthesia	_____	RN, LPN, MA, Other _____
Intra-service		
Assist physician in performing procedure	10	**RN, LPN, MA,**, Other _____

CPT Code: 64614

`ost-service

Monitor pt following service/check tubes, monitors, drains	_____	RN, LPN, MA, Other _____
Clean room/equipment	1	**RN, LPN, MA,**, Other _____
Complete diagnostic forms, lab & X-ray requisitions	_____	RN, LPN, MA, Other _____
Review/read X-ray, lab, and pathology reports	_____	RN, LPN, MA, Other _____
Check dressings & wound/ home care instructions/coordinate office visits/prescriptions	_____	RN, LPN, MA, Other _____
Other Activity (please specify)		
_____	_____	RN, LPN, MA, Other _____

End. Patient leaves office

Post-Service Period
Start: Patient leaves office

Conduct phone calls/call in prescriptions	5	**RN, LPN, MA,**, Other _____
Office visits		
Greet patient, escort to room		
Provide gowning		
Interval history & vital signs & chart		
`ssemble previous test reports/results		
ssist physician during exam		
Assist with dressings, wound care, suture removal		
Prepare Dx test, prescription forms		
Post service education, instruction, counseling		
Clean room/equip, check supplies		
Coordinate home or outpatient care	_____	RN, LPN, MA, Other _____
List total number of office visits	**A**_____	
Total office visit time (A * B)	**B**_____	
Conduct phone calls between office visits	5	**RN, LPN, MA,**, Other _____
Other Activity (please specify)		
_____	_____	RN, LPN, MA, Other _____

End: With last office visit before end of global period

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
February 2000

Complex Cataract

Work Relative Value Recommendations

CPT code 66982 *Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, endocapsular rings, or primary posterior capsulorrhexis) or patients in the amblyogenic developmental stage*, was created to describe complex extracapsular cataract removal. Complicated cataract extraction cases are infrequently performed and most often referred to surgeons experienced in specialized techniques for removal of these complex lenses. The specialty society surveyed its members and determined that 1.5% of all cataract cases will be reported utilizing this new code. These cases represent the management of complicated cases due to previous trauma, concurrent disease states, or congenital abnormalities. Most often, specialized equipment or techniques are used during the procedure making the cases more time consuming and complicated with more risk and requiring more frequent postoperative follow-up. There is an extraordinary amount of work involved in performing the preoperative evaluation, increased time of performing the procedure and the use of specialized intraoperative devices and techniques and an increase in follow-up visits. These factors differentiate these cases from cataract surgery (CPT code 66984) in which no specific specialized devices or techniques are necessary.

Based on the utilization rate of code 66984, 1.6 million cases are performed per year, with a projected utilization rate of 24,000 cases per year for new code 66982. **Therefore, the RUC recommends a work value of 13.50 for new code 66982.** To maintain work neutrality, the work value for CPT code 66984 should be decreased from a work value of 10.28 to a new revised work value. **Therefore, the RUC recommends a revised work value of 10.23 for code 66984.**

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Practice Expense Recommendation

The RUC recommends that the direct practice expense inputs for this new code be equivalent to code 66984 with the additional clinical staff time and supplies to reflect one additional office visit. The specific inputs are attached on the summary form. This service is performed in a facility setting only.

CPT Code (●New) (▲Revised)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommen-dation
▲66984	U1	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification);	090	10.23
●66982	U2	complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, endocapsular rings, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage (To code implant at time of concurrent surgery, use 66983, 66984, or 66982)	090	13.50

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: 66982 Tracking Number: U1 Global Period: 090 **Recommended RVW:** 13.50

CPT Descriptor:

Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure) manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification);

Complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, endocapsular rings, or primary posterior capsulorrhexis) or patients in the amblyogenic developmental stage.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 71 year old patient with chronic angle closure glaucoma who eight years ago had laser iridotomies with subsequent posterior synechiae. Is currently taking a topical beta blocker twice a day and pilocarpine 2% four times a day with an IOP of 19. Over the past two years the patient has experienced a gradual and painless loss of vision to a level of 20/100 which interferes with their ability to read and drive. The pupil is fixed at 2.5 mm and will not dilate. The lens has 3+ nuclear sclerosis. A cataract extraction is performed using mechanical means, iris hooks, to open the small pupil.

Or

A 5 year old child is noted to have developed traumatic cataract with 20/200 vision following blunt trauma three months prior to surgery. An extracapsular cataract extraction with IOL implantation is performed under general anesthesia. Post-op vigorous amblyopia therapy is begun.

Description of Pre-Service Work:

The patient history and physical exam are reviewed as are all the appropriate pre operative tests. The family is counseled in the preoperative area. The preoperative history, note and exam are documented in the patient record.

Description of Intra-Service Work:

The patient is draped and prepped in the usual sterile manner and the operating microscope is swung into place. A fornyx based flap is then performed and a scleral groove is made for the phacoemulsification port. A side port incision is then made. Despite vigorous dilation, the pupil remains fixed at 2.5 mm so under viscoelastic a spatula is used to lyse all posterior synechiae. Four incisions are then made for the Grieshaber hooks which are inserted and the iris is then retracted to 6mm. The phacoemulsification then proceeds in the usual manner. The hooks are then removed and the four wounds are then checked for water tightness. The eye is then dressed after the usual subconjunctival injections.

Or

The child is draped in the usual sterile manner and the microscope swung into place. After anterior capsulotomy, the usual automated aspiration technique is used to remove the soft nuclear opacity. A posterior capsulotomy is performed prior to IOL insertion. The eye is then dressed in the usual sterile manner after antibiotic injections are given.

Description of Post-Service Work:

The patient is seen in the post-operative area after the op note is dictated. Post op instructions are then given and arrangement for follow up the next day is made. The patient is then seen periodically in the office over the next 90 days mm until the wound is stable and visual rehabilitation is obtained. Amblyopia therapy is commenced.

SURVEY DATA:

Presenter(s) Steven Kamenetzky, MD

Specialty(s): American Academy of Ophthalmology

Sample Size: 90 Response Rate: (%): 36 Median RVW: 13.5

Type of Sample (Circle One): **random,** panel, convenience. Explanation of sample size: _____

25th Percentile RVW: 13.00 75th Percentile RVW: 15.00 Low: 11.28 High: 27.5

Median Pre-Service Time: 40 Median Pre-Service Day of Procedure Time: 20

Median Intra-Service Time: 60

25th Percentile Intra-Svc. Time: 40 75th Percentile Intra-Svc. Time: 60 Low: 25 High: 80

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	15	
Critical Care:	0	
Other Hospital Visits:	0	
Discharge Day Mgmt.:	36	
Office Visits:	115	5 - 99213

CPT Code: 66982

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure) manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)	10.28

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

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

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	40	25
Median Intra-Time	60	45
Median Immediate Post-service Time	15	10
Median of Aggregate Critical Care Times	0	0
Median of Aggregate Other Hospital Visit Times	0	0
Median Discharge Day Management Time	15	10
Median of Aggregate Office Visit Times	128	100

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4	3
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4	3
Urgency of medical decision making	3	3

Technical Skill/Physical Effort (Mean)

Technical skill required	5	4
Physical effort required	4	3

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	5	3

Outcome depends on the skill and judgement of physician	5	4
Estimated risk of malpractice suit with poor outcome	5	4

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4	3
Intra-Service intensity/complexity	5	3
Post-Service intensity/complexity	4	3

ADDITIONAL RATIONALE

With the advent of argon laser iridotomies and trabecuooplasty in the early 1980's there has been produced a pool of patients who have developed extensive scarring of the iris to the human lens. As a result, the pupil has become bound down and fixed in a very small position which precludes visualization at the time of cataract surgery years later. This scarring of the pupil has lead to the development of new instrumentation to pull open the pupil for better visualization during the surgery. At the time of surgery, dissection is carried out to break the old adhesions. The retaining hooks are secured. Each hook (four in all) requires a separate incision into the eye and then each hook must be placed around the pupil and a self retaining spring is then used to hold the pupil open so the cataract can be visualized. After the procedure is performed, each hook must be carefully rotated and removed. The intraservice time is much more complex than for the standard cataract because of the scarring and poor visualization. The iotrogenic risk of posterior capsular tears and vitreous loss is much higher. The post operative course is much more complicated than for a normal cataract because of the secondary iritis caused by the iris manipulation and the frequent high spikes of intraocular pressure during the post op period. Almost all of these patients have underlying glaucoma. Thus the greater number of post op visits. In the amblyogenic patient , the intraservice work is more complex because of the addition of a planned posterior capsulotomy and anterior mechanical vitrectomy. This is never done in an adult cataract. If these additional procedures are not performed there will be a rapid opacification of the posterior capsule and subsequent worsening of the amblyopia. All children in the amblyogenic age group also have the additional need for patching and the treatment of amblyopia the post op period. In addition, many of these kids are fit with anaphakic contact lens within the global period.In light of the greater complexity, technical skill, and length of the intraservice work, the greater number and complexity of the postop visits, and the greater iatrogenic risk of vitreous loss and capsular rupture, a recommended work value of 13.50 was is made.

FREQUENCY INFORMATION

How was this service previously reported? 66984

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

Specialty Ophthalmology ___ Commonly ___ Sometimes X Rarely

Specialty ___ ___ Commonly ___ Sometimes ___ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology Frequency 24000 (1.5% of 1.6million)

Specialty _____ Frequency_____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Ophthalmology Frequency 20000

Specialty _____ Frequency_____

Do many physicians perform this service across the United States? _____Yes X No

PRACTICE EXPENSE DIRECT INPUTS

The supplies, staff time and overhead expenses are as follows:

OMP (Ophthalmic Medical Personnel) 24 minutes pre-time
130 minutes post-time

Supply Code	Decription	Out-Office Number Used	Cost
11302	gloves, non-sterile	10 pair	
53076	Myolfrin 2.5%	.5 ml	
52301	Betadine	5ml	
31103	cotton tipped applicators	10 item	
11110	pad, chin restite	5 item	
31101	swab, alcohol	10 item	
52306	Glutaraldehyde	5 ounces	
53013	fluorsine strips	5 item	
53065	mydriacil 1%	.5 ml	
53073	rev eyes	.5 ml	
53074	ophthaine	.5 ml	
11121	post myd spectacles	2 pair	

Overhead Equipment

Exam Lane
Screening Lane
Crash cart, no defibrilator

AMA SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Implantation or Replacement of Osseointegrated Implant Temporal Bone

69714

Work Relative Value Recommendations
New code 69714 *Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy* was created to describe placement of an osseointegrated device without mastoidectomy to restore hearing sensitivity and speech. Currently, CPT does not contain a code that accurately describes this service; therefore the unlisted code 69799 *Unlisted procedure, middle ear was reported.*

The RUC compared the work survey results to survey reference code 69632 *Tympanoplasty without mastoidectomy (including canalplasty, atticottomy and/or middle ear surgery, initial or revision; with ossicular chain reconstruction (eg, postfenestration)* (work RVU = 12.75). When evaluating the results of the work survey, new code 69714 has comparable work estimates and intensity and complexity measures. The recommended work relative value for new code 69714 is slightly higher than the reference code 69632, as the intraoperative work for 69714 requires more technical skill to assure the durability of the implant. New code 69714 requires greater mental effort and judgement than the reference service code (69632). Postoperatively, new code 69714 requires more work to monitor the wound and area of the implant. Therefore, the RUC agreed that the recommended work relative value of 14.00, which is also the median survey work value, is appropriate. **The RUC recommends a work relative value recommendation of 14.00 for code 69714.**

69715

Work Relative Value Recommendations

New code 697X2 *Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy* was created to describe placement of an osseointegrated device with mastoidectomy to restore hearing sensitivity and speech. CPT code 69714 involves greater work due to the mastoidectomy that is performed to address the chronic mastoid infections. Currently, CPT does not contain an existing CPT code, which accurately describes this service; therefore the unlisted code 69799 *Unlisted procedure, middle ear* was reported.

The RUC compared code 697X2 to the reference service code 69642 *Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction* (work RVU = 16.84) and noted that the new code 697X2 requires greater time and intensity and complexity measures. The median survey work relative value was 18.25, which the RUC agreed was an appropriate work value given the greater intensity and complexity measures for new code 697X2. **The RUC recommends a work relative value of 18.25 for code 69715.**

69717

Work Relative Value Recommendations

New code 69717 *Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy* was created to describe replacement of a new integrated implant without performing a mastoidectomy. New code 69717 represents a revision to code 69714, where the implant is removed and replaced. Currently, CPT does not contain an existing CPT code, which accurately describes this service; therefore the unlisted code 69799 *Unlisted procedure, middle ear* was reported.

When evaluating new code 69717, the RUC compared this work to 69714 and agreed that the intraoperative technical skill was greater for code 69717 than in 69714. The RUC agreed the additional 0.98 RVU's added to the recommended work RVU = (14.00) for code 69714 to calculate a recommended work RVU of 14.98 for 69717 was appropriate. The RUC also compared new code 69717 to the reference service code 69711 *Removal or repair of electromagnetic bone conduction hearing device in temporal bone* (work RVU = 10.44). New code 69717 requires greater time and intensity and complexity measures than the reference service code. The RUC agreed that the recommended work relative value of 14.98, which was also the survey median value was appropriate. **The RUC recommends a work relative value of 14.98 for code 69717.**

69718

Work Relative Value Recommendations

New code 69718 *Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy* was created to describe replacement of a new integrated implant while performing a mastoidectomy. This code describes the replacement as well as the removal. A separate site needs to be found to place a new device; however the device is placed within in the same surgical field. Currently, CPT does not contain an existing CPT code, which accurately describes this service; therefore the unlisted code 69799 *Unlisted procedure, middle ear* was reported.

The RUC compared new code 69718 to the reference service code 69642 *Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction* (work RVU = 16.84). The RUC agreed the new code was greater in time and intensity and complexity measures than the reference service code. New code 69718 has a recommended work relative value of 18.50, which the RUC agreed was appropriate. **The RUC recommends a work relative value of 18.50 for code 69718.**

Practice Expense Recommendations

The direct practice inputs were developed by a specialty consensus panel. The specialty society used the E/M standard clinical staff time for their post-operative office visits. The RUC approved the recommended inputs with only minor modifications to the supplies. All practice expense recommendations are for the facility setting only.

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		Auditory System **Middle Ear** ***Other Procedures***		
●69714	OO1	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy	090	14.00
●69715	OO2	with mastoidectomy	090	18.25
●69717	OO3	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy	090	14.98
●69718	OO4	with mastoidectomy	090	18.50

CPT Code: 69714 **Global Period**: 090 **Recommended RVW**: 14.00

CPT Descriptor: Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy

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Typical Patient (*Survey Vignette*):
An 8-year-old male presents for an osseointegrated implant to restore hearing that has diminished due to chronic otitis media. Previous trials with a hearing aid prosthetic device in the ear resulted in additional infections. At operation, the bone and overlying skin are prepared and the integrated implant and abutment are fitted. Postoperatively, the patient is followed by the surgeon, as necessary, through the 90-day global period

CLINICAL DESCRIPTION OF SERVICE

Pre-service work - Day before surgery:
- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up
- Review planned incisions and procedure

Pre-service work - Day of surgery:
- Change into scrub clothes
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions and obtain informed consent
- Review audiogram, rating the air- and bone-conduction thresholds for each ear and the speech recognition scores for each ear
- Review bony architecture of the temporal bone as displayed on CT scan
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work:
- Measurement and mark site for optimal placement of titanium fixture
- Inject Xylocaine with epinephrine for anesthetic and hemostasis.
- Incise skin to expose mastoid cortex, creating an overlying skin flap and periosteal flap
- Drill pilot hole and ascertain lack of dural contact and lack of sigmoid sinus exposure
- Enlarge pilot hole with spiral drilling to achieve 3.5 mm opening
- Perform final site preparation with controlled tapping of the implantation site
- Place fixture and secure the abutment to the fixture
- Perforate the overlying skin flap, reducing surrounding soft tissues to a maximal thickness of less than 3mm
- Perform gauze wrapping to seat the flap on to the subjacent bone with maximal pressure

Post-op Same day work through discharge
- Write orders for post-op labs and medications
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Answer patient/family questions
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company
- Review instructions for post-discharge wound care and home care with patient and family
- Answer insurance staff questions

- Write orders for post-discharge medications
- Chart patient discharge notes

Post-op Office work - After discharge from hospital
- Examine and talk with patient
- Check wounds and patient progress to confirm implant stability and insure that soft tissues surrounding the implant site are seated on bony surface without subdermal hematoma
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician
- Write orders for medications
- Discuss progress with patient/family
- Dictate patient progress notes for medical chart
- Dictate procedure outcome letter for referring physician

SURVEY DATA

Presenter(s): John Niparko, MD
James H. Kelly, MD

Specialty(s): American Academy of Otolaryngology – Head and Neck Surgery, Inc.

Sample Size: 56 **Response Rate**: 21 (38%):

Type of Sample: random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	7.50	12.68	**14.00**	18.00	30.00
Time (min) and Visits					
24 Hr Preceding Service			**30**		
Day Of Service					
Pre-Service			**25**		
Intra-Service	30	75	**90**	105	250
Immed. Post-Service			**30**		
Post-Service	**Total Time**	**CPT code / # of visits**			
Critical Care		none			
Other Hospital		none			
Discharge Management	36	99238			
Office Visits	68	99213 x 1; 99212 x 3			

KEY REFERENCE SERVICE(S):

'00 RVW	Global	CPT	Descriptor
12.75	090	69632	Tympanoplasty without mastoidectomy (including canalplasty, atticottomy and/or middle ear surgery, initial or revision; with ossicular chain reconstruction (eg, postfenestration)

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

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

TIME ESTIMATES (MEDIAN)	Survey CPT 69714 (n=21)	Ref CPT 69632 (n=5)
Pre-service time	55	45
Intra-service time	90	90
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	0	0
Discharge management time	21	21
Total office visit time	68	53
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	3.25	3.20
Intra-service	3.33	3.40
Post-service	3 00	2.60
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3 62	3 40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3 81	3.40
Urgency of medical decision making	2.29	2.00
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	3.71	4.20
Physical effort required	3.19	3.40
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	3.14	3.40
Outcome depends on the skill and judgement of physician	3.71	4.00
Estimated risk of malpractice suit with poor outcome	3.00	3.20

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation

New codes 69714-69718 describe a family of infrequently performed procedures for the insertion and replacement of a new device to restore hearing sensitivity and speech. 69714 is for implantation of the device. 69717 is for removal and replacement of the device. 69715 and 69718 add the work of a mastoidectomy to 69714 and 69717.

69714 can be considered the base code for this family **The median survey RVW of 14.00 is recommended for 69714**. This value is slightly greater than the reference service 69632, which has an RVW of 12 75 Intraoperatively, 69714 requires more technical skill than 69632 to assure the durability of the implant Postoperative, 69714 requires more work to monitor the wound and area of implant, including cleaning of the site

The survey median RVW of 14.98 is recommended for 69717. This code is essentially a "revision" to 69714, where the implant is removed and replaced. The intraoperative technical skill for 69717 is greater than for 69714. The additional 0.98 rvu's fairly represent the overall increase in total work to perform this *revision* code.

The survey median RVW of 18.25 is recommended for 69715 and the survey median RVW of 18 50 is recommended for 607X4 The difference between 69714 and 69715 would be 4.25 and between 69717 and 69718 would be 3.52. This fairly accounts for the additional intraoperative work to perform a mastoidectomy. These differences also compares well with the difference between 69632 *Tympanoplasty without mastoidectomy* and 69642 *Tympanoplasty with mastoidectomy* (16.84-12.75 = 4.09) or fifty percent of 69501 *Simple mastoidectomy*, which has an RVW of 9.07 (50%=4.53).

In summary, this family of codes are ranked as 69717 slightly greater than 69714, and 69715 and 69718 adding the work of a mastoidectomy to 69714 and 69717. The survey median RVW for each new code correctly rank order the codes within this family and relative to other comparable procedures.

FREQUENCY INFORMATION

How was this service previously reported?

69799 Unlisted procedure, middle ear

How often do physicians in your specialty perform this service?

Specialty: otolaryngology ~~Commonly~~ ~~Sometimes~~ **Rarely**

For your specialty, estimate the number of times this service might be provided nationally in a one-year period?

OO1-OO4 are rarely performed operations. In 1999, a total of 100 osseointegrated implant procedures were performed. It is estimated that the four new codes will be performed in the following ratio: 70:10:10:10 for OO1:OO2:OO3:OO4 respectively.

Do many physicians perform this service across the United States? No

CPT Code: 69715 **Global Period**: 090 **Recommended RVW**: 18.25

CPT Descriptor: Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy

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Typical Patient (*Survey Vignette*):
An 8-year-old male presents for an osseointegrated implant to restore hearing that has diminished due to chronic otitis media. Previous trials with a hearing aid prosthetic device in the ear resulted in additional infections. At operation, a mastoidectomy is performed to address the chronic mastoid infections; the temporal bone and overlying skin are prepared, and the integrated implant and abutment are fitted. Postoperatively, the patient is followed by the surgeon, as necessary, through the 90-day global period.

CLINICAL DESCRIPTION OF SERVICE

Pre-service work - Day before surgery:
- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up
- Review planned incisions and procedure

Pre-service work - Day of surgery:
- Change into scrub clothes
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions and obtain informed consent
- Review audiogram, rating the air- and bone-conduction thresholds for each ear and the speech recognition scores for each ear
- Review bony architecture of the temporal bone as displayed on CT scan
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work:
- Measurement and mark site for optimal placement of titanium fixture
- Inject Xylocaine with epinephrine for anesthetic and hemostasis.
- Incise skin to expose mastoid cortex, creating an overlying skin flap and periosteal flap
- Perform mastoidectomy for excision of disease and exposure of nonaerated segments of the mastoid air cell system
- Drill pilot hole and ascertain lack of dural contact and lack of sigmoid sinus exposure
- Enlarge pilot hole with spiral drilling to achieve 3.5 mm opening
- Perform final site preparation with controlled tapping of the implantation site
- Place fixture and secure the abutment to the fixture
- Perforate the overlying skin flap, reducing surrounding soft tissues to a maximal thickness of less than 3mm
- Perform gauze wrapping to seat the flap on to the subjacent bone with maximal pressure

Post-op Same day work through discharge
- Write orders for post-op labs and medications
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Answer patient/family questions
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company

- Review instructions for post-discharge wound care and home care with patient and family
- Answer insurance staff questions
- Write orders for post-discharge medications
- Chart patient discharge notes

Post-op Office work - After discharge from hospital
- Examine and talk with patient
- Check wounds and patient progress to confirm implant stability and insure that soft tissues surrounding the implant site are seated on bony surface without subdermal hematoma
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician
- Write orders for medications
- Discuss progress with patient/family
- Dictate patient progress notes for medical chart
- Dictate procedure outcome letter for referring physician

SURVEY DATA

Presenter(s): John Niparko, MD
James H. Kelly, MD

Specialty(s). American Academy of Otolaryngology – Head and Neck Surgery, Inc.

Sample Size: 56 **Response Rate**: 18 (33%):

Type of Sample: random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	16.00	16.88	**18.25**	22.00	30.00
Time (min) and Visits					
24 Hr Preceding Service			**30**		
Day Of Service					
Pre-Service			**28**		
Intra-Service	90	120	**155**	203	240
Immed. Post-Service			**30**		
Post-Service	**Total Time**	**CPT code / # of visits**			
Critical Care		none			
Other Hospital		none			
Discharge Management	36	99238			
Office Visits	76	99213 x 2; 99212 x 2			

KEY REFERENCE SERVICE(S):

'00 RVW	Global	CPT	Descriptor
16.84	090	69642	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction

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

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

TIME ESTIMATES (MEDIAN)	Survey CPT 69715 (n=18)	Ref CPT 69642 (n=14)
Pre-service time	58	40
Intra-service time	155	138
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	0	0
Discharge management time	29	36
Total office visit time	76	53
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	4.00	3.50
Intra-service	4 44	4.14
Post-service	3 78	3 21
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	4.22	3.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.22	3.79
Urgency of medical decision making	2 89	3.00
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	4.56	4.36
Physical effort required	4.06	3.71
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	4.11	4.07
Outcome depends on the skill and judgement of physician	4.39	4.29
Estimated risk of malpractice suit with poor outcome	4.00	4.07

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation

New codes 69714-69718 describe a family of infrequently performed procedures for the insertion and replacement of a new device to restore hearing sensitivity and speech 69714 is for implantation of the device. 69717 is for removal and replacement of the device 69715 and 69718 add the work of a mastoidectomy to 69714 and 69717.

69714 can be considered the base code for this family The median survey RVW of 14.00 is recommended for 69714. This value is slightly greater than the reference service 69632, which has an RVW of 12 75. Intraoperatively, 69714 requires more technical skill than 69632 to assure the durability of the implant Postoperative, 69714 requires more work to monitor the wound and area of implant, including cleaning of the site.

The survey median RVW of 14.98 is recommended for 69717. This code is essentially a "revision" to 69714, where the implant is removed and replaced. The intraoperative technical skill for 69717 is greater than for 69714. The additional 0.98 rvu's fairly represent the overall increase in total work to perform this *revision* code.

The survey median RVW of 18.25 is recommended for 69715 and the survey median RVW of 18.50 is recommended for 607X4. The difference between 69714 and 69715 would be 4.25 and between 69717 and 69718 would be 3.52. This fairly accounts for the additional intraoperative work to perform a mastoidectomy. These differences also compares well with the difference between 69632 *Tympanoplasty without mastoidectomy* and 69642 *Tympanoplasty with mastoidectomy* (16.84-12.75 = 4.09) or fifty percent of 69501 *Simple mastoidectomy*, which has an RVW of 9.07 (50%=4.53).

In summary, this family of codes are ranked as 69717 slightly greater than 69714, and 69715 and 69718 adding the work of a mastoidectomy to 69714 and 69717. The survey median RVW for each new code correctly rank order the codes within this family and relative to other comparable procedures.

FREQUENCY INFORMATION

How was this service previously reported?

69799 Unlisted procedure, middle ear

How often do physicians in your specialty perform this service?

Specialty: otolaryngology ~~Commonly~~ ~~Sometimes~~ **Rarely**

For your specialty, estimate the number of times this service might be provided nationally in a one-year period?

OO1-OO4 are rarely performed operations. In 1999, a total of 100 osseointegrated implant procedures were performed. It is estimated that the four new codes will be performed in the following ratio: 70:10:10:10 for OO1:OO2:OO3:OO4 respectively.

Do many physicians perform this service across the United States? No

CPT Code: 69717 **Global Period**: 090 **Recommended RVW**: 14.98

CPT Descriptor: Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy

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Typical Patient (*Survey Vignette*):
A 16-year-old male presents for removal and replacement of an osseointegrated implant. At operation, the implant is removed, the bone and overlying skin are revised for fitting with a new integrated implant and abutment. Postoperatively, the patient is followed by the surgeon, as necessary, through the 90-day global period.

CLINICAL DESCRIPTION OF SERVICE:

Pre-service work - Day before surgery:
- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up
- Review planned incisions and procedure

Pre-service work - Day of surgery:
- Change into scrub clothes
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions and obtain informed consent
- Review audiogram, rating the air- and bone-conduction thresholds for each ear and the speech recognition scores for each ear
- Review bony architecture of the temporal bone as displayed on CT scan
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work:
- Measurement and mark site for optimal placement of titanium fixture
- Inject Xylocaine with epinephrine for anesthetic and hemostasis.
- Incise skin to expose mastoid cortex, creating an overlying skin flap and periosteal flap
- Remove existing implant with incision of surrounding soft tissue or drill out of surrounding bone
- Drill pilot hole for replacement implant and ascertain lack of dural contact and lack of sigmoid sinus exposure
- Enlarge pilot hole with spiral drilling to achieve 3.5 mm opening
- Perform final site preparation with controlled tapping of the implantation site
- Place fixture and secure the abutment to the fixture
- Perforate the overlying skin flap, reducing surrounding soft tissues to a maximal thickness of less than 3mm
- Perform gauze wrapping to seat the flap on to the subjacent bone with maximal pressure

Post-op Same day work through discharge
- Write orders for post-op labs and medications
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Answer patient/family questions
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company
- Review instructions for post-discharge wound care and home care with patient and family

- Answer insurance staff questions
- Write orders for post-discharge medications
- Chart patient discharge notes

Post-op Office work - After discharge from hospital
- Examine and talk with patient
- Check wounds and patient progress to confirm implant stability and insure that soft tissues surrounding the implant site are seated on bony surface without subdermal hematoma
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician
- Write orders for medications
- Discuss progress with patient/family
- Dictate patient progress notes for medical chart
- Dictate procedure outcome letter for referring physician

SURVEY DATA

Presenter(s): John Niparko, MD
James H. Kelly, MD

Specialty(s): American Academy of Otolaryngology – Head and Neck Surgery, Inc.

Sample Size: 56 **Response Rate**: 18 (33%):

Type of Sample: random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	9.50	11.25	**14.98**	17.00	33.68
Time (min) and Visits					
24 Hr Preceding Service			**30**		
Day Of Service					
Pre-Service			**20**		
Intra-Service	60	80	**95**	120	180
Immed. Post-Service			**28**		
Post-Service	**Total Time**	**CPT code / # of visits**			
Critical Care		none			
Other Hospital		none			
Discharge Management	36	99238			
Office Visits	68	99213 x 1; 99212 x 3			

KEY REFERENCE SERVICE(S):

'00 RVW	Global	CPT	Descriptor
10.44	090	69711	Removal or repair of electromagnetic bone conduction hearing device in temporal bone

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

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

TIME ESTIMATES (MEDIAN)	Survey CPT 69717 (n=18)	Ref CPT 69711 (n=8)
Pre-service time	50	35
Intra-service time	95	68
Immediate Post-service time	28	20
Total critical care time	0	0
Total other hospital visit time	0	0
Discharge management time	24	21
Total office visit time	68	53
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	3.29	2.67
Intra-service	3.65	2.33
Post-service	3 06	2 00
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3 61	2.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.61	2.33
Urgency of medical decision making	2.61	2.00
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	3.89	2.00
Physical effort required	3.56	2.17
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	3 17	2.00
Outcome depends on the skill and judgement of physician	3.61	2.17
Estimated risk of malpractice suit with poor outcome	3.11	2.33

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

New codes 69714-69718 describe a family of infrequently performed procedures for the insertion and replacement of a new device to restore hearing sensitivity and speech 69714 is for implantation of the device 69717 is for removal and replacement of the device. 69715 and 69718 add the work of a mastoidectomy to 69714 and 69717.

69714 can be considered the base code for this family. The median survey RVW of 14.00 is recommended for 69714. This value is slightly greater than the reference service 69632, which has an RVW of 12 75. Intraoperatively, 69714 requires more technical skill than 69632 to assure the durability of the implant Postoperative, 69714 requires more work to monitor the wound and area of implant, including cleaning of the site.

The survey median RVW of 14.98 is recommended for 69717. This code is essentially a "revision" to 69714, where the implant is removed and replaced The intraoperative technical skill for 69717 is greater than for 69714. The additional 0.98 rvu's fairly represent the overall increase in total work to perform this *revision* code

The survey median RVW of 18.25 is recommended for 69715 and the survey median RVW of 18.50 is recommended for 607X4. The difference between 69714 and 69715 would be 4.25 and between 69717 and 69718 would be 3.52 This fairly accounts for the additional intraoperative work to perform a mastoidectomy. These differences also compares well with the difference between 69632 *Tympanoplasty without mastoidectomy* and 69642 *Tympanoplasty with mastoidectomy* (16.84-12.75 = 4.09) or fifty percent of 69501 *Simple mastoidectomy*, which has an RVW of 9.07 (50%=4.53).

In summary, this family of codes are ranked as 69717 slightly greater than 69714, and 69715 and 69718 adding the work of a mastoidectomy to 69714 and 69717. The survey median RVW for each new code correctly rank order the codes within this family and relative to other comparable procedures.

FREQUENCY INFORMATION

How was this service previously reported?

69799 Unlisted procedure, middle ear

How often do physicians in your specialty perform this service?

Specialty: otolaryngology ~~Commonly~~ ~~Sometimes~~ **Rarely**

For your specialty, estimate the number of times this service might be provided nationally in a one-year period?

OO1-OO4 are rarely performed operations. In 1999, a total of 100 osseointegrated implant procedures were performed. It is estimated that the four new codes will be performed in the following ratio: 70:10:10:10 for OO1:OO2:OO3:OO4 respectively.

Do many physicians perform this service across the United States? No

CPT Code: 69718 **Global Period**: 090 **Recommended RVW**: 18.50

CPT Descriptor: Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy

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Typical Patient (*Survey Vignette*):
A 16-year-old male presents for removal and replacement of an osseointegrated implant. At operation, a mastoidectomy is performed to address the chronic mastoid infections, the implant is removed, and the bone and overlying skin are revised for fitting with a new integrated implant and abutment.
Postoperatively, the patient is followed by the surgeon, as necessary, through the 90-day global period.

CLINICAL DESCRIPTION OF SERVICE

Pre-service work - Day before surgery:
- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up
- Review planned incisions and procedure

Pre-service work - Day of surgery:
- Change into scrub clothes
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions and obtain informed consent
- Review audiogram, rating the air- and bone-conduction thresholds for each ear and the speech recognition scores for each ear
- Review bony architecture of the temporal bone as displayed on CT scan
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra-service work:
- Measurement and mark site for optimal placement of titanium fixture
- Inject Xylocaine with epinephrine for anesthetic and hemostasis.
- Incise skin to expose mastoid cortex, creating an overlying skin flap and periosteal flap
- Remove existing implant with incision of surrounding soft tissue or drill out of surrounding bone
- Perform mastoidectomy for excision of disease and exposure of nonaerated segments of the mastoid air cell system
- Drill pilot hole for replacement implant and ascertain lack of dural contact and lack of sigmoid sinus exposure
- Enlarge pilot hole with spiral drilling to achieve 3.5 mm opening
- Perform final site preparation with controlled tapping of the implantation site
- Place fixture and secure the abutment to the fixture
- Perforate the overlying skin flap, reducing surrounding soft tissues to a maximal thickness of less than 3mm
- Perform gauze wrapping to seat the flap on to the subjacent bone with maximal pressure

Post-op Same day work through discharge
- Write orders for post-op labs and medications
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Answer patient/family questions
- Dictate post-op report
- Discuss procedure outcome with referring physician

- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company
- Review instructions for post-discharge wound care and home care with patient and family
- Answer insurance staff questions
- Write orders for post-discharge medications
- Chart patient discharge notes

Post-op Office work - After discharge from hospital

- Examine and talk with patient
- Check wounds and patient progress to confirm implant stability and insure that soft tissues surrounding the implant site are seated on bony surface without subdermal hematoma
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician
- Write orders for medications
- Discuss progress with patient/family
- Dictate patient progress notes for medical chart
- Dictate procedure outcome letter for referring physician

SURVEY DATA

Presenter(s): John Niparko, MD
James H. Kelly, MD

Specialty(s): American Academy of Otolaryngology – Head and Neck Surgery, Inc.

Sample Size: 56 **Response Rate**: 18 (33%):

Type of Sample: random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	16.00	17.13	**18.50**	25.75	35.00
Time (min) and Visits					
24 Hr Preceding Service			**30**		
Day Of Service					
Pre-Service			**23**		
Intra-Service	100	150	**175**	240	280
Immed. Post-Service			**30**		
Post-Service	**Total Time**	**CPT code / # of visits**			
Critical Care		none			
Other Hospital		none			
Discharge Management	36	99238			
Office Visits	76	99213 x 2; 99212 x 2			

KEY REFERENCE SERVICE(S):

'00 RVW	Global	CPT	Descriptor
16.84	090	69642	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction

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

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

TIME ESTIMATES (MEDIAN)	Survey CPT 69718 (n=18)	Ref CPT 69642 (n=14)
Pre-service time	53	35
Intra-service time	175	140
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	0	0
Discharge management time	29	34
Total office visit time	76	53
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	4.28	3.54
Intra-service	4.50	4.08
Post-service	3.67	3.31
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	4.11	3.85
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.17	3.85
Urgency of medical decision making	3.11	3.15
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	4.50	4.23
Physical effort required	4.06	3.69
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	4.11	4.08
Outcome depends on the skill and judgement of physician	4.28	4.23
Estimated risk of malpractice suit with poor outcome	3.94	4.15

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

New codes 69714-69718 describe a family of infrequently performed procedures for the insertion and replacement of a new device to restore hearing sensitivity and speech. 69714 is for implantation of the device 69717 is for removal and replacement of the device 69715 and 69718 add the work of a mastoidectomy to 69714 and 69717.

69714 can be considered the base code for this family. The median survey RVW of 14 00 is recommended for 69714. This value is slightly greater than the reference service 69632, which has an RVW of 12.75 Intraoperatively, 69714 requires more technical skill than 69632 to assure the durability of the implant. Postoperative, 69714 requires more work to monitor the wound and area of implant, including cleaning of the site.

The survey median RVW of 14.98 is recommended for 69717. This code is essentially a "revision" to 69714, where the implant is removed and replaced. The intraoperative technical skill for 69717 is greater than for 69714. The additional 0 98 rvu's fairly represent the overall increase in total work to perform this *revision* code.

The survey median RVW of 18 25 is recommended for 69715 **and the survey median RVW of 18.50 is recommended for 607X4** The difference between 69714 and 69715 would be 4.25 and between 69717 and 69718 would be 3 52. This fairly accounts for the additional intraoperative work to perform a mastoidectomy. These differences also compares well with the difference between 69632 *Tympanoplasty without mastoidectomy* and 69642 *Tympanoplasty with mastoidectomy* (16.84-12.75 = 4.09) or fifty percent of 69501 *Simple mastoidectomy*, which has an RVW of 9.07 (50%=4.53)

In summary, this family of codes are ranked as 69717 slightly greater than 69714, and 69715 and 69718 adding the work of a mastoidectomy to 69714 and 69717. The survey median RVW for each new code correctly rank order the codes within this family and relative to other comparable procedures.

FREQUENCY INFORMATION

How was this service previously reported?

69799 Unlisted procedure, middle ear

How often do physicians in your specialty perform this service?

Specialty: otolaryngology ~~Commonly~~ ~~Sometimes~~ **Rarely**

For your specialty, estimate the number of times this service might be provided nationally in a one-year period?

OO1-OO4 are rarely performed operations. In 1999, a total of 100 osseointegrated implant procedures were performed. It is estimated that the four new codes will be performed in the following ratio: 70:10:10:10 for OO1:OO2:OO3:OO4 respectively.

Do many physicians perform this service across the United States? No

CPT Code: 697/4 Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy

AMA/Specialty Society Update Process
Summary of Recommendation
010 or 090 Day Global Periods
Out-Of-Office Direct Inputs

Sample Size:_____ Response Rate: (%):_____ Global Period:_____

Tracking Number:_____ Reference Code 1 _____ Reference Code 2_____

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

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

vork group of 7 practicing otolaryngologists was convened to review the survey results for physician work. ..is work group included 3 subspecialists, two individuals in academic practice, three in private practice and one in a large multispecialty private practice. Three are from the middle Atlantic region, two are from the southwest, one is from the mid-west, and one is from the west. This group identified a reference code with comparable resource inputs. AAO-HNS staff then reviewed the identified reference code and made adjustments as needed to be consistent with the number of post-operative office visits identified by the survey on physician work and to be consistent with the RUC instructions for developing direct practice expense inputs for new/revised codes. The reference code used for new code 697/4 was existing code 69632.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
Complete pre-service diagnostic and referral forms, coordinate pre-surgery services, schedule space and equipment in facility, review test and exam results, provide pre-service education and obtain consent, follow-up phone calls and respond to clinical questions from patient.

Intra-Service Clinical Labor Activities:

Provide coordination of care activities while patient is in hospital; e.g., coordination of home or outpatient care, provide education, instructions and counseling to family members. The patient is treated by a variety of physicians; anestheiologists, cardiologists, pulmonary medicine, etc., each

-t-Service Clinical Labor Activities: providing recommendations, and consultation to family members.

CPT Code: 697/4 Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy

Conduct phone calls and call in prescriptions; three office visits (99213- 1; 99212- 3); conduct phone calls with patic and/or family members between visits.

Clinical Labor	Pre-Service Time Prior to Admission	Service Period (Admission to Discharge)	Coordination of Care*	Post-Service Time After Discharge**	Number of Office Visits	Total Time of Office Visits
RN						
LPN						
MA						
RN/LPN/MA	73		30	30	4	117

*By staff in the physician's office during the service period.

**Excluding Time of Office Visits

Medical Supplies	Quantity of Supplies	Units Used for Purchase
Patient gown, disposable	4	Item
Pillow case, disposable	4	Item
Gloves, non sterile	~~4~~ 8	Pair
Thermometer probe cover	4	Item
Tongue depressor	4	Item
Exam table paper	28	Feet
Sterile Gloves	4	Pair
Alcohol swabs	8	Item
Steri-strips	8	Package
Tape	48	Inches
10 ml betadine	80	Units
Gauze packages, 10 4x4	8	Package
Tincture Binzoin Swab	4	Item

Procedure Specific Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Equipment Cost
No Equipment				

CPT Code: 697/4 Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy

Overhead Medical Equipment	**No. of units in practice**	**Equipment Cost**
Fiberoptic exam light		$609
Reclining exam chair w/headrest		$4495
Light Source		$1700
Suction machine		$732
Crash cart, no defibrillator		$1136

CPT Code: 69714 Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy

TYPE OF SERVICE: Surgical Procedures
010 and 090 Global Periods

SITE OF SERVICE: OUT-OF-OFFICE

Clinical Services	Minutes	Staff Type – Circle
Pre-Service Period *Start: Following visit when decision for surgery or procedure made*		
Complete pre-service diagnostic & referral forms	10	RN, LPN, MA, Other RN/LPN/MA
Coordinate pre-surgery services	10	RN, LPN, MA, Other RN/LPN/MA
Schedule space and equipment in facility	10	RN, LPN, MA, Other RN/LPN/MA
Office visit before surgery/procedure Review test and exam results	27	RN, LPN, MA, Other RN/LPN/MA
Provide pre-service education/obtain consent	10	RN, LPN, MA, Other RN/LPN/MA
Follow-up phone calls & prescriptions	6	RN, LPN, MA, Other RN/LPN/MA
Other Activity (please specify) _____	_____	RN, LPN, MA, Other
End: When patient enters hospital for surgery/procedure		
Service Period *Start: Patient admitted to hospital for surgery/procedure* *Pre-service services*		
Review charts	_____	RN, LPN, MA, Other _____
Greet patient and provide gowning	_____	RN, LPN, MA, Other _____
Obtain vital signs	_____	RN, LPN, MA, Other _____
Provide pre-service education/obtain consent	_____	RN, LPN, MA, Other _____
Prepare room, equipment, supplies	_____	RN, LPN, MA, Other _____
Prepare and position patient/ monitor patient/ set up IV	_____	RN, LPN, MA, Other _____
Sedate/apply anesthesia	_____	RN, LPN, MA, Other _____
Intra-service		
Assist physician in performing surgery/procedure	_____	RN, LPN, MA, Other _____

CPT Code: 697/4 Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy

Post-service

Monitor pt. following service/check tubes, monitors, drains	_____	RN, LPN, MA, Other
Clean room/equipment by physician staff	_____	RN, LPN, MA, Other
Assist with ICU or hospital visits	_____	RN, LPN, MA, Other
Total Number of ICU visits	_____	
Total Number of hospital visits	_____	
Complete diagnostic forms, lab & X-ray requisitions	_____	RN, LPN, MA, Other
Review/read X-ray, lab, and pathology reports	_____	RN, LPN, MA, Other
Discharge day management services, check dressings & wound/ home care instructions/coordinate office visits/prescriptions	_____	RN, LPN, MA, Other
Coordination of care by staff in office	30	RN, LPN, MA, Other RN/LPN/MA
Other Activity (please specify)		
_____	_____	RN, LPN, MA, Other _____

End: Patient discharge from hospital

Post-Service Period
Start: Patient discharge from hospital

Conduct phone calls/call in prescriptions	15	RN, LPN, MA, Other RN/LPN/MA
Office visits Greet patient, escort to room Provide gowning Interval history & vital signs & chart Assemble previous test reports/results Assist physician during exam Assist with dressings, wound care, suture removal Prepare Dx test, prescription forms Post service education, instruction, counseling Clean room/equip, check supplies Coordinate home or outpatient care		RN, LPN, MA, Other
List total number of office visits (99213 x 1 + 99212 x 3) = 4	**A** 4	
Total office visit time (A * B)	**B** 117	
Conduct phone calls between office visits	15	RN, LPN, MA, Other RN/LPN/MA
Other Activity (please specify)		RN, LPN, MA, Other

End: With last office visit before end of global period

CPT Code: 697/5

Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy

AMA/Specialty Society Update Process
Summary of Recommendation
010 or 090 Day Global Periods
Out-Of-Office Direct Inputs

Sample Size:_____ Response Rate: (%):_____ Global Period:_____

Tracking Number:_____ Reference Code 1 _____ Reference Code 2_____

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

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

A work group of 7 practicing otolaryngologists was convened to review the survey results for physician work. This work group included 3 subspecialists, two individuals in academic practice, three in private practice and one in a large multispecialty private practice. Three are from the middle Atlantic region, two are from the southwest, one is from the mid-west, and one is from the west. This group identified a reference code with comparable resource inputs. AAO-HNS staff then reviewed the identified reference code and made adjustments as needed to be consistent with the number of post-operative office visits identified by the survey on physician work and to be consistent with the RUC instructions for developing direct practice expense inputs for new/revised codes. The reference code used for new code 697/5 was existing code 69642.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
Complete pre-service diagnostic and referral forms, coordinate pre-surgery services, schedule space and equipment in facility, review test and exam results, provide pre-service education and obtain consent, follow-up phone calls and respond to clinical questions from patient.

Intra-Service Clinical Labor Activities:

Provide coordination of care activities while patient is in hospital; e.g., coordination of home or outpatient care, provide education, instructions and counseling to family members. The patient is treated by a variety of physicians; anestheiologists, cardiologist, pulmonary medicine, etc., each providing recommendations, and consultations ' family members.

Post-Service Clinical Labor Activities:

Conduct phone calls and call in prescriptions; three office visits (99213- 2; 99212- 2); conduct phone calls with patient and/or family members between visits.

CPT Code: 69715

Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy

Clinical Labor	Pre-Service Time Prior to Admission	Service Period (Admission to Discharge)	Coordination of Care*	Post-Service Time After Discharge**	Number of Office Visits	Total Time of Office Visits
RN						
LPN						
MA						
RN/LPN/MA	73		30	30	4	126

*By staff in the physician's office during the service period.

**Excluding Time of Office Visits

Medical Supplies	Quantity of Supplies	Units Used for Purchase
Patient gown, disposable	4	Item
Pillow case, disposable	4	Item
Gloves, non sterile	~~4~~ 8	Pair
Thermometer probe cover	4	Item
Tongue depressor	4	Item
Exam table paper	28	Feet
Sterile Gloves	4	Pair
Alcohol swabs	8	Item
Steri-strips	8	Package
Tape	48	Inches
10 ml betadine	80	Units
Gauze packages, 10 4x4	8	Package
Tincture Binzoin Swab	4	Item

Procedure Specific Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Equipment Cost
No Equipment				

CPT Code: 69715

Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy

Overhead Medical Equipment	No. of units in practice	Equipment Cost
Fiberoptic exam light		$609
Reclining exam chair w/headrest		$4495
Light Source		$1700
Suction machine		$732
Crash cart, no defibrillator		$1136

CPT Code: 69715

Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy

TYPE OF SERVICE: Surgical Procedures
010 and 090 Global Periods

SITE OF SERVICE: OUT-OF-OFFICE

Clinical Services	Minutes	Staff Type – Circle
Pre-Service Period		
Start: Following visit when decision for surgery or procedure made		
Complete pre-service diagnostic & referral forms	10	RN, LPN, MA, Other RN/LPN/MA
Coordinate pre-surgery services	10	RN, LPN, MA, Other RN/LPN/MA
Schedule space and equipment in facility	10	RN, LPN, MA, Other RN/LPN/MA
Office visit before surgery/procedure Review test and exam results	27	RN, LPN, MA, Other RN/LPN/MA
Provide pre-service education/obtain consent	10	RN, LPN, MA, Other RN/LPN/MA
Follow-up phone calls & prescriptions	6	RN, LPN, MA, Other RN/LPN/MA
ıer Activity (please specify)		
_____	_____	RN, LPN, MA, Other
End: When patient enters hospital for surgery/procedure		
Service Period		
Start. Patient admitted to hospital for surgery/procedure		
Pre-service services		
Review charts	_____	RN, LPN, MA, Other _____
Greet patient and provide gowning	_____	RN, LPN, MA, Other _____
Obtain vital signs	_____	RN, LPN, MA, Other _____
Provide pre-service education/obtain consent	_____	RN, LPN, MA, Other _____
Prepare room, equipment, supplies	_____	RN, LPN, MA, Other _____
Prepare and position patient/ monitor patient/ set up IV	_____	RN, LPN, MA, Other _____
Sedate/apply anesthesia	_____	RN, LPN, MA, Other _____
Intra-service		
Assist physician in performing surgery/procedure	_____	RN, LPN, MA, Other _____

CPT Code: 697/5

Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator with mastoidectomy

Post-service

Monitor pt. following service/check tubes, monitors, drains	_____	RN, LPN, MA, Other
Clean room/equipment by physician staff	_____	RN, LPN, MA, Other
Assist with ICU or hospital visits	_____	RN, LPN, MA, Other
Total Number of ICU visits	_____	
Total Number of hospital visits	_____	
Complete diagnostic forms, lab & X-ray requisitions	_____	RN, LPN, MA, Other
Review/read X-ray, lab, and pathology reports	_____	RN, LPN, MA, Other
Discharge day management services, check dressings & wound/ home care instructions/coordinate office visits/prescriptions	_____	RN, LPN, MA, Other
Coordination of care by staff in office	30	RN, LPN, MA, Other RN/LPN/MA
Other Activity (please specify)		
_____	_____	RN, LPN, MA, Other _____

End: Patient discharge from hospital

Post-Service Period
Start: Patient discharge from hospital

Conduct phone calls/call in prescriptions	15	RN, LPN, MA, Other RN/LPN/MA
Office visits Greet patient, escort to room Provide gowning Interval history & vital signs & chart Assemble previous test reports/results Assist physician during exam Assist with dressings, wound care, suture removal Prepare Dx test, prescription forms Post service education, instruction, counseling Clean room/equip, check supplies Coordinate home or outpatient care	_____	RN, LPN, MA, Other
List total number of office visits (99213 x 2 + 99212 x 2) = 4	A 4	
Total office visit time (A * B)	B 126	
Conduct phone calls between office visits	15	RN, LPN, MA, Other RN/LPN/MA
Other Activity (please specify)	_____	RN, LPN, MA, Other

End: With last office visit before end of global period

CPT Code: 697/7 Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy

AMA/Specialty Society Update Process
Summary of Recommendation
010 or 090 Day Global Periods
Out-Of-Office Direct Inputs

Sample Size:_____ Response Rate: (%):_____ Global Period:_____

Tracking Number:_____ Reference Code 1 _____ Reference Code 2_____

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

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

·work group of 7 practicing otolaryngologists was convened to review the survey results for physician work. ; work group included 3 subspecialists, two individuals in academic practice, three in private practice and one in a large multispecialty private practice. Three are from the middle Atlantic region, two are from the southwest, one is from the mid-west, and one is from the west. This group identified a reference code with comparable resource inputs. AAO-HNS staff then reviewed the identified reference code and made adjustments as needed to be consistent with the number of post-operative office visits identified by the survey on physician work and to be consistent with the RUC instructions for developing direct practice expense inputs for new/revised codes. The reference code used for new code 697/7 was existing code 69711.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
Complete pre-service diagnostic and referral forms, coordinate pre-surgery services, schedule space and equipment in facility, review test and exam results, provide pre-service education and obtain consent, follow-up phone calls and respond to clinical questions from patient.

Intra-Service Clinical Labor Activities:

Provide coordination of care activities while patient is in hospital; e.g., coordination of home or outpatient care, provide education, instructions and counseling to family members. The patient is treated by a variety of physicians; anestheiologists, cardiologists, pulmonary medicince, etc., each provi providing recommendations and consultations with family members.

Post-Service Clinical Labor Activities:

luct phone calls and call in prescriptions; three office visits (99213- 1; 99212- 3); conduct phone calls with patient or family members between visits.

CPT Code: 697/7 Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy

Clinical Labor	Pre-Service Time Prior to Admission	Service Period (Admission to Discharge)	Coordination of Care*	Post-Service Time After Discharge**	Number of Office Visits	Total Time of Office Visits
RN						
LPN						
MA						
RN/LPN/MA	73		30	30	4	117

*By staff in the physician's office during the service period.

**Excluding Time of Office Visits

Medical Supplies	Quantity of Supplies	Units Used for Purchase
Patient gown, disposable	4	Item
Pillow case, disposable	4	Item
Gloves, non sterile	~~4~~ 8	Pair
Thermometer probe cover	4	Item
Tongue depressor	4	Item
Exam table paper	28	Feet

Procedure Specific Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Equipment Cost
No Equipment				

Overhead Medical Equipment	No. of units in practice	Equipment Cost
Fiberoptic exam light		$609
Reclining exam chair w/headrest		$4495

CPT Code: 697/7 Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy

TYPE OF SERVICE: Surgical Procedures
010 and 090 Global Periods

SITE OF SERVICE: OUT-OF-OFFICE

Clinical Services	Minutes	Staff Type – Circle
Pre-Service Period		
Start: Following visit when decision for surgery or procedure made		
Complete pre-service diagnostic & referral forms	10	RN, LPN, MA, Other RN/LPN/MA
Coordinate pre-surgery services	10	RN, LPN, MA, Other RN/LPN/MA
Schedule space and equipment in facility	10	RN, LPN, MA, Other RN/LPN/MA
Office visit before surgery/procedure Review test and exam results	27	RN, LPN, MA, Other RN/LPN/MA
Provide pre-service education/obtain consent	10	RN, LPN, MA, Other RN/LPN/MA
Follow-up phone calls & prescriptions	6	RN, LPN, MA, Other RN/LPN/MA
Other Activity (please specify)		RN, LPN, MA, Other
End: When patient enters hospital for surgery/procedure		
~~Service Period~~		
Start: Patient admitted to hospital for surgery/procedure		
Pre-service services		
Review charts		RN, LPN, MA, Other
Greet patient and provide gowning		RN, LPN, MA, Other
Obtain vital signs		RN, LPN, MA, Other
Provide pre-service education/obtain consent		RN, LPN, MA, Other
Prepare room, equipment, supplies		RN, LPN, MA, Other
Prepare and position patient/ monitor patient/ set up IV		RN, LPN, MA, Other
Sedate/apply anesthesia		RN, LPN, MA, Other
Intra-service		
Assist physician in performing surgery/procedure		RN, LPN, MA, Other

CPT Code: 697/7 Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy

Post-service

Monitor pt. following service/check tubes, monitors, drains		RN, LPN, MA, Other
Clean room/equipment by physician staff		RN, LPN, MA, Other
Assist with ICU or hospital visits		RN, LPN, MA, Other
Total Number of ICU visits		
Total Number of hospital visits		
Complete diagnostic forms, lab & X-ray requisitions		RN, LPN, MA, Other
Review/read X-ray, lab, and pathology reports		RN, LPN, MA, Other
Discharge day management services, check dressings & wound/ home care instructions/coordinate office visits/prescriptions		RN, LPN, MA, Other
Coordination of care by staff in office	30	RN, LPN, MA, Other RN/LPN/MA
Other Activity (please specify)		
		RN, LPN, MA, Other

nd: Patient discharge from hospital

Post-Service Period
Start: Patient discharge from hospital

Conduct phone calls/call in prescriptions	15	RN, LPN, MA, Other RN/LPN/MA
Office visits Greet patient, escort to room Provide gowning Interval history & vital signs & chart Assemble previous test reports/results Assist physician during exam Assist with dressings, wound care, suture removal Prepare Dx test, prescription forms Post service education, instruction, counseling Clean room/equip, check supplies Coordinate home or outpatient care		RN, LPN, MA, Other
List total number of office visits (99213 x 1 + 99212 x 3) = 4	**A** 4	
Total office visit time (A * B)	**B** 117	
Conduct phone calls between office visits	15	RN, LPN, MA, Other RN/LPN/MA
Other Activity (please specify)		RN, LPN, MA, Other

d: With last office visit before end of global period

CPT Code: 697/8 Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy

AMA/Specialty Society Update Process
Summary of Recommendation
010 or 090 Day Global Periods
Out-Of-Office Direct Inputs

Sample Size:_____ Response Rate: (%):_____ Global Period:_____

Tracking Number:_____ Reference Code 1 _____ Reference Code 2_____

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

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

A work group of 7 practicing otolaryngologists was convened to review the survey results for physician wc This work group included 3 subspecialists, two individuals in academic practice, three in private practice ai one in a large multispecialty private practice. Three are from the middle Atlantic region, two are from the southwest, one is from the mid-west, and one is from the west. This group identified a reference code with comparable resource inputs. AAO-HNS staff then reviewed the identified reference code and made adjustments as needed to be consistent with the number of post-operative office visits identified by the survey on physician work and to be consistent with the RUC instructions for developing direct practice expense inputs for new/revised codes. The reference code used for new code 697/8 was existing code 69642.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
Complete pre-service diagnostic and referral forms, coordinate pre-surgery services, schedule space and equipment in facility, review test and exam results, provide pre-service education and obtain consent, follow-up phone calls and respond to clinical questions from patient.

Intra-Service Clinical Labor Activities:

Provide coordination of care activities while patient is in hospital; e.g., coordination of home or outpatient care, provide education, instructions and counseling to family members. The patient is treated by a variety of physicians; anestheiologist, cardiologist, pulmonary medicine, etc., each providing recommendations and consultations with family members.

Post-Service Clinical Labor Activities:

CPT Code: 69718 Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy

Conduct phone calls and call in prescriptions; three office visits (99213- 2; 99212- 2); conduct phone calls with patient and/or family members between visits.

Clinical Labor	Pre-Service Time Prior to Admission	Service Period (Admission to Discharge)	Coordination of Care*	Post-Service Time After Discharge**	Number of Office Visits	Total Time of Office Visits
RN						
LPN						
MA						
RN/LPN/MA	73		30	30	4	126

*By staff in the physician's office during the service period.

**Excluding Time of Office Visits

Medical Supplies	Quantity of Supplies	Units Used for Purchase
Patient gown, disposable	4	Item
Pillow case, disposable	4	Item
Gloves, non sterile	8	Pair
Thermometer probe cover	4	Item
Tongue depressor	4	Item
Exam table paper	28	Feet
Sterile Gloves	4	Pair
Alcohol swabs	8	Item
Steri-strips	8	Package
Tape	48	Inches
10 ml betadine	80	Units
Gauze packages 10 4x4	8	Package
Tincture Benzoin Swab	4	Item

Procedure Specific Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Equipment Cost
No Equipment				

CPT Code: 697 18 Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy

TYPE OF SERVICE: Surgical Procedures
010 and 090 Global Periods

SITE OF SERVICE: OUT-OF-OFFICE

Clinical Services	Minutes	Staff Type – Circle
Pre-Service Period		
Start: Following visit when decision for surgery or procedure made		
Complete pre-service diagnostic & referral forms	10	RN, LPN, MA, Other RN/LPN/MA
Coordinate pre-surgery services	10	RN, LPN, MA, Other RN/LPN/MA
Schedule space and equipment in facility	10	RN, LPN, MA, Other RN/LPN/MA
Office visit before surgery/procedure Review test and exam results	27	RN, LPN, MA, Other RN/LPN/MA
Provide pre-service education/obtain consent	10	RN, LPN, MA, Other RN/LPN/MA
Follow-up phone calls & prescriptions	6	RN, LPN, MA, Other RN/LPN/MA
Other Activity (please specify)		
_____	_____	RN, LPN, MA, Other
End: When patient enters hospital for surgery/procedure		
Service Period		
Start: Patient admitted to hospital for surgery/procedure		
Pre-service services		
Review charts	_____	RN, LPN, MA, Other _____
Greet patient and provide gowning	_____	RN, LPN, MA, Other _____
Obtain vital signs	_____	RN, LPN, MA, Other _____
Provide pre-service education/obtain consent	_____	RN, LPN, MA, Other _____
Prepare room, equipment, supplies	_____	RN, LPN, MA, Other _____
Prepare and position patient/ monitor patient/ set up IV	_____	RN, LPN, MA, Other _____
Sedate/apply anesthesia	_____	RN, LPN, MA, Other _____
Intra-service		
Assist physician in performing surgery/procedure	_____	RN, LPN, MA, Other _____

CPT Code: 69718 Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy

Post-service

Monitor pt. following service/check tubes, monitors, drains	_____	RN, LPN, MA, Other
Clean room/equipment by physician staff	_____	RN, LPN, MA, Other
Assist with ICU or hospital visits	_____	RN, LPN, MA, Other
Total Number of ICU visits	_____	
Total Number of hospital visits	_____	
Complete diagnostic forms, lab & X-ray requisitions	_____	RN, LPN, MA, Other
Review/read X-ray, lab, and pathology reports	_____	RN, LPN, MA, Other
Discharge day management services, check dressings & wound/ home care instructions/coordinate office visits/prescriptions	_____	RN, LPN, MA, Other
Coordination of care by staff in office	30	RN, LPN, MA, Other RN/LPN/MA
Other Activity (please specify)		
_____	_____	RN, LPN, MA, Other _____

End: Patient discharge from hospital

Post-Service Period
Start: Patient discharge from hospital

Conduct phone calls/call in prescriptions	15	RN, LPN, MA, Other RN/LPN/MA
Office visits Greet patient, escort to room Provide gowning Interval history & vital signs & chart Assemble previous test reports/results Assist physician during exam Assist with dressings, wound care, suture removal Prepare Dx test, prescription forms Post service education, instruction, counseling Clean room/equip, check supplies Coordinate home or outpatient care		RN, LPN, MA, Other
List total number of office visits (99213 x 2 + 99212 x 2) = 4	**A** 4	
Total office visit time (A * B)	**B** 126	
Conduct phone calls between office visits	15	RN, LPN, MA, Other RN/LPN/MA
Other Activity (please specify)		RN, LPN, MA, Other

End: With last office visit before end of global period

AMA SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Computed Tomographic Angiography

Work Relative Value Recommendations

Although the CPT Editorial Panel approved eight new codes for computed tomographic angiography, the radiologists presented recommendations for only two codes in this family. The RUC, therefore, is presenting recommendations for the following two codes in this series of eight codes.

70496

New code 70496 *Computed tomographic angiography, head, without contrast material(s), followed by contrast material(s), including image post-processing* was created to describe CTA of the head without contrast materials followed by contrast material. This is a new technique used for imaging vessels. The information gathered from CTAs is used in the evaluation of vascular anatomy, vascular disorders such as aneurysms, stenoses, cases of suspected vascular trauma, and in the follow-up of organ transplantation.

●70496 (SS1) Computed tomographic angiography, head, without contrast material(s), followed by contrast material(s), including image post-processing **1.75**

70498

New code 70498 *Computed tomographic angiography, neck, without contrast material(s), followed by contrast material(s), including image post-processing* was created to describe CTA of the neck without contrast materials followed by contrast material. This is a new technique used for imaging vessels.

●70498 (SS2) Computed tomographic angiography, neck, without contrast material(s), followed by contrast material(s), including image post-processing **1.75**

The specialty society may present recommendations on the remaining six codes from this family at the February 2001 RUC meeting. The RUC will forward any resulting recommendations to HCFA after this meeting.

The RUC agreed that these services were most similar in work to CPT code 70541 *Magnetic resonance angiography, head and/or neck, with or without contrast material(s)* (work RVU = 1.81). The specialty's survey data indicated that these new services require 37-38 minutes of physician time. This is comparable to the previous RUC survey total time for 70541 of 40 minutes. The patients who receive CTA are patients that typically are unable to utilize the MRA, as they may have a pacemaker or aneurysm clip or are claustrophobic or unwilling to remain motionless.

The RUC also reviewed the relationship of these new services to the existing CT codes, including 70470 *Computerized axial tomography, head or brain; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.27) and 70492 *Computerized axial tomography, soft tissue neck; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.45) and agreed that these CTA services require significantly more physician time than traditional CT as there are more studies to review.

Practice Expense Recommendations

The RUC agreed that the attached list of practice expenses accurately reflected the resources required for each of the procedures, 70496 and 70498, in the non-facility setting.

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●70496	SS1	Computed tomographic angiography, head, without contrast material(s), followed by contrast material(s), including image post-processing	XXX	1.75
●70498	SS2	Computed tomographic angiography, neck, without contrast material(s), followed by contrast material(s), including image post-processing	XXX	1.75
●71275	SS3	Computed tomographic angiography, chest, without contrast material(s), followed by contrast material(s), including image post-processing	XXX	No recommendation at this time
●72191	SS4	Computed tomographic angiography, pelvis, without contrast material(s), followed by contrast material(s), including image post-processing (For CTA aorto-iliofemoral runoff, use 75635)	XXX	No recommendation at this time
●73206	SS5	Computed tomographic angiography, upper extremity, without contrast material(s), followed by contrast material(s), including image post-processing	XXX	No recommendation at this time
●73706	SS6	Computed tomographic angiography, lower extremity, without contrast material, followed by contrast material(s), including image post-processing (For CTA aorto-iliofemoral runoff, use 75635)	XXX	No recommendation at this time

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●74175	SS7	Computed tomographic angiography, abdomen, without contrast material(s), followed by contrast material(s), including image post-processing (For CTA aorto-iliofemoral runoff, use 75635)	XXX	No recommendation at this time
●75635	SS8	Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, radiological supervision and interpretation, without contrast material(s), followed by contrast material(s), including image post-processing	XXX	No recommendation at this time

PLEASE INSERT INTO TAB D

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:	**70496**	Tracking Number:	**SS1**	Global Period.	XXX	**Recommended RVW:**	**1.75**

CPT Descriptor:
Computed tomographic angiography, head, without contrast material(s), followed by contrast material(s), including image post-processing

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
Fifty-eight year old female with suspected intracranial aneurysm.

Description of Pre-Service Work:
- Describe the procedure to the patient and obtain informed consent where applicable
- Review any prior applicable studies

Description of Intra-Service Work:

- Obtain/review non-contrast CT images to localize the vascular phase sequence and to screen those patients who are not candidates for the arterial phase component of the study.
- Supervise low- or iso-osmolar contrast injection.
- Obtain the arterial phase CT images and review to ensure adequate anatomic coverage.
- Create and/or supervise two-dimensional reconstructions of the vasculature and associated organs, interpret, and annotate.
- Supervise and/or create three-dimensional reconstructions of the vasculature and associated organs. Adjust the projection of the three-dimensional reconstructions to optimize visualization of anatomy or pathology.
- Interpret the axial source images of the pre-contrast sequence, and arterial phase sequence, as well as the two-dimensional and three-dimensional reformatted images resulting from the study, often including cine review.
- Compare to all pertinent available prior studies.

Description of Post-Service Work:

- Dictate, audit, and sign the final report.

SURVEY DATA:

Presenter(s). James P Borgstede, MD, ACR RUC Advisor
J Arliss Pollock, MD; ASNR RUC Advisor

Specialty(s): Radiology
Neuroradiology

Sample Size 583 Response Rate: (%). 50/583 Median RVW: 2.055

Type of Sample (Circle One): random panel convenience Explanation of sample size: _____

25th Percentile RVW: 1.75 75th Percentile RVW: 2.4 Low: 1.25 High: 4.5

Median Pre-Service Time: 8.00 Median Intra-Service Time: 20.00

25th Percentile Intra-Service Time: 15.00 75th Percentile Intra-Svc Time: 30 Low: 0 High: 60

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	10.00	
Critical Care:	N/A	N/A
Other Hospital Visits:	N/A	N/A
Discharge Day Mgmt.:	N/A	N/A
Office Visits:	N/A	N/A

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
70470	Computerized axial tomography, head or brain; without contrast material, followed by contrast material(s) and further sections	1.27

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	8.00	5.00
Median Intra-Time	20.00	8.00
Median Immediate Post-service Time	10.00	5.00
Median of Aggregate Critical Care Times	N/A	N/A
Median of Aggregate Other Hospital Visit Times	N/A	N/A
Median Discharge Day Management Time	N/A	N/A
Median of Aggregate Office Visit Times	N/A	N/A

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.52	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3 62	3.00
Urgency of medical decision making	3.58	3.57

Technical Skill/Physical Effort (Mean)

Technical skill required	3.86	2.86
Physical effort required	2.22	1.86

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.28	3.43
Outcome depends on the skill and judgement of physician	4.16	3.79
Estimated risk of malpractice suit with poor outcome	3.94	4.07

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.52	2.31
Intra-Service intensity/complexity	3.96	2.93
Post-Service intensity/complexity	2.98	2.42

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The 25th percentile value most accurately reflects the physician work in the opinion of the ACR RUC committee. This opinion was confirmed by the ASNR RUC committee.

FREQUENCY INFORMATION

How was this service previously reported? With existing CT head codes plus 76375 (Computed tomography, coronal, sagittal, ad/or 3-dimensional reconstruction)

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

Specialty Radiology ___ Commonly X Sometimes ___ Rarely

Specialty Neuroradiolgy ___ Commonly X Sometimes ___ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty _____ Frequency _____

Specialty _____ Frequency _____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty NeuroRadiology Frequency *78,000

Specialty _____ Frequency _____

Do many physicians perform this service across the United States?

___ Yes X No

* It is difficult to estimate the number of times this procedure is performed nationally. Based on 1998 BMAD data for CT Head or Brain studies, we have estimated that number of times CT Head or Brain with contrast studies are performed.

PLEASE INSERT INTO TAB D

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:	70498	Tracking Number:	SS2	Global Period:	XXX	Recommended RVW:	1.75

CPT Descriptor:
Computed tomographic angiography, neck, without contrast material(s), followed by contrast material(s), including image post-processing

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
74 year old male with previous myocardial infarction and permanent pace maker (precluding MRA) presents with two TIAs to be evaluated for carotid stenosis.

Description of Pre-Service Work:
- Describe the procedure to the patient and obtain informed consent where applicable
- Review any prior applicable studies

Description of Intra-Service Work:

- Obtain/review non-contrast CT images to localize the vascular phase sequence and to screen those patients who are not candidates for the arterial phase component of the study.
- Supervise low- or iso-osmolar contrast injection.
- Obtain the arterial phase CT images and review to ensure adequate anatomic coverage.
- Create and/or supervise two-dimensional reconstructions of the vasculature and associated organs, interpret, and annotate.
- Supervise and/or create three-dimensional reconstructions of the vasculature and associated organs. Adjust the projection of the three-dimensional reconstructions to optimize visualization of anatomy or pathology.
- Interpret the axial source images of the pre-contrast sequence, and arterial phase sequence, as well as the two-dimensional and three-dimensional reformatted images resulting from the study, often including cine review.
- Compare to all pertinent available prior studies.

Description of Post-Service Work:

- Dictate, audit, and sign the final report.

SURVEY DATA:

Presenter(s). James P Borgstede, MD, ACR RUC Advisor
J. Arliss Pollock, MD, ASNR RUC Advisor

Specialty(s): Radiology
Neuroradiology

Sample Size: 583 Response Rate: (%): 43/583 Median RVW: 2.33

Type of Sample (Circle One): random panel convenience Explanation of sample size.

25th Percentile RVW: 1.81 75th Percentile RVW: 2 4 Low: 1.45 High 4.5

Median Pre-Service Time 7.00 Median Intra-Service Time: 20.00

25th Percentile Intra-Service Time: 15.00 75th Percentile Intra-Svc Time: 30 Low. 2.00 High: 60

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	10.00	
Critical Care:	N/A	N/A
Other Hospital Visits:	N/A	N/A
Discharge Day Mgmt.:	N/A	N/A
Office Visits:	N/A	N/A

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
70541	Magnetic resonance angiography, head and/or neck, with or without contrast material(s)	1.81

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	7.00	5.00
Median Intra-Time	20.00	15 00
Median Immediate Post-service Time	10.00	10.00
Median of Aggregate Critical Care Times	N/A	N/A
Median of Aggregate Other Hospital Visit Times	N/A	N/A
Median Discharge Day Management Time	N/A	N/A
Median of Aggregate Office Visit Times	N/A	N/A

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.31	2.94
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.33	2.94
Urgency of medical decision making	3.33	2.80
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.69	3.38
Physical effort required	1.98	1.69
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.07	2.06
Outcome depends on the skill and judgement of physician	3.95	3.50
Estimated risk of malpractice suit with poor outcome	3.69	3.13

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.41	1.64
Intra-Service intensity/complexity	4.00	3.00
Post-Service intensity/complexity	2.96	2.29

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation

The consensus panel felt that a physician work value of 1.75 more accurately reflects the physician work involved with this procedure.

FREQUENCY INFORMATION

How was this service previously reported? With existing CT neck codes plus 76375 (Computed tomography, coronal, sagittal, ad/or 3-dimensional reconstruction)

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

Specialty Radiology ___ Commonly X Sometimes ___ Rarely

Specialty Neuroradiolgy ___ Commonly X Sometimes ___ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty _____ Frequency _____

Specialty _____ Frequency _____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty NeuroRadiology Frequency *95,000

Specialty _____ Frequency _____

Do many physicians perform this service across the United States?

___ Yes X No

* It is difficult to estimate the number of times this procedure is performed nationally. Based on 1998 BMAD data for CT Neck studies, we have estimated that number of times CT Neck with contrast studies are performed.

CPT Code: 70496

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

AMA/Specialty Society Update Process
Summary of Recommendation
XXX Global Period

In Office Direct Inputs

Sample Size: ____ Response Rate: (%): ____ Global Period: XXX

Tracking Number: SS1 Reference Code 1 _____ Reference Code 2 _____

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The technologist finds and reviews appropriate previous studies and assembles them for radiologist's review.

Intra-Service Clinical Labor Activities:
The technologist greets the patient and provides a gown. The RT questions the patient regarding contrast allergies. The RT explains the feelings the patient will experience during contrast injection and the importance of remaining motionless. The technologist then positions the patient on the CT table. An IV is started. The IV must be adequate to accommodate high volume rapid power injection and thus must be angiocath. Noncontrast CT images are then obtaned to localize the appropriate area to be scanned in the vascular phase. A test bolus is injected to confirm optimum timing for the diagnostic scan. The RT supervises the contrast injection. The original axial images are obtained. Arterial phase images are technically reviewed for appropriate anatomic coverage. The patient is assisted from the CT table when it has been accertained that the original images are satisfactory. The patient is counseled reqarding post contrast thrombophlebitis and delayed reactions to contrast. With the radiologist's assistance, 2-D reconstructions of the vasculature are created. 3-D reconstructions of the vasculature are also created. Creation of 2-D and 3-D reconstructions typically require more than one attempt for optimum visulization of anatomy and pathology.

Post-Service Clinical Labor Activities:
Radiology Technologist hangs films and prepares for radiologic interpretation.

Clinical Labor	**Pre-Service Time**	**Service Period (Day of service)**	**Post-Service Time After Day of Service)**
RN			
LPN			
MA			
~~Radiology Technologist (RT)~~ Angio Technician (1002)	~~8~~ 5	~~104~~ 92	5

CPT Code: 70496

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

Medical Supplies	Quantity of Supplies	Units Used for Purchase
18G NEEDLE OR VIAL ACCESS	1	Item
4 WAY STOPCOCK	1	Item
ALCOHOL WIPE	1	Item
ANGIOCATHETER	1	Item - $2.13 Moore Medical
BAND AID	1	Item
~~CONNECTING TUBE~~ Connecting tube	~~1~~ 1	~~Item~~ Item $2.55 Moore Medical
~~CONTRAST~~ Contrast 150 ml	~~150 cc~~ 150 ml	~~Cc~~ $102.60 Picker
CONTRAST SYRINGE 200 CC	1	Item $10.78 Picker
~~COTTON BALL~~	~~1~~	~~Item~~
D5W	250cc	bottle
EXTENSION TUBING	76CM	Cm $1.40 Moore Medical
FILM, 14x17	6	Sheets
FILM JACKET	1	Item
GLOVES, sterile	1	Pair
GOWN	1	Item
~~PAPER TAPE~~ tape, paper	6 inches	
SALINE CC	10	cc

Separately billable?

Procedure Specific Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Equipment Cost
CT SCANNER	1	45	48	$1,000,000 Marconi
INJECTOR	1	45	10	
POST PROCESSING WORK STATION	1	30	30	$180,000 GE

Overhead Medical Equipment	No. of units in practice	Equipment Cost
CRASH CART	1	
DEFIBRILLATOR	1	
EKG MACHINE	1	
FILM ALTERNATOR	1	
~~LASER PRINTER~~ Laser Printer	~~1~~ 1	$71,400 Picker
~~SUCTION MACHINE~~	~~1~~	

CPT Code: 70496

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

Type of Service: Evaluation/Management Services or Diagnostic Tests

XXX Global Period

SITE OF SERVICE: In-Office

Clinical Services	Minutes	Staff Type – Circle	
Pre-Service Period			
Start. When appointment for service is made			
Review/read X-ray, lab, and pathology reports	~~8~~ 5min	RN, LPN, MA, Other ~~RT~~	|
Other Clinical Activity (please specify)			
_____		RN, LPN, MA, Other ~~RT~~	|
End: Patient arrival at office for service			
Service Period			
Start: Patient arrival at office for service			
Greet patient/provide gowning	~~5~~ 3 min	RN, LPN, MA, Other ~~RT~~	|
Obtain vital signs		RN, LPN, MA, Other _____	
Prep and position patient	7 min	RN, LPN, MA, Other ~~RT~~	|
Prepare room, equipment, supplies	5 min	RN, LPN, MA, Other ~~RT~~	|
Assist physician during exam	20 min	RN, LPN, MA, Other ~~RT~~	|
Education/instruction/ counseling	~~4~~ 2min	RN, LPN, MA, Other ~~RT~~	|
Coordinate home or outpatient care	~~4 min~~	RN, LPN, MA, Other ~~RT~~	|
Clean room/equipment	5 min	RN, LPN, MA, Other ~~RT~~	|
Other Clinical Activity (please specify)			
Starting IV for high volume and rate power injection	~~9~~ 5 min	RT or RN	|
Post-processing time	45 min	RN, LPN, MA, Other ~~RT~~	|
End: Patient leaves office			
Post-Service Period			
Start: Patient leaves office			
Phone calls between visits with patient, family pharmacy		RN, LPN, MA, Other _____	
Other Activity (please specify)			
Hang films for radiologic interpretation	5 min	RN, LPN, MA, Other ~~RT~~	|
End: When appointment for next office visit is made.			

CPT Code: 70498

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

AMA/Specialty Society Update Process
Summary of Recommendation
XXX Global Period

In Office Direct Inputs

This is a consensus panel recommendation.

Sample Size: ____ Response Rate: (%): ____ Global Period: XXX

Tracking Number: SS2 Reference Code 1 ____ Reference Code 2 _____

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %:
_____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The technologist finds and reviews appropriate previous studies and assembles them for radiologist's review.

Intra-Service Clinical Labor Activities:
The technologist greets the patient and provides a gown. The RT questions the patient regarding contrast allergies. The RT explains the feelings the patient will experience during contrast injection and the importance of remaining motionless. The technologist then positions the patient on the CT table. An IV is started. The IV must be adequate to accommodate high volume rapid power injection and thus must be angiocath. Noncontrast CT images are then obtaned to localize the appropriate area to be scanned in the vascular phase. A test bolus is injected to confirm optimum timing for the diagnostic scan. The RT supervises the contrast injection. The original axial images are obtained. Arterial phase images are technically reviewed for appropriate anatomic coverage. The patient is assisted from the CT table when it has been accertained that the original images are satisfactory. The patient is counseled reqarding post contrast thrombophlebitis and delayed reactions to contrast. With the radiologist's assistance, 2-D reconstructions of the vasculature are created. 3-D reconstructions of the vasculature are also created. Creation of 2-D and 3-D reconstructions typically require more than one attempt for optimum visulization of anatomy and pathology.

Post-Service Clinical Labor Activities:
Radiology Technologist hangs films and prepares for radiologic interpretation.

Clinical Labor	**Pre-Service Time**	**Service Period (Day of service)**	**Post-Service Time After Day of Service)**
RN			
LPN			
MA			
~~Radiology Technologist (RT)~~ Angio Technician (1002)	~~8~~ 5	~~104~~ 92	5

CPT Code: 70498

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost and Source
18G NEEDLE OR VIAL ACCESS	1	Item	
4 WAY STOPCOCK	1	Item	
ALCOHOL WIPE	1	Item	
ANGIOCATHETER	1	Item	2 13 Moore Medical
BAND AID	1	Item	
~~CONNECTING TUBE~~ Connecting Tube	~~1~~ 1	~~Item~~ item	2.55 Moore Medical
~~CONTRAST~~ Contrast	~~150 cc~~ 150	~~Cc~~ cc	102.60 Picker
~~CONTRAST SYRINGE 200 CC~~ Contrast Syringe 200 cc	~~1~~ 1	~~Item~~ Item	10.78 Picker
~~COTTON BALL~~	~~1~~	~~Item~~	
~~D5W~~ D5W	~~250cc~~ 250 cc	~~Bottle~~ Bottle	
~~EXTENSION TUBING~~ Tubing, extension	76CM	cm	1.40 Moore Medical
FILM 14 x 17	6	Sheets	
FILM JACKET	1	Item	
GLOVES, sterile	1	Pair	
GOWN, patient	1	Item	
~~PAPER TAPE~~ tape, paper	6	inches	
SALINE CC	10	cc	

separately 13.1 cost

Procedure Specific Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Equipment Cost
~~CT SCANNER~~ CT Scanner	~~1~~ 1	~~45~~ 45	~~48~~ 48	1,000,000 Marconi
~~INJECTOR~~ Injector	~~1~~ 1	~~45~~ 45	~~10~~ 10	
~~POST PROCESSING WORK STATION~~ Post processing work station	~~1~~ 1	~~45~~ 30	~~30~~ 30	180,000 GE

Overhead Medical Equipment	No. of units in practice	Equipment Cost
CRASH CART	1	
DEFIBRILLATOR	1	
EKG MACHINE	1	
FILM ALTERNATOR	1	
~~LASER PRINTER~~ Printer, laser	~~1~~ 1	71,400 Picker
~~SUCTION MACHINE~~ Suction Machine	~~1~~ 1	

delete per HCFA

CPT Code: 70498

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

Type of Service: Evaluation/Management Services or Diagnostic Tests

XXX Global Period

SITE OF SERVICE: In-Office

Clinical Services	Minutes	Staff Type – Circle
Pre-Service Period		
Start: When appointment for service is made		
Review/read X-ray, lab, and pathology reports	~~8~~ 5min	RN, LPN, MA, Other ~~RT~~
Other Clinical Activity (please specify)		
_____		RN, LPN, MA, Other ~~RT~~
End. Patient arrival at office for service		
Service Period		
Start: Patient arrival at office for service		
Greet patient/provide gowning	~~5~~ 3 min	RN, LPN, MA, Other ~~RT~~
Obtain vital signs		RN, LPN, MA, Other _____
Prep and position patient	7 min	RN, LPN, MA, Other ~~RT~~
Prepare room, equipment, supplies	5 min	RN, LPN, MA, Other ~~RT~~
Assist physician during exam	20 min	RN, LPN, MA, Other ~~RT~~
Education/instruction/ counseling	~~4~~ 2min	RN, LPN, MA, Other ~~RT~~
Coordinate home or outpatient care	~~4 min~~	RN, LPN, MA, Other ~~RT~~
Clean room/equipment	5 min	RN, LPN, MA, Other ~~RT~~
Other Clinical Activity (please specify)		
Starting IV for high volume and rate power injection	~~9~~ 5min	RT or RN
Post-processing time	45 min	RN, LPN, MA, Other ~~RT~~
End: Patient leaves office		
Post-Service Period		
Start: Patient leaves office		
Phone calls between visits with patient, family pharmacy		RN, LPN, MA, Other _____
Other Activity (please specify)		
Hang films for radiologic interpretation	5 min	RN, LPN, MA, Other ~~RT~~
End: When appointment for next office visit is made.		

AMA SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Magnetic Resonance Imaging Procedures

Work Relative Value Recommendations

The CPT Editorial Panel has revised five Magnetic Resonance Imaging (MRI) codes and added ten codes to specify MRI without contrast; with contrast; and without contrast material, followed by contrast material(s) and further sequences. The specialty has only presented recommendations for three codes that represent MRI for orbit, face, and neck. The specialty society may present recommendations on the remaining twenty-one MRI codes at the February 2001 RUC meeting. The RUC will forward any resulting recommendations to HCFA after this meeting.

The RUC understands that when these MRI codes were evaluated, gadolinium (contrast material) was not in widespread use and therefore, code 70540 *Magnetic resonance (eg, proton) imaging, orbit, face, and neck* (work RVU = 1.48) was valued assuming "without contrast material." The RUC recommendations, therefore, that revised 70540 be considered editorial and reflect no change in work.

The RUC did not agree with the increment proposed by the specialty for adding "contrast materials" and "without contrast materials, followed by contrast material(s) and further sequences." The RUC recommends that an increment of .30 to reflect the additional physician work in performing the MRI with contrast materials. The RUC determined that the current increment between codes 70551 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material* (work RVU = 1.48) and 70552 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material* (work RVU = 1.78) is appropriate. This increment of .30 should be added to 70540 to determine a recommended work relative value of 1.78 for 70542 *Magnetic resonance (eg, proton) imaging, orbit, face, and neck; with contrast material.*

Code 70543 *Magnetic resonance (eg, proton) imaging, orbit, face and neck; without contrast material, followed by contrast material(s) and further sequences should be valued at* 70540 (1.48) and ½ 70542 (1.78) for a recommended work RVU of 2.36. This is also consistent with the increment between codes 70551 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material* (work RVU = 1.48) and 70553 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences* (work RVU = 2.36).

Practice Expense Recommendations

The RUC agreed with the facilitation committee's recommendation that all three codes, 70540, 70542, and 70543, be cross walked to existing CPEP inputs for codes 70551, 70552, 70553. Existing CPEP data to be cross-walked are attached.

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲70540	TT1	Magnetic resonance (eg, proton) imaging, orbit, face, and neck; without contrast material(s)	XXX	1.48 (No Change)
●70542	TT2	with contrast material(s)	XXX	1.78
●70543	TT3	without contrast material, followed by contrast material(s) and further sequences	XXX	2.36
▲71550	TT4	Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s)		No recommendation at this time

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●71551	TT5	with contrast material(s)	XXX	No recommendation at this time
●71552	TT6	without contrast material, followed by contrast material(s) and further sequences	XXX	No recommendation at this time
▲72196	TT7	Magnetic resonance (eg, proton) imaging, pelvis; with contrast material(s)	XXX	No recommendation at this time
●72195	TT8	without contrast material(s)	XXX	No recommendation at this time
●72197	TT9	without contrast material(s), followed by contrast material(s) and further sequences	XXX	No recommendation at this time

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●73218	TT10	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s)	XXX	No recommendation at this time
●73219	TT11	with contrast material(s)	XXX	No recommendation at this time
▲73220	TT12	~~Magnetic resonance (eg, proton) imaging, upper extremity, other than joint;~~ without contrast material(s), followed by contrast material(s) and further sequences	XXX	No recommendation at this time
▲73221	TT13	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)	XXX	No recommendation at this time

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●73222	TT14	with contrast material(s)	XXX	No recommendation at this time
●73223	TT15	without contrast material(s), followed by contrast material(s) and further sequences	XXX	No recommendation at this time
●73718	TT16	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s),	XXX	No recommendation at this time
●73719	TT17	with contrast material(s)	XXX	No recommendation at this time
▲73720	TT18	~~Magnetic resonance (eg, proton) imaging, lower extremity other than joint~~; without contrast material(s), followed by contrast material(s) and further sequences	XXX	No recommendation at this time

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲73721	TT19	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material(s)	XXX	No recommendation at this time
●73722	TT20	with contrast material(s)	XXX	No recommendation at this time
●73723	TT21	without contrast material, followed by contrast material(s) and further sequences	XXX	No recommendation at this time
▲74181	TT22	Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)	XXX	No recommendation at this time
●74182	TT23	with contrast material(s)	XXX	No recommendation at this time
●74183	TT24	without contrast material(s), followed by with contrast material(s) and further sequences	XXX	No recommendation at this time

Combined
AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code	70542	Tracking Number:	TT2	Global Period:	XXX	Recommended RVW:	~~1.9~~ 1.78 (RUC)

CPT Descriptor.
Magnetic Resonance (eg, proton) imaging, orbit, face, and neck; with contrast material(s)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
72 year old male with neck mass, biopsy positive for squamous cell carcinoma is referred for MR for staging to determine extent of nodal involvement which will require imaging. Patient brings with him unenhanced scan.

Description of Pre-Service Work:
-Review request and history
-Review any prior applicable imaging studies
-Set protocol for exam including selection of pulse sequences and contrast dosage.

Description of Intra-Service Work:
-Review exam to assure that all needed pulse sequences and imaging planes have been acquired
-Interpret contrast enhanced study
-Compare to applicable prior studies

Description of Post-Service Work:
-dictate, review and sign report
-communicate findings to referring physician and patient as appropriate

Presenter(s): James P Borgstede, MD (ACR)
J. Arliss Pollock, MD (ASNR)

Specialty(s): The American College of Radiology
The American Society of Neuroradiology

SURVEY DATA:

Sample Size: 518 Response Rate: (%) 63 (12%) Median RVW 1.9

Type of Sample (Circle One): random panel convenience Explanation of sample size:

25th Percentile RVW. 1.7 75th Percentile RVW: 2.5 Low: 1 31 High 3 5

Median Pre-Service Time. 8 00 Median Intra-Service Time. 15.00

25th Percentile Intra-Service Time: 10 75th Percentile Intra-Svc Time: 20 Low: 2 High: 45

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	10	N/A
Critical Care:	N/A	N/A
Other Hospital Visits:	N/A	N/A
Discharge Day Mgmt.:	N/A	N/A
Office Visits:	N/A	N/A

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
70540	Magnetic resonance (eg, proton) imaging, orbit, face, and neck	1.48

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	7.00	8.00
Median Intra-Time	15.00	10.00
Median Immediate Post-service Time	10.00	10.00
Median of Aggregate Critical Care Times	N/A	N/A
Median of Aggregate Other Hospital Visit Times	N/A	N/A
Median Discharge Day Management Time	N/A	N/A
Median of Aggregate Office Visit Times	N/A	N/A

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.74	3.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.52	3.04
Urgency of medical decision making	2.95	3.04
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.70	3.56
Physical effort required	2.27	2.28
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.57	2.38
Outcome depends on the skill and judgement of physician	4.10	3.71
Estimated risk of malpractice suit with poor outcome	3.18	3.08

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.80	2.28
Intra-Service intensity/complexity	3.98	3.80
Post-Service intensity/complexity	3 10	3.21

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation

FREQUENCY INFORMATION

How was this service previously reported? 70540

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

Specialty NeuroRadiology X Commonly ___ Sometimes ___ Rarely

Specialty ___ ___ Commonly ___ Sometimes ___ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neuroradiology Frequency 100,000 *

Specialty ___ Frequency ___

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Neuroradiology Frequency 35,000 *

Specialty ___ Frequency ___

Do many physicians perform this service across the United States? X Yes ___ No

*These numbers are estimated on 1998 BMAD data. These numbers reflect the total number of MRI studies (unenhanced, enhanced, and unenhanced followed by enhanced).

Combined
AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:	**70543**	Tracking Number:	**TT3**	Global Period:	**XXX**	**Recommended RVW:**	**~~2.4~~ 2.36 (RUC)**

CPT Descriptor.
Magnetic Resonance (eg, proton) imaging, orbit, face, and neck; without contrast material(s) followed by contrast material(s) and further sections

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
72 year old male with neck mass, biopsy positive for squamous cell carcinoma is referred for MR for staging to determine extent of nodal involvement which will require imaging.

Description of Pre-Service Work:
-Review request and history
-Review any prior applicable imaging studies
-Set protocol for exam including selection of pulse sequences for both unenhanced and enhanced portions of exam and contrast dosage

Description of Intra-Service Work:
-Review unenhanced exam to assure that all needed pulse sequences are acquired prior to contrast administration
-Review enhanced portion of exam to assure that all needed pulse sequences and planes have been obtained
-Interpret unenhanced and enhanced portions of exam, comparing them to determine any pathologic enhancement
-Compare to any prior applicable exams

Description of Post-Service Work:
-dictate, review and sign report
-communicate results to referring physician

Presenter(s): James P Borgstede, MD (ACR)
J. Arliss Pollock, MD (ASNR)

Specialty(s): The American College of Radiology
The American Society of Neuroradiology

SURVEY DATA:

Sample Size: 518 Response Rate: (%): 63 (12%) Median RVW. 2 4

Type of Sample (Circle One) random panel convenience Explanation of sample size:

25th Percentile RVW: 2.0 75th Percentile RVW. 2.57 Low: 1 48 High: 3.6

Median Pre-Service Time: 8 Median Intra-Service Time: 15

25th Percentile Intra-Service Time: 10 75th Percentile Intra-Svc Time: 20 Low: 5 High: 60

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	10.00	N/A
Critical Care.	N/A	N/A
Other Hospital Visits:	N/A	N/A
Discharge Day Mgmt.:	N/A	N/A
Office Visits:	N/A	N/A

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
70540	Magnetic resonance (eg, proton) imaging, orbit, face, and neck	1 48

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	7.00	7.00
Median Intra-Time	20.00	10.00
Median Immediate Post-service Time	10.00	6 00
Median of Aggregate Critical Care Times	N/A	N/A
Median of Aggregate Other Hospital Visit Times	N/A	N/A
Median Discharge Day Management Time	N/A	N/A
Median of Aggregate Office Visit Times	N/A	N/A

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.8	3.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.6	3.29
Urgency of medical decision making	3.00	3.08
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.83	3.71
Physical effort required	2.38	2.54
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.62	2.58
Outcome depends on the skill and judgement of physician	4.22	3.92
Estimated risk of malpractice suit with poor outcome	3.22	3.04

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.73	2.96
Intra-Service intensity/complexity	4.14	3 86
Post-Service intensity/complexity	3.08	3.26

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

FREQUENCY INFORMATION

How was this service previously reported? 70540

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

Specialty NeuroRadiology X Commonly ___ Sometimes ___ Rarely

Specialty ___ ___ Commonly ___ Sometimes ___ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neuroradiology Frequency 100,000 *

Specialty ___ Frequency ___

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Neuroradiology Frequency 35,000 *

Specialty ___ Frequency ___

Do many physicians perform this service across the United States? X Yes ___ No

*These numbers are estimated on 1998 BMAD data. These numbers reflect the total number of MRI studies (unenhanced, enhanced, and unenhanced followed by enhanced).

CPT Codes: 70540, 70542, 70543 (TT1-TT3)
AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

TT1, TT2, and TT3 were cross walked to the following CPEP data:

70540 Cross walked to: ***CPT Code:*** 70551 Magnetic resonance (eg, proton) imaging, brain (including brain stem), without contrast material

Global Period XXX

CPEP *C 6* ***Physician Time:*** 36 ***Minutes*** ***HCFA Office Visits:*** 0 ***CPT Code*** 70551

Clinical Labor *Code* 70551	Pre In Office	Intra In Office	Post In Office	Pre Out Office	Intra Out Office	Post Out Office	Equipment Code	Supply Item Code	Qty of Supply units in office	Qty of Supply units out office
MRI Technician	0	96	0	0		0				
RN	0	21	0	0		0				

Medical Supplies *Code* 70551	Pre In Office	Intra In Office	Post In Office	Pre Out Office	Intra Out Office	Post Out Office	Equipment Code	Supply Item Code	Qty of Supply units in office	Qty of Supply units out office
drape, sheet	0	0	0	0	0	0		11106	2 item	0 item
film, 14x17	0	0	0	0	0	0		73402	10 sheet	0 sheet
gloves, non-sterile	0	0	0	0	0	0		11302	1 pair	0 pair
patient gown, disposable	0	0	0	0	0	0		11107	1 item	0 item

Overhead Equipment *Code* 70551	Pre In Office	Intra In Office	Post In Office	Pre Out Office	Intra Out Office	Post Out Office	Equipment Code	Supply Item Code	Qty of Supply units in office	Qty of Supply units out office
crash cart , no defibrilator							E91002		0	0

Procdure Specific Equipment *Code* 70551	Pre In Office	Intra In Office	Post In Office	Pre Out Office	Intra Out Office	Post Out Office	Equipment Code	Supply Item Code	Qty of Supply units in office	Qty of Supply units out office
MR Room							E51058			

CPT Codes.), 70542, 70543 (TT1-TT3)
AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

70542 Cross walked to: ***CPT Code:*** 70552 Magnetic resonance (eg, proton) imaging, brain (including brain stem), with contrast material(s)

Global Period XXX

CPEP *C 6* ***Physician Time:*** 43 ***Minutes*** ***HCFA Office Visits:*** 0 ***CPT Code*** 70552

Clinical Labor *Code* 70552	Pre In Office	Intra In Office	Post In Office	Pre Out Office	Intra Out Office	Post Out Office	Equipment Code	Supply Item Code	Qty of Supply units in office	Qty of Supply units out office
MRI Technician	0	96	0	0		0				
RN	0	21	0	0		0				

Medical Supplies *Code* 70552	Pre In Office	Intra In Office	Post In Office	Pre Out Office	Intra Out Office	Post Out Office	Equipment Code	Supply Item Code	Qty of Supply units in office	Qty of Supply units out office
angiocatheter 20 to 25g	0	0	0	0	0	0		91106	1 item	0 item
contrast (1% methylene blue)	0	0	0	0	0	0		93110	10 ml	0 ml
drape, sheet	0	0	0	0	0	0		11106	2 item	0 item
film, 14x17	0	0	0	0	0	0		73402	10 sheet	0 sheet
gloves, non-sterile	0	0	0	0	0	0		11302	1 pair	0 pair
iv infusion set	0	0	0	0	0	0		91110	1 set	0 set
patient gown, disposable	0	0	0	0	0	0		11107	1 item	0 item
syringe med rad 150 cc cartridge	0	0	0	0	0	0		73615	1 item	0 item

Overhead Equipment *Code* 70552	Pre In Office	Intra In Office	Post In Office	Pre Out Office	Intra Out Office	Post Out Office	Equipment Code	Supply Item Code	Qty of Supply units in office	Qty of Supply units out office
crash cart , no defibrilator							E91002		0	0

Procdure Specific Equipment *Code* 70552	Pre In Office	Intra In Office	Post In Office	Pre Out Office	Intra Out Office	Post Out Office	Equipment Code	Supply Item Code	Qty of Supply units in office	Qty of Supply units out office
MR Room							E51058			

CPT Codes: 70540, 70542, 70543 (TT1-TT3)
AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

70543 Cross walked to: ***CPT Code:*** 70553 Magnetic resonance (eg, proton) imaging, brain (including brain stem), without contrast material, followed by contrast material(s) and further sequences

Global Period XXX

CPEP *C 6* ***Physician Time:*** 56 ***Minutes*** ***HCFA Office Visits:*** 0 ***CPT Code*** 70553

Clinical Labor *Code* 70553	Pre In Office	Intra In Office	Post In Office	Pre Out Office	Intra Out Office	Post Out Office	Equipment Code	Supply Item Code	Qty of Supply units in office	Qty of Supply units out office
MRI Technician	0	116	0	0		0				
RN	0	21	0	0		0				

Medical Supplies *Code* 70553	Pre In Office	Intra In Office	Post In Office	Pre Out Office	Intra Out Office	Post Out Office	Equipment Code	Supply Item Code	Qty of Supply units in office	Qty of Supply units out office
angiocatheter 20 to 25g	0	0	0	0	0	0		91106	1 item	0 item
contrast (1% methylene blue)	0	0	0	0	0	0		93110	10 ml	0 ml
drape, sheet	0	0	0	0	0	0		11106	2 item	0 item
film, 14x17	0	0	0	0	0	0		73402	14 sheet	0 sheet
gloves, non-sterile	0	0	0	0	0	0		11302	1 pair	0 pair
iv infusion set	0	0	0	0	0	0		91110	1 set	0 set
patient gown, disposable	0	0	0	0	0	0		11107	1 item	0 item
syringe med rad 150 cc cartridge	0	0	0	0	0	0		73615	1 item	0 item

Overhead Equipment *Code* 70553	Pre In Office	Intra In Office	Post In Office	Pre Out Office	Intra Out Office	Post Out Office	Equipment Code	Supply Item Code	Qty of Supply units in office	Qty of Supply units out office
crash cart , no defibrilator							E91002		0	0

Procdure Specific Equipment *Code* 70553	Pre In Office	Intra In Office	Post In Office	Pre Out Office	Intra Out Office	Post Out Office	Equipment Code	Supply Item Code	Qty of Supply units in office	Qty of Supply units out office
MR Room							E51058			

AMA SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Magnetic Resonance Angiography (Head & Neck)

Work Relative Value Recommendations

The CPT Editorial Panel deleted the current code 70541 *Magnetic resonance angiography, head and/or neck, with or without contrast material(s)* (work RVU = 1.81) and replaced this code with six new codes to differentiate magnetic resonance angiography (MRA) for head and MRA for neck, and to indicate performance of studies with contrast. Distinct codes to describe the anatomical sites is justified as these two services, if done at the same patient encounter, require removal of the patient from the magnet bore, placement of separate MR imaging coils for the evaluation of distinct anatomic regions, and re-centering the patient, including new scout sequences. Two separate studies are produced and must be interpreted and reported separately.

In addition, no current codes exist for the performance of these studies with the dynamic administration of contrast materials, which was not generally utilized for this procedure when the code was originally developed in 1994. The RUC agreed with this argument and would like to emphasize to HCFA that these new codes report new technology, therefore, work neutrality should not be an issue.

The RUC reviewed the existing RUC survey time for code 70541 of 41 minutes and compared this to the surveyed time for the six new services. The RUC also reviewed the current work relative value for 70541 of 1.81 and agreed that 1.20 was reasonable for each anatomical site (head and neck) with or without contrast. Based on this review, the RUC agreed that the specialty society recommendations were appropriate as listed below:

70544	MRA, head; without contrast material	1.20
70545	with contrast material (s)	1.20
70546	with contrast, followed by contrast	1.80
70547	MRA, neck; without contrast material	1.20
70548	with contrast material (s)	1.20
70549	with contrast, followed by contrast	1.80

Codes 70546 and 70549 reflect the addition of the work relative value for 70544/70547 and ½ the work relative value for 70545/70548 (1.20+. 60 = 1.80).

Practice Expense Recommendations

The RUC recommended direct practice expense inputs are attached for services performed in a non-facility setting. The RUC reduced the proposed time of 10 minutes to greet the patient to the standard time of three minutes. A series of modifications were also made to the supplies and equipment as illustrated on the attached summary forms.

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	**Tracking Number**	**CPT Descriptor**	**Global Period**	**Work RVU Recommendation**
70541 (d)		~~*Magnetic resonance angiography, head and/or neck, with or without contrast material(s)*~~	XXX	1.81
●70544	PP1	Magnetic resonance angiography, head; without contrast material(s)	XXX	1.20
●70545	PP2	with contrast material(s)	XXX	1.20
●70546	PP3	without contrast material(s), followed by contrast material(s) and further sequences	XXX	1.80

●70547	PP4	Magnetic resonance angiography, neck; without contrast material(s)	XXX	1.20
●70548	PP5	with contrast material(s)	XXX	1.20
●70549	PP6	without contrast material(s), followed by contrast material(s) and further sequences	XXX	1.80

Combined
AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code	**70544**	Tracking Number:	**PP1**	Global Period	**XXX**	**Recommended RVW:**	**1.20**

CPT Descriptor:
Magnetic resonance angiography, head; without contrast material(s)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
A 45-year-old male presents with family history of cerebral aneurysm. His aunt and father both died of ruptured cerebral aneurysms, which places him in a high-risk group Rather than undergoing an invasive cerebral angiogram with attendant risks and costs, his physician orders an MRA of the brain to exclude cerebral aneurysm.

Currently the MR angiography procedure entails a 3-D time-of-flight gradient echo sequence sensitive to blood flow covering the vertebrobasilar and the circle of Willis to the proximal middle cerebral M1 and M2 branches. The data obtained would consist of between 64 and 128 images at 1-2 mm in thickness which are then processed by a ray algorithm to produce a "maximum intensity projections" (MIPs) which are the MRA equivalents of subtraction angiograms. Various regions of interest delineated by radiologists are then performed on this data set by the technologist to produce "coned down" views of the arterial tree. Typically these would include separate postprocessing of the left and right internal carotid, middle and anterior cerebral arteries as well as the vertebrobasilar system. From 12-18 MIPs at various angles around an artery per region are produced The would then be reviewed with the 128 partitions (separate images) by the radiologist The post-processing a post-service time usually requires approximately 20 – 30 minutes of technical time followed by interpretation by the physician.

Description of Pre-Service Work:
The physician reviews any previous studies, CT or MR, and protocols the study.

Description of Intra-Service Work:
Physician reviews the images obtained including the 128 partitions and the MIP images in the 360 rotations. The physician determines any areas of interest for post-processing for coned down views.

Description of Post-Service Work:
The physician reviews and interprets all images and dictates a report. If there is a positive finding, it is communicated to the referring physician Dictated report is reviewed and signed.

SURVEY DATA:

Presenter(s) J Arliss Pollock, M D., ASNR RUC Advisor
James P Borgstede, MD, ACR RUC Advisor

Specialty(s) American Society of Neuroradiology
American College of Radiology

Sample Size 480 Response Rate (%) 37/480 (7.7%) Median RVW 1 81

Type of Sample (Circle One): random panel Convenience Explanation of sample size.

25th Percentile RVW 1 80 75th Percentile RVW. 1.81 Low 1 2 High 2.20

Median Pre-Service Time 5.00 Median Intra-Service Time. 10.00

25th Percentile Intra-Service Time 5.00 75th Percentile Intra-Svc Time: 15.00 Low: 0 High: 40

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	10	N/A
Critical Care.	N/A	N/A
Other Hospital Visits:	N/A	N/A
Discharge Day Mgmt :	N/A	N/A
Office Visits	N/A	N/A

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
70541	Magnetic resonance angiography, head and/or neck, with or without contrast material(s)	1.81

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	5 00	4 00
Median Intra-Time	10 00	10.00
Median Immediate Post-service Time	10 00	10.00
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.21	3.08
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.14	3.00
Urgency of medical decision making	3.43	3.40
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.46	3.72
Physical effort required	1.56	1.66
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.38	2.24
Outcome depends on the skill and judgement of physician	4.10	4.12
Estimated risk of malpractice suit with poor outcome	3 84	3.84

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	1.76	1 52
Intra-Service intensity/complexity	3.27	2 14
Post-Service intensity/complexity	2 51	2.63

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation

The RVU recommendation of 1.2 is based on the assumption that in many instances only one non-contrast exam will be performed This results in lowering of the current RVU for both studies to accommodate those instances in which both are performed.

FREQUENCY INFORMATION

How was this service previously reported? 70541

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty

Specialty Neuroradiology X Commonly ___ Sometimes ___ Rarely

Specialty Radiology X Commonly ___ Sometimes ___ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neuroradiology Frequency We estimate that 192,400 70541 studies are performed nationally in a one-year period. We estimate that over 80% of head studies performed are performed without contrast

Specialty Radiology Frequency

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Neuroradiology Frequency According to BMAD data, the frequency of CPT 70541 is 148,000. We estimate that over 80% of head studies performed are performed

_____ without contrast

Specialty Radiology Frequency _____

Do many physicians perform this service across the United States? X Yes _____ No

Combined
AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code	70545	Tracking Number	PP2	Global Period	XXX	Recommended RVW:	1.20

CPT Descriptor.
Magnetic resonance angiography, head; with contrast material(s)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
A 45-year-old female with an unresectable arteriovenous malformation presents for stereotactic gamma knife radiotherapy The morning of her examination she is placed in a stereotactic head frame by a neurosurgeon. An MR angiogram through the region of her arteriovenous malformation is then obtained using 3D time-of-flight (TOF) following intravenous administration of contrast material. An intravenous line had been placed in the forearm connected to a power injector (injection procedure coded separately 90780). It has been shown that intravenous contrast material increases the conspicuity of cerebral arteriovenous malformations and is the optimal technique for localizing the arteriovenous malformation nidus prior to stereotactic radiation therapy.

After her MRA study, the patient was then transferred to the radiation therapy suite where her images are transferred to the radiation oncology computer. Both the post-contrast enhanced MRA partition views (approximately 60-100 images), as well as maximum intensity projections of the nidus using post-processing techniques, are interpreted by the radiologist.

Description of Pre-Service Work:
The physician reviews previous studies- angiograms, MRA, MR, and CT. Physician protocols the study.

Description of Intra-Service Work:
Physician reviews the obtained images for technical quality and satisfactory coverage.

Description of Post-Service Work:
Physician reviews and interprets the study, and dictates a report. Physician discusses the findings with the neurosurgeon and radiation oncologist. Dictated report is reviewed and signed.

SURVEY DATA:

Presenter(s): J Arliss Pollock, MD; ASNR RUC Advisor
James P Borgstede, MD, ACR RUC Advisor

Specialty(s): American Society of Neuroradiology
American College of Radiology

Sample Size 480 Response Rate: (%). 35/480 (7 3%) Median RVW 1.9

Type of Sample (Circle One) random panel convenience Explanation of sample size:

25th Percentile RVW 1 81 75th Percentile RVW 2.05 Low: 1.50 High: 3 80

Median Pre-Service Time. 5.00 Median Intra-Service Time: 15 00

25th Percentile Intra-Service Time: 5.00 75th Percentile Intra-Svc Time 20 00 Low 0 High: 60

Median Post-Service Time

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	10.00	N/A
Critical Care:	N/A	N/A
Other Hospital Visits.	N/A	N/A
Discharge Day Mgmt..	N/A	N/A
Office Visits:	N/A	N/A

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
70541	Magnetic resonance angiography, head and/or neck, with or without contrast material(s)	1 81

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	5.00	3 50
Median Intra-Time	15.00	10.00
Median Immediate Post-service Time	10.00	7.50
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.29	3 17
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.46	3 17
Urgency of medical decision making	3.89	3.47
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.74	3 69
Physical effort required	1.89	1 77
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.89	2.39
Outcome depends on the skill and judgement of physician	4.26	4 17
Estimated risk of malpractice suit with poor outcome	3.86	3 82

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.12	1 52
Intra-Service intensity/complexity	3.59	1 21
Post-Service intensity/complexity	2.90	2 60

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation

The RVU recommendation of 1.2 is based on the assumption that no significant additional physician time will be required for a single contrast scan than that required for a scan done without contrast.

FREQUENCY INFORMATION

How was this service previously reported? 70541

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

Specialty Neuroradiology ___ Commonly X Sometimes ___ Rarely

Specialty Radiology ___ Commonly X Sometimes ___ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neuroradiology Frequency We estimate that 192,400 70541 studies are performed nationally in a one-year period. We estimate that less than 10% of head studies performed are performed with contrast

Specialty Radiology Frequency

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Neuroradiology Frequency According to BMAD data, the frequency of CPT 70541 is 148,000. We estimate that less than 10% of head studies performed are performed with contrast

Specialty Radiology Frequency _____

Do many physicians perform this service across the United States? _____ Yes X No

Combined
AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:	70546	Tracking Number:	PP3	Global Period	XXX	Recommended RVW:	1.80

CPT Descriptor.
Magnetic resonance angiography, head; without contrast material(s), followed by contrast material(s) and further sequences

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
A 63-year-old man presents with headache and blurred vision. MR imaging using T1 and T2-weighted images had revealed the suspicion of an aneurysm of the carotid artery within or adjacent to the cavernous sinus. The decision to operate depends in part on the access to carotid aneurysm. If the aneurysm is above the carotid ring, the fibrous roof of the cavernous sinus then the patient is at risk of developing subarachnoid hemorrhage if the aneurysm ruptures and the access by the surgeon is possible. If the aneurysm neck is within the blood filled cavernous sinus, surgery is contraindicated as the access to the cavernous sinus is limited and the risk of subarachnoid hemorrhage is low. Routine angiography cannot differentiate the carotid ring as it cannot detect the cavernous sinus and its relationship to the aneurysm.

A non-contrast followed by a contrast enhanced MRA is ordered and performed with the 3D time of flight technique (injection procedure coded separately 90780) This permits verification of the carotid ring aneurysm The contrast enhanced MRA opacifies the cavernous sinus permitting visualization of the aneurysm in relation tc the cavernous sinus. 3D reformatted images are performed in the axial, coronal and sagittal plane, in addition to the routine maximum intensity projections These verify that the aneurysm is indeed arising within the opacified cavernous sinus. An endovascular approach is taken with successful coiling of the aneurysm.

Description of Pre-Service Work:
Physician reviews previous studies- MR, angiograms. Physician protocols the study.

Description of Intra-Service Work:
Physician reviews all images and assesses adequacy of the study to identify the margins of the cavernous sinus in relation to the aneurysm.

Description of Post-Service Work:
Physician reviews and interprets the study and dictates a report. The findings are conveyed to the referring physician. Dictated report is reviewed and signed.

SURVEY DATA:

Presenter(s). J. Arliss Pollock, MD, ASNR RUC Advisor
James P Borgstede, MD, ACR RUC Advisor

Specialty(s). American Society of Neuroradiology
American College of Radiology

Sample Size 480 Response Rate (%) 38/480 (7 9%) Median RVW: 2 25

Type of Sample (Circle One): random Panel convenience Explanation of sample size:

25th Percentile RVW. 1.85 75th Percentile RVW. 2.50 Low 1.20 High. 3.62

Median Pre-Service Time: 6 00 Median Intra-Service Time: 15 00

25th Percentile Intra-Service Time: 10.00 75th Percentile Intra-Svc Time: 25 Low: 0 High. 60

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	10	N/A
Critical Care:	N/A	N/A
Other Hospital Visits.	N/A	N/A
Discharge Day Mgmt..	N/A	N/A
Office Visits:	N/A	N/A

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
70541	Magnetic resonance angiography, head and/or neck, with or without contrast material(s)	1 81

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	6.00	5.00
Median Intra-Time	15 00	15.00
Median Immediate Post-service Time	10.00	10.00
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.59	3.26
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.54	3.13
Urgency of medical decision making	3.81	3.47

Technical Skill/Physical Effort (Mean)

Technical skill required	3.73	3.52
Physical effort required	1.94	1 90

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.84	2.08
Outcome depends on the skill and judgement of physician	4.24	3.95
Estimated risk of malpractice suit with poor outcome	3.97	3.82

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.27	1.83
Intra-Service intensity/complexity	3.78	3.54
Post-Service intensity/complexity	3 00	2 70

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation

The RVU recommendation of 1 8 is based on the assumption that a large number of exams will continue to be done without contrast. The additional value represents the additional physician work involved in determining the need for contrast, and guiding the RT in determining areas of interest for both data acquisition and post-processing ROI for MIP post-processing and filming.

FREQUENCY INFORMATION

How was this service previously reported? 70541

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty

Specialty Neuroradiology ___ Commonly X Sometimes ___ Rarely

Specialty Radiology ___ Commonly X Sometimes ___ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neuroradiology Frequency We estimate that 192,400 70541 studies are performed nationally in a one-year period. We estimate that less than 10% of head studies performed are performed without contrast followed by contrast

Specialty Radiology Frequency

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Neuroradiology Frequency According to BMAD data, the frequency of CPT 70541 is 148,000. We estimate that less than 10% of head studies performed are performed

without contrast followed by contrast

Specialty Radiology

Frequency

Do many physicians perform this service across the United States? _____ Yes X No

Combined
AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code	70547	Tracking Number	PP4	Global Period:	XXX	Recommended RVW:	1.20

CPT Descriptor:
Magnetic resonance angiography, neck; without contrast material(s)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 62-year-old female presents with a transient ischemic attack involving the left side of her body with decrease in right vision. This occurred transiently several times over a two-week period A Doppler ultrasound was obtained and was non-diagnostic due to calcification. An MR angiography of the carotid artery was ordered A 2D and 3D time-of-flight MR angiography was performed without contrast material. This was performed using an anterior neck coil

2D TOF images were obtained from the supraaortic vasculature through the proximal circle of Willis. 3D TOF imaging of the carotid bifurcation was performed to increase the accuracy and spatial resolution. The data obtained would consist of between 64 and 128 images at 1-2 mm in thickness which are then processed by a ray algorithm to produce "maximum intensity projections" (MIPs) which are the MRA equivalents of subtraction angiograms Various regions of interest delineated by radiologists are then performed on this data set by the technologist to produce "coned down" views of the arterial tree. Typically these would include separate post-processing of the left and right internal carotid arteries. This data set can be rotated around the vessel to allow a 3D view of the vascular tree This demonstrated a 75% stenosis of the internal carotid artery just distal to the carotid bifurcation. Patient then went on to endarterectomy on the basis of the MRA.

Description of Pre-Service Work:

Physician reviews any previous studies – CT or MR, and protocols the study.

Description of Intra-Service Work:

Physician reviews the images obtained including the 128 partitions and the MIP images in the 360 rotations. The physician determines any areas of interest for post-processing for coned down views.

Description of Post-Service Work:

The physician reviews and interprets all images and dictates a report. If there is a positive finding, it is communicated to the referring physician. Dictated report is reviewed and signed.

SURVEY DATA:

Presenter(s) J Arliss Pollock, MD; ASNR RUC Advisor
James P Borgstede, MD, ACR RUC Advisor

Specialty(s): American Society of Neuroradiology
American College of Radiology

Sample Size: 480 Response Rate (%) 38/480 (7.9%) Median RVW: 1.81

Type of Sample (Circle One): random panel convenience Explanation of sample size:

25th Percentile RVW 1.8 75th Percentile RVW: 1.81 Low. 1.0 High 1.95

Median Pre-Service Time: 5.00 Median Intra-Service Time: 10.00

25th Percentile Intra-Service Time. 5.00 75th Percentile Intra-Svc Time: 15.00 Low: 0 High: 15.00

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	10.00	N/A
Critical Care:	N/A	N/A
Other Hospital Visits:	N/A	N/A
Discharge Day Mgmt.:	N/A	N/A
Office Visits:	N/A	N/A

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
70541	Magnetic resonance angiography of head and/or neck, with or without contrast material(s)	1.81

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	5.00	5.00
Median Intra-Time	10.00	10 00
Median Immediate Post-service Time	10.00	10.00
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.05	2.96
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.16	2.96
Urgency of medical decision making	3.45	3.32

Technical Skill/Physical Effort (Mean)

Technical skill required	3.39	3.48
Physical effort required	1.59	1.79

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.55	2.24
Outcome depends on the skill and judgement of physician	4.00	3.80
Estimated risk of malpractice suit with poor outcome	3.63	3.36

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	1 85	1.60
Intra-Service intensity/complexity	3 32	3.29
Post-Service intensity/complexity	2.55	2.57

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The RVU recommendation of 1.2 is based on the assumption that in many instances only one non-contrast exam will be performed. This results in lowering of the current RVU for both studies to accommodate those instances in which both are performed.

FREQUENCY INFORMATION

How was this service previously reported? 70541

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

Specialty Neuroradiology X Commonly ___ Sometimes ___ Rarely

Specialty Radiology X Commonly ___ Sometimes ___ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neuroradiology Frequency We estimate that 192,400 70541 studies are performed nationally in a one-year period. We estimate that approximately 60% of neck studies performed are performed without contrast

Specialty Radiology Frequency

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Neuroradiology Frequency According to BMAD data, the frequency of CPT 70541 is 148,000. We estimate that approximately 60% of neck studies performed are

_____ performed without contrast

Specialty Radiology Frequency _____

Do many physicians perform this service across the United States? X Yes _____ No

Combined
AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code.	**70548**	Tracking Number	**PP5**	Global Period.	**XXX**	**Recommended RVW:**	**1.20**

CPT Descriptor:
Magnetic resonance angiography, neck; with contrast material(s)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 72-year-old man was referred for evaluation of his carotid arteries following an endarterectomy for a high grade carotid stenosis. He had a history of recurrent TIAs. Prior MRAs had been performed but the image quality was degraded by patient motion. Doppler ultrasound demonstrated equivocal findings of recurrent stenosis. It was elected to perform a contrast enhanced MRA of the carotid circulation using dynamic bolus and dynamic 3D short TR and short flip angle sequences.

The patient was placed on the MR scanner with an anterior neck coil and a 2D localizing sequence obtained prior to the administration of contrast material. An intravenous line had been placed in the forearm connected to a power injector (injection procedure coded separately 90780). This was followed by a test bolus of contrast material of 2cc followed by imaging obtained at the level of the bifurcation every second until the contrast appears. This indicated the circulation time required for contrast arrival at the bifurcation. The 3D time-of-flight MRA sequence was then performed using a slab of 40mm thick centered at the carotid bifurcation. 2 MRA sequences are performed successively during the intravenous injection of 0.2 mm/kg of intravenous gadolinium contrast material administered at a rate of 5cc per second. The 3D slab was repeated twice during the bolus of contrast. The coronal partitions were visualized independently and also post-processed into a data set of maximum intensity projections (MIPS) which are then viewed by the radiologist. This required approximately 20-30 minutes of post-processing and post-service time by technologists. The radiologist must be present for the test injection, the localization of the carotid bifurcation, as well as the acquisition during power injection of 5cc of gadolinium over the course of approximately 15 seconds.

This patient was found to have a high-grade re-stenosis of the carotid bifurcation requiring re-endarterectomy. Conventional angiography was not performed.

Description of Pre-Service Work:

The physician reviews previous MRA studies and protocols the study.

Description of Intra-Service Work:

Physician reviews the obtained images for technical quality and satisfactory coverage.

Description of Post-Service Work:

Physician reviews and interprets the study, and dictates a report. Physician discusses the findings with the referring physician. Dictated report is reviewed and signed.

SURVEY DATA:

Presenter(s) J Arliss Pollock, MD, ASNR RUC Advisor
James P Borgstede, MD; ACR RUC Advisor

Specialty(s) American Society of Neuroradiology
American College of Radiology

Sample Size: 480 Response Rate: (%): 33/480 (6.9%) Median RVW. 1 9

Type of Sample (Circle One) random panel convenience Explanation of sample size.

25th Percentile RVW 1.81 75th Percentile RVW. 2 4 Low: 1 5 High 4.5

Median Pre-Service Time: 10 Median Intra-Service Time 15.00

25th Percentile Intra-Service Time: 10.00 75th Percentile Intra-Svc Time: 20.00 Low: 5 High: 60

Median Post-Service Time.

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	10.00	N/A
Critical Care:	N/A	N/A
Other Hospital Visits	N/A	N/A
Discharge Day Mgmt.:	N/A	N/A
Office Visits:	N/A	N/A

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
70541	Magnetic resonance angiography of head and/or neck, with or without contrast material(s)	1 81

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	10 00	4.50
Median Intra-Time	15 00	5.00
Median Immediate Post-service Time	10 00	10 00
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.18	2.95
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.24	3.00
Urgency of medical decision making	3.41	3.26
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.65	4.37
Physical effort required	1.91	1.68
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.79	2.17
Outcome depends on the skill and judgement of physician	4.03	3.68
Estimated risk of malpractice suit with poor outcome	3.65	3.56

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.19	1 75
Intra-Service intensity/complexity	3.59	3 26
Post-Service intensity/complexity	2.68	2 56

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The RVU recommendation of 1.2 is based on the assumption that no significant additional physician time will be required for a single contrast scan than that required for a scan done without contrast.

FREQUENCY INFORMATION

How was this service previously reported? 70541

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

Specialty Neuroradiology ___ Commonly X Sometimes ___ Rarely

Specialty Radiology ___ Commonly X Sometimes ___ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neuroradiology Frequency We estimate that 192,400 70541 studies are performed nationally in a one-year period. We estimate that approximately 12% of neck studies performed are performed with contrast

Specialty Radiology Frequency ___

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Neuroradiology Frequency According to BMAD data, the frequency of CPT 70541 is 148,000. We estimate that approximately 12% of neck studies performed are performed with contrast

Specialty Radiology Frequency _____

Do many physicians perform this service across the United States? _____ Yes X No

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Combined
AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:	70549	Tracking Number	PP6	Global Period	XXX	Recommended RVW:	1.80

CPT Descriptor:
Magnetic resonance angiography, neck; without contrast material(s), followed by contrast material(s) and further sequences

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 72-year-old man was referred for evaluation of his carotid arteries following a small watershed infarction of his left hemisphere He had a prior history of TIA's 2D TOF followed by 3D TOF MRA of the carotid bifurcation revealed suggestion of a higher grade stenosis of 80%, however patient motion degraded the image quality. Doppler ultrasound demonstrated heavy calcification at the carotid bifurcation. It was elected to perform a contrast enhanced MRA of the carotid circulation using dynamic bolus and dynamic 3D short TR and short angle sequences.

The patient was placed on the MR scanner with an anterior neck coil and a 2D and 3D TOF sequence obtained prior to the administration of contrast material. An intravenous line had been placed in the forearm connected to a power injector (injection procedure coded separately 90780). A pre-contrast localizer study was performed to locate the carotid bifurcation Generally a physician must be present for this portion of the examination This was followed by a test bolus of contrast material of 2 cc followed by imaging obtained at the level of the bifurcation every second until the contrast appears This indicated the circulation time required for contrast arrival at the bifurcation. The 3D TOF MRA sequence was then performed using a slab of 40 mm thick centered at the carotid bifurcation. Two MRA sequences are performed successively during the intravenous injection of 0.2 mm/kg of intravenous gadolinium contrast material administered at a rate of 5 cc per second. The 3D slab was repeated twice during the bolus of contrast. The coronal partitions were visualized independently and also post-processed into a data set of maximum intensity projections (MIPS) which are then viewed by the radiologist. This required approximately 20-30 minutes of post-processing and post-service time by technologists. The radiologist must be present for the test injection, the localization of the carotid bifurcation, as well as the acquisition during power injection of 5 cc of gadolinium over the course of approximately 15 seconds. This patient was found to have a high-grade stenosis of the carotid bifurcation requiring endarterectomy. Conventional angiography was not required.

Description of Pre-Service Work:

Physician reviews previous MRA studies and protocols the study.

Description of Intra-Service Work:

Physician reviews all images and addresses adequacy of the study to identify stenosis.

Description of Post-Service Work:

Physician reviews and interprets the study and dictates a report. Findings are conveyed to the referring physician. Dictated report is reviewed and signed.

SURVEY DATA:

Presenter(s): J Arliss Pollock, MD, ASNR RUC Advisor
James P Borgstede, MD; ACR RUC Advisor

Specialty(s) American Society of Neuroradiology
American College of Radiology

Sample Size. 480 Response Rate. (%) 31/480 (6 5%) Median RVW. 2 00

Type of Sample (Circle One): random panel convenience Explanation of sample size: _____

25th Percentile RVW. 1.85 75th Percentile RVW. 2.5 Low: 1 5 High: 4.5

Median Pre-Service Time: 10 Median Intra-Service Time: 20

25th Percentile Intra-Service Time: 13 75th Percentile Intra-Svc Time· 30 Low: 5 High: 60

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time	10.00	N/A
Critical Care:	N/A	N/A
Other Hospital Visits:	N/A	N/A
Discharge Day Mgmt ·	N/A	N/A
Office Visits:	N/A	N/A

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
70541	Magnetic resonance angiography of head and/or neck, with or without contrast material(s)	1.81

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	10.00	5 00
Median Intra-Time	20.00	12.50
Median Immediate Post-service Time	10.00	10.00
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.32	3.09
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.35	3.04
Urgency of medical decision making	3.61	3.33

Technical Skill/Physical Effort (Mean)

Technical skill required	3.93	3.61
Physical effort required	2.06	1.85

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.93	2.38
Outcome depends on the skill and judgement of physician	4.12	3.85
Estimated risk of malpractice suit with poor outcome	3.67	3.57

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.31	1.66
Intra-Service intensity/complexity	3.90	3.38
Post-Service intensity/complexity	2.96	2.58

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The RVU recommendation of 1.8 is based on the assumption that a large number of exams will continue to be done without contrast. The additional value represents the additional physician work involved in determining the need for contrast, and guiding the RT in determining areas of interest for both data acquisition and post-processing ROI for MIP post-processing and filming.

FREQUENCY INFORMATION

How was this service previously reported? 70541

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

Specialty Neuroradiology ___ Commonly X Sometimes ___ Rarely

Specialty Radiology ___ Commonly X Sometimes ___ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neuroradiology Frequency We estimate that 192,400 70541 studies are performed nationally in a one-year period. We estimate that less than 30% of neck studies performed are performed without contrast followed by contrast

Specialty Radiology Frequency

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Neuroradiology Frequency According to BMAD data, the frequency of CPT 70541 is 148,000. We estimate that less than 30% of neck studies performed are performed

without contrast followed by contrast

Specialty Radiology

Frequency

Do many physicians perform this service across the United States? _____ Yes __X__ No

CPT Code: 70544

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

AMA/Specialty Society Update Process
Summary of Recommendation
XXX Global Period

In Office Direct Inputs

Sample Size: 480 Response Rate: (%): 3% (12) Global Period: XXX

Tracking Number: PP1 Reference Code 1 70541 Reference Code 2 70551

Geographic Practice Setting %: Rural 16% Suburban 33% Urban 50%

Type of Practice %: _____Solo Practice
42% Single Specialty Group
42% Multispecialty Group
16% Medical School Faculty Practice Plan

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Radiology Technologist reviews and assembles x-rays, lab, and pathology reports

Intra-Service Clinical Labor Activities:

Radiology Technologist greets patient, conducts pre-MR interview (metal screen), reassures patient, preps and positions patient, prepares room, equipment, and supplies, acquires and reviews exam, has radiologist come to review exam, completes post-processing, and finally cleans the room and equipment.

Post-Service Clinical Labor Activities:

The Medical Assistant assembles films and prepares for radiologist interpretation.

Clinical Labor	**Pre-Service Time**	**Service Period (Day of service)**	**Post-Service Time After Day of Service)**
~~RN~~			
LPN			
MA			10
~~Radiology Technologist~~ Angio Technician (1002)	5	~~81~~ 74	

CPT Code: 70544

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost or HCFA code
EAR PLUGS	2	Ea	$0 10 each $.20 per pair
FILM 14X17	8	Sheets	73402
FILM JACKETS	1	Item	73405
HEAD COVER	1	Item	$0 05 each
~~LINEN~~	~~1~~	~~Item~~	
MRA EDUCATIONAL BROCHURE	1	Unit	11115
OPTICAL DISK (73409)	1	1	73409

Procedure Specific Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Equipment Cost
MR IMAGING SYSTEM	1	30	48	E51058
~~NEUROVASCULAR COIL~~	~~1~~	~~30~~	~~20~~	$40,000 GE
POST PROCESSING WORK STATION	1	30	30	$180,000 GE
~~MR ANGIO PACKAGE~~	~~1~~	~~30~~	~~30~~	Software for workstation included above in price of workstation

Overhead Medical Equipment	No. of units in practice	Equipment Cost
~~ALTERNATOR~~ Film Alternator	1	$30,000 – per HCFA overhead equipment price list
~~COIL CABINET~~	~~1~~	
CRASH CART	1	E91002
~~ECHO PLANAR IMAGING PACKAGE~~	~~1~~	
~~LASER CAMERA~~	~~1~~	$48,750 Sterling Diagnostic
~~MRI STRETCHER~~	~~1~~	E11002
~~MRI WHEELCHAIR~~	~~1~~	E11008
~~PT LOCKER~~	~~1~~	
~~PT AUDIO/VIDEO~~	~~1~~	$16,000 (Audio alone)
~~PULSE OXIMETER~~	~~1~~	E55003

CPT Code: 70544

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

Type of Service: Evaluation/Management Services or Diagnostic Tests

XXX Global Period

SITE OF SERVICE: In-Office

Clinical Services	Minutes	Staff Type – Circle
Pre-Service Period		
Start: When appointment for service is made		
Review/assemble X-ray, lab, and pathology reports	5 min	RN, LPN, MA, Other ~~RT~~
Other Clinical Activity (please specify)		
_____	_____	RN, LPN, MA, Other _____
End. Patient arrival at office for service		
Service Period		
Start: Patient arrival at office for service		
Greet patient/Conduct pre-MR interview for metal screen/reassurance to patient	~~10~~ 3 min	RN, LPN, MA, Other ~~RT~~
Obtain vital signs		RN, LPN, MA, Other _____
Prep and position patient	5 min	RN, LPN, MA, Other ~~RT~~
Prepare room, equipment, supplies	5 min	RN, LPN, MA, Other ~~RT~~
Acquire and review exam/Have radiologist come to review exam	26 min	RN, LPN, MA, Other ~~RT~~
Education/instruction/ counseling		RN, LPN, MA, Other _____
Coordinate home or outpatient care		RN, LPN, MA, Other _____
Clean room/equipment	5 min	RN, LPN, MA, Other ~~RT~~
Other Clinical Activity (please specify)		
Post-processing time	30 min	RN, LPN, MA, Other ~~RT~~
End. Patient leaves office		
Post-Service Period		
Start: Patient leaves office		
Phone calls between visits with patient, family pharmacy	_____	RN, LPN, MA, Other _____
Other Activity (please specify)		
Assembly of films/preparation for radiologic interpretation	10 min	RN, LPN, MA, Other _____
End: When appointment for next office visit is made.		

CPT Code: 70545

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

AMA/Specialty Society Update Process
Summary of Recommendation
XXX Global Period

In Office Direct Inputs

Sample Size: 480 Response Rate: (%): 2% (11) Global Period: XXX

Tracking Number: PP2 Reference Code 1 70541 Reference Code 2 70552

Geographic Practice Setting %: Rural 18% Suburban 27% Urban 55%

Type of Practice %: ____Solo Practice
36% Single Specialty Group
45% Multispecialty Group
18% Medical School Faculty Practice Plan

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Radiology Technologist reviews and assembles x-rays, lab, and pathology reports

Intra-Service Clinical Labor Activities:

Radiology Technologist greets patient, conducts pre-MR interview (metal screen), reassures patient, preps and positions patient, prepares room, equipment, and supplies, starts angiocath, acquires and reviews exam, completes post-processing, and finally cleans the room and equipment. RN obtains vital signs.

Post-Service Clinical Labor Activities:

The Medical Assistant assembles films and prepares for radiologist interpretation.

Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)
~~RN~~		~~4~~	
LPN			
MA			10
~~Radiology Technologist~~ Angio Technologist	5	~~83~~ 72	

delete

CPT Code: 70545

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

Medical Supplies	Quantity of Supplies	Units Used for Purchase	Costs and HCFA codes
ALCOHOL SWAB	1	Item	31101
ANGIOCATH	1	Item	91106
BANDAID	1	Item	31502
CONNECTING TUBING	1	Item	91109
EAR PLUGS	2	Ea	$0 10 Each ($0 20 per pair)
FILM 14X17	8	Sheets	73402
FILM JACKETS	1	Item	73405
HEAD COVER	1	Item	$0 05 each
HEPARIN LOCK	I	Item	53008
~~LINEN~~	~~1~~	~~Item~~	
MRA EDUCATIONAL BROCHURE	1	Unit	11115
~~MR CONTRAST~~	~~1 Vial~~	~~10 cc~~	
SALINE FLUSH	1 Vial	10 cc	10 mL vial = $2.30 Abott
SYRINGE	2	5 cc	91411
DISPOSABLE POWER INJECTOR SYRINGE	1		$12 each - Medrad
OPTICAL DISK	1		73409

Procedure Specific Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Equipment Cost
MR IMAGING SYSTEM	1	30	48	E51058
~~NEUROVASCULAR COIL~~	~~1~~	~~30~~	~~20~~	$40,000 GE
POST PROCESSING WORK STATION	1	~~30~~	~~30~~	$180,000 GE
~~MR ANGIO PACKAGE~~	~~1~~	~~30~~	~~30~~	Software for workstation included above in price of workstation

Overhead Medical Equipment	No. of units in practice	Equipment Cost
~~ALTERNATOR~~ film alternator	1	$30,000 – per HCFA overhead equipment list -
~~COIL CABINET~~	~~1~~	
CRASH CART	1	E91002
~~ECHO PLANAR IMAGING PACKAGE~~	~~1~~	
~~LASER CAMERA~~	~~1~~	$48,750 Sterling Diagnostic
~~MRI STRETCHER~~	~~1~~	E11002
~~MRI WHEELCHAIR~~	~~1~~	E11008
~~PT LOCKER~~	~~1~~	
~~PT AUDIO/VIDEO~~	~~1~~	$16,000 (Audio Alone)
~~PULSE OXIMETER~~	~~1~~	E55003

CPT Code: 70545

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

Type of Service: Evaluation/Management Services or Diagnostic Tests

XXX Global Period

SITE OF SERVICE: In-Office

Clinical Services	Minutes	Staff Type – Circle
Pre-Service Period		
Start: When appointment for service is made		
Review/Assemble X-ray, lab, and pathology reports	**5 min**	RN, LPN, MA, **Other ~~- RT~~**
Other Clinical Activity (please specify)		
_____		RN, LPN, MA, Other _____
End: Patient arrival at office for service		
Service Period		
Start: Patient arrival at office for service		
Greet patient/Conduct pre-MR interview (metal screen)/reassurance to patient	**~~10~~ 3 min**	RN, LPN, MA, **Other - ~~RT~~**
~~Obtain vital signs~~	**~~4 min~~**	**RN**, LPN, MA, Other
Prep and position patient	**5 min**	RN, LPN, MA, **Other – ~~RT~~**
Prepare room, equipment, supplies	**5 min**	RN, LPN, MA, **Other – ~~RT~~**
Start angiocath	**5 min**	RN, LPN, MA, **Other – ~~RT~~**
Acquire exam	**20 min**	RN, LPN, MA, **Other – ~~RT~~**
Education/instruction/ counseling	**3 min**	RN, LPN, MA, **Other - ~~RT~~**
Coordinate home or outpatient care		RN, LPN, MA, Other _____
Clean room/equipment	**5 min**	RN, LPN, MA, **Other – ~~RT~~**
Other Clinical Activity (please specify)		
Post-processing time	**30 min**	RN, LPN, MA, **Other – ~~RT~~**
End: Patient leaves office		
Post-Service Period		
Start: Patient leaves office		
Phone calls between visits with patient, family pharmacy		RN, LPN, MA, Other _____
Other Activity (please specify)		
Assembly of films/preparation for radiologic interpretation	**10 min**	RN, LPN, **MA**, Other _____
End: When appointment for next office visit is made.		

CPT Code: 70546

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

AMA/Specialty Society Update Process
Summary of Recommendation
XXX Global Period

In Office Direct Inputs

Sample Size: 480 Response Rate: (%): 2% (11) Global Period: XXX

Tracking Number: PP3 Reference Code 1 70541 Reference Code 2 70553

Geographic Practice Setting %: Rural 18% Suburban 27% Urban 55%

Type of Practice %:
- ____ Solo Practice
- 36% Single Specialty Group
- 45% Multispecialty Group
- 18% Medical School Faculty Practice Plan

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Radiology Technologist reviews and assembles x-rays, lab, and pathology reports

Intra-Service Clinical Labor Activities:

Radiology Technologist greets patient, conducts pre-MR interview (metal screen), reassures patient, preps and positions patient, prepares room, equipment, and supplies, starts angiocath, acquires and reviews the exam, has radiologist come to review exam, completes post-processing, and finally cleans the room and equipment. RN obtains vital signs.

Post-Service Clinical Labor Activities:

The Medical Assistant assembles films and prepares for radiologist interpretation.

Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)
~~RN~~		~~4~~	
LPN			
MA			10
~~Radiology Technologist~~ Angio Technologist (1002)	5	~~120~~ 113	

CPT Code: 70546

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

Medical Supplies	Quantity of Supplies	Units Used for Purchase	HCFA codes and cost quotes
ALCOHOL SWAB	1	Item	31101
ANGIOCATH	1	Item	91106
BANDAID	1	Item	31502
CONNECTING TUBING	1	Item	91109
EAR PLUGS	2	Ea	$0 10 each ($0 20 per pair
FILM 14X17	8	Sheets	73402
FILM JACKETS	1	Item	73405
HEAD COVER	1	Item	$0.05 each
HEAPRIN LOCK	1	Item	53008
~~LINEN~~	~~1~~	~~Item~~	
MRA EDUCATIONAL BROCHURE	1	Unit	11115
~~MR CONTRAST~~	~~1 Vial~~	~~10 cc~~	
SALINE FLUSH	1 Vial	10 cc	10 ml vial = $2.30 Abbott
SYRINGE	2	5 cc	91411
DISPOSABLE POWER INJECTOR SYRINGE	1		$12 each Medrad
OPTICAL DISK	1 .1		73409

Procedure Specific Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Equipment Cost
MR IMAGING SYSTEM	1	30	48	E51058
~~NEUROVASCULAR COIL~~	~~1~~	~~30~~	~~20~~	$40,000 GE
POST PROCESSING WORK STATION	1	30	30	$180,000 GE
~~POWER INJECTOR MR COMPATIBLE~~	~~1~~	~~10~~	~~10~~	$38,500 Medrad

Overhead Medical Equipment	No. of units in practice	Equipment Cost
~~ALTERNATOR~~ film alternator	1	$30,000 – per HCFA overhead equipment list
~~COIL CABINET~~	~~1~~	
CRASH CART	1	E91002
~~ECHO PLANAR IMAGING PACKAGE~~	~~1~~	
~~LASER CAMERA~~	~~1~~	$48,750 Sterling Diagnostic
~~MRI STRETCHER~~	~~1~~	E11002
~~MRI WHEELCHAIR~~	~~1~~	E11008
~~PT LOCKER~~	~~1~~	
~~PT AUDIO/VIDEO~~	~~1~~	$16,000 (Audio alone)
~~PULSE OXIMETER~~	~~1~~	E55003

CPT Code: 70546

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

Type of Service: Evaluation/Management Services or Diagnostic Tests

XXX Global Period

SITE OF SERVICE: In-Office

Clinical Services	Minutes	Staff Type – Circle
Pre-Service Period *Start: When appointment for service is made*		
Review/Assemble X-ray, lab, and pathology reports	5 min	RN, LPN, MA, Other - ~~RT~~ |
Other Clinical Activity (please specify)		
_____		RN, LPN, MA, Other _____
End: Patient arrival at office for service		
Service Period *Start: Patient arrival at office for service*		
Greet patient/Conduct pre-MR interview (metal screen)/reassurance to patient	~~10~~ 3 min	RN, LPN, MA, Other - ~~RT~~ |
Obtain vital signs	~~4 min~~	RN, LPN, MA, Other _____ |
Prep and position patient	5 min	RN, LPN, MA, Other – ~~RT~~ |
Start angiocath	5 min	RN, LPN, MA, Other – ~~RT~~ |
Prepare room, equipment, supplies	6 min	RN, LPN, MA, Other – ~~RT~~ |
Acquire and review exam/Have radiologist come to review	41 min	RN, LPN, MA, Other – ~~RT~~ |
Education/instruction/ counseling	3 min	RN, LPN, MA, Other - ~~RT~~ |
Coordinate home or outpatient care		RN, LPN, MA, Other _____
Clean room/equipment	5 min	RN, LPN, MA, Other - ~~RT~~ |
Other Clinical Activity (please specify)		
Post-processing time	45 min	RN, LPN, MA, Other - ~~RT~~ |
End. Patient leaves office		
Post-Service Period *Start: Patient leaves office*		
Phone calls between visits with patient, family pharmacy		RN, LPN, MA, Other _____
Other Activity (please specify)		
Assembly of films/preparation for radiologic interpretation	10 min	RN, LPN, MA, Other _____
End: When appointment for next office visit is made.		

CPT Code: 70547

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

AMA/Specialty Society Update Process
Summary of Recommendation
XXX Global Period

In Office Direct Inputs

Sample Size: 480 Response Rate: (%): 2% (10) Global Period: XXX

Tracking Number: PP4 Reference Code 1 70541 Reference Code 2 70540

Geographic Practice Setting %: Rural 20% Suburban 20% Urban 60%

Type of Practice %: _____Solo Practice
40% Single Specialty Group
40% Multispecialty Group
20% Medical School Faculty Practice Plan

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Radiology Technologist reviews and assembles x-rays, lab, and pathology reports

Intra-Service Clinical Labor Activities:

Radiology Technologist greets patient, conducts pre-MR interview (metal screen), reassures patient, preps and positions patient, prepares room, equipment, and supplies, acquires and reviews the exam, has radiologist come to review exam, completes post-processing, and finally cleans the room and equipment.

Post-Service Clinical Labor Activities:

The Medical Assistant assembles films and prepares for radiologist interpretation.

Clinical Labor	**Pre-Service Time**	**Service Period (Day of service)**	**Post-Service Time After Day of Service)**
~~RN~~			
LPN			
MA			10
~~RT~~ Angio Technologist (1002)	5	~~81~~ 74	

CPT Code: 70547

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost quotes or HCFA code
EAR PLUGS	2	Ea	$0.10 each ($0.20 per pair
FILM 14X17	8	Sheets	73402
FILM JACKETS	1	Item	73405
HEAD COVER	1	Item	$0.50 each
~~LINEN~~	~~1~~	~~Item~~	
MRA EDUCATIONAL BROCHURE	1	Unit	11115
OPTICAL DISC	1		73409

Procedure Specific Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Equipment Cost
MR IMAGING SYSTEM	1	30	48	E51058
~~NEUROVASCULAR COIL~~	~~1~~	~~30~~	~~20~~	$29,000 Medrad
POST PROCESSING WORK STATION	1	30	30	$180,000 GE
~~MR ANGIO PACKAGE~~	~~1~~	~~30~~	~~30~~	Softward for workstation included above in price of workstation

Overhead Medical Equipment	No. of units in practice	Equipment Cost
ALTERNATOR Film Alternator	1	$30,000 Per HCFA overhead equipment price list
~~COIL CABINET~~	~~1~~	
CRASH CART	1	E91002
~~ECHO PLANAR IMAGING PACKAGE~~	~~1~~	
~~LASER CAMERA~~	1	$48,750 * GE
~~MRI STRETCHER~~	1	E11002
~~MRI WHEELCHAIR~~	1	E11008
~~PT LOCKER~~	~~1~~	
~~PT AUDIO/VIDEO~~	~~1~~	$16,000 (Audio alone)
~~PULSE OXIMETER~~	1	E55003

CPT Code: 70547

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

Type of Service: Evaluation/Management Services or Diagnostic Tests

XXX Global Period

SITE OF SERVICE: In-Office

Clinical Services	Minutes	Staff Type – Circle
Pre-Service Period		
Start: When appointment for service is made		
Review/Assemble X-ray, lab, and pathology reports	5 min	RN, LPN, MA, Other ~~RT~~
Other Clinical Activity (please specify)		
_____	_____	RN, LPN, MA, Other _____
End: Patient arrival at office for service		
Service Period		
Start. Patient arrival at office for service		
Greet patient/Conduct pre-MR interview (metal screen)/reassure patient	~~10~~ 3min	RN, LPN, MA, Other ~~RT~~
Obtain vital signs		RN, LPN, MA, Other _____
Prep and position patient	5 min	RN, LPN, MA, Other ~~RT~~
Prepare room, equipment, supplies	5 min	RN, LPN, MA, Other – ~~RT~~
Acquire and review exam/Have radiologist come to review	26 min	RN, LPN, MA, Other – ~~RT~~
Education/instruction/ counseling		RN, LPN, MA, Other _____
Coordinate home or outpatient care		RN, LPN, MA, Other _____
Clean room/equipment	5 min	RN, LPN, MA, Other – RT
Other Clinical Activity (please specify)		
Post-processing time	30 min	RN, LPN, MA, Other – ~~RT~~
End: Patient leaves office		
Post-Service Period		
Start: Patient leaves office		
Phone calls between visits with patient, family pharmacy	_____	RN, LPN, MA, Other _____
Other Activity (please specify)		
Assembly of films/preparation for radiologic interpretation	10 min	RN, LPN, MA, Other _____
End: When appointment for next office visit is made.		

CPT Code: 70548

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

AMA/Specialty Society Update Process
Summary of Recommendation
XXX Global Period

In Office Direct Inputs

Sample Size: 480 Response Rate: (%): 2% (11) Global Period: XXX

Tracking Number: PP5 Reference Code 1 70541 Reference Code 2 76375

Geographic Practice Setting %: Rural 18% Suburban 27% Urban 55%

Type of Practice %: _____Solo Practice
36%Single Specialty Group
45%Multispecialty Group
18%Medical School Faculty Practice Plan

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Radiology Technologist reviews and assembles x-rays, lab, and pathology reports

Intra-Service Clinical Labor Activities:

Radiology Technologist greets patient, conducts pre-MR interview (metal screen), reassures patient, preps and positions patient, prepares room, equipment, and supplies, starts angiocath, acquires and reviews the exam, completes post-processing, and finally cleans the room and equipment. RN obtains vital signs.

Post-Service Clinical Labor Activities:

The Medical Assistant assembles films and prepares for radiologist interpretation.

Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)
~~RN~~		~~4~~	
LPN			
MA			10
~~Radiology Technologist~~Angio Technologist (1002)	5	~~83~~ 76	

CPT Code: 70548

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

Medical Supplies	Quantity of Supplies	Units Used for Purchase	HCFA Code or Cost Estimate
ALCOHOL SWAB	1	Item	31101
ANGIOCATH	1	Item	91106
BANDAID	1	Item	31502
CONNECTING TUBING	1	Item	91109
EAR PLUGS	2	Ea	$0.10 each ($0.20 per pair)
FILM 14X17	8	Sheets	73402
FILM JACKETS	1	Item	73405
HEAD COVER	1	Item	$0.05 each
HEPARIN LOCK	1	Item	53008
~~LINEN~~	~~1~~	~~Item~~	
MRA EDUCATIONAL BROCHURE	1	Unit	11115
~~MR CONTRAST~~	~~1 VIAL~~	~~10 cc~~	
SALINE FLUSH	1 VIAL	10 cc	10 ML vial = $2.30 Abbott
SYRINGE	2	5 cc	91411
OPTICAL DISC	1		73409
DISPOSABLE POWER INJECTOR SYRINGE	1	1	$12 each Medrad

Procedure Specific Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Equipment Cost
MR IMAGING SYSTEM	1	30	48	E51058
~~NEUROVASCULAR COIL~~	~~1~~	~~30~~	~~20~~	$40,000 GE
POST PROCESSING WORK STATION	1	30	30	$180,000 GE
~~POWER INJECTOR MR COMPATIBLE~~	~~1~~	~~10~~	~~10~~	$38,500 GE
~~MR ANGIO PACKAGE~~	~~1~~	~~30~~	~~30~~	Software for workstation included above in price workstation

Overhead Medical Equipment	No. of units in practice	Equipment Cost
~~ALTERNATOR~~ Film Alternator	1	$30,000- per HCFA overhead equipment price list
~~COIL CABINET~~	~~1~~	
CRASH CART	1	E91002
~~ECHO PLANAR IMAGING PACKAGE~~	~~1~~	
~~MRI STRETCHER~~	~~1~~	E11002
~~MRI WHEELCHAIR~~	~~1~~	E11008
~~PT LOCKER~~	~~1~~	
~~PT AUDIO/VIDEO~~	~~1~~	$16,000 (Audio alone)
~~PULSE OXIMETER~~	~~1~~	E55003

CPT Code: 70548

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

Type of Service: Evaluation/Management Services or Diagnostic Tests

XXX Global Period

SITE OF SERVICE: In-Office

Clinical Services	Minutes	Staff Type – Circle
Pre-Service Period		
Start: When appointment for service is made		
Review/Assemble X-ray, lab, and pathology reports	5 min	RN, LPN, MA, Other ~~RT~~
Other Clinical Activity (please specify)		
_____		RN, LPN, MA, Other _____
End: Patient arrival at office for service		
Service Period		
Start: Patient arrival at office for service		
Greet patient/Conduct pre-MR interview (metal screen)/reassurance to patient	~~10~~ 3 min	RN, LPN, MA, Other - ~~RT~~
Obtain vital signs	~~4 min~~	RN, LPN, MA, Other _____
Prep and position patient	5 min	RN, LPN, MA, Other ~~RT~~
Prepare room, equipment, supplies	5 min	RN, LPN, MA, Other ~~RT~~
Start angiocath	5 min	RN, LPN, MA, Other ~~RT~~
Acquire exam	20 min	RN, LPN, MA, Other ~~RT~~
Education/instruction/ counseling	3 min	RN, LPN, MA, Other - ~~RT~~
Coordinate home or outpatient care		RN, LPN, MA, Other _____
Clean room/equipment	5 min	RN, LPN, MA, Other - ~~RT~~
Other Clinical Activity (please specify)		
Post-processing time	30 min	RN, LPN, MA, Other ~~RT~~
End: Patient leaves office		
Post-Service Period		
Start: Patient leaves office		
Phone calls between visits with patient, family pharmacy		RN, LPN, MA, Other _____
Other Activity (please specify)		
Assembly of films/preparation for radiologic interpretation	10 min	RN, LPN, MA, Other _____
End: When appointment for next office visit is made.		

CPT Code: 70549

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

AMA/Specialty Society Update Process
Summary of Recommendation
XXX Global Period

In Office Direct Inputs

Sample Size: 480 Response Rate: (%): 2% (11) Global Period: XXX

Tracking Number: PP6 Reference Code 1 70541 Reference Code 2 76375

Geographic Practice Setting %: Rural 18% Suburban 27% Urban 55%

Type of Practice %: _____Solo Practice
36% Single Specialty Group
45%Multispecialty Group
18% Medical School Faculty Practice Plan

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Radiology Technologist reviews and assembles x-rays, lab, and pathology reports

Intra-Service Clinical Labor Activities:

Radiology Technologist greets patient, conducts pre-MR interview (metal screen), reassures patient, preps and positions patient, prepares room, equipment, and supplies, starts angiocath, acquires and reviews the exam, has radiologist come to review exam, completes post-processing, and finally cleans the room and equipment. RN obtains vital signs.

Post-Service Clinical Labor Activities:

The Medical Assistant assembles films and prepares for radiologist interpretation.

Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)
~~RN~~		~~4~~	
LPN			
MA			10
~~Radiology Technologist~~Angio Technologist (1002)	5	~~120~~ 113	

CPT Code: 70549

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

Type of Service: Evaluation/Management Services or Diagnostic Tests

XXX Global Period

SITE OF SERVICE: In-Office

Clinical Services	Minutes	Staff Type – Circle
Pre-Service Period		
Start When appointment for service is made		
Review/Assemble X-ray, lab, and pathology reports	5 min	RN, LPN, MA, Other ~~- RT~~
Other Clinical Activity (please specify)		
_____		RN, LPN, MA, Other _____
End· Patient arrival at office for service		
Service Period		
Start. Patient arrival at office for service		
Greet patient/Conduct pre-MR interview (metal screen)/reassurance to patient	~~10~~ 3 min	RN, LPN, MA, Other - ~~RT~~
Obtain vital signs	~~4 min~~	RN, LPN, MA, Other _____
Prep and position patient	5 min	RN, LPN, MA, Other ~~- RT~~
Start angiocath	5 min	RN, LPN, MA, Other ~~- RT~~
Prepare room, equipment, supplies	6 min	RN, LPN, MA, Other – ~~RT~~
Acquire and review exam/Have radiologist come to review	41 min	RN, LPN, MA, Other ~~- RT~~
Education/instruction/ counseling	3 min	RN, LPN, MA, Other - ~~RT~~
Coordinate home or outpatient care		RN, LPN, MA, Other _____
Clean room/equipment	5 min	RN, LPN, MA, Other - ~~RT~~
Other Clinical Activity (please specify)		
Post-processing time	45 min	RN, LPN, MA, Other - ~~RT~~
End· Patient leaves office		
Post-Service Period		
Start· Patient leaves office		
Phone calls between visits with patient, family pharmacy		RN, LPN, MA, Other _____
Other Activity (please specify)		
Assembly of films/preparation for radiologic interpretation	10 min	RN, LPN, MA, Other _____
End: When appointment for next office visit is made.		

AMA SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Magnetic Resonance Guidance Needle Placement

Work Relative Value Recommendations

New code 76393 *Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation* was created to describe MR guidance. MR guidance is used to assist in the associated procedures (e.g., biopsy) for minimally invasive tissue sampling, fluid collection, as well as for guidance of injection of diagnostic substances. Currently, CPT does not contain an existing code that accurately describes MR guidance for needle placement; therefore the unlisted code 76499 *Unlisted diagnostic radiologic procedure* was reported.

The RUC recommends that the work relative value unit for 76393 *Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation* be 1.50. The RUC agreed that 76393 is more work than 76360 *Computed tomography guidance for needle biopsy, radiological supervision and interpretation* (work RVU = 1.16) as this new service requires more physician time and has a higher level of intensity than 76360, as indicated in the specialty's survey data. **The RUC recommends a work relative value of 1.50 for code 76393.**

Practice Expense Recommendations

The attached direct practice expense inputs for services performed in a non-facility setting reflect a RUC reduction of clinical staff time to 45 minutes, as well as, deletions in the medical supplies and overhead equipment categories.

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●76393	UU1	Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation (For procedure see appropriate organ or site (eg 20206, 20220, 20225, 32400, 32405, 47000, 48102, 49180, 50200, 50390, 60100	XXX	1.50

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code	76393	Tracking Number:	UU1	Global Period.	XXX	Recommended RVW:	1.50

CPT Descriptor.
Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiologic supervision and interpretation

(For procedure see appropriate organ or site (eg 20206, 20220, 20225, 32400, 32405, 47000, 48102, 49180, 50200, 50390, 60100)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
45 year old male with known colon cancer is discovered to have a solid mass within the liver, best visualized on MRI. He is being considered for segmental hepatic resection with no other identifiable metastatic disease. He is referred for a percutaneous core biopsy of the mass. Because it is best seen on MRI, this modality is used for guidance of the biopsy (biopsy procedure coded separately, 47000 biopsy of liver, needle; percutaneous).

Description of Pre-Service Work:
-review patient record and prior imaging studies
-select MR pulse sequences for best visualization

Description of Intra-Service Work:
-review scout images to confirm lesion location
-select safest biopsy path to lesion
-confirm proper position of biopsy needle, each pass
-evaluate post biopsy images for complication

Description of Post-Service Work:
-dictate, review and sign report
-communicate findings to referring physician and pathologist if applicable

SURVEY DATA:

Presenter(s): James P. Borgstede, MD (ACR)
Robert L Vogelzang, MD (SCVIR)

Specialty(s): American College of Radiology
Society of Cardiovascular & Interventional Radiology

Sample Size: 148 Response Rate: (%): 24 (16%) Median RVW: 2.3

Type of Sample (Circle One): random panel convenience Explanation of sample size

25th Percentile RVW 1 50 75th Percentile RVW. 2 45 Low: 1.16 High: 3.00

Median Pre-Service Time. 20.00 Median Intra-Service Time: 42.50

25th Percentile Intra-Service Time: 30.00 75th Percentile Intra-Svc Time. 60.00 Low: 20.00 High: 150.00

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	15.00	N/A
Critical Care:	N/A	N/A
Other Hospital Visits:	N/A	N/A
Discharge Day Mgmt.:	N/A	N/A
Office Visits:	N/A	N/A

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
76360	Computerized tomography guidance for needle biopsy, radiological supervision and interpretation	1.16

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	20.00	17.5
Median Intra-Time	42 50	32.50
Median Immediate Post-service Time	15.00	15.00
Median of Aggregate Critical Care Times	N/A	N/A
Median of Aggregate Other Hospital Visit Times	N/A	N/A
Median Discharge Day Management Time	N/A	N/A
Median of Aggregate Office Visit Times	N/A	N/A

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.57	3.15
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.61	3.00
Urgency of medical decision making	3.30	2.77

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	3 46
Physical effort required	2.74	3.08

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.74	3.38
Outcome depends on the skill and judgement of physician	3.96	3.46
Estimated risk of malpractice suit with poor outcome	3.48	3.23

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.00	2.75
Intra-Service intensity/complexity	4 17	3.57
Post-Service intensity/complexity	2.77	2.75

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

FREQUENCY INFORMATION

How was this service previously reported? 71550, 72196, 74181, or 76499

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

Specialty Radiology ___ Commonly ___ Sometimes X Rarely

Specialty _____ ___ Commonly ___ Sometimes ___ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Radiology Frequency 71550 * 33,000
72196 * 145,000
74181 * 133,000
76499 * 26,000

Specialty _____ Frequency _____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty Radiology Frequency 71550 * 11,000
72196 * 48,000
74181 * 44,000
76499 * 9,000

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? ___ Yes ___ No

*These totals are based on 1998 BMAD data. These codes were designed to describe the diagnostic imaging of these respective anatomic regions and not describe guidance for invasive procedures. We are unable to determine the percentage of procedures performed as guidance.

4

AMA/Specialty Society Update Process
Summary of Recommendation
XXX Global Period

In Office Direct Inputs

These recommendations were derived from a Consensus Panel.

Sample Size: N/A Response Rate: (%) N/A Global Period: XXX
Tracking Number: UU1 Reference Code 1 _____ Reference Code 2 _____

Geographic Practice Setting %: Rural _____ Suburban _____ Urban _____

Type of Practice %:
_____ Solo Practice
_____ Single Specialty Group
_____ Multispecialty Group
_____ Medical School Faculty Practice Plan

Please describe the clinical activities of your staff:

Service Period Clinical Labor Activities:

Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)
RN			
LPN			
MA			
~~Registered Technologist (RT)~~MRI Technologist (1021)	~~5 minutes~~	~~125~~ 78 45minutes	~~5 minutes~~

Medical Supplies	Quantity of Supplies	Units Used for Purchase
Film	1	item
~~10 cc syringe~~	~~2~~	~~EACH~~
~~18 G needles~~	~~2~~	~~EACH~~
~~22 G needle~~	~~1~~	~~EACH~~
~~25 G needle~~	~~1~~	~~EACH~~
~~4x4 gauze pads~~	~~2~~	~~PKG~~

Medical Supplies – cont.	Quantity of Supplies	Units Used for Purchase
~~Band-aid~~	1	EACH
~~Betadine~~	~~1~~	~~EACH~~
~~Bio-hazard bag~~	~~1~~	~~EACH~~
~~Formalin~~	~~1~~	~~EACH~~
~~Lidocaine~~	~~1~~	~~EACH~~
~~MRI compatible needle~~	~~1~~	~~EACH~~
~~Scalpel~~	~~1~~	~~EACH~~
~~Skin marker~~	~~1~~	~~EACH~~
~~Specimen container~~	~~1~~	~~EACH~~
~~Sterile gloves~~	~~1~~	~~PAIR~~
~~Sterile towels~~	~~6~~	~~EACH~~
Film 14X17	2	

Procedure Specific Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Equipment Cost
MR Room E51084	1			

Overhead Medical Equipment	No. of units in practice	Equipment Cost
~~MRI machine~~	~~1~~	
~~Printer~~	~~1~~	
~~Crash cart~~	~~1~~	

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

CPT Code: 76393

Type of Service: Evaluation/Management Services or Diagnostic Tests
XXX Global Period

SITE OF SERVICE: In-Office

Clinical Services	Minutes	Staff Type – Circle	
Pre-Service Period			
Start: When appointment for service is made.			
Schedule space and equipment in facility	~~5~~	RN, LPN, MA, Other	~~RT~~
Review/read X-ray, lab, and pathology reports		RN, LPN, MA, Other	
Other Clinical Activity (please specify)		RN, LPN, MA, Other	
End: Patient arrival for service or physician arrives at patient's hospital unit. (ie: contact between physician and patient for service)			
Service Period			
Start: Patient arrival for service or physician arrives at patient's hospital unit.			
Greet patient/provide gowning	~~10~~ 3	RN, LPN, MA, Other	~~RT~~
Obtain vital signs	~~5~~	RN, LPN, MA, Other	~~RT~~
Prep and position patient	~~15~~ ~~5~~	RN, LPN, MA, Other	~~RT~~
Prepare room, equipment, supplies	~~10~~	RN, LPN, MA, Other	~~RT~~
Assist physician during exam	45	RN, LPN, MA, Other	MRI Tech ~~RT~~
Education/instruction/ counseling	~~205~~	RN, LPN, MA, Other	~~RT~~
Coordinate home or outpatient care	~~5~~	RN, LPN, MA, Other	~~RT~~
Clean room/equipment by physician staff	~~1510~~	RN, LPN, MA, Other	~~RT~~
Other Activity (please specify)		RN, LPN, MA, Other	
End: Patient leaves facility or physician leaves patient's hospital unit.			
Post-Service Period			
Start: Patient leaves facility or physician leaves patient's hospital unit.			
Phone calls between visits with patient, family pharmacy	~~5~~	RN, LPN, MA, Other	~~RT~~
Other Activity (please specify)		RN, LPN, MA, Other	
End When appointment for next office visit is made.			

AMA SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Fetal Biophysical Profile

76818

Work Relative Value Recommendations

Existing CPT code 76818 *Fetal biophysical profile* was revised to specify a fetal biophysical profile performed with non-stress testing. When performing this procedure, the physician evaluates fetal breathing movements, fetal movement, fetal tone and quantification of amniotic fluid.

The RUC compared code 76818 to the work RVU of reference service code 59025 *Fetal non-stress test* (work RVU = 0.53); however this value did not include the work of the ultrasound. The RUC added the work of a limited ultrasound, code 76815 *Echography, pregnant uterus, B-scan and/or real time with image documentation; limited (fetal size, heart beat, placental location, fetal position, or emergency in the delivery room)* (work RVU = 0.65) to the work RVU of code 59025 (0.53), to obtain a total relative work value of 1.18. The RUC compared this work value to the recommended work value and survey median work value of 1.05 for CPT code 76818, which the RUC agreed was an appropriate value. **The RUC recommends a work relative value of 1.05 for code 76818**.

Practice Expense Recommendations

The direct inputs were developed by a specialty consensus panel. The RUC approved the supplies with minor changes and with the deletion of the tachodynanometer, autoclave, and fiberoptic exam light from the equipment categories. The RUC recommends no direct practice expense inputs in the facility setting.

76819

Work Relative Value Recommendations

New CPT code 76819 *Fetal biophysical profile; without stress or non-stress testing* was created to specify fetal biophysical profile performed without non-stress testing. When performing this procedure, the physician evaluates fetal breathing movements, fetal movement, fetal tone and quantification of amniotic fluid without performing a non-stress.

The RUC compared new code 76819 to the reference survey code 76815 (work RVU = 0.65). When evaluating the new code 76819, the time and intensity and complexity measures were greater for the new code than the reference service code (76815). Also, the physician work is more intense due to the high-risk status of the patient. Existing code 76818 has a work RVU of 0.77 and is valued without stress or non-stress testing. Therefore, the RUC agreed that the recommended survey work RVU of 0.77 was appropriate. **The RUC recommends a work relative value of 0.77 for code 76819.**

Practice Expense Recommendations

The RUC approved the recommended direct inputs with minor changes to supplies and the deletion of some overhead equipment. The laser printer was moved from the procedure specific to overhead equipment category. The RUC does not recommend any direct inputs in the facility setting.

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	**Tracking Number**	**CPT Descriptor**	**Global Period**	**Work RVU Recommendation**
▲76818	MM1	Fetal biophysical profile; with non-stress testing	XXX	1.05
●76819	MM2	without stress or non-stress testing (For amniotic fluid index without non-stress test, use 76815)	XXX	0.77

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 76818 Tracking Number: MM1 Global Period: XXX **Recommended RVW:** 1.05

CPT Descriptor: Fetal biophysical profile; with non-stress testing.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 27-year old woman is at 42 weeks gestation, two weeks past her due date. She needs evaluation of fetal well being in order to facilitate a decision of whether to induce labor or not. A fetal biophysical profile with non-stress testing is obtained.

Description of Pre-Service Work:

Pre-service work includes the evaluation of estimated gestational age and documentation of the pregnancy complication requiring fetal testing.

Description of Intra-Service Work:

The patient is placed in recumbent position or in a cardiac chair and fetal heart sounds are located with continuous wave Doppler transducer that is then secured in place with belts or straps. A tocodynamometer is also secured to the uterine fundus to record uterine contradictions and a paper tracing of the heart rate and uterine activity is made for up to 30 minutes. Following the non-stress test, an abdominal transducer is used to perform the following four observations to complete the biophysical profile: 1) fetal breathing movements (one or more episodes of rhythmic fetal breathing movements of 30 seconds or more within 30 minutes), 2) fetal movements (three or more discrete body or limb movements within 30 minutes), 3) fetal tone (one or more episodes of fetal extremity extension with return to flexion), 4) quantification of amniotic fluid volume (a pocket of amniotic fluid that measures at least 1 cm in two planes perpendicular to each other).

Description of Post-Service Work:

Post-service work includes informing the patient of the findings and determination of an appropriate testing interval or other intervention and reporting the test results to the responsible physician. The transducers are cleaned. A formal report is dictated.

SURVEY DATA:

Presenter(s) George Hill, MD, Sandra Reed, MD, James Borgsted, MD

Specialty(s): American College of Obstetricians and Gynecologists, American College of Radiologists

Sample Size: 216 Response Rate: (%): 31 (14%) Median RVW: 1.05

Type of Sample (Circle One): random, **panel**, convenience. Explanation of sample size: _____

25th Percentile RVW: .87 75th Percentile RVW: 1.5 Low: .20 High: 3.5

Median Pre-Service Time: 10 Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 10 75th Percentile Intra-Svc Time: 40 Low: 3 High: 70

Median Post-Service Time:	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	8	
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
76805	Echography, pregnant uterus....complete	0.99
59025	Fetal non-stress test	0.53

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT 76805
Median Pre-Time	10	10
Median Intra-Time	30	20
Median Immediate Post-service Time	8	7
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.26	3.57
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.23	3.00
Urgency of medical decision making	4.00	2.86

Technical Skill/Physical Effort (Mean)

Technical skill required	3.72	4.00
Physical effort required	2.65	2.64

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.61	3.29
Outcome depends on the skill and judgement of physician	4.03	3.93
Estimated risk of malpractice suit with poor outcome	4.65	4.21

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.28	1.86
Intra-Service intensity/complexity	3.41	3.29
Post-Service intensity/complexity	2.81	2.64

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

Most respondents compared 76818 to 76805 (Complete OB ultrasound), indicating that 76818 required more intra-service and post-service time and greater mental effort. The ultrasound portion of the BPP is a less extensive examination than 76805, but it is typically performed in a high-risk situation. Moreover, 76818 also includes 59025 (Fetal non-stress test -- .53). Adding together 76805 and 59025 yields 1.26 RVUs. Since the ultrasound portion of 76818 does require somewhat less work than 76805, the survey median of 1.05 seems reasonable.

FREQUENCY INFORMATION

How was this service previously reported? 76818

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

Specialty___Ob/Gyn_____ __X__Commonly _____Sometimes _____Rarely

Specialty___Radiology_____ _____Commonly _____Sometimes __X____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Total utilization of 76818 and 7681X is unknown, since most of these procedures are paid for by private insurers and no comprehensive utilization database is available. A small percentage of pregnant women develop complications necessitating a biophysical profile.

Specialty _____ Frequency_____

Specialty _____ Frequency_____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

In 1997 Medicare paid for slightly more than 2000 biophysical profile procedures. The split between 76818 and 7681X is unknown, as is the split between radiologists and obstetricians.

Specialty _____ Frequency_____

Specialty _____ Frequency_____

Do many physicians perform this service across the United States? __X__Yes _____No

---

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 76819 Tracking Number: MM2 Global Period: XXX **Recommended RVW:** 0.77

CPT Descriptor: Fetal biophysical profile; without non-stress testing.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 27-year old woman is at 42 weeks gestation, two weeks past her due date. She needs evaluation of fetal well being in order to facilitate a decision of whether to induce labor or not. A fetal biophysical profile without non-stress testing is obtained.

Description of Pre-Service Work:

The pre-service work includes evaluation of the estimated gestational age and documentation of the pregnancy complication requiring fetal testing.

Description of Intra-Service Work:

An abdominal transducer is used to perform the following four observations to complete the biophysical profile: 1) fetal breathing movements (one or more episodes of rhythmic fetal breathing movements of 30 seconds or more within 30 minutes), 2) fetal movements (three or more discrete body or limb movements within 30 minutes), 3) fetal tone (one or more episodes of fetal extremity extension with return to flexion), 4) quantification of amniotic fluid volume (a pocket of amniotic fluid that measures at least 1 cm in two planes perpendicular to each other).

Description of Post-Service Work:

Post-service work includes informing the patient of the findings and determination of an appropriate testing interval or other intervention and reporting the test results to the responsible physician. The transducers are cleaned. A formal report is dictated.

SURVEY DATA:

Presenter(s) George Hill, MD, Sandra Reed, MD and James Borgsted, MD

Specialty(s): American College of Obstetricians and Gynecologists, American College of Radiology

Sample Size: 216 Response Rate: (%): 35 (16%) Median RVW: 0.95

Type of Sample (Circle One): random, **panel,** convenience. Explanation of sample size: _____

25th Percentile RVW: 0.70 75th Percentile RVW: 1.11 Low: 0.54 High: 3.23

Median Pre-Service Time: 10 Median Intra-Service Time: 22.5

25th Percentile Intra-Svc Time: 10 75th Percentile Intra-Svc Time: 30 Low: 5 High: 45

Median Post-Service Time:	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	7	
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
76815	Echograph, pregnant uterus; limited (fetal size, heart beat, placental location, ...)	0.65

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT 76815
Median Pre-Time	10	10
Median Intra-Time	22.5	20
Median Immediate Post-service Time	7	7
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.57	3.14
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.43	3.43
Urgency of medical decision making	4.00	2.86

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	4.00
Physical effort required	2.50	2.64

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.00	3.29
Outcome depends on the skill and judgement of physician	4.07	3.93
Estimated risk of malpractice suit with poor outcome	4.64	4.21

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.43	2.15
Intra-Service intensity/complexity	3.38	3.27
Post-Service intensity/complexity	2.95	2.70

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

Survey respondents most frequently chose 76815 (Limited obstetric ultrasound -- .65 RVUs) as a reference service. The ultrasound examination performed for 76819 is more work than 76815. The ultrasound portion of a biophysical profile includes evaluation of four elements (fetal breathing movements, amniotic fluid volume, muscle tone, and movement) while the limited OB ultrasound typically includes observation of only one element (eg, fetal position). In addition, physician work for 76819 is more intense due to the higher risk status of the patient. This greater intensity is reflected in respondent's higher rankings for urgency of medical decision making and psychological stress for 76819. ACOG and ACR recommend assigning 0.77 RVUs which is slightly higher than the 25th percentile survey result of 0.70.

FREQUENCY INFORMATION

How was this service previously reported? 76818-52

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

Specialty Ob/Gyn _____ X Commonly ____ Sometimes ____ Rarely

Specialty _____ ____ Commonly ____ Sometimes ____ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Total utilization of 76818 and 76819 is unknown, since most of these procedures are paid for by private insurers and no comprehensive utilization database is available. A small percentage of pregnant women develop complications necessitating a biophysical profile.

Specialty _____ Frequency_____

Specialty _____ Frequency_____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

In 1997 Medicare paid for slightly more than 2000 biophysical profile procedures. The split between 76818 and 76819 is unknown, as is the split between radiologists and obstetricians.

Specialty _____ Frequency_____

Specialty _____ Frequency_____

Do many physicians perform this service across the United States? __X__Yes _____No

---

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

CPT Code: 76818

AMA/Specialty Society Update Process
Summary of Recommendation
XXX Global Period

In Office Direct Inputs

Sample Size:__6__ Response Rate: (%):_N/A__ Global Period:_XXX__

Tracking Number:__MM1____ Reference Code 1__76805__ Reference Code 2_____

A consensus panel of 6 ACOG Fellows from various geographic locations and representing the range of ob-gyn specialties met to determine the direct practice inputs for a number of ob-gyn procedures.

Clinical Labor	**Pre-Service Time**	**Service Period (Day of service)**	**Post-Service Time After Day of Service)**
RN/LPN/MA		25	
Ultrasound Technician	5	30	7

Medical Supplies	**Quantity of Supplies**	**Units Used for Purchase**
Aquasonic gel	30 ml	Liter
Drape, sheet	1 item	100/case
EKG paper	6 sheet	
Exam table paper	7 foot	125 ft/roll, 12 rolls/case
~~Film, radiographic~~ 73402 film, 14" x 17"	2 sheets	
Gloves, non-sterile	2 pair	100/box
Gown, disposable	1 item	50/case
Pillow case, disposable	1 item	100/case
~~Laser paper~~	~~1 sheet~~	~~500/ream~~
~~Ultrasonic cleaning solution~~ 11520 transducer wipe	1 ~~cc~~ wipe	~~1 gallon~~

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

CPT Code: 76818

Procedure Specific Medical Equipment	**No. of units in practice**	**Minutes of use per procedure**	**Hours per week in use for all services**
Ultrasound, transducers, and vaginal probe E52001	1	30	
Diasonic software E52002	1	30	
~~Tocodynamometer~~	~~1~~	~~30~~	
Fetal non-stress test monitor E13404	1	30	
Overhead Medical Equipment	**No. of units in practice**		
Power table	1		
Crash cart, no defibrillator	1		
~~Autoclave~~	~~1~~		
~~Fiberoptic exam light~~	~~1~~		
Ultrasound table	1-4		
Laser Printer	1		

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

CPT Code: 76818

Type of Service: Evaluation/Management Services or Diagnostic Tests
XXX Global Period

SITE OF SERVICE: In-Office

Clinical Services	Minutes	Staff Type – Circle
Pre-Service Period *Start: When appointment for service is made*		
Review/read X-ray, lab, and pathology reports	5	RN, LPN, MA, Other _____
Other Clinical Activity (please specify)		
_____	_____	RN, LPN, MA, Other _____
End: Patient arrival at office for service		
Service Period *Start: Patient arrival at office for service*		
Greet patient/provide gowning	4	RN, LPN, MA, Other _Ultrasound Tech____
Obtain vital signs	0	RN, LPN, MA, Other _____
Prep and position patient	4	RN, LPN, MA, Other _Ultrasound Tech_____
Prepare room, equipment, supplies	4	RN, LPN, MA, Other _Ultrasound Tech_____
Assist physician during exam	15	RN, LPN, MA, Other _____
Education/instruction/ counseling	4	RN, LPN, MA, Other _Ultrasound Tech____
Coordinate home or outpatient care	0	RN, LPN, MA, Other _____
Clean room/equipment	4	RN, LPN, MA, Other _Ultrasound Tech_____
Other Clinical Activity (please specify)		
Conduct fetal biophysical profile scan.	20	RN, LPN, MA, Other _Ultrasound Tech only____
End: Patient leaves office		
Post-Service Period *Start: Patient leaves office*		
Phone calls between visits with patient, family pharmacy	7	RN, LPN, MA, Other _____
Other Activity (please specify)		
	_____	RN, LPN, MA, Other _____
End: When appointment for next office visit is made.		

AMA/Specialty Society Update Process
Summary of Recommendation
XXX Global Period

In Office Direct Inputs

Sample Size:__6__ Response Rate: (%):_N/A__ Global Period:_XXX_

Tracking Number:__MM2____ Reference Code 1_76815_ Reference Code 2_____

A consensus panel of 6 ACOG Fellows from various geographic locations and representing the range of ob-gyn specialties met to determine the direct practice inputs for a number of ob-gyn procedures.

Clinical Labor	**Pre-Service Time**	**Service Period (Day of service)**	**Post-Service Time After Day of Service)**
RN/LPN/MA			
Ultrasound Technician	5~~0~~	30	7

Medical Supplies	**Quantity of Supplies**	**Units Used for Purchase**
Aquasonic gel	30 ml	Liter
Drape, sheet	1 item	100/case
Exam table paper	7 foot	125 ft/roll, 12 rolls/case
~~Film, radiographic~~ 73402 film, 14' x 17"	2 sheets	
Gloves, non-sterile	2 pair	100/box
Gown, disposable	1 item	50/case
Pillow case, disposable	1 item	100/case
~~Laser paper~~	~~1 sheet~~	~~500/ream~~
~~Ultrasonic cleaning solution~~ 11520 transducer wipe	1 ~~cc~~ wipe	~~1 gallon~~

Procedure Specific Medical Equipment	**No. of units in practice**	**Minutes of use per procedure**	**Hours per week in use for all services**
Ultrasound, transducers, and vaginal probe	1	23	
Diasonic software	1	23	
~~Laser printer~~	~~1~~	~~23~~	

Overhead Medical Equipment	**No. of units in practice**
Power table	1
Crash cart, no defibrillator	1
~~Autoclave~~	~~1~~
~~Fiberoptic exam light~~	~~1~~
Ultrasound table	1-4
Laser Printer	1

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

CPT Code: 76819

Type of Service: Evaluation/Management Services or Diagnostic Tests
XXX Global Period

SITE OF SERVICE: In-Office

Clinical Services	Minutes	Staff Type – Circle
Pre-Service Period		
Start: When appointment for service is made		
Review/read X-ray, lab, and pathology reports	5	RN, LPN, MA, Other _____
Other Clinical Activity (please specify)		
_____	_____	RN, LPN, MA, Other _____
End: Patient arrival at office for service		
Service Period		
Start: Patient arrival at office for service		
Greet patient/provide gowning	2	RN, LPN, MA, Other _____
Obtain vital signs	0	RN, LPN, MA, Other _____
Prep and position patient	2	RN, LPN, MA, Other _____
Prepare room, equipment, supplies	2	RN, LPN, MA, Other _____
Assist physician during exam	0	RN, LPN, MA, Other _____
Education/instruction/ counseling	2	RN, LPN, MA, Other _____
Coordinate home or outpatient care	0	RN, LPN, MA, Other _____
Clean room/equipment	2	RN, LPN, MA, Other _____
Other Clinical Activity (please specify)		
Conduct fetal biophysical profile scan.	20	RN, LPN, MA, Other _____
End: Patient leaves office		
Post-Service Period		
Start: Patient leaves office		
Phone calls between visits with patient, family pharmacy	7	RN, LPN, MA, Other _____
Other Activity (please specify)		
	_____	RN, LPN, MA, Other _____
End: When appointment for next office visit is made.		

CPT Code: 76819

AMA/Specialty Society Update Process
Summary of Recommendation
XXX Global Period
Out-Of-Office Direct Inputs

Sample Size:__6__ Response Rate: (%):_N/A__ Global Period:__XXX___

Tracking Number:__MM2____ Reference Code 1_76815_ Reference Code 2_____

A consensus panel of 6 ACOG Fellows from various geographic locations and representing the range of ob-gyn specialties met to determine the direct practice inputs for a number of ob-gyn procedures.

The RUC recomends no direct inputs for this procedure in the out of office setting.

Clinical Labor	Pre-Service Time	Service Period	Coordination of Care*	Post-Service Time
RN/LPN/MA				

*By staff in the physician's office during the service period.

Medical Supplies	Quantity of Supplies	Units Used for Purchase
None		

Procedure Specific Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services
None			

Overhead Medical Equipment	No. of units in practice
~~Power table~~	~~1~~
~~Crash cart, no defibrillator~~	~~1~~
~~Autoclave~~	~~1~~
~~Fiberoptic exam light~~	~~1~~

AMA/Specialty Society RVS Update Committee Recommended Practice Expense Direct Inputs

CPT Code: 76819

Type of Service: Evaluation/Management and Diagnostic Tests
XXX Global Period

SITE OF SERVICE: Out-of-Office

Clinical Services	Minutes	Staff Type – Circle
Pre-Service Period		
Start: When appointment for service is made.		
Schedule space and equipment in facility	0	RN, LPN, MA, Other _____
Review/read X-ray, lab, and pathology reports	0	RN, LPN, MA, Other _____
Other Clinical Activity (please specify)		
_____	0	RN, LPN, MA, Other _____
End: Patient arrival for service or physician arrives at patient's hospital unit. (ie: contact between physician and patient for service)		
Service Period		
Start: Patient arrival for service or physician arrives at patient's hospital unit.		
Greet patient/provide gowning	0	RN, LPN, MA, Other _____
Obtain vital signs	0	RN, LPN, MA, Other _____
Prep and position patient	0	RN, LPN, MA, Other _____
Prepare room, equipment, supplies	0	RN, LPN, MA, Other _____
Assist physician during exam	0	RN, LPN, MA, Other _____
Education/instruction/ counseling	0	RN, LPN, MA, Other _____
Coordinate home or outpatient care	0	RN, LPN, MA, Other _____
Clean room/equipment by physician staff	0	RN, LPN, MA, Other _____
Coordination of care by staff in office	0	RN, LPN, MA, Other _____
Other Activity (please specify)		
_____	0	RN, LPN, MA, Other _____
End: Patient leaves facility or physician leaves patient's hospital unit.		
Post-Service Period		
Start: Patient leaves facility or physician leaves patient's hospital unit.		
Phone calls between visits with patient, family pharmacy	0	RN, LPN, MA, Other _____
Other Activity (please specify)		
_____	0	RN, LPN, MA, Other _____
End: When appointment for next office visit is made.		

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

April 2000
Photon Beam Treatment Delivery

There are currently two existing codes to describe photon beam treatment delivery. These codes are carrier priced and the RUC requests that they, along with the two new codes, remain carrier-priced. In addition, the specialty society agreed that none of these codes require physician work.

Code (●New) (▲Revised) (D Deletion) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommenda-tion
▲77520	G1	Proton treatment ~~beam~~ delivery; simple, ~~to a single treatment area, single port, custom block, with or~~ without compensation~~, with treatment set-up and verification images~~	XXX	Carrier Price
●77522	G2	simple, with compensation	XXX	Carrier Price
▲77523	G3	~~Proton beam delivery, to one or two treatment areas, two or more ports, two or more custom blocks, and two or more compensators, with treatment set-up and verification images~~ intermediate	XXX	Carrier Price
●77525	G4	complex	XXX	Carrier Price

A S T R O
The American Society
For Therapeutic Radiology and Oncology, Inc.

October 1, 1999

Sherry Smith
Director
Physician Payment Systems
American Medical Association
515 North State Street
Chicago, IL 60610

Dear Sherry,

The American Society for Therapeutic Radiology and Oncology (ASTRO) submitted a RUC level of interest form on September 17, 1999 regarding two new (7750X1, 7750X2) and two revised (77520, 77523) proton beam treatment delivery codes. We indicated that ASTRO does not wish to develop primary RVS recommendations but would like the opportunity to comment on RVS recommendations developed by other societies.

It is our understanding that none of these codes contain physician work and are technical component codes only. It is also our understanding that these codes will be carrier priced in the states in which these services are being provided.

Thank you for the opportunity to comment on this important issue.

Best regards,

Wendy J.M. Smith, MPH

Wendy J.M. Smith, M.P.H.
Director of Health Care Policy

2500 Fair Lakes Circle, Suite 375 Fairfax, VA 22033-3882 (800) 962-7876 (703) 502-1550 Fax: (703) 502-7852

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
February 2000

Hemodialysis Flow Study

Work Relative Value Recommendations

New CPT code 90940 *Hemodialysis access flow study to determine blood flow in grafts and arteriovenous fistulae by an indicator dilution method, hook-up, measurement and disconnection* was added to describe a hemodialysis access flow study to determine blood flow in grafts and arteriovenous fistulae by an indicator dilution method, hook-up, measurement and disconnection. This new code describes the technical component of a hemodialysis access flow study. There is no additional code for the professional component of this procedure since the physician work component is captured in the Monthly Capitated Payment (MPC) activities provided by physicians to patients receiving dialysis support.

Practice Expense Recommendations

The direct expense inputs for code 90940 when performed in a non-facility setting are attached in the Specialties Summary of Recommendation Form. The RUC recommends that a mix of the personnel be utilized for clinical staff practice expense. In addition, it was noted that 42% of the time the clinical staff are paid by the facility and 58% of the time separate personnel employed by the physician are utilized. Therefore, the typical clinical staff inputs are as follows:

RN/LPN/MA/PA/Dialysis Tech: 5.1 minutes pre-service; 17.9 minutes service period

The RUC also recommends a change to the specialty recommendation for medical supplies and equipment. Seventy to eighty percent of the time the Transonics equipment is utilized. Therefore, the RUC recommends deletion of the Critline supplies, procedure specific medical equipment and overhead equipment. It was also noted that the Transonics monitoring system is used for other purposes.

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

Code (●New) (▲Revised)	Track-ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
●90940	H1	Hemodialysis access flow study to determine blood flow in grafts and arteriovenous fistulae by an indicator dilution method, hook-up, measurement and disconnection (For duplex scan of hemodialysis access, use 93990)	XXX	Physician work is bundled into monthly capitated payment. Direct expense inputs attached to compute technical component.

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: 90940

CPT Descriptor:

Hemodialysis access flow study to determine flow in grafts and arteriovenous fistulae by an indicator dilution method, hook-up, measurement and disconnection.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used:

A 63-year-old dialysis patient dialyzes three times per week with blood flow from a left arm arterio-venous loop graft. During the regularly scheduled dialysis session the blood flow rate in the AV access is determined to avoid flow-limiting stenosis to assure adequacy of dialysis and avoidance of access clotting. The typical procedure requires attaching the sensors to the arterial and venous bloodlines of the dialyzer and recording flow. Then, the blood pump is stopped, the lines reversed, the pump restarted and an indicator injected. Blood flow is remeasured and recorded. The pump is then stopped again and the bloodlines returned to their dialysis mode and dialysis resumed. The information is then appropriately logged.

Description of Pre-Service Physician Work (assigned to M.C.P.):

A through evaluation of the monthly blood work and needle insertion activities during the dialysis sessions is undertaken, with emphasis on the functionality of the blood access. An examination of the physical characteristics of the access with attention to flow bruits, pulse pressures and needle insertion site anatomy as well as the cutaneous aspects of both the distal and proximal anastomosis sites. A review of machine-generated access flow pressure readings and changes in readings in response to various physician-directed arteriovenous fistula (graft) maneuvers.

Description of Intra-Service Physician Work (assigned to M.C.P.):

Supervisory aspects of the attachment of the device to the blood-lines and the injection of the indicator substance, or the prescription change in the machine setting ultrafiltration rates with subsequent monitoring of indicator variation. Evaluation of the quality of the resultant data with respect to variability, consistancy and reproducability.

Description of Post-Service Physician Work (assigned to M.C.P.):

Calculation of the percent recirculation of already detoxified blood within the fistula (graft) during the dialysis session and the effect of this recirculation on the reduction of effective dialysis delivery during the individual sessions. Decision on the method of correction with use of stenting, surgery or interventional dilation. Patient counseling for proper care and protection of the fistula (graft) with special attention to the methods of needle insertion rotation and post-removal hemostasis.

CPT Code: 90940 - Renal Physicians Association – R.U.C. Survey

SURVEY DATA:

Presenter: **Emil P. Paganini, M.D.**

Specialty: **Nephrology**

Sample Size: **179 Dialysis Clinics** Response Rate: **75%** Final Median RVW: **M.C.P.**

Explanation of Sampling Technique:

The RUC suggested survey tool for capturing the in office direct costs of providing vascular access flow recirculation data was submitted to 52 dialysis entities comprising non-for-profit, for-profit, free-standing, and hospital-based dialysis centers or corporations.These entities than surveyed their individual centers representing a total of 179 dialysis clinics and over 12,000 patient at risk. The data was submitted to the RPA/ASN Relative Value Concensus Panel which consists of representative nephrologists from all aspects of practice and geographic situations. Practice managers and administrators were also asked to review and comment on the data returned. The panel refined the data to generate the final RVW recommendation. It is recognized that the physician work component is covered in the Monthly Capitated Payment evaluation and Management activities already in place (90918 - 90921)

Median *Physician* Pre-Service Time: **20min** Median *Physician* Intra-Service Time: **2min**

5th Percentile Intra-Svc Time: **1min** 75th Percentile Intra-Svc Time: **3min** Low: **0min** High: **10min**

Median *Physician* Same Day Post-Service Time: **5min**

Number of Post Procedure Visits: **MCP** Total Time of Post Procedure Visits: **MCP**

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Total RVU*
93965-TC	Non-invasive physiologic studies of extremity veins.	1.22
93970-TC	Duplex scan of extremity veins including responses to compression and other maneuvers	4.55
93990-TC	Duplex scan of hemodialysis access	2.75

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* Fed Register Vol 64, No 211 / Nov. 2, 1999

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

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

TIME ESTIMATES (Median)	CPT CODE 909XI	REFERENCE SERVICE 1 – 93965	REFERENCE SERVICE 2 - 93970
Median Pre-Time	6.15 min		
Median Intra-Time	11.1 min		
Median Post-Time	7.9 min		

INTENSITY/COMPLEXITY MEASURES

Mental Effort and Judgement 0f Technical Staff (Mean)

[Physician work assigned to M.C.P. and not assessed here]

The number of possible diagnosis and/or the number of management options that must be considered.	Dx – 4 Rx – 5		
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed.	Complex: Lab, P.E., Mechanical		
Urgency of medical decision making.	Moderate		

Technical Skill/Physical Effort of Technical Staff (Mean)

[Physician work assigned to M.C.P. and not assessed here]

Technical skill required	Moderate		
Physical effort required	Moderate		

Psychological Stress of Technical staff (Mean)

[Physician work assigned to M.C.P. and not assessed here]

The risk of significant complications, morbidity and/or mortality	Low		
Outcome depends on the skill and judgement of physician	Low		
Estimated risk of malpractice suite with poor outcome	Low		

INTENSITY/COMPLEXITY MEASURES Cont'd

[Physician work assigned to M.C.P. and not assessed here]

Time Segments (Mean)	CPT Code 909XI	Reference Service 1	Reference Service 2
Pre-Service intensity/complexity	Low/Mod		
Intra-Service intensity/complexity	Mod/Low		
Post-Service intensity/complexity	Low/Low		

ADDITIONAL RATIONALE

This newly developed technology has been assessed as highly prodictive of fistula and graft malfunction when there is a blood flow problem at its basis. The National Kidney Foundation published a multi-specialty generated practice guideline for the appropriate monitoring and diagnosing of hemodialysis fistula and graft dysfunctions and recommended that this procedure be utilized. This is clearly an additional series of activities within the dialysis session pointed toward the evaluation and management of the dialysis access. The current submission is an attempt a capturing the technical component of that service. The reference services are used as the closest equivalent to this procedure, but either ·derstate (93965-TC) or overstate (93970-TC) the actual technical aspects of the service.

FREQUENCY INFORMATION:

How was this service previously reported? This represents a NEW service

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?

The recommended use of this technique for the evaluation of access fistula flow stands at twice yearly, with a higher frequency among patients who have demonstrated access flow problems. In this latter group of patients, quarterly and in some monthly evaluations may be neccessary. Eliminating any screening of access for flow related problems, and concentrating on the patients with clearly problematic access function, 200,000 procedures annually could be anticipated nationally.

Do many physicians perform this service across the United States? __X___Yes _____No

CPT Code: 90940 - Renal Physicians Association – R.U.C. Survey

IN OFFICE DIRECT INPUTS

Sample Size: 179 Response Rate:(%): 75 Global Period: XXXX

Tracking Number: 909XI Reference Code 1: 93965-TC Reference Code 2: 93970-TC

Geographic Practice Setting %: Rural: 20.8% Suburban: 20.5% Urban: 40.7%

Type of Practice%:
7.9%__Solo Practice
49.6%_Single Specialty Group
21.8%_Multispecialty Group
7.7%__Medical School Faculty Practice Plan

Clinical Labor (% reported user)	**Pre-Service Time**	**Service Period (Day of Service)**	**Post-Service Time (After Day of Service)**
RN (26%)	5.8 Min	22.4 Min	0
LPN (14.5%)	7.3 Min	21.0 Min	0
PA (17.8%)	6.0 Min	16.2 Min	0
Dialysis Tech (42%)	4.5 Min	17.5 Min	0
Physician (<3%)	XXXXXXX	XXXXXXX	XXXXXXX
RN/LPN/MA/PA/ Dialysis Tech	**5.1 Min**	**17.9 Min**	**0**

Medical Supplies	**Quantity of Supplies per Procedure**	**Units Used for Purchase (Cost)**
10 cc Syringe (Transonics)	2	
Disposable Gloves (pair)	1	
Underpad	1	
Alcohol Sponges	2	
Mask	1	

CPT Code: 90940 - Renal Physicians Association – R.U.C. Survey

Procedure Specific Medical Equipment	No. of Units in practice/ clinic surveyed	Minutes of Use per Procedure	Hours per week in use for all services
Transonic Monitor	1 (2)	~25 Min	25 Min/pt/mo

Overhead Medical Equipment	No. of Units in Practice
Transonics Monitoring System: ($10,000.00)	See Above
Maintenance Costs (-)	
Software Costs (-)	

AMA SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Cutaneous Electrogastrography Provocative Testing

91132
New code 91132 *Electrogastrography, diagnostic, transcutaneous* was created to describe a procedure performed for diagnosing disorders of gastric motility which frequently involves the electrical activity of the stomach. An EGG device is positioned on the abdomen and usually placed over the epigastrium and an EGG is performed.

The RUC recommends that CPT code 91132 (VV1) be carrier-priced as currently very few physicians in the United States are performing these services. After these services become more widespread, the specialty societies will present relative value recommendations to the RUC.

91133
New code 91133 *Electrogastrography, diagnostic, transcutaneous; with provocative testing* was created to describe a procedure performed for diagnosing disorders of gastric motility which frequently involves the electrical activity of the stomach. New code 91133 includes provocative testing.

The RUC recommends that these services be carrier-priced as currently very few physicians in the United States are performing these services. After these services become more widespread, the specialty societies will present relative value recommendations to the RUC.

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		Gastroenterology **<u>Gastric Physiology</u>**		
●91132	VV1	Electrogastrography, diagnostic, transcutaneous;	000	Carrier Priced
●91133	VV2	with provocative testing	000	Carrier Priced

AMA SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Auditory Evoked Potentials Services

92585

Work Relative Value Recommendation

The RUC agreed that the physician work for this service has not changed, as the revision does not relate to the physician review and interpretation. **The RUC recommends that the work of 92585 remain unchanged at 0.50 work RVU.**

Practice Expense Recommendation

The RUC did approve the recommended inputs for the non-facility setting for Z1, with the deletion of several supplies. There are no direct inputs when the service is performed in a facility setting.

92586

Work Relative Value Recommendation

New code 92586 *Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited* was added to CPT to allow the reporting of state mandated testing for hearing loss in newborns to accurately bill for auditory brainstem response testing (ABRs) performed on infants that may be limited in scope. There is currently a code 92585 for all ABRs; however, limited ABRs are being increasingly performed as part of mandated infant hearing testing by the states. The only way an audiologist can bill for these services is to append the modifier –52 (reduced services), which is unrecognized by most payers. As this new service does not typically require review by a physician, there is no physician work. **The RUC recommends no physician work relative values for code 92586.**

Practice Expense Recommendation

The RUC recommends no direct practice expense inputs for Z2, as it is only performed in the facility setting.

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲92585	Z1	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive	XXX	0.50
●92586	Z2	limited	XXX	0.00

American Academy of Otolaryngology — Head and Neck Surgery, Inc.

DEDICATED TO CARE OF THE EARS, NOSE, THROAT, AND RELATED STRUCTURES OF THE HEAD AND NECK

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April 7, 2000

James G. Hoehn, MD
Chair, AMA RUC
515 North State Street
Chicago, Illinois 60610

Re: 92585-8x – Auditory Evoked Potentials

Dear Dr. Hoehn:

On behalf of the American Academy of Otolaryngology – Head and Neck Surgery (AAO-HNS), I am pleased to submit recommendations for work RVUs for auditory evoked potentials, also known as auditory brainstem response (ABR) testing. These codes will be presented during the April 2000 RUC meeting.

The full descriptions of the new and revised codes and our recommended work RVUs are as follows:

> 92585 Auditory evoked potentials for evoked response audiometry ~~and/or testing of the central nervous system~~; comprehensive
> **Recommended work RVU: 0.50**
>
> **9258x Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited**
> **Recommended work RVU: 0.50**

Background

The current CPT book includes a single code for auditory evoked potentials (92585). In response to a request from the American Speech-Language-Hearing Association, the existing code was split into two codes by the CPT Editorial Panel. The existing code was revised by adding the word "comprehensive" and a new code for limited testing was created.

These services are considered to be diagnostic tests by Medicare. As such, they have both a professional component (reported with modifier –26) and a technical component (reported with modifier –TC). Work RVUs are assigned to only the professional component. The work RVU of any technical component service is zero. When the procedures are performed

in a physician's office, payment is made for the "global" service (reported without a modifier). The global payment equals the sum of the payments for the professional and technical components. When the service is performed in the hospital, payment is made only for the professional component because Medicare payments for technical component services are made to the hospital, not the physician.

The following is a listing of the current RVUs in the 2000 fee schedule:

CPT	Mod	Work RVU	PE RVU	Malpr RVU
92585		0.50	2.81	0.14
92585	26	0.50	0.92	0.02
92585	TC	0.00	1.89	0.12

You will note that the highest RVUs are those assigned to the practice expense of the technical component. This is because the testing itself (the technical component) typically takes 90 minutes and it is performed by audiologists who are more highly paid than most other office personnel.

Rationale for recommended work RVUs

The creation of a new code for limited testing affects only the technical component of the service, which can be performed in a shorter period of time. While limited testing reduces the time required to perform the test, it has no effect on the physician work which is the same, whether or not the testing performed by the audiologist is comprehensive or limited. This physician work always includes interpreting the results of the test and preparing a written report. In many cases, it is also necessary to interpret the results in light of the patient's diagnosis and family history and to discuss the results with a referring physician.

Therefore, we recommend that the existing work RVUs for code 92585 be maintained and that the same RVUs be assigned to the new code for limited testing. We do not believe that survey results will be helpful because the addition of the word "comprehensive" to the existing code will suggest that the work has increased when in fact, there has been no change.

Practice expense RVUs

We completed (enclosed) the required form for the direct inputs of the practice expense RVUs. The principal change is in the time to perform the test which is reduced from 90 minutes for the comprehensive code to 30 minutes for the limited code.

I look forward to discussing these codes with the RUC and will be prepared to answer any questions at that time. In the meantime, should there be any questions, please do not hesitate to contact Beverly Nissenbaum in our department of health policy and government affairs at 703-519-1537 or email: BNissenbaum@entnet.org.

Sincerely,

James H. Kelly, MD/bn

James H. Kelly, MD
AAO-HNS AMA RUC Advisor

Enclosures
JHK/bn/dg

cc: *Charles F. Koopmann, MD, MSHA*
Bill Moran, MD
Dwight Lee, MD
G. Richard Holt, MD, MPH
Neil O. Ward, MD
John Niparko, MD
David Reiter, MD
Sherry Smith, AMA
Patrick Gallagher, AMA
Mark Candor, ASHA
Beverly Nissenbaum

CPT Code: 92585 Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive

AMA/Specialty Society Update Process
Summary of Recommendation
XXX Global Period

In Office Direct Inputs

Sample Size:_____ Response Rate: (%):_____ Global Period:_____

Tracking Number:_____ Reference Code 1_____ Reference Code 2_____

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

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

A workgroup of 7 practicing otolaryngologists was convened to review the survey results for physician work. This workgroup included 3 subspecialists, two individuals in academic practice, three in private practice and one in a large mutispecialty private practice. Three are from the middle Atlantic region, two are from the southwest, one is from the mid-west, and one is from the west. This workgroup identified a reference code with comparable resource inputs. AAO-HNS staff then reviewed the identified reference code and made adjustments of the inputs as needed to be consistent with the number of post-operative office visits identified by the survey on physician work and to be consistent with the RUC instructions for developing direct practice expense inputs for new/revised codes. The reference code used for revised code 92585 was existing code 92585.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

None

Intra-Service Clinical Labor Activities:

Review patient chart. Greet patient. Perform room prep/prepare or set-up medical equipment and supplies. Prep (e.g., dress, move, and position) patient. The patient's skin is prepped and electrodes are placed on appropriate areas of the head and ear. An insert earphone is placed in the car and impedances are checked. Clicks are presented at high intensity levels to the ear. Approximately 1,500 click stimuli are presented and responses are stored and averaged, resulting in one ABR. The process is repeated as a measure of

reliability. The click stimuli are then reduced in intensity and are run again, The procedure is completed three to five times until no repeatable stimuli are obtained. This total procedure is repeated in the opposite car. Following click stimuli, a low frequency tone burst is presented through the insert earphone and the same presentations as the click stimuli is repeated. In random fashion, a no-stimulus run is made for control purposes. The electrodes are then removed, the head cleaned, and the patient checked. Clean room/equipment.

Post-Service Clinical Labor Activities:

Prepare report for interpretation by physician.

Clinical Labor	**Pre-Service Time**	**Service Period (Day of service)**	**Post-Service Time After Day of Service)**
RN			
LPN			
MA			
Audiologist	0	85	5

Medical Supplies	**Quantity of Supplies**	**Units Used for Purchase**
~~drape, sheet~~	~~1~~	~~item~~
~~patient gown, disposable~~	~~1~~	~~item~~
exam table paper	1	foot
gloves, non-sterile	1	pair
swab, alcohol	1	item
~~band aid, 3/4" x 3"~~	~~1~~	~~item~~
~~gauze, sterile 4 x 4 (10 pack)~~	~~1~~	~~pack~~
~~tape~~	~~6~~	~~inch~~
~~Betadine~~	~~10~~	~~ml~~
acetone	1	ounce
conductive jelly, 5g	1	item
recording paper, 22 inch.	1	item
Collodion, 2oz tube	1	item
magneto-optical disk, 128 MB	1	item
needle, 18 to 24 gauge	1	item
tb syringe	1	syringe

CPT Code: 92585 Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive

Type of Service: Evaluation/Management Services or Diagnostic Tests
XXX Global Period

SITE OF SERVICE: In-Office

Clinical Services	Minutes	Staff Type – Circle
Pre-Service Period		
Start: When appointment for service is made		
Review/read X-ray, lab, and pathology reports	0	
Other Clinical Activity (please specify)		
_____	0	
End: Patient arrival at office for service		
Service Period		
Start: Patient arrival at office for service		
Greet patient/provide gowning	1	Audiologist
Obtain vital signs	0	
Prep and position patient	5	Audiologist
Prepare room, equipment, supplies	5	Audiologist
Assist physician during exam	0	
Education/instruction/ counseling	0	
Coordinate home or outpatient care	0	
Clean room/equipment	4	Audiologist
Other Clinical Activity (please specify)		
Perform test. See description above.	70	Audiologist
End: Patient leaves office		
Post-Service Period		
Start: Patient leaves office		
Phone calls between visits with patient, family pharmacy	0	
Other Activity (please specify)	5	Audiologist
Prepare report for interpretation by physician.		
End: When appointment for next office visit is made.		

AMA SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Intracardiac Echocardiography During Therapeutic/Diagnostic Intervention

Work Relative Value Recommendations
New code 93662 *Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)* was created to describe intracardiac echocardiography which is an imaging tool used with interventional cardiology and electrophysiology applications. Using this technology, the physician is able to directly image cardiac structures and catheter position relative to cardiac anatomy during procedures.

The RUC compared new code 93662 to the reference service code 92978 *Intravascular ultrasound (coronary vessel or graft) during therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure)* (work RVU = 1.80). New code 93662 has a higher intra-service time than the reference code, in which the 55 minutes is dedicated to the imaging itself, which is performed during and following the primary procedure of placing the ultrasound probe. The intensity and complexity measures are greater for new code than the reference service code. The RUC agreed that the recommended work value of 2.80 was appropriate. **The RUC recommends a work relative value of 2.80.**

Practice Expense Recommendations
There are no direct practice expense inputs, as this is an add-on code performed in a facility setting.

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●93662	WW1	Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure) (Use 93662 in conjunction with 93621, 93622, 93651, or 93652, as appropriate) (Do not report 92961 in addition to code 93662)	ZZZ	2.80

CPT Code: 93662 Tracking Number: WW1 Global Period: ZZZ **Recommended RVW: 2.80**

CPT Descriptor: Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)

(Use 93662 in conjunction with 93621, 93622, 93651, or 93652, as appropriate)

(Do not report (92961 in addition to code 93662)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Typical Patient: A 27-year-old male with recurrent palpitations and a left-sided accessory pathway. Diagnosis of paroxysmal supraventricular tachycardia (ICD-9 code 427.0) and Wolff-Parkinson-White Syndrome (ICD-9 code 426.7)

Typical Service: The patient is brought to the EP lab for a diagnostic EP study with possible catheter ablation. After the initial assessment, the accessory pathway is localized to left lateral mitral annulus (coded separately). The ICE catheter is introduced into the right atrium. Evidence of a pericardial effusion is ruled out and the fossa ovalis is imaged, as well as the left atrium (work attributable to the ICE). Using further ICE imaging, (also work attributable to the ICE), the transseptal apparatus is positioned to the mid-portion of the fossa ovalis and transseptal puncture is performed (coded separately). The ablation catheter is then advanced to the left atrium and the accessory pathway is successfully mapped and ablated (coded separately). Imaging continues throughout the case, (work attributable to the ICE) to watch for the development of a pericardial effusion and to assess electrode/tissue contact during ablation.

Description of Pre-Service Work:

A pertinent history is obtained and physical examination of the vascular access site is performed. Appropriate laboratory tests including blood tests, chest x-ray, and ECG are reviewed. The risks and benefits of and alternatives to the procedure are discussed with the patient and informed consent is obtained. This discussion is documented in the patient's chart.

Description of Intra-Service Work:

The patient is brought to the procedure room where they are prepped and draped as part of the electrophysiology study. Blood pressure, ECG, and pulse oximetry are monitored. Local anesthesia ia administered, and an 8F-10F sheath is placed in the venous access site using standard percutaneous techniques. The echocardiography probe is advanced thru the sheath to the right atrium under fluoroscopic guidance. The echocardiographic images are displayed . The images are reviewed by the physician intermittantly throughout the electrophysiology procedure to assist with transseptal puncture, assess intracardiac anatomy and/or monitor for complications (perforation, tamponade). The probe and sheath are removed at the completion of the electrophysiology procedure and hemostasis obtained. The results of the procedure are carefully documented.

Description of Post-Service Work:

The patient is observed to make certain hemostasis is adequate and they are then transferred back to their hospital room.

SURVEY DATA:

Presenter(s) James Maloney, M.D. and David Schwartzman, M.D.

Specialty(s): Cardiology

Sample Size: 102 Response Rate: (%): (16.7%) 17 responses Median RVW: 3.31

Type of Sample (Circle One): random, panel, convenience.

Explanation of sample size:

Sample of physicians who perform the service and names provided by the North American Society of Pacing and Electrophysiology

25th Percentile RVW: 2.575 75th Percentile RVW: 4.95 Low: 1 High: 10

Median Pre-Service Time (day of procedure): 5 minutes Median Intra-Service Time: 55 minutes

25th Percentile Intra-Svc Time: 30 minutes 75th Percentile Intra-Svc Time: 86.25 minutes

Low: 15 High: 240

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	10	99212
Critical Care:	N/A	N/A
Other Hospital Visits:	N/A	N/A
Discharge Day Mgmt.:	N/A	N/A
Office Visits:	N/A	N/A

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
92978	Intravascular ultrasound (coronary vessel or graft) during therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure)	1.80

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service CPT
Median Pre-Time (day of procedure in minutes)	5	10
Median Intra-Time	55	30
Median Immediate Post-service Time	10	15
Median of Aggregate Critical Care Times	N/A	N/A
Median of Aggregate Other Hospital Visit Times	N/A	N/A
Median Discharge Day Management Time	N/A	N/A
Median of Aggregate Office Visit Times	N/A	N/A

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.81	3.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.47	2.60
Urgency of medical decision making	3.81	3.60

Technical Skill/Physical Effort (Mean)

Technical skill required	4.31	3.80

Physical effort required	3.56	3.60

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.88	3.60
Outcome depends on the skill and judgement of physician	4.44	3.80
Estimated risk of malpractice suit with poor outcome	4.06	4.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.15	3.00
Intra-Service intensity/complexity	4.40	3.80
Post-Service intensity/complexity	2.46	2.50

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The American College of Cardiology has a Cardiovascular RUC committee who met to discuss the recommended work RVU. The committee determined that the 2.8 value placed intracardiac echocardiography appropriately within the category of other echocardiography procedures and therefore recommended a lower value than the median RVU (3.31) from the sampled physicians.

FREQUENCY INFORMATION

How was this service previously reported? Using reference procedure 92978.

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

Specialty Cardiology _____ _____Commonly __X_Sometimes _____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty _Cardiology_____ Frequency_7,500-10,000

For your specialty, estimate the number of times this service might be**provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty ___Cardiology Frequency 3,500-5,000

Do many physicians perform this service across the United States? _____Yes __X__No

---

AMA SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Peripheral Vascular Rehabilitation

Work Relative Value Recommendations

New code 93668 *Peripheral arterial disease vascular rehabilitation, per session* was created which describes supervised, treadmill based programs of progressive limb exercise, with a subsequent transition to a home-based exercise prescription. This service is intended to treat patients with intermittent claudication, patients recovering from peripheral vascular surgeries or from peripheral angioplasty/stenting procedures. Currently, CPT does not contain an existing CPT code that accurately describes therapeutic vascular rehabilitation.

The RUC evaluated the survey results for new code 93668 *Peripheral arterial disease vascular rehabilitation, per session* and agreed that there was no physician work.

Practice Expense Recommendations

The RUC recommends that there are direct inputs for this service when performed in a non-facility setting. Specifically, the RUC recommends 20 minutes of RN/Exercise physiologist time for this service, as well as supplies and equipment as attached.

Medicine
Cardiovascular
Other Procedures

Peripheral vascular rehabilitative physical exercise consists of a series of sessions, lasting 45-60 minutes per session, involving use of either a motorized treadmill or a track to permit each patient to achieve symptom-limited claudication. Each session is supervised ~~on a one-to-one basis~~ by an exercise physiologist, ~~physical therapist~~, or nurse. The supervising provider monitors the individual patient's claudication threshold and other cardiovascular limitations for adjustment of workload. During this supervised rehabilitation program, the development of new arrhythmias, symptoms that might suggest angina or the continued inability of the patient to progress to an adequate level of exercise may require physician review and examination of the patient. These physician services would be separately reported with an appropriate level E/M service code.

● 93668	AA1	Peripheral arterial disease vascular rehabilitation, per session	XXX	0.00 No physician work

CPT Code: 93668 Tracking Number: AA1 Global Period: 000 **Recommended RVW: .28 0.00 (RUC)**

CPT Descriptor: Peripheral Arterial Disease Vascular Rehabilitation, per session

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Explanatory Note: Peripheral vascular rehabilitative physical exercise consists of a series of sessions, lasting 45-60 minutes per session, involving use of either a motorized treadmill or a track to permit each patient to achieve symptom-limited claudication. Each session is supervised on a one-to-one basis by an exercise physiologist, physical therapist, or nurse. The supervising provider monitors the individual patient's claudication threshold and other cardiovascular limitations for adjustment of workload. During this supervised rehabilitation program, the development of new arrhythmias, symptoms that might suggest angina or the continued inability of the patient to progress to an adequate level of exercise may require physician review and examination of the patient. These physician services would be separately reported with an appropriate level E/M service code.

Typical Patient: The typical patient with PAD and its hallmark symptom, claudication, is over 60 years of age, may be male or female, and has a positive atherosclerosis risk factor profile that includes a high prevalence of diabetes, remote or current tobacco use, hypertension, and hypercholesterolemia. These patients also suffer co-morbid atherosclerotic syndromes including manifestions of coronary artery disease (transient ischemic attacks or stroke). Note that these co-morbid conditions themselves are rarely the cause of the exercise limitation. Recent data from the 1999 national PARTNERS study demonstrates that atherosclerosis risk factors are significantly less intensively treated in the PAD population, and knowledge of the importance of risk factor intervention in this population in this population is less in both PAD patients, and their physicians, compared to patients with other atherosclerotic cardiovascular conditions.

Typical Service: The treating physician is responsible for both the direct care of the patient who receives PAD rehabilitation, as well as programmatic responsibility for the efficacy of the rehabilitation program. The work of the treating physician includes his/her immediate availability to the exercise provider and patient for direct supervision as is deemed clinically necessary. Physician work will also include the global and ongoing supervision of the rehabilitation program; supervision of the ongoing training and efficacy of PAD rehabilitation personnel; supervision of clinical safety standards during rehabilitation; and supervision of use of calibrated motorized treadmill and monitoring equipment.

Description of Pre-Service Work:

This evaluation is performed to detect underlying cardiac disease and to provide information required for calculating the individual exercise prescription. If this test does not reveal clinical data that would exclude such participation, as noted above, the patient will be entered into a vascular rehabilitation program. A graded exercise Doppler stress test using a motorized treadmill will be utilized to assess functional status and the exercise symptom limitation. The test can be supervised by a non-physician physiologist or nurse, under the general supervision of a physician. The parameters to be obtained include 12-lead ECG, heart rate, blood pressure, and pre- and post-exercise ankle-brachial index data. Exertional claudication symptoms will be dynamically recorded. The onset of claudication (the initial claudication distance, or ICD) and the peak walking distance (or absolute claudication distance, or ACD) will be recorded. A physician will interpret the exercise test tracings as well as its physiologic (pre- and post-exercise ABI) data. Based on these data, inclusion or exclusion in further rehabilitation

will be determined. If inclusion in a supervised rehabilitation program is appropriate, an individualized exercise program will be established based on predicted treadmill grades and speeds that will be effective in eliciting functional improvement during later sessions.

Description of Intra-Service Work:

Patients enter a series of rehabilitative physical exercise sessions that will use either a motorized treadmill or a track to permit each patient to achieve their symptom-limited claudication threshold within 10-15 minutes of dynamic exercise. These sessions are usually supervised on a one-to-one basis by an exercise physiologist, physical therapist, or nurse, and may include the work of a vascular technologist. The supervising provider will monitor the individual patient's claudication threshold and other cardiovascular limitations to adjust the workload accordingly. The patient will then rest and then repeat the exercise protocol, so that bouts of exercise are continued until 30-45 minutes of exercise have been accrued. This program of exercise should occur at least three times per week for at least 12 weeks (36 visits). Whether patients require ECG monitoring should be determined on a case-by-case basis. The patient will also attend educational sessions that will include discussion of: (1) the causes of PAD, (2) the role of exercise in maintaining functional status, (3) management and normalization of atherosclerosis risk factors, (4) the importance of antiplatelet therapies to prevent heart attack, stroke, and death, (5) other coronary and/or cerebral ischemic warning symptoms (angina, MI; TIA, stroke). During this supervised rehabilitation program, the development of new arrhythmias, symptoms that might suggest angina or the continued inability of the patient to progress to an adequate level of exercise may require physician review and examination of the patient.

Description of Post-Service Work:

At the end of the 12-week program, the supervising physician will review documentation of the patient's exercise performance. Based on this data, the physician or a designated exercise specialist will create an individualized program of exercise prescription intended to sustain the early gains made during supervised rehabilitation. The atherosclerosis risk factor profile will be reviewed with the patient, and a report prepared for the referring or primary physician(s). Other interventions (smoking cessation counseling or other risk factor therapeutic interventions, for example) would also be appropriate at this visit.

SURVEY DATA:

Presenter(s) James Maloney, M.D., and Alan Hirsch, M.D.
Specialty(s): Cardiology and Cardiology/Vascular Surgery

Sample Size: 60 Response Rate: (%): (36.6%) 22 Median RVW: 1.06

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: Names provided by physicians who perform the service.

25th Percentile RVW: 0.28 75th Percentile RVW: 0.75 Low: 0.05 High: 12.00

Median Pre-Service Time: 15 Median Intra-Service Time: 10

25th Percentile Intra-Svc Time: 5.625 75th Percentile Intra-Svc Time: 26.25 Low: 0 High: 120

Median Post-Service Time:	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	10	99212

Critical Care:	N/A	N/A
Other Hospital Visits:	N/A	N/A
Discharge Day Mgmt.:	N/A	N/A
Office Visits:	N/A	N/A

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
93798	Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)	.28

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	**CPT Code**	**Reference Service CPT**
Median Pre-Time	15	15
Median Intra-Time	10	10
Median Immediate Post-service Time	10	10
Median of Aggregate Critical Care Times	N/A	N/A
Median of Aggregate Other Hospital Visit Times	N/A	N/A
Median Discharge Day Management Time	N/A	N/A
Median of Aggregate Office Visit Times	N/A	N/A

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.95	2.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.24	3.00
Urgency of medical decision making	2.38	2.20

Technical Skill/Physical Effort (Mean)

Technical skill required	2.52	2.50
Physical effort required	2.10	1.90

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.62	2.80
Outcome depends on the skill and judgement of physician	2.71	3.00
Estimated risk of malpractice suit with poor outcome	2.38	2.50

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.89	2.27
Intra-Service intensity/complexity	2.79	2.64
Post-Service intensity/complexity	2.70	2.64

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The American College of Cardiology has a Cardiovascular RUC committee who met to discuss the recommended work RVU. The committee determined that the .28 value placed peripheral vascular rehabilitation in a similar category of cardiac rehabilitation. The committee determined the .28 value was a better representation than the median RVU (1.06) from the sampled physicians. It was also the code cited most often and used as the reference procedure.

FREQUENCY INFORMATION

How was this service previously reported? Code 97110 or 97139 (unlisted therapeutic procedure); or, code 93797 (cardiac rehabilitation; without continuous ECG monitoring) or code 93798 (Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session).

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

Specialty__Cardiology_____ ____Commonly _X__Sometimes _____Rarely

Specialty__Vascular Surgery_____ _____Commonly _X__Sometimes _____Rarely

Specialty__Interventional Radiology ____ _____Commonly _X__Sometimes _____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty ___Cardiology_____ Frequency____1,000-10,000__

Specialty ___Vascular Surgery_____ Frequency____1,000-10,000__

Specialty__ Interventional Radiology_____ Frequency____100-1,000____

Note: the frequency numbers are estimates. Data are not readily available at this time.

For your specialty, estimate the number of times this service might be**provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty ___Cardiology_____ Frequency_not available

Specialty ___Vascular Surgery_____ Frequency_not available

Specialty___Interventional Radiology_____ Frequency_not available

Note: all frequency data are estimates. Actual numbers are unknown at this time. Most patients with claudication are over age 55 and an estimated 50-65% are in the Medicare age bracket.

Do many physicians perform this service across the United States? _____Yes ___X__No

AMA/Specialty Society Update Process
Summary of Recommendation
000 Day Global Period

In Office Direct Inputs

CPT Descriptor: Peripheral Arterial Disease Vascular Rehabilitation, per session. Code 93668. Tracking number AA1.

Questions below are not applicable – survey was not conducted.

Sample Size:___ Response Rate: (%):_____ Global Period:_____

Tracking Number:_____ Reference Code 1_____ Reference Code 2_____

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Patient orientation to the program. Completion of miscellaneous paperwork.

Intra-Service Clinical Labor Activities.

Supervision of patient during exercise session. Progressive conferences with patient. Discharge conference. Completion of report to referring physician.

Clinical Labor	Staff Type	Pre-Service Time	Service Period (Day of service)
~~Nurse~~ RN/Exercise Physiologist	1033	~~0.25 hours~~ 5 minutes	~~*20 minutes~~ 15 minutes

~~Note: At the RUC meeting, HCFA indicated it would allow 20 minutes of clinical time. There is an assumption that the CPT code will be revised to address the 1 to 1 supervision ratio issue~~. The RUC assumed that this service is not performed with 1 to 1 supervision and agreed that the RN or exercise physiologist is typically supervising three or four patients. Each patient typically undergoes Peripheral Arterial Disease Vascular Rehabilitation for 1 hour.

Medical Supplies	Quantity of Supplies	Supply Code
Razor, disposable	1	11104
~~Patient education booklet (50 items)~~	~~1~~	~~11115~~
~~Paper towel~~	~~1~~	~~11118~~
Swab, alcohol	2	31101
Gauze, ~~5x9~~ 4x4, non sterile	1	31501
EKG paper	1	71005
ECG electrodes disposable	3	71006

Procedure Specific Medical Equipment	Equip Code	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Equipment Cost
Treadmill w/ECG monitor	E55020	varies	60	3**	$16,000
Blood Pressure monitor	E55006	varies	60	varies	$2,995

**Note: 3 sessions per week (for one hour each) per patient.

Overhead Medical Equipment	No. of units in practice	Equipment Code
Crash Cart	Varies	E91002
Defibrillator	Varies	E55001

~~Note: additional practice expenses not included on this form include: cost of rent, depreciation on equipment, clerical support salaries and benefits, HVAC, telephones, computers, printers, copiers, insurance, etc. One patient per 100 square feet is the industry standard for rent calculation.~~

AMA SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Photodynamic Therapy

96570

Work Relative Value Recommendations

CPT code 96570 *Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and esophagus)* was created to describe photodynamic therapy used for treatment in esophageal cancer. CPT code 96570 is used to report the application of a light source to activate the photoactive drug, for the first 30 minutes. A continuous wave of argon-pumped dye laser is used to deliver a red light to the target tissues containing the photoactive drug. Upon application of the light, the photoactive drug produces single oxygen destroying the cells in which the drug has collected.

The specialty societies presenting relative value recommendations for Photodynamic Therapy at the RUC recognized that their survey data was insufficient and requested the RUC to develop interim recommendations for these new CPT codes. This issue will be reviewed again by the specialty societies and any new recommendations will be presented at the February 2001 RUC meeting. The RUC will reconsider this issue and will forward any recommendations to HCFA at that time.

These codes were added to CPT in 2000 and therefore, HCFA has already established relative values for these services. The RUC reviewed the current work relative values for these add-on codes and thought that they were reasonable and agreed that they be proposed as interim RUC recommendations.

96570 (XX1)	Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minutes (List separately; in addition to code for endoscopy or bronchoscopy procedures of lung and esophagus)	**1.10**

Practice Expense Recommendations
As CPT code 96570 is an add-on code with a global period of ZZZ, there are no practice expense inputs.

96571

Work Relative Value Recommendations
New code 96571 *Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and esophagus)* was created to describe photodynamic therapy used for treatment in esophageal cancer. Code 96571 is used to report the application of a light source to activate the photoactive drug for each additional 15-minutes after the first initial 30 minutes. A continuous wave of argon-pumped dye laser is used to deliver a red light to the target tissues containing the photoactive drug. Upon application of the light, the photoactive drug produces single oxygen destroying the cells in which the drug has collected.

The specialty societies presenting relative value recommendations for Photodynamic Therapy at the RUC recognized that their survey data was insufficient and requested the RUC to develop interim recommendations for these new CPT codes. This issue will be reviewed again by the specialty societies and any new recommendations will be presented at the February 2001 RUC meeting. The RUC will reconsider this issue and will forward any recommendations to HCFA at that time.

These codes were added to CPT in 2000 and therefore, HCFA has already established relative values for these services. The RUC reviewed the current work relative values for these add-on codes and thought that they were reasonable and agreed that they be proposed as interim RUC recommendations.

96571 (XX2)	each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and esophagus).	**0.55**

Practice Expense Recommendation
As CPT code 96571 is an add-on code with a global period of ZZZ, there are no practice expense inputs.

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●96570	XX1	Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and esophagus)	ZZZ	1.10 (Interim)
●96571	XX2	each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and esophagus) (Use 96570, 96571 in conjunction with codes 31641, 43228 as appropriate)	ZZZ	.55 (Interim)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 96570 Tracking Number: XX1 Global Period: ZZZ **Recommended RVW: ~~5.21~~ 1.10 (RUC)**

CPT Descriptor: Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minutes. (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and esophagus)

CLINICAL DESCRIPTION OF SERVICE:

Vignette used in survey:
A 63 y.o. white male patient with a history of smoking and some alcohol use complains of extreme difficulty with swallowing. Endoscopic examination is performed and reveals a diagnosis of esophageal cancer. A computed tomography scan shows adjacent lymph node and celiac involvement. A determination is made that the patient is not a candidate for surgical resection. The patient receives radiation therapy and
chemotherapy.

Subsequently, the patient develops recurrent complaints of dysphagia. Reassessment reveals that the tumor has progressed and is surgically non-resectable. Palliative therapy of the patient's dysphagia using photodynamic therapy for 30 minutes has been proposed.

Description of Pre-service work:
- Patient receives intravenous injection of photoactive drug (Photofrin)
- Patient is monitored for adverse reaction to drug

Description of Intra-service work:
- Patient is sedated with intravenous Demerol, Versed or Valium
- Endoscope is passed through to the esophagus and the 5 cm tumor is localized
- Endoscope is passed distal to the tumor
- Diffuser tip is inserted , the laser light source is activated and applied to the tumor
- 12.5 minutes of endoscopic laser light application using a 2.5cm cylindrical diffusing fiberoptic endoscope are required for every 2.5 cm of tumor length
- During each application, the light source is periodically turned off so that the position of both
- the endoscope and the diffuser may be checked.
- With sedation and pauses to recheck position, the treatment session takes 30 minutes.

Description of Post-service work
- Patient is re-examined 2-3 days after the procedure
- Patient is counseled to remain out of reflected or direct sunlight for one month because of increased risk of serious sunburn
- Dictate and check procedure report

SURVEY DATA:

Presenter(s): Joel Brill, MD

Specialty(s): AGA, ASGE - Gastroenterology

Sample Size: 12 Response Rate: (%): 75 Median RVW: 5.21

Type of Sample: panel.

Explanation of sample size: This is a new procedure that is increasing in frequency yet there are not enough experts that perform this service regularly to receive 30 responses back at this time.

Median RVW: 5.22

25th Percentile RVW: 3.98 75th Percentile RVW: 5.92 Low:3.77 High: 9.05

Median Intra-Service Time: 50

25th Percentile Intra-Svc Time: 41.25 75th Percentile Intra-Svc Time: 60 Low: 30 High: 100

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
43288	Esophageal endoscopy with ablation	3.77

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	NA	NA
Median Intra-Time	50	45
Median Immediate Post-service Time	NA	NA
Median of Aggregate Critical Care Times	NA	NA
Median of Aggregate Other Hospital Visit Times	NA	NA
Median Discharge Day Management Time	NA	NA
Median of Aggregate Office Visit Times	NA	NA

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.25	3.72
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.83	3.64

Urgency of medical decision making	3.66	3.72

Technical Skill/Physical Effort (Mean)

Technical skill required	3.91	4.36
Physical effort required	3.91	4.0

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.33	4.45
Outcome depends on the skill and judgement of physician	4.25	4.36
Estimated risk of malpractice suit with poor outcome	3.58	3.82

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	NA	NA
Intra-Service intensity/complexity	4.08	3.90
Post-Service intensity/complexity	NA	NA

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The process used consisted of a survey of 12 physicians (panel sample) who typically perform this service. Final recommendations and work values were reviewed by 3 physicians representing the AGA, ACG, ASGE. These physicians reviewed all components of work and practice expense for newly proposed CPT codes as well as the information provided for the reference procedures

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FREQUENCY INFORMATION

How was this service previously reported? _____

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

Specialty gastroenterology ___X__Commonly _____Sometimes _____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty gastroenterology Frequency___2000_____

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty gastroenterology Frequency 80%

Do many physicians perform this service across the United States? Yes, within gastroenterology/GI endoscopy

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 96571 Tracking Number: XX2 Global Period: ZZZ **Recommended RVW: ~~3.88~~ 0.55 (RUC)**

CPT Descriptor: Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); additional 15 minutes beyond first 30 minutes.
(List separately in addition to code for endoscopy or bronchoscopy procedures of lung and esophagus)

CLINICAL DESCRIPTION OF SERVICE:

Vignette used in survey:
An additional 15 minutes beyond original 30 minutes is spent assessing the patient described below: A 63 y.o. white male patient with a history of smoking and some alcohol use complains of extreme difficulty with swallowing. Endoscopic examination is performed and reveals a diagnosis of esophageal cancer. A computed tomography scan shows adjacent lymph node and celiac involvement. A determination is made that the patient is not a candidate for surgical resection. The patient receives radiation therapy and
chemotherapy.

Subsequently, the patient develops recurrent complaints of dysphagia. Reassessment reveals that the tumor has progressed and is surgically non-resectable. Palliative therapy of the patient's dysphagia using photodynamic therapy for 30 minutes has been proposed.

Description of Pre-service work:
- Patient receives intravenous injection of photoactive drug (Photofrin)
- Patient is monitored for adverse reaction to drug

Description of Intra-service work:
- Patient is sedated with intravenous Demerol, Versed or Valium
- Endoscope is passed through to the esophagus and the 5 cm tumor is localized
- Endoscope is passed distal to the tumor
- Diffuser tip is inserted , the laser light source is activated and applied to the tumor
- 12.5 minutes of endoscopic laser light application using a 2.5cm cylindrical diffusing fiberoptic endoscope are required for every 2.5 cm of tumor length
- During each application, the light source is periodically turned off so that the position of both
- the endoscope and the diffuser may be checked.
- With sedation and pauses to recheck position, the treatment session takes 30 minutes.

Description of Post-service work
- Patient is re-examined 2-3 days after the procedure
- Patient is counseled to remain out of reflected or direct sunlight for one month because of increased risk of serious sunburn
- Dictate and check procedure report

SURVEY DATA:

Presenter(s): Joel Brill, MD

Specialty(s): AGA, ASGE - Gastroenterology

Sample Size: 10 Response Rate: (%): 63 Median RVW: 3.88

Type of Sample: panel.

Explanation of sample size: This is a new procedure that is increasing in frequency yet there are not enough experts that perform this service regularly to receive 30 responses back at this time.

Median RVW: 3.88

25th Percentile RVW: 3.19 75th Percentile RVW: 4.55 Low: 1.0 High: 7.5

Median Intra-Service Time: 25

25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 45 Low: 15 High: 90

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
43288	Esophageal endoscopy with ablation	3.77

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including the data from the service that you are rating as well as the key reference services.**

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT
Median Pre-Time	NA	NA
Median Intra-Time	34.3	33.5
Median Immediate Post-service Time	NA	NA
Median of Aggregate Critical Care Times	NA	NA
Median of Aggregate Other Hospital Visit Times	NA	NA
Median Discharge Day Management Time	NA	NA
Median of Aggregate Office Visit Times	NA	NA

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.9	3.66

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.6	3.33
Urgency of medical decision making	3.6	3.88

Technical Skill/Physical Effort (Mean)

Technical skill required	3.9	4.22
Physical effort required	3.8	3.88

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.1	4.22
Outcome depends on the skill and judgement of physician	4.4	4.33
Estimated risk of malpractice suit with poor outcome	3.5	3.67

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	NA	NA
Intra-Service intensity/complexity	4	4
Post-Service intensity/complexity	NA	NA

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The process used consisted of a survey of 10 physicians (panel sample) who typically perform this service. Final recommendations and work values were reviewed by 3 physicians representing the AGA, ACG, ASGE. These physicians reviewed all components of work and practice expense for newly proposed CPT codes as well as the information provided for the reference procedures

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FREQUENCY INFORMATION

How was this service previously reported? _____

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

Specialty gastroenterology_____ __X___Commonly _____Sometimes _____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty gastroenterology_____ Frequency__1000___

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty gastroenterology_____ Frequency 80%

Do many physicians perform this service across the United States? Yes, by gastroenterologists.

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2000

Ocular Function Screening

The CPT Editorial Panel approved a new code for ocular function screening. The specialty society has informed the RUC that these services require no physician work and will not be covered by Medicare as they are screening services.

Code (●New) (▲Revised) (D Deletion) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●99172	W1	*Visual function screening, automated or semi-automated bilateral quantitative determination of visual acuity, ocular alignment, color vision by pseudoisochromatic plates, and field of vision (may include all or some screening of the determination(s) for contrast sensitivity, vision under glare)* *(This service must employ graduated visual acuity stimuli that allow a quantitative determination of visual acuity (eg, Snellen chart). This service may not be used in addition to a general ophthalmological service or an E/M service)* Do not report 99172 in conjunction with 99173)	XXX	No Physician Work