

RUC Recommendations

For CPT 2002

RUC Meetings:

February 2001 and April 2001

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS RECOMMENDATIONS

Table of Contents

Issues	Tab
RUC Recommendation for CPT 2002:	
Anesthesia for Gastric Restrictive Procedure for Morbid Obesity	1
Anesthesia Services	2
Anesthesia for Interventional Radiology Procedures	3
Anesthesia for Obstetrical Procedures	4
Any Method, Any Approach & Any Technique	5
Insertion/Removal/Removal with Reinsertion Nonbiodegradable Androgen Suppression Implant	6
Injection of Trigger Points/Carpal/Tarsal Canal	7
Hand/Finger/Wrist/Forearm Musculoskeletal/ Vascular/Nerve Procedures	8
Closed Treatment of Metacarpal Fracture	9
Hallux Valgus Repair	10
Arthroscopic Shoulder Procedures	11
Arthroscopic Distal Claviclectomy	12
Implantation/Removal of Ventricular Assist Device	13
Vascular Procedures	14
Ultrasound Guided Intravascular Thrombin Injection	15
Pediatric Venipuncture	16
Esophagoplasty for Congenital Defect	17

Repair Small Intestine Atesia	18
Laparoscopic Colon Procedures	19
Placement of Anal Seton and Excision of Ileoanal Reservoir	20
Ablation of Hepatic Tumors	21
Repair Inguinal Hernia (less than 37 weeks gestation)	22
Cystourethroscopy	23
Insertion of Tandem Cuff	24
Urethral Sphincter Procedures	25
Transurethral Destruction of Prostate by Water-Induced Thermotherapy	26
Penile Procedures	27
Penile Prosthesis	28
Lesion of Testis	29
Gynecological Oncology Procedures	30
Therapeutic Amniotic Fluid Reduction	31
Implantation of Sacral Nerve Neurostimulator Electrodes	A
Ocular Photodynamic Therapy	B
Radiology Editorial Revisions	C
Radiotherapy	D
Radiation Treatment Delivery	E
Immunization (Two or More Injections)	F
Revised Hemodialysis Access Flow Measurement	G
Pulsed Irrigation Procedures of the Bowel	H

Noninvasive Anterior Chamber Biometry	I
Continuous Glucose Monitoring System	J
Percutaneous Transluminal Coronary Thrombectomy	K
Transcatheter Placement of Radiation Delivery Device (Intravascular Coronary Brachytherapy)	L
Microvolt T-wave Alternans Assessment of Ventricular Arrhythmia	M
Intracardiac Electrophysiology – Mapping, Comprehensive EP,& Analysis of Pacing Cardioverter Defibrillators	N
Thoracic Electrical Bioimpedance	O
Allergy Immunotherapy (Definition of Dose)	P
Neurology Procedures	Q
Gait and Motion Analysis	R
Photodynamic Therapy Destruction of Malignant/ Non-Malignant Skin Lesions	S
Analysis of Computer Transmitted Data	T
Patient Transport	U

American Medical Association

Physicians dedicated to the health of America



James G. Hoehn, MD
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May 24, 2001

Terry Kay
Center for Health Plans and Providers
Health Care Financing Administration
7500 Security Boulevard, C4-01-15
Baltimore, Maryland 21244

Dear Mr. Kay:

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 2002. Under separate cover, the RUC will forward practice expense refinement recommendations for existing codes and work relative value recommendations for a few remaining interim values for CPT 2001 and codes that you had specifically requested a RUC review. The RUC Health Care Professionals Advisory Committee (HCPAC) Review Board will separately forward their recommendations to you, as well.

Enclosed is one binder of RUC recommendations for new and revised codes. The total number of coding changes for CPT 2002 is 423, including 190 additions, 200 revisions, and 33 deletions. ~~Fifty-three~~ of these coding changes are not payable on the RBRVS (eg, laboratory services, vaccines, and services paid through the home health agency payment system), and accordingly, the RUC does not submit any information on these codes. In addition, fifteen of the new and revised codes were reviewed by the RUC HCPAC Review Board as they describe services provided by non-MD/DO health professionals. Of the remaining 322 new and revised codes, the RUC submits 314 recommendations at this time. The RUC is recommending that nine codes be carrier-priced in 2002, until the RUC has further opportunity to review data for these services.

The summary table in the attached binder 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 2001 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.

Terry Kay
May 24, 2001
Page Two

The RUC had submitted an updated time file to you in March 2001. Your staff had queried AMA staff on a series of End Stage Renal Disease (ESRD) codes and the physician time allocated to these services. The RUC has reviewed this issue and our conclusions are attached to this letter.

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. Also, cost estimates for medical supplies and equipment not listed on "HCFA's Labor, Supply and Equipment List for the Year 2001" are based on provided source(s) as noted, such as manufacturer's catalogue prices and may not reflect wholesale prices, quantity or cash discounts, prices for used equipment or any other factors which may alter the cost estimates

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: Paul Rudolf, MD
Ken Simon, MD
Carolyn Mullen
Rick Ensor
Sherry Smith
Patrick Gallagher

**AMA/Specialty Society RVS Update Committee
Physician Time Recommendation for codes 90921 and 90925**

As a result of the HCFA review of the RUC physician time submission, HCFA questioned the RUC time submitted for codes 90921 through 90925. It was discovered that the original summary of recommendation form was altered to not include the pre and post-service time for the code, and therefore the time submitted to HCFA was incorrect. As a result, the RUC met on short notice to clarify the RUC recommendation of physician time for these codes. After discussing the RUC recommendation on work relative values from 1994, the RUC agreed to use the same building-block methodology for developing physician time as was used for developing the work relative value. For code 90921, the RUC utilized the following building block methodology to develop the work RVU:

Calculation of RUC RVW Recommendation for code 90921

FOR HEMODIALYSIS

Total number of dialysis per month (week)	13	(Standard – patient receives dialysis 3 times per week)
Total number of visits per month	6.9	(Mendenhall = 6.8/1991 RPA Survey = 6.9)
Visits in office	1.2	(1991 RPA Survey)
Visits in dialysis unit	5.7	(1991 RPA Survey)
Interventions in dialysis	3.3	(1991 RPA Survey)

Translation to Equivalent Work Values

Face to Face:

99215 (1.51) X 1.2	1.812	(1991 RPA Survey and 1994 RUC Survey)
99213 (0.55) X 3.3	1.815	(3.3 interventions per month – 1991 RPA Survey)
99212 (0.38) X 2.4	0.912	(remaining dialysis visits per month)
Total Visits 6.9		

Care Plan Oversight: 99375 (1.06) X 1 1.060

Hemodialysis Relative Work Value 5.599

FOR PERITONEAL DIALYSIS:

47% of hemodialysis (5.599 X .47) 2.632 (Ratio used by RUC and CMD panel in previous calculations)

Blend of Hemodialysis (82% of Patients) and Peritoneal Dialysis (18% of Patients)

$(0.82 \times 5.599) + (0.18 \times 2.632) = 5.06$

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**AMA/Specialty Society RVS Update Committee
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Blend of Hemodialysis (82% of Patients) and Peritoneal Dialysis (18% of Patients)
(0.82 X 5.599) + (0.18 X 2.632) = **5.06**

The RUC agreed that the physician time should mirror this building block methodology and used the following calculation that utilized the full RUC times for the 1.2 office visits and the care plan oversight, but agreed that only the face to face time should be used for the remaining E/M visits. The face to face time was used rather than the full time because the committee and the Renal Physicians Association representative agreed that including all of the pre and post service time for these visits would lead to double counting of pre and post-service time. Using the same building block methodology, a total of 182 minutes for code 90921 calculated as follows.

99215 1.2 X 59=71
99213 3.3 X 15=49.5
99212 2.4 X 10=24
99375 =57 minutes
total hemodialysis time = 201.5
total peritoneal dialysis = .47X201.5=94.7

(.82 X201.5) + (0.18X94.7) = **182 minutes total time**

Since the work value for 90925 was developed by taking 1/30 of the value of 90921, the RUC aged to use the same methodology for calculating physician time and recommends 6 minutes for 90925.

The RUC recognized that recommending this time for code 90921 creates a rank order anomaly within the time currently used for this family of codes, but at this time the RUC recommends that HCFA review the times that it is currently using for this family to remove any possible rank orders.

- **The RUC recommends that HCFA not use the RUC times previously submitted in March 2001 for ERSD services (codes 90918 through 90925).**
- **The RUC recommends 182 minutes of physician time for code 90921 and 6 minutes for code 90925.**
- **The RUC will continue to review the physician time of the pediatric ERSD services (90918 – 90920, 90922 – 90924)**

✓ Arthroscopic Distal Claviclectomy (Tab 12)

Please add a post-operative incision kit to the list of medical supplies.

Esophagoplasty for Congenital Defect (Tab 17)

The direct practice expense inputs on the cover sheet are incorrect. Please rely on the attached summary sheets. In addition, the min. multi-specialty supply packages should be 5.

Repair Small Intestine Atresia (Tab 18)

The pre-time on the spreadsheet for 44126 and 44127 should be changed to 30 minutes.

Laparoscopic Colon Procedures (Tab 19)

The number of min. multi-specialty supply packages should be 3 for code 4420X3.

Placement of Anal Seton and Excision and Ileoanal Reservoir (Tab 20)

The number of min. multi-specialty supply packages should be 3 for code 460XX.

The total clinical staff office visit time should be 54 minutes.

Urethral Sphincter Procedures (Tab 25)

The MMSP should be 3 (rather than 4) for code 534X2.

Transurethral Destruction of Prostate by Water-Induced Thermotherapy (Tab 26)

The tape should be deleted from code 53853.

Gynecological Oncology Procedures (Tab 30)

We want to clarify that the "ob-gyn supply package for an office visit" is the ob/gyn min supply for office visit + pelvic exam+ drape sheet packages.

We will clarify with the ACOG staff and the PEAC whether the Disinfectant solution should be moved from the office visit package for OB/GYN services to the pelvic supply package.

Radiation Treatment Delivery (Tab E)

Please delete normal saline from the list of supplies

Noninvasive Anterior Chamber Biometry (Tab I)

Please change the staff type to COMT/COT/CST/RN

The paper towels should be deleted from supplies

The screening lane should be deleted from equipment

A new piece of equipment should be added – optical coherence biometer (\$25, 950).

Continuous Glucose Monitoring System (Tab J)

Please remove the MMSP from the summary of recommendation for this code.

Neurology Procedures (Tab Q)

The drape sheet should not have been deleted for WW1, code 95875.

**RUC Recommendations
for CPT 2002 New and Revised Codes
Currently Assigned Interim Work Relative Values**

- Nonbiodegradable Androgen Suppression Implants (11981-11983)
- Therapeutic Injections (20526–20612)
- Ventricular Assist Device (33979 and 33980)
- Elbow Surgery (24344 and 24346)
- Ablation of Hepatic Tumors (47370–47382, 76362-76490)
- Digitization of Mammographic Filming (76085)
- Gait and Motion Studies (96004)
- Intracardiac Electrophysiology (93609 and 93613)

AMA/Specialty Society & VS Update Committee
Summary of Recommendations

April 2002

Non-Biodegradable Androgen Suppression Implants

Codes 11981, 11982, and 11983 are new for CPT 2002, and were added to CPT to describe insertion, removal, and removal with reinsertion of a non-biodegradable drug delivery implant. These codes were initially created to describe a once-yearly implant containing leuprolide acetate for the treatment of prostate cancer. However, because various types of medications for various indications can be administered using this type of implant, the CPT Editorial Panel voted to keep the descriptors generic. That is why the type of drug is not listed in the descriptors of these codes.

At the April 2001 RUC meeting, the RUC recommended that CMS develop RVUs for these codes by cross-walking the RVUs from CPT codes 11975, 11976, and 11977, insertion, removal and removal with reinsertion of implantable contraceptive capsules. In April 2002, urology submitted a second letter again requesting a crosswalk to the contraceptive capsule codes. The RUC adopted this as an interim solution and requested that the specialty survey these codes for review at a future RUC meeting. During the April 2002 RUC meeting the specialty noted that the CPT descriptors for these codes do not apply specifically to a urology-related service. The RUC understands that a survey of urologists who perform this procedure for a drug specific to urology would not apply to other specialties that may use this code for other drug implants in the future. RUC also agreed that the implant insertion would be equivalent work to the contraceptive capsule insertion and a survey is unlikely to produce different results. The RUC therefore validates its May 2001 recommendation to value 11981 identical to 11975. However, the RUC believes that the work for the removal codes may be different than the removal of multiple contraceptive capsules. Therefore, the RUC could not validate the previous recommendations for the removal codes, 11982 and 11983. The RUC recommends that the cross-walked values for 11982 and 11983 remain interim for an additional year and requests urology to survey these codes for the April 2003 RUC meeting.

The RUC recommends that CMS accept the work RVU of the code 11981 *Insertion, non-biodegradable drug delivery implant* as cross-walked to 11975 *Insertion, implantable contraceptive capsules* (Work RVU = 1.48). In addition, the RUC recommends CMS use the interim crosswalk values of codes 11982, and 11983, to 11976, and 11977 respectively, with the understanding that the RUC's earlier recommendations for these two codes have not been validated and a survey will be completed for the April 2003 RUC meeting. Along with the work value crosswalk, the RUC recommends the following physician time crosswalk.

CPT Code	Crosswalk Code	Total Time
11981	11975	39
11982	11976	44
11983	11977	69

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
●11981	Insertion, non-biodegradable drug delivery implant	XXX	1.48 (no change)
●11982	Removal, non-biodegradable drug delivery implant	XXX	1.78 (no change) Interim
●11983	Removal with reinsertion, non-biodegradable drug delivery implant	XXX	3.30 (no change) Interim

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

April 2002

Therapeutic Injections

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

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

The RUC extensively reviewed these services, with an average intra-time of 5 minutes, in comparison to other physician services with low intra-service time. The RUC compared these injection codes to other services with similar intra-service times, including:

- CPT code 67515 *Injection of medication or other substance into Tenon's capsule* (work RVU = 0.61), with an intra-time of 6 minutes.
- CPT code 64405 *Injection, anesthetic agent; greater occipital nerve* (work RVU = 1.32), with an intra-time of 12 minutes.
- CPT code 65205 *Removal of foreign body, external eye; conjunctival superficial* (work RVU = 0.71), with an intra-time of 5 minutes.
- 11950 *Subcutaneous injection of filling material (eg, collagen); 1 cc or less* (work RVU = 0.83), with an intra-service time of 15 minutes.

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

The RUC recommends the following relative values for these codes:

CPT 20526	0.94
CPT 20550	0.75
CPT 20551	0.75
CPT 20552	0.66
CPT 20553	0.75
CPT 20612	0.70

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

Practice Expense

The consensus group presented direct practice expense data with the assumption that a separate Evaluation and Management service would be typically be reported on the same date. The RUC made minor modifications to the direct practice expense inputs for these services regarding phone calls in the post-service period. These practice expense recommendations will be attached to this summary.

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
•20526	AM1	Injection, therapeutic (eg, local anesthetic, corticosteroid); carpal tunnel	000	0.94

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲20550	AM2	Injection; tendon sheath, ligament, ganglion cyst	000	0.75
•20551	AM3	tendon origin/insertion	000	0.75
•20552	AM4	single or multiple trigger point(s), one or two muscle(s) group(s)	000	0.66
•20553	AM5	single or multiple trigger point(s), three or more muscle(s) group(s)	000	0.75
▲20600	AM7	Arthrocentesis, aspiration and/or injection; small joint or bursa or ganglion cyst (eg, fingers, toes)	000	0.66 (no change)
▲20605	AM8	intermediate joint or bursa or ganglion cyst (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)	000	0.68 (no change)
•20612	AM6	Aspiration and/or injection of ganglion cyst(s) any location (To report multiple ganglion cyst aspirations/injections, use 20612 and append modifier ‘-59’)	000	0.70

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

(April 2002)

CPT Code: 20526

Global: 000

Recommended RVW: ~~4.00~~

RUC Rec. 0.94

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

Survey Vignette (Typical Patient)

A 40-year-old legal secretary diagnosed with carpal tunnel syndrome, who has failed to respond to job modification, NSAIDs, and splinting, undergoes a steroid injection into the carpal tunnel.

Note: When completing this survey, please only consider the physician work related to the injection procedure. Do NOT consider any evaluation & management (E/M) work related to this patient encounter. For example, review of history and preservice exam would be E/M work that is separately billable.

CLINICAL DESCRIPTION OF SERVICE:

Description of Pre-Service Work:

The patient's involved hand is placed on a sterile barrier and prepped. The physician gloves.

Description of Intra-Service Work:

The palmaris longus tendon is palpated as it penetrates the hand at the wrist. The injection is then carried out at the wrist flexion crease just ulnar to the palmaris longus to avoid injury to the median nerve.

Description of Post-Service Work:

The injection area is cleansed and a bandage is applied. The patient is monitored for any potential complications from the injection.

SURVEY DATA

Presenter(s): David F. Martin, MD

Specialty(s): American Academy of Neurology; American Academy of Orthopaedic Surgeons; American Academy of Physical Medicine and Rehabilitation; American College of Rheumatology; American Orthopaedic Foot and Ankle Society; American Podiatric Medical Association; American Society of Anesthesiologists; American Society of Plastic Surgeons; American Society for Surgery of the Hand; North American Spine Society

CPT: 20526

Sample Size: 1351 Resp n: 89 Resp %: 6.59%

Sample Type: Random: mail, fax, email

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	0.50	0.70	1.00	1.27	2.63
Pre-Service			6		
Intra-Service	1	3	5	5	30
Post-Service			5		

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2002 RVW	Glob
20605	Arthrocentesis, aspiration and/or injection; intermediate joint, bursa or ganglion cyst (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)	0.68	000

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

	Svy CPT	Ref CPT
TIME ESTIMATES (MEDIAN)		
Pre-service time	6	7
Intra-service time	5	14
Post-service time	5	7
<i>Total Time</i>	16	28

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	2.03	1.97
Intra-service	3.05	2.78
Post-service	1.92	1.90

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	2.83	2.63
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.83	2.54
Urgency of medical decision making	2.07	2.05

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.49	2.95
Physical effort required	2.34	2.32

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.02	2.46
Outcome depends on the skill and judgment of physician	3.27	2.85
Estimated risk of malpractice suit with poor outcome	2.83	2.29

CONSENSUS RVW RECOMMENDATIONS FOR NEW/REVISED INJECTION CODES

CPT	Original Descriptors (CPT2002)	Original RVW
20550	Injection, tendon sheath, ligament, trigger points or ganglion cyst	0.86
20600	Arthrocentesis, aspiration and/or injection; small joint, bursa or ganglion cyst (eg, fingers, toes)	0.66
20605	Arthrocentesis, aspiration and/or injection; intermediate joint, bursa or ganglion cyst (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)	0.68

CPT	Final New/Revised Descriptors for 2003	Recommended RVW
• 20526	Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel	1.00
▲ 20550	Injection; tendon sheath, ligament	0.80
• 20551	Injection; tendon origin/insertion	0.80
• 20552	Injection; single or multiple trigger point(s), one or two muscle(s)	0.70
• 20553	Injection; single or multiple trigger point(s), three or more muscles	0.80
▲ 20600	Arthrocentesis, aspiration and/or injection; small joint, bursa (eg, fingers, toes)	0.66
▲ 20605	Arthrocentesis, aspiration and/or injection; intermediate joint, bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)	0.68
• 20612	Aspiration and/or injection of ganglion cyst, any location	0.75

Over the past two years, the CPT Editorial Panel has reviewed three *injection* CPT codes. After the initial review, CPT 20550 was split into three codes (20550, 20552, and 20553). Additionally, two new codes (20526 and 20551) were created for correct coding of procedures not accurately described by 20550. A second review of the codes one year later resulted in "ganglion cyst" being taken out of 20550, 20600, and 20605 to create a new code (20612).

By survey and discussion, it is the consensus of the specialties who reviewed these codes (and who provide these services most frequently) that the rank order shown above under recommended RVW is appropriate for the new/revised codes. Two points can be made to support these recommendations:

- Codes 20526, 20550, 20551, 20552, and 20553 each relate well to the original code 20550. The original code was valued at 0.86 Work-rvu's. The recommendations for the new codes are all below this value, with the exception of carpal tunnel injection (20526), which is a new code not previously described by 20550. The consensus of the specialties was that 20526 should be valued higher than the other codes because of the increased risk/intensity/complexity when injecting near the median nerve.
- Code 20612 is the result of taking "ganglion cyst" out of the old descriptors for 20550, 20600, and 20605. As such, the value should appropriately be somewhere between the old values for these codes (0.66, 0.68, 0.86). The recommended survey median Work-rvu of 0.75 fits well.

Revision of these codes was undertaken by the CPT Editorial Panel to more clearly define the different injections and allow for accurate coding. This was not a five-year review issue, and as such, family budget neutrality should be maintained. The recommended RVWs for these new/revised codes are guaranteed to not increase the total payment for this family because every code recommendation (with the exception of 20526) is at or below the original RVW. We recommend the RVWs as shown in the table above.

FREQUENCY INFORMATION

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

CPT 20550 may have been used, but technically/clinically, this descriptor did not describe a therapeutic carpal tunnel injection.

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

Often

3. 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.

See Attachment A, next page

4. 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.

See Attachment A, next page

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Yes, many physicians.

Attachment A

Medicare 2000 Utilization for CPT 20550 by Specialty

Podiatry	219,623
Anesthesiology	177,893
orthopaedic surgery	175,162
family practice	119,808
Rheumatology	118,109
physical medicine and rehabilitation	90,018
internal medicine	86,760
Neurology	36,581
general practice	36,304
clinic or group practice (not gppp)	18,860
hand surgery	14,086
general surgery	9,915
osteopathic manipulative therapy	6,647
plastic & reconstructive surgery	5,940
pathology	5,030
emergency medicine	4,418
nurse practitioner	4,344
neurosurgery	2,950
physician assistant	2,949
oral surgery (dentists only)	2,122
preventive medicine	1,932
cardiology	1,798
pulmonary disease	1,622
otolaryngology	1,550
psychiatry	1,417

allergy/immunology	1,387
geriatric medicine	1,288
hematology/oncology	832
obstetrics/gynecology	832
diagnostic radiology	563
crna, anesthesia assistant	555
gastroenterology	448
endocrinology	412
infectious disease	392
pediatric medicine	358
ophthalmology	257
medical oncology	212
nephrology	173
maxillofacial surgery	91
addiction medicine	76
dermatology	74
thoracic surgery	64
urology	60
critical care (intensivists)	53
independently-practicing p.t.	41
vascular surgery	40
peripheral vascular disease	35
colorectal surgery	20
unknown physician specialty	10
Medicare TOTAL	1,154,111

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

(April 2002)

CPT Code: 20550

Global: 000

~~Recommended RVW: 0.80~~
RUC Rec. 0.75

CPT Descriptor: Injection, tendon sheath, ligament

Survey Vignette (Typical Patient)

Option A. A 50-year-old woman presents with stenosing tenosynovitis of the right index finger which is treated with a steroid injection into its flexor tendon sheath.

Option B. A 46-year-old female diagnosed with plantar fasciitis, who has failed to respond to NSAIDs, modifications in shoe gear and stretching exercises, presents with plantar fasciitis of the right foot which is treated with a steroid injection into the plantar fascia.

Note: When completing this survey, please only consider the physician work related to the injection procedure. Do NOT consider any evaluation & management (E/M) work related to this patient encounter. For example, review of history and preservice exam would be E/M work that is separately billable.

CLINICAL DESCRIPTION OF SERVICE:

Option A.

Description of Pre-Service Work:

The patient's involved hand is placed on a sterile barrier and prepped. The physician gloves.

Description of Intra-Service Work:

The proximal edge of the A-1 pulley of the right index finger is located. The injection is given into the flexor tendon sheath.

Description of Post-Service Work:

The injection area is cleansed and a bandage is applied. The patient is monitored for any potential complications from the injection.

Option B.

Description of Pre-Service Work:

Communicate with other professionals; review of treatment options; review of x-rays; review procedure with patient; discuss possible complications; obtain patient consent; and communicate with patient's family. Prepare injection by mixing a local anesthetic with a steroid. The patient's involved foot is placed on a sterile barrier and prepped. The physician gloves.

Description of Intra-Service Work:

The medial and lateral tubercles of the calcaneus are palpated and the point of maximum tenderness is identified. The medial and central bands of the plantar fascia are localized. A medial approach is utilized and the injection is given superficial to the plantar fascia.

Description of Post-Service Work:

The injection area is cleansed and a bandage is applied. The patient is monitored for any potential complications from the injection. Instruct patient and/or care giver on appropriate activities and home care. Discuss future management of the condition. Completion of medical record.

SURVEY DATA**Presenter(s):** David F. Martin, MD

Specialty(s): American Academy of Neurology; American Academy of Orthopaedic Surgeons; American Academy of Physical Medicine and Rehabilitation; American College of Rheumatology; American Orthopaedic Foot and Ankle Society; American Podiatric Medical Association; American Society of Anesthesiologists; American Society of Plastic Surgeons; American Society for Surgery of the Hand; North American Spine Society

CPT: 20550**Sample Size:** 1437**Resp n:** 176**Resp %:** 12.25%**Sample Type:** Random: mail, fax, email

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	0.45	0.68	0.80	0.98	4.00
Pre-Service			10		
Intra-Service	1	4	5	8	30
Post-Service			5		

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'02RVW	Glob
20600	Arthrocentesis, aspiration and/or injection; small joint, bursa or ganglion cyst (eg, fingers, toes)	0.66	000

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

	Svy CPT	Ref CPT
TIME ESTIMATES (MEDIAN)		
Pre-service time	10	7
Intra-service time	5	11
Post-service time	5	7
<i>Total Time</i>	20	25

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	2.10	2.08
Intra-service	2.71	2.51
Post-service	1.98	1.94

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	2.43	2.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.25	2.30
Urgency of medical decision making	2.02	2.40

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.04	2.82
Physical effort required	2.15	2.08

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	2.46	2.24
Outcome depends on the skill and judgment of physician	3.00	2.76
Estimated risk of malpractice suit with poor outcome	2.31	2.08

RATIONALE:

Please see "CONSENSUS RVW RECOMMENDATIONS FOR NEW/REVISED INJECTION CODES" on Work Summary Recommendation Form for CPT 20526

FREQUENCY INFORMATION

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

20550

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

Often

3. 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.

See Attachment A, next page

4. 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.

See Attachment A, next page

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Yes, many physicians.

Attachment A

Medicare 2000 Utilization for CPT 20550 by Specialty

podiatry	219,623
anesthesiology	177,893
orthopaedic surgery	175,162
family practice	119,808
rheumatology	118,109
physical medicine and rehabilitation	90,018
internal medicine	86,760
neurology	36,581
general practice	36,304
clinic or group practice (not gppp)	18,860
hand surgery	14,086
general surgery	9,915
osteopathic manipulative therapy	6,647
plastic & reconstructive surgery	5,940
pathology	5,030
emergency medicine	4,418
nurse practitioner	4,344
neurosurgery	2,950
physician assistant	2,949
oral surgery (dentists only)	2,122
preventive medicine	1,932
cardiology	1,798
pulmonary disease	1,622
otolaryngology	1,550
psychiatry	1,417

allergy/immunology	1,387
geriatric medicine	1,288
hematology/oncology	832
obstetrics/gynecology	832
diagnostic radiology	563
crna, anesthesia assistant	555
gastroenterology	448
endocrinology	412
infectious disease	392
pediatric medicine	358
ophthalmology	257
medical oncology	212
nephrology	173
maxillofacial surgery	91
addiction medicine	76
dermatology	74
thoracic surgery	64
urology	60
critical care (intensivists)	53
independently-practicing p.t.	41
vascular surgery	40
peripheral vascular disease	35
colorectal surgery	20
unknown physician specialty	10
Medicare TOTAL	1,154,111

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

(April 2002)

CPT Code: 20551

Global: 000

~~Recommended RVW: 0.80~~

RUC Rec: 0.75

CPT Descriptor: Injection, tendon origin/insertion

Survey Vignette (Typical Patient)

Option A. A 35-year-old man is treated for lateral epicondylitis with an injection into the origin of the extensor carpi radialis brevis (ECRB) on the lateral epicondyle.

Option B. A 35-year-old man is treated for peroneus brevis tendonitis of the left foot with an injection into the insertion of the peroneus brevis tendon at the base of the fifth metatarsal.

Note: When completing this survey, please only consider the physician work related to the injection procedure. Do NOT consider any evaluation & management (E/M) work related to this patient encounter. For example, review of history and preservice exam would be E/M work that is separately billable.

CLINICAL DESCRIPTION OF SERVICE:

Option A.

Description of Pre-Service Work:

The patient's involved elbow is placed on a sterile barrier and prepped. The physician gloves.

Description of Intra-Service Work:

The region of the insertion of the ECRB on the lateral epicondyle is localized and injected.

Description of Post-Service Work:

The injection area is cleansed and a bandage is applied. The patient is monitored for any potential complications from the injection.

Option B.

Description of Pre-Service Work:

Communicate with other professionals; review of treatment options; review of x-rays; review procedure with patient; discuss possible complications; obtain patient consent; and communicate with patient's family. Prepare injection by mixing a local anesthetic with a steroid. The patient's involved foot is placed on a sterile barrier and prepped. The physician gloves.

Description of Intra-Service Work:

The region of the insertion of the peroneus brevis tendon on the base of the fifth metatarsal is localized and injected.

Description of Post-Service Work:

The injection area is cleansed and a bandage is applied. The patient is monitored for any potential complications from the injection. Instruct patient and/or care giver on appropriate activities and home care. Discuss future management of the condition. Completion of medical record.

SURVEY DATA**Presenter(s):** David F. Martin, MD

Specialty(s): American Academy of Neurology; American Academy of Orthopaedic Surgeons; American Academy of Physical Medicine and Rehabilitation; American College of Rheumatology; American Orthopaedic Foot and Ankle Society; American Podiatric Medical Association; American Society of Anesthesiologists; American Society of Plastic Surgeons; American Society for Surgery of the Hand; North American Spine Society

CPT: 20551**Sample Size:** 1437 **Resp n:** 143 **Resp %:** 9.95%**Sample Type:** Random: mail, fax, email

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RWV	0.55	0.68	0.80	0.95	1.93
Pre-Service			10		
Intra-Service	1	3	5	6	20
Post-Service			5		

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'02RVW	Glob
20605	Arthrocentesis, aspiration and/or injection; intermediate joint, bursa or ganglion cyst (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)	0.68	000

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

	Svy CPT	Ref CPT
TIME ESTIMATES (MEDIAN)		
Pre-service time	10	7
Intra-service time	5	14
Post-service time	5	7
<i>Total Time</i>	20	28

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	2.13	2.19
Intra-service	2.72	2.73
Post-service	2.02	2.02

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	2.81	2.58
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.52	2.44
Urgency of medical decision making	2.06	2.09

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	2.88	2.88
Physical effort required	2.27	2.25

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	2.52	2.38
Outcome depends on the skill and judgment of physician	2.89	2.69
Estimated risk of malpractice suit with poor outcome	2.20	2.19

RATIONALE:

Please see "CONSENSUS RVW RECOMMENDATIONS FOR NEW/REVISED INJECTION CODES" on Work Summary Recommendation Form for CPT 20526

FREQUENCY INFORMATION

1. How was this service previously reported (if unlisted code, please ensure that the medicare frequency for this unlisted code is reviewed)?
2. How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Often

3. 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.

See Attachment A, next page

4. 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.

See Attachment A, next page

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Yes, many physicians.

Attachment A

Medicare 2000 Utilization for CPT 20550 by Specialty

podiatry	219,623
anesthesiology	177,893
orthopaedic surgery	175,162
family practice	119,808
rheumatology	118,109
physical medicine and rehabilitation	90,018
internal medicine	86,760
neurology	36,581
general practice	36,304
clinic or group practice (not gppp)	18,860
hand surgery	14,086
general surgery	9,915
osteopathic manipulative therapy	6,647
plastic & reconstructive surgery	5,940
pathology	5,030
emergency medicine	4,418
nurse practitioner	4,344
neurosurgery	2,950
physician assistant	2,949
oral surgery (dentists only)	2,122
preventive medicine	1,932
cardiology	1,798
pulmonary disease	1,622
otolaryngology	1,550
psychiatry	1,417

allergy/immunology	1,387
geriatric medicine	1,288
hematology/oncology	832
obstetrics/gynecology	832
diagnostic radiology	563
crna, anesthesia assistant	555
gastroenterology	448
endocrinology	412
infectious disease	392
pediatric medicine	358
ophthalmology	257
medical oncology	212
nephrology	173
maxillofacial surgery	91
addiction medicine	76
dermatology	74
thoracic surgery	64
urology	60
critical care (intensivists)	53
independently-practicing p.t.	41
vascular surgery	40
peripheral vascular disease	35
colorectal surgery	20
unknown physician specialty	10
Medicare TOTAL	1,154,111

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

(April 2002)

CPT Code: 20552

Global: 000

~~Recommended RW: 0.70~~

RUC Rec. 0.66

CPT Descriptor: Injection, single or multiple trigger point(s), one or two muscle(s)

Survey Vignette (Typical Patient)

A 60 year-old female presents with a three- month history of pain in the low left back above the posterior iliac crest with radiation of pain into the left buttock. Muscle relaxants, NSAIDs, and physical therapy have been ineffective in relieving her pain. She undergoes injection of the trigger point in the multifidus muscle left of the L5 spinous process.

Note: When completing this survey, please only consider the physician work related to the injection procedure. Do NOT consider any evaluation & management (E/M) work related to this patient encounter. For example, review of history and preservice exam would be E/M work that is separately billable.

CLINICAL DESCRIPTION OF SERVICE:

Description of Pre-Service Work:

The patient is positioned prone and the lower back around the spine is prepped and draped in a sterile manner.

Description of Intra-Service Work:

After identification of the trigger point in the multifidus muscle left of the L5 spinous process by palpation, a 1.5-2 inch 25 gauge needle is inserted through the skin into the muscle. The needle is advanced a short distance, about 2 to 4 centimeters observing for any complaints of paresthesias but searching for the area of maximum tenderness. If any complaints or paresthesias are encountered the needle is withdrawn slightly until they stop. Next the injectant solution is infiltrated in a fanwise method into the trigger point after aspiration is negative for blood.

Description of Post-Service Work:

The injection area is cleansed and a bandage is applied. The patient is monitored for any potential complications from the injection.

SURVEY DATA**Presenter(s):** David F. Martin, MD

Specialty(s): American Academy of Neurology; American Academy of Orthopaedic Surgeons; American Academy of Physical Medicine and Rehabilitation; American College of Rheumatology; American Orthopaedic Foot and Ankle Society; American Podiatric Medical Association; American Society of Anesthesiologists; American Society of Plastic Surgeons; American Society for Surgery of the Hand; North American Spine Society

CPT: 20552**Sample Size:** 1281 **Resp n:** 50 **Resp %:** 3.90%**Sample Type:** Random: mail, fax, email

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	0.40	0.60	0.70	0.97	1.90
Pre-Service			5		
Intra-Service	1	4.25	5	10	30
Post-Service			3.5		

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'02RVW	Glob
20600	Arthrocentesis, aspiration and/or injection; small joint, bursa or ganglion cyst (eg, fingers, toes)	0.66	000

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

	Svy CPT	Ref CPT
TIME ESTIMATES (MEDIAN)		
Pre-service time	5	7
Intra-service time	5	11
Post-service time	3.5	7
<i>Total Time</i>	13.5	25

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	1.75	1.75
Intra-service	2.23	2.38
Post-service	1.67	1.83

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	2.46	2.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.00	2.15
Urgency of medical decision making	1.46	1.77

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	2.23	2.77
Physical effort required	1.69	1.69

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	1.69	2.08
Outcome depends on the skill and judgment of physician	2.23	2.54
Estimated risk of malpractice suit with poor outcome	1.69	2.08

RATIONALE:

Please see "CONSENSUS RVW RECOMMENDATIONS FOR NEW/REVISED INJECTION CODES" on Work Summary Recommendation Form for CPT 20526

FREQUENCY INFORMATION

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

20550

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

Often

3. 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.

See Attachment A, next page

4. 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.

See Attachment A, next page

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Yes, many physicians.

Attachment A
Medicare 2000 Utilization for CPT 20550 by Specialty

podiatry	219,623
anesthesiology	177,893
orthopaedic surgery	175,162
family practice	119,808
rheumatology	118,109
physical medicine and rehabilitation	90,018
internal medicine	86,760
neurology	36,581
general practice	36,304
clinic or group practice (not gppp)	18,860
hand surgery	14,086
general surgery	9,915
osteopathic manipulative therapy	6,647
plastic & reconstructive surgery	5,940
pathology	5,030
emergency medicine	4,418
nurse practitioner	4,344
neurosurgery	2,950
physician assistant	2,949
oral surgery (dentists only)	2,122
preventive medicine	1,932
cardiology	1,798
pulmonary disease	1,622
otolaryngology	1,550
psychiatry	1,417

allergy/immunology	1,387
geriatric medicine	1,288
hematology/oncology	832
obstetrics/gynecology	832
diagnostic radiology	563
crna, anesthesia assistant	555
gastroenterology	448
endocrinology	412
infectious disease	392
pediatric medicine	358
ophthalmology	257
medical oncology	212
nephrology	173
maxillofacial surgery	91
addiction medicine	76
dermatology	74
thoracic surgery	64
urology	60
critical care (intensivists)	53
independently-practicing p.t.	41
vascular surgery	40
peripheral vascular disease	35
colorectal surgery	20
unknown physician specialty	10
Medicare TOTAL	1,154,111

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

(April 2002)

CPT Code: 20553

Global: 000

~~Recommended RW: 0.80~~

RUC Rec. 0.75

CPT Descriptor: Injection, single or multiple trigger point(s), three or more muscles

Survey Vignette (Typical Patient)

A 40 year-old male presents with chronic left neck and right upper back pain resulting from cervical degenerative disk disease and myofascial pain syndrome. The patient has already completed a trial of physical therapy and NSAID therapy without relief of his pain. He undergoes injection of the trigger points in the left multifidus muscle, the left trapezius muscle, and the right levator scapular muscle.

Note: When completing this survey, please only consider the physician work related to the injection procedure. Do NOT consider any evaluation & management (E/M) work related to this patient encounter. For example, review of history and preservice exam would be E/M work that is separately billable.

CLINICAL DESCRIPTION OF SERVICE:

Description of Pre-Service Work:

The patient is placed in a sitting position and the shoulders and posterior neck are prepped and draped in a sterile manner.

Description of Intra-Service Work:

After identification of the three trigger points by palpation, a 1.5-2.0 inch 25 gauge needle is inserted through the skin into the muscles. The needle is advanced a short distance, about 1 to 3 centimeters, observing for any complaints of paresthesias, but searching for the areas of maximum tenderness. If any complaints or paresthesias are encountered the needle is withdrawn slightly until they stop. Next 1 to 3 cc of the injectant solution is infiltrated in a fanwise method into the trigger points after aspiration is negative for blood.

Description of Post-Service Work:

The injection area is cleansed and a bandage is applied. The patient is monitored for any potential complications from the injection.

SURVEY DATA**Presenter(s):** David F. Martin, MD

Specialty(s): American Academy of Neurology; American Academy of Orthopaedic Surgeons; American Academy of Physical Medicine and Rehabilitation; American College of Rheumatology; American Orthopaedic Foot and Ankle Society; American Podiatric Medical Association; American Society of Anesthesiologists; American Society of Plastic Surgeons; American Society for Surgery of the Hand; North American Spine Society

CPT: 20553**Sample Size:** 1281 **Resp n:** 47 **Resp %:** 3.67%**Sample Type:** Random: mail, fax, email

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	0.52	0.70	0.80	1.10	2.60
Pre-Service			7		
Intra-Service	2	5	10	12	40
Post-Service			5		

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'02RVW	Glob
20600	Arthrocentesis, aspiration and/or injection; small joint, bursa or ganglion cyst (eg, fingers, toes)	0.66	000

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

	Svy CPT	Ref CPT
TIME ESTIMATES (MEDIAN)		
Pre-service time	7	7
Intra-service time	10	11
Post-service time	5	7
<i>Total Time</i>	22	25

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	2.00	1.90
Intra-service	2.64	2.55
Post-service	1.90	2.00

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	2.60	2.45
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.20	2.09
Urgency of medical decision making	1.90	1.82

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	2.60	2.91
Physical effort required	2.20	1.82

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	2.00	2.09
Outcome depends on the skill and judgment of physician	2.60	2.45
Estimated risk of malpractice suit with poor outcome	2.00	2.20

RATIONALE:

Please see "CONSENSUS RVW RECOMMENDATIONS FOR NEW/REVISED INJECTION CODES" on Work Summary Recommendation Form for CPT 20526

FREQUENCY INFORMATION

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

20550

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

Often

3. 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.

See Attachment A, next page

4. 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.

See Attachment A, next page

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Yes, many physicians.

Attachment A

Medicare 2000 Utilization for CPT 20550 by Specialty

Podiatry	219,623
Anesthesiology	177,893
orthopaedic surgery	175,162
family practice	119,808
Rheumatology	118,109
physical medicine and rehabilitation	90,018
internal medicine	86,760
Neurology	36,581
general practice	36,304
clinic or group practice (not gppp)	18,860
hand surgery	14,086
general surgery	9,915
osteopathic manipulative therapy	6,647
plastic & reconstructive surgery	5,940
pathology	5,030
emergency medicine	4,418
nurse practitioner	4,344
neurosurgery	2,950
physician assistant	2,949
oral surgery (dentists only)	2,122
preventive medicine	1,932
cardiology	1,798
pulmonary disease	1,622
otolaryngology	1,550
psychiatry	1,417

allergy/immunology	1,387
geriatric medicine	1,288
hematology/oncology	832
obstetrics/gynecology	832
diagnostic radiology	563
crna, anesthesia assistant	555
gastroenterology	448
endocrinology	412
infectious disease	392
pediatric medicine	358
ophthalmology	257
medical oncology	212
nephrology	173
maxillofacial surgery	91
addiction medicine	76
dermatology	74
thoracic surgery	64
urology	60
critical care (intensivists)	53
independently-practicing p.t.	41
vascular surgery	40
peripheral vascular disease	35
colorectal surgery	20
unknown physician specialty	10
Medicare TOTAL	1,154,111

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

(April 2002)

CPT Code: 20612

Global: 000

Recommended RVW: 0.75

RUC Rec: 0.70

CPT Descriptor: Aspiration and/or injection of ganglion cyst, any location

Survey Vignette (Typical Patient)

Option A. A 25-year-old female presents with a ganglion cyst on the dorsum of the left wrist, which is treated with aspiration/injection.

Option B. A 40 year-old female presents with a ganglion cyst of the extensor digitorum longus tendon on the right foot, which is treated with aspiration/injection.

Note: When completing this survey, please only consider the physician work related to the injection procedure. Do NOT consider any evaluation & management (E/M) work related to this patient encounter. For example, review of history and preservice exam would be E/M work that is separately billable.

CLINICAL DESCRIPTION OF SERVICE:

Option A:

Description of Pre-Service Work:

Communicate with other professionals; review of treatment options; review of x-rays; review procedure with patient; discuss possible complications; obtain patient consent; and communicate with patient's family. Prepare three separate syringes: (1) local anesthetic; (2) empty syringe with needle to aspirate; (3) steroid. Prepare for culture of aspirate. The patient's involved hand is placed on a sterile barrier and prepped. The physician gloves.

Description of Intra-Service Work:

The local anesthetic is administered to the area surrounding the ganglion cyst. Using the empty syringe, the ganglion cyst is aspirated thoroughly. The aspirate is cultured. The ganglion cyst is injected with the steroid.

Description of Post-Service Work:

The injection area is cleansed and a compression bandage is applied. The patient is monitored for any potential complications from the injection. Instruct patient and/or care giver on appropriate activities and home care. Discuss future management of the condition. Completion of medical record.

Option B:

Description of Pre-Service Work:

Communicate with other professionals; review of treatment options; review of x-rays; review procedure with patient; discuss possible complications; obtain patient consent; and communicate with patient's family. Prepare three separate syringes: (1) local anesthetic; (2) empty syringe with needle to aspirate; (3) steroid. Prepare for culture of aspirate. The patient's involved foot is placed on a sterile barrier and prepped. The physician gloves.

Description of Intra-Service Work:

The local anesthetic is administered to the area surrounding the ganglion cyst. Using the empty syringe, the ganglion cyst is aspirated thoroughly. The aspirate is cultured. The ganglion cyst is injected with the steroid.

Description of Post-Service Work:

The injection area is cleansed and a compression bandage is applied. The patient is monitored for any potential complications from the injection. Instruct patient and/or care giver on appropriate activities and home care. Discuss future management of the condition. Completion of medical record.

SURVEY DATA**Presenter(s):** David F. Martin, MD

Specialty(s): American Academy of Neurology; American Academy of Orthopaedic Surgeons; American Academy of Physical Medicine and Rehabilitation; American College of Rheumatology; American Orthopaedic Foot and Ankle Society; American Podiatric Medical Association; American Society of Anesthesiologists; American Society of Plastic Surgeons; American Society for Surgery of the Hand; North American Spine Society

CPT: 20612**Sample Size:** 1437 **Resp n:** 141 **Resp %:** 9.81%**Sample Type:** Random: mail, fax, email

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	0.50	0.68	0.75	1.06	3.01
Pre-Service			10		
Intra-Service	1	5	5	10	25
Post-Service			5		

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'02RVW	Glob
20605	Arthrocentesis, aspiration and/or injection; intermediate joint, bursa or ganglion cyst (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)	0.68	000

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

	Svy CPT	Ref CPT
TIME ESTIMATES (MEDIAN)		
Pre-service time	10	7
Intra-service time	5	14
Post-service time	5	7
<i>Total Time</i>	20	28

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	2.29	2.31
Intra-service	2.85	2.71
Post-service	2.13	2.10

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	2.58	2.58
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.50	2.48
Urgency of medical decision making	2.04	2.02

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	2.92	2.80
Physical effort required	2.38	2.39

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	2.63	2.46
Outcome depends on the skill and judgment of physician	2.88	2.81
Estimated risk of malpractice suit with poor outcome	2.13	2.10

RATIONALE:

Please see "CONSENSUS RWV RECOMMENDATIONS FOR NEW/REVISED INJECTION CODES" on Work Summary Recommendation Form for CPT 20526

FREQUENCY INFORMATION

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

20550, 20600 or 20605

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

Often

3. 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.

See Attachment A, next page

4. 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.

See Attachment A, next page

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Yes, many physicians.

Attachment A

Combined Medicare 2000 Utilization for CPT 20550, 20600, 20612 by Specialty

podiatry	532,729	hematology/oncology	1,629
orthopaedic surgery	358,014	psychiatry	1,494
rheumatology	212,666	diagnostic radiology	1,324
anesthesiology	183,405	obstetrics/gynecology	907
family practice	170,318	infectious disease	751
internal medicine	142,583	gastroenterology	722
physical medicine and rehabilitation	100,011	pediatric medicine	704
general practice	46,432	endocrinology	560
clinic or group practice (not gppp)	38,672	crna, anesthesia assistant	555
neurology	37,745	nephrology	366
hand surgery	25,822	medical oncology	284
general surgery	13,674	ophthalmology	275
plastic & reconstructive surgery	8,062	dermatology	207
emergency medicine	7,514	urology	182
osteopathic manipulative therapy	7,321	maxillofacial surgery	163
nurse practitioner	5,884	thoracic surgery	132
physician assistant	5,143	critical care (intensivists)	123
pathology	5,096	addiction medicine	76
neurosurgery	3,180	vascular surgery	70
cardiology	2,456	peripheral vascular disease	60
oral surgery (dentists only)	2,386	independently-practicing p.t.	41
pulmonary disease	2,041	interventional radiology	22
allergy/immunology	1,947	colorectal surgery	20
geriatric medicine	1,941	unknown physician specialty	10
preventive medicine	1,932	Medicare Total	1,929,373
otolaryngology	1,722		



American Academy of
Orthopaedic Surgeons

AAOS

American Association of
Orthopaedic Surgeons

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**AMA/Specialty Society Update Process
RUC Summary of Recommendation
000 Day Global Period**

CPT: 20526	Injection, therapeutic (eg local anesthetic, corticosteroid), carpal tunnel
20550	Injection, tendon sheath, ligament
20551	Injection, tendon origin/insertion
20552	Injection, single or multiple trigger point(s), one or two muscle(s)
20553	Injection, single or multiple trigger point(s), three or more muscles
20612	Aspiration and/or injection of ganglion cyst, any location

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

A consensus panel of experts representing the various subspecialty societies involved in the work survey process developed the inputs for clinical staff time and procedure specific medical equipment and supplies. All specialty societies represented were invited to participate and present their data and input. The consensus panel consisted of various representatives from the specialty societies, which represented a combination of rural, suburban, and urban practices; solo, single and multi-specialty groups, as well as medical school faculty. A consensus panel was then convened via e-mail correspondence and the panel reached consensus for all the inputs.

The following specialties developed the attached practice expense inputs:

American Academy of Neurology
American Academy of Orthopaedic Surgeons
American Academy of Physical Medicine and Rehabilitation
American College of Rheumatology
American Orthopaedic Foot and Ankle Society
American Podiatric Medical Association
American Society of Anesthesiologists
American Society of Plastic Surgeons
American Society for Surgery of the Hand
North American Spine Society

CLINICAL STAFF TIME

Pre-Service Clinical Labor Activities:

None.

Intra-Service Clinical Labor Activities:

The intra-service clinical staff times for the surveyed codes were cross-walked from previously approved PEAC codes (20550, 20600, 20605, and 20610).

Post-Service Clinical Labor Activities:

The post-service phone calls for the surveyed codes were cross-walked from previously approved PEAC codes (20550, 20600, 20605, and 20610).

SUPPLIES AND EQUIPMENT

Intra-service medical supplies and procedure specific equipment recommendations are based on a review of supply and equipment data.

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Implantation/Removal of Ventricular Assist Device

CPT created two new codes to differentiate the insertion and removal of an implantable intracorporeal ventricular assist devices, as opposed to extracorporeal. These codes were first published in CPT 2002 edition. In 2001 the specialty society was prepared to present its recommendation for CPT codes 33979 *Insertion of ventricular assist device; implantable intracorporeal, single ventricle* and 33980 *Removal of ventricular assist device; implantable intracorporeal, single ventricle*, however, upon further review of the survey responses the specialty society concluded that the survey respondents did not accurately assess the time required for these procedures due to a comparison with the reference code that had a 90 day global period. The specialty society requested to bring these codes back to the RUC when additional data from an NIH study became available. In the interim, the specialty society requested that the codes be carrier priced for 2002. The RUC agreed with the specialty society request that the codes be carrier priced for a year, and the specialty has now submitted a recommendation at the April 2002 RUC meeting.

33979

The RUC began its review of the code by questioning the assignment of a XXX global period to this code. There was considerable concern that such a designation was inappropriate and the RUC discussed the possibility of valuing the code as a 000 day global period. The RUC agreed that since the code was surveyed as an XXX global period, there is insufficient data to value the code with a 000 day global period. Additionally, CMS has assigned XXX global period for the other VAD codes and valuing the code with the XXX global period would at least be consistent with other codes in the family. Therefore, the committee focused on valuing the code with a XXX global period.

The RUC compared 33979 to code 33975 *Insertion of ventricular assist device; extracorporeal, single ventricle* (work RVU = 21.00, RUC recommended value 39.00 RVU, XXX global period). This code has undergone a great deal of refinement by CMS where the initial global period of 90 days was changed to 010, and finally to XXX. The presenters were unable to describe the rationale for a XXX global period for these codes. The RUC began the comparison with the RUC recommended RVU of 39.00 for code 33975 and adjusted the value to account for the differences in the code as described below. To account for the additional 80 minutes of intra service time in code 33979, the RUC assigned an IWPUT of 0.113 (same as survey estimate and similar to reference service used in

survey) resulting in an additional RVU of 9.00. This IWPUR was felt to be appropriate reflection of the intensity of this procedure and was calculated by the specialty based on the survey data and their recommended RVU of 52.50. To account for the differences in post service time the RUC subtracted 2.00 RVUs for 30 minutes of critical care (33979 post-service was 30 minutes less than 33975), resulting in a final value of 46.00. This value also placed the code in the proper rank order with the other VAD codes and was similar to the survey's 25th percentile value (work RVU = 45.00).

RUC recommended value of 33975	39.00	
plus 80 minutes x .113=	9.00	
minus 30 minutes of critical care	<u>(2.00)</u>	
Total Work RVU		46.00

The RUC recommends a work RVU of 46.00 for code 33979.

33980

The RUC discussed the 90 day global period assigned to this code and after much discussion concluded that the recommended value of 56.25 and a global period of 90 days would be appropriate for this code. Initially, the RUC had difficulty valuing the code with a 90 day global period due to a very wide range of length of stay for this code. A RUC facilitation committee developed a building block methodology for valuing the code with a 000 day global period. However, once the RUC examined this proposal, it concluded that the building block analysis supported the original specialty society recommendation. The RUC agreed with the specialty society rationale stating that the code should have a higher value than the reference code 33863 *Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with aortic root replacement using composite prosthesis and coronary reconstruction* (work RVU = 45.00) since the typical patient undergoing 33863 has a life-threatening disease (aortic atherosclerosis with aneurysm and/or dissection) and may or may not have reached the stage of life-threatening criticality. He/she is frequently elderly with concomitant degenerative diseases, including diabetes, coronary artery disease, peripheral vascular disease, renal disease and/or arthritis. In comparison, the typical patient undergoing 33980 *Removal of ventricular assist device, implantable intracorporeal, single ventricle* (proposed work RVU = 56.25) is typically younger, but has undergone a challenging period of cardiac stabilization and recovery from end-stage heart failure over a period of weeks or months. He/she is healthier than before the implant but still capable of becoming

very unstable after the assist device is removed, requiring several days of ICU care. Immediate postoperative stabilization is very intense and challenging and tests the surgeon's management skills. Both patients are difficult to manage following surgery and a significant amount of critical care, intensive care, and postoperative management is required. The technical similarities between the two procedures include: a median sternotomy (in the case of the VAD patient, always a repeat sternotomy); institution of cardiopulmonary bypass; aortic cross-clamping; mobilization; exposure and surgical entry into major vessels and the heart; weaning from cardiopulmonary bypass; establishment of hemostasis; and closure of the sternotomy and abdominal incisions. In the case of the aortic graft, the surgeon must transect the aorta, graft the aneurysm, replace the native aortic valve with a prosthetic valve, and isolate and then reimplant the coronary ostia. An explantation of the VAD involves re-dissection of the heart with removal of the outflow graft, removal of the inflow cuff from the heart and the aorta, and subsequent repair of all sites. Following that, the pericardial site of the driveline connection is sutured closed as is the interior site. Given these significant differences in work as well as a building block methodology that supported a work RVU value of 45.50 assuming a 000 day global period, the RUC concluded that the survey 75th percentile work value of 56.25 is appropriate. **The RUC recommends a work RVU of 56.25 for code 33980.**

Practice Expense

The RUC is forwarding a practice expense recommendation of zero inputs for these codes but the specialty requests to submit pre-service and intra-service time at a later date pending the outcome of IG and GAO reports that will address the topic of physicians bringing their office clinical staff to the hospital.

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
•33979	KK5	Insertion of ventricular assist device; implantable intracorporeal, single ventricle	XXX	46.00
•33980	KK7	Removal of ventricular assist device; implantable intracorporeal, single ventricle	090	56.25

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

(April 2002)

CPT Code: 33979 (KK5)

Global: XXX

Recommended RVW: -52-50

RUC Recommended RVW 46 00

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

Survey Vignette (Typical Patient)

A 56-year-old man diagnosed with ischemic cardiomyopathy was admitted to the hospital with worsening heart failure. His history included hypertension, diabetes mellitus, multiple silent myocardial infarctions, atrial fibrillation, and a previous coronary artery bypass. Transesophageal echocardiography showed a severely hypokinetic left ventricle and a large left atrial thrombus obstructing the pulmonary veins. In addition there was minimal pericardial effusion and mildly depressed right ventricular function. Pulmonary arterial pressure was 75/30 mm Hg. All bypass vein and arterial grafts were patent. After admission his condition worsened, with increased coagulopathy (liver congestion), increased central venous pressure, and reduced urine output. Right heart failure required inotropic support, which resulted in marginal improvement. The patient required intubation for respiratory decompensation, and it was decided that he required an LVAD. He underwent implantation of an intracorporeal left ventricular assist device. [PLEASE ONLY CONSIDER THE PHYSICIAN WORK RELATED TO INSERTION OF THE INTRACORPOREAL VAD]

CLINICAL DESCRIPTION OF SERVICE:

Pre- service work:

- Confirm OR start time – notify patient/family, Answer patient/family questions
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient/family, Obtain informed consent
- Write pre-operative orders for peri-operative medications
- Perform an interval history and physical examination
- Review pre-operative work-up: Chest x-ray, Laboratory results (CBC, electrolytes, renal function), CT scans and other staging studies (EG, PET scan, bone and brain scans, etc.), Pathology biopsy reports, Cardiology assessment, Pulmonary function tests and arterial blood gas values
- Review planned incisions and procedure
- Accompany patient to operating room
- Change into scrub clothes
- Check with lab – check on availability of blood and/or cross match
- Coordinate care with the OR team, including anesthesia, nursing, physician assistants, and pump technicians.
- Supervise Swan Ganz catheter insertion, inotropic support management, intubation, Foley catheter insertion. Insert CVH lines.
- Because patient's heart is very weak and can be very unstable, the surgeon must prepare for the need to go on cardiopulmonary bypass urgently if needed - Supervise setup of bypass equipment
- Review length and type of anesthesia with anesthesiologist, however, because of patient instability the surgeon must be in the operating room for induction of anesthesia and be ready to manage problems that might ensue from induction.
- Review planned procedure and positioning and draping of patient
- Verify that perioperative drugs (antibiotics, heparin) have been administered
- Verify placement of support stockings or sequential compression devices on lower extremities for prophylaxis against deep vein thrombosis/pulmonary embolus
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

Intra- service work -- skin to skin

Under general endotracheal anesthesia, in the supine position, the patient was prepped and draped in standard aseptic fashion. The previous midline incision was re-entered. The device pocket was created with electrocautery. The inferior phrenic vessels on the diaphragm were identified and ligated. The driveline egress site was created in the right upper abdomen. The LVAD was brought onto the field and placed into the pocket. The driveline was tunneled out from the right upper quadrant incision. Preparation for cardiopulmonary bypass

(CPB) included ACT guided heparinization, cannulation of the aorta (3-0 Prolene purse string, Sarns 8.0 mm), and cannulation of the SVC (3-0 Prolene purse string, 28 DLP) and IVC (3-0 Prolene purse string, 28 DLP). A Bentley cardioplegia needle was secured in the ascending aorta with a 4-0 Prolene. An apical LV vent was placed and the patient was cooled to 32 degrees C. The patient's pressure was temporarily reduced to 50 mHg. The aortic cross clamp was applied, and 4:1 blood cardioplegia, 1000 ml, was given antegrade. The left atriotomy was re-opened and the left atrium inspected with findings described above. A large thrombus was removed, and no residual thrombus confirmed remained. The atriotomy was closed with running 3-0 Prolene. The patient was de-aired in standard fashion, and the atriotomy was tied shut. The aortic pressure was temporarily reduced to 50 mHg. The aortic cross clamp was removed, and the patient was ventilated and de-aired once again. The apex was cored and the LV and tract was cleared of thrombus. The inflow cuff was attached to the apex of the LV using pledgeted 2-0 Tevdek sutures in a mattress fashion. The cuff was attached to the LVAD and secured with #2 Tevdek tie as well as two umbilical tapes. A partial occluding clamp was placed on the greater curvature of the ascending aorta. The outflow graft length was measured and the graft was sewn to an elliptico-longitudinal aortotomy using semi-continuous running 3-0 Prolene buttressed with a Teflon felt strip washer. The pressure decreased to 50 mmHg, aortic root suction applied and the clamp released. The device was allowed to fill with blood and the outflow graft was subsequently attached. A de-airing hole was made in the outflow graft, and the device was slowly de-aired. The patient was weaned from cardiopulmonary bypass with Levophed, milrinone, dobutamine, and pitressin. LVAD flows were 5.5 to 7 L/min. After protamine administration and decannulation, hemostasis was satisfactory. Two right ventricular and two right atrial pacing wires were placed, a #36 anterior mediastinal, #32 left pleural chest tubes were placed. Two large JP drains were placed in the abdominal pocket. The sternum was closed with 7 wires, the abdominal fascia with #2 Prolene, and the skin and subcutaneous tissue closed in layers of 0, 2-0, and 4-0 Vicryl.

Postop same-day work through discharge from recovery

- Apply dressing
- Write an OP note in the patient's record
- Manage postoperative medications such as inotropes, heparin
- Manage fluid. Monitor ventilatory support and other non-cardiac subsystems such as renal output.
- Monitor for postoperative bleeding and coagulopathic event such as thromboembolism.
- Use of blood products is managed judiciously.
- Supervise operation of the LVAD pump and drivelines
- Monitor for tamponade and other signs of heart failure.
- Anticipate necessity to reopen emergently because of complications
- Sign OR forms, including pre- and postoperative diagnosis, operations performed
- Write orders for postop labs, films, medications, diet and patient activity
- Review recovery room care and medications with staff
- Discuss procedure outcome with family. Discuss procedure outcome with referring physician
- Dictate postop report. Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company

SURVEY DATA

Presenter(s): Sidney Levitsky, MD Eric Rose, MD

Specialty(s): Society of Thoracic Surgeons

CPT: 33979

Sample Size: 45 **Resp n:** 21 **Resp %:** 47%

Sample Type: random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	30.00	45.00	52.50	60.00	80.00
Pre-Service Time			120		
Intra-Service Time	270	360	410	420	500
Post-Service Time			150		

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'02RVW	Glob
47134	Donor hepatectomy, with preparation and maintenance of allograft; partial, from living donor	39.16	XXX

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

TIME ESTIMATES (MEDIAN)	Svy CPT 33979	Ref CPT 47134
Pre-service	120	120
Intra-service	410	270
Post-service	150	200
TOTAL TIME	680	590

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	4.60	3.83
Intra-service	4.60	4.00
Post-service	4.80	3.67

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.67	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.50	3.50
Urgency of medical decision making	4.67	3.33

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.50	4.17
Physical effort required	4.67	3.50

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	5.00	3.67
Outcome depends on the skill and judgment of physician	4.83	3.83
Estimated risk of malpractice suit with poor outcome	4.33	4.17

ADDITIONAL RATIONALE

The typical patient undergoing 47134 (live donor hepatectomy) is a healthy individual with no major organ system disease. This person is donating a portion of his/her liver to another person, and to undergo this procedure, he/she must have a rigorous medical screening certifying fitness for surgery.

The typical patient undergoing 33979 (insertion intracorporeal VAD) is in end-stage heart failure, suffering from debilitating cardiac disease and usually concomitant other major organ system failure as well. Insertion of an intracorporeal ventricular assist device is a life-saving measure. Along with the technicalities of implanting the device, the surgeon must manage the patient's associated life-threatening problems, such as renal failure, liver failure, respiratory failure, coagulopathies, hemorrhage, and/or infection.

From an intraoperative technical standpoint, the two procedures are comparable with regard to the necessity to mobilize the target organs and perform surgical incisions of major blood vessels. In the case of the liver donor, a laparotomy is performed and transection and oversewing of the vessels and other major structures of the hepatic system occurs. The challenge of maintaining hemostasis during the blood vessel interventions is paramount in both patients.

In addition, insertion of the VAD involves a median sternotomy; institution of cardiopulmonary bypass; creation of a device pocket in the abdominal preperitoneal plane; creation of a driveline egress site in the right upper abdominal quadrant; creation of an apical hole in the pericardium; and exposure and venting of the left ventricular apex to allow attachment of the inflow cuff of the device. The outflow graft is sewn to an aortotomy. The device is tested and hemostasis is achieved in both the abdominal and surgical fields before the patient is weaned from cardiopulmonary bypass.

With respect to postoperative work, we note that preparation and maintenance of the allograft would be included in the postop work/time of 47134, whereas the postop for 33979 involves stabilizing the critically ill patient before discharge to ICU. The intensity/complexity measure for postoperative time reflects this significant difference.

Although codes with XXX global do not lend themselves well to BBM analysis, a back of the envelope calculation using this methodology indicates that the survey median RVW matches well with the reference code (see table below).

Based on the discussion above that compares new code 33979 with 47134, we know that the total work for 33979 is greater than 47134. **We are recommending the survey median of 52.50 rvu's.**

<u>BBM Analysis</u>			<u>Med SvyRVW</u>	<u>47134 RVW</u>		
			52.50			39.16
Pre-service	Time	Intensity	(=time x intensity)	Time	Intensity	(=time x intensity)
Pre time	120	0.0224	2.69	120	0.0224	2.69
Pre-service total			2.69			2.69
Post-service	Time	Intensity		Time	Intensity	
Immediate post time	150	0.0224	3.36	200	0.0224	4.48
Post-service total			3.36			4.48
Intra-service	Time	IWPUT		Time	IWPUT	
	410	0.113	46.45	270	0.118	31.99

FREQUENCY INFORMATION

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

Procedure approved by FDA September 28, 1998

33999 Unlisted procedure, cardiac surgery (1999 Medicare frequency = 1,826)

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

Specialty: cardiothoracic surgery Commonly Sometimes Rarely

3. 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: cardiothoracic surgery Frequency: estimate 900/year

4. 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: cardiothoracic surgery Frequency: estimate 200/year

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to a few medical centers.

CPT Code: 33980 (KK7)

Global: 090

Recommended RVW: 56.25

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

Survey Vignette (Typical Patient)

A 35-year-old man with a history of cardiogenic shock secondary to acute viral myocarditis had undergone placement of an implantable, intracorporeal left ventricular assist device. He continued to be consistently febrile despite antibiotic treatment with vancomycin/ceftriaxone/erythromycin. He was also noted to have vocal cord paralysis. The patient was evaluated for possible cardiac recovery and VAD removal. The LVAD was set at fixed rate and the patient underwent a right heart catheterization, which revealed improved hemodynamics, but still elevated PAs. The patient underwent cardiopulmonary exercise with a peak VO₂ of 16 and ejection fraction within normal range. Because of interval improvements, the decision was made to attempt device removal. In preparation for the explant, maximal medical therapy was reinstated (inotropes, pressors, and afterload-reducing agents).

[NOTE: only consider the surgeon's work the day prior to the operation through the 90-day global period. The work performed prior to this time (eg, evaluation for cardiac recovery) would be separately reportable.]

CLINICAL DESCRIPTION OF SERVICE:

Pre- service work:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up: History and physical examination, Chest x-ray, Laboratory results (CBC, electrolytes, renal function), CT scans and other staging studies (EG, PET scan, bone and brain scans, etc), Pathology biopsy reports, Cardiology assessment, Pulmonary function tests and arterial blood gas values
- Review planned incisions and procedure
- Confirm OR start time – notify patient and family
- Accompany patient to operating room
- Change into scrub clothes
- Check with lab – check on availability of blood and/or cross match
- 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, Obtain informed consent
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that perioperative drugs (insulin, antibiotics, inotropes, heparin) have been administered
- Verify placement of support stockings or sequential compression devices on lower extremities for prophylaxis against deep vein thrombosis/pulmonary embolus
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Supervise setup of cardiopulmonary bypass equipment
- Supervise or perform catheter insertions, e.g. Foley, Swan-Ganz, CVH
- Scrub and gown

Intra- service work -- skin to skin

Under general endotracheal anesthesia in the supine position, a median sternotomy was completed carefully and the LVAD pocket opened. The pericardial space contained moderate adhesions. The heart was evaluated by TEE, with an ejection fraction estimated as 65% without inotropes. No left ventricular thrombus or purulent material was found in the LVAD pocket. Some serous material in the pocket was cultured. The heart was carefully dissected and a pericardial well was created with 2-0 silk. Preparation for cardiopulmonary bypass (CPB) included ACT-guided heparinization. The LVAD outflow graft was cannulated (3-0 Prolene purse string sutures, Sarns 6.5mm). Cannulation of the right atrium (3-0 Prolene purse string sutures, 36/51) was completed. Intraoperatively the patient had decreased blood pressure after aprotinin administration requiring epinephrine, levophed, and pitressin. In addition, he had increased bleeding requiring multiple transfusions of blood products. Cardiopulmonary bypass was initiated and the dissection of the heart completed. The patient remained at 36 degrees Celsius. The inflow to the LVAD was freed and separated from the LVAD. The driveline was dissected free and the device was removed from the field. The inflow cuff was removed. The cored hole at the apex was

closed with double 2-0 Prolene purse string sutures and 3-0 Prolene mattress type sutures buttressed with Dacron graft materials. When the purse string suture was tied down, de-airing maneuver was completed. The patient was weaned from CPB with levophed and pitressin. After protamine and decannulation, the outflow graft was stapled close to the aorta and the stump oversewn using 4-0 Prolene running suture. Hemostasis was unsatisfactory even with a large amount of protamine administration, requiring blood product transfusion. Satisfactory hemostasis was obtained after a lengthy and meticulous hemostatic procedure. Two right ventricular and two right atrial pacing wires were placed. #36 (anterior mediastinal) and #32 (left pleural) chest tubes were placed. A large JP drain was placed in the abdominal pocket. Sternum was closed with wire (6), and the skin closed in layers with 0, 3-0 and 4-0 Dexon.

Postop same-day work through discharge from recovery

- Apply dressing
- Write an OP note in the patient's record
- Manage postoperative medications such as inotropes, heparin
- Manage fluid
- Monitor ventilatory support and other non-cardiac subsystems such as renal output.
- Monitor for postoperative bleeding and coagulopathic event such as thromboembolism.
- Use of blood products is managed judiciously.
- Supervise operation of the pump and drivelines
- Monitor for tamponade and other signs of heart failure.
- Sign OR forms, including pre- and postoperative diagnosis, operations performed
- Write orders for postop labs, films, medications, diet and patient activity
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Dictate postop report
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company

Post-op same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Manage volume resuscitation, fluid, and medications
- Review lab and blood gas interpretations
- Monitor ventilatory support and other non-cardiac subsystems such as renal output.
- Monitor for postoperative bleeding and coagulopathic event such as thromboembolism.
- Review nursing/other staff patient chart notes
- Answer nursing/other staff questions
- Write orders for following day's labs, films, medications, diet, and patient activity
- Chart patient progress notes

Post-op other hospital work – beginning on post-op day 1 until discharge day:

- Examine patient, check wounds and patient progress
- Manage volume resuscitation, fluid, and medications
- Review lab and blood gas interpretations
- Monitor ventilatory support and other non-cardiac subsystems such as renal output.
- Monitor for postoperative bleeding and coagulopathic event such as thromboembolism.
- Encourage ambulation and pulmonary physiotherapy
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions, answer insurance staff questions (verbal and written)
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes

Discharge day work:

- Examine and talk with patient, check wounds and patient progress
- Check final pathology/lab/film reports and discuss with patient
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, handling of wound or any drains, return appointment to office, etc.
- Coordinate care with other physicians
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- Answer patient/family, nursing/other staff, insurance staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op office work – After discharge from hospital:

- Examine and talk with patient, check wounds and patient progress
- Remove sutures/drains
- Answer patient/family, insurance staff questions
- Coordinate care with other physicians
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Dictate patient progress notes for medical chart
- Discuss patient progress with referring physician (verbal and written)

SURVEY DATA

Presenter(s): Sidney Levitsky, MD Eric Rose, MD

Specialty(s): Society of Thoracic Surgeons

CPT: 33980

Sample Size: 45 **Resp n:** 26 **Resp %:** 58%

Sample Type: random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	40.00	46.75	50.00	56.25	60.00
Pre-Service Time			178		
Intra-Service Time	240	300	360	360	420

Post-Service Time Total Min CPT code / # of visits

Day of Surgery:

Immediate Same Day	108	
Other Same Day	90	99291x1 99292x1

After Day of Surgery:

Critical Care	330	4days @120/90/60/60 99291x4 99292x3	LOS = 18
Other Hospital	390	99233*x2 99232*x1 99232x8 99231x2	
Dischg Day Mgmt	45	99239	
Office Visits	160	99214x3 99213x2	

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'02RVW	Glob
33863	Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with aortic root replacement using composite prosthesis and coronary reconstruction	36.47 45.00	090

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Svy CPT 33980 Ref CPT 33863
TIME ESTIMATES (MEDIAN)

	Svy CPT 33980	Ref CPT 33863
Pre-service	178	60
Intra-service	360	360
Same Day Immediate Post-service	108	70
Same Day Other Post-service	90 (ICU)	63 (ICU)
Post Total critical care (not same day)	330 (ICU)	0
Post Total other hospital visit (not same day)	390	125
Discharge management	45	36
Total office visit	160	61
TOTAL TIME	1,661	775

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

	Svy CPT 33980	Ref CPT 33863
Pre-service	4.87	4.00
Intra-service	4.87	4.67
Post-service	4.80	3.73

MENTAL EFFORT AND JUDGMENT

	Svy CPT 33980	Ref CPT 33863
The number of possible diagnosis and/or the number of management options that must be considered	4.73	4.27
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.87	4.27
Urgency of medical decision making	4.47	4.00

TECHNICAL SKILL/PHYSICAL EFFORT

	Svy CPT 33980	Ref CPT 33863
Technical skill required	4.47	4.80
Physical effort required	4.87	4.40

PSYCHOLOGICAL STRESS

	Svy CPT 33980	Ref CPT 33863
The risk of significant complications, morbidity and/or mortality	4.87	4.40
Outcome depends on the skill and judgment of physician	4.93	4.80
Estimated risk of malpractice suit with poor outcome	4.20	4.53

ADDITIONAL RATIONALE

The typical patient undergoing 33863 (ascending aortic graft, coronary reconstruction and composite prosthesis replacement) has a life-threatening disease (aortic atherosclerosis with aneurysm and/or dissection) and may or may not have reached the stage of life-threatening criticality. He/she is frequently elderly with concomitant degenerative diseases, including diabetes, coronary artery disease, peripheral vascular disease, renal disease and/or arthritis. In comparison, the typical patient undergoing 33980 (explant intracorporeal VAD) is typically younger, but has undergone a challenging period of cardiac stabilization and recovery from end-stage heart failure over a period of weeks or months. He/she is healthier than before the implant but still capable of becoming very unstable after the assist device is removed, requiring several days of ICU care. Immediate postoperative stabilization is very intense and challenging and tests the surgeon's management skills. Both patients are difficult to manage following surgery and a significant amount of critical care, intensive care, and postoperative management is required.

The technical similarities between the two procedures include: a median sternotomy (in the case of the VAD patient, always a repeat sternotomy); institution of cardiopulmonary bypass; aortic cross-clamping; mobilization; exposure and surgical entry into major vessels and the heart; weaning from cardiopulmonary bypass; establishment of hemostasis; and closure of the sternotomy and abdominal incisions.

In the case of the aortic graft, the surgeon must transect the aorta, graft the aneurysm, replace the native aortic valve with a prosthetic valve, and isolate and then reimplant the coronary ostia.

Explantation of the VAD involves re-dissection of the heart with removal of the outflow graft, removal of the inflow cuff from the heart and the aorta, and subsequent repair of all sites. Following that, the pericardial site of the driveline connection is sutured closed as is the interior site.

Additionally, the following question was included on the survey. Percentage response distribution is shown.

As necessary, for the typical patient described on this survey, do you – as the surgeon – perform daily critical care such as:

Yes 100%	No 0%	Volume resuscitation and fluid management
Yes 100%	No 0%	Cardiac and/or ventilator management
Yes 74%	No 26%	Continuous or frequent vital sign monitoring
Yes 100%	No 0%	Ordering and reviewing postoperative X-rays and laboratory studies
Yes 100%	No 0%	Lab and blood gas interpretations
Yes 100%	No 0%	Medication management (eg, antibiotics, pain management)

Based on the discussion above that compares new code 33980 with 33863, we know that the total work for 33980 is greater than 33863. In estimating - by magnitude - the RVW for the survey, we believe the survey respondents discounted the value of the postoperative work, which they clearly indicated included ICU care, in both the question about postoperative visits and the question about daily critical care activities. The BBM analysis on the next page supports this assumption, where a negative input is calculated for 360 minutes of intraoperative time using the median survey RVW. It is clear that if this RVW were assigned, the surgeon would be *paying* to do the operation. **We are recommending the survey 75th percentile RVW of 56.25** which would bring the input into a positive range, although still not reflective of the level of intensity for this procedure, nor compensatory for 360 minutes of intraoperative work.

FREQUENCY INFORMATION

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

Procedure approved by FDA September 28, 1998
33999 Unlisted procedure, cardiac surgery (1999 Medicare frequency = 1,826)

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

Specialty: cardiothoracic surgery Commonly Sometimes Rarely

3. 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: cardiothoracic surgery Frequency: less than 900

4. 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: cardiothoracic surgery Frequency: less than 200

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to a few medical centers.

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
Facility-ONLY Direct Inputs**

CPT Long Descriptor:

CPT	DESCRIPTION	GLOBAL
33980	Removal of ventricular assist device; implantable intracorporeal, single ventricle	90
33979	Insertion of ventricular assist device; implantable intracorporeal, single ventricle	XXX

CLINICAL STAFF TIME:

In each service period, the clinical staff has been indicated as "RN." This is consistent with PEAC and RUC approval for cardiothoracic clinical staff designation.

Pre-service period clinical staff time: To be supplied after GAO/OIG report is issued regarding various aspects of the practice expense methodology and its implementation by CMS.

Service period clinical staff time: Only time related to discharge data management is provided. Additional time, if allowed, will be supplied after GAO/OIG report is issued regarding various aspects of the practice expense methodology and its implementation by CMS.

Post-service period clinical staff time: For the 90-day global code, standard EM postop visit times for clinical staff have been applied.

SUPPLIES AND EQUIPMENT – POSTOPERATIVE OFFICE VISITS:

Standard PEAC office visit supplies and postoperative incision care kits and equipment have been applied to the 90-day global code..

AMA/Specialty Society RVS Update Committee Recommendation

	A	B	C	D	E
1	Tab 6 33979 33980 PE Details (April 2002)	CPT:		33980	33979
2		DESCRIPTOR:		Removal of ventricular assist device, implantable intracorporeal, single ventricle	Insertion of ventricular assist device, implantable intracorporeal, single ventricle
3		GLOBAL:		90	XXX
4		CMS Code	CMS Desc	Facility	Facility
5	PRE-service time	33	RN	pending	pending
6	SERVICE time	33	RN	pending	pending
7	Discharge management time	33	RN	15	0
8	POST-service time	33	RN	231	0
9	PRE-SERVICE CLINICAL STAFF TIME				
10	BEGINS after consultation when a decision to perform surgery was made (office / facility)				
11	Complete pre-service diagnostic & referral forms (5/5)	33	RN	pending	pending
12	(10/20)	33	RN	pending	pending
13	OV before surgery Review test and exam results (0/0)	33	RN	pending	pending
14	Schedule space and equipment in facility (0/8)	33	RN	pending	pending
15	Provide pre-service education/obtain consent (10/20)	33	RN	pending	pending
16	Follow-up phone calls & prescriptions (10/7)	33	RN	pending	pending
17	ENDS with admission to site of service				
18	SERVICE PERIOD CLINICAL STAFF TIME				
19	BEGINS with admission to site of service				
20	Service period time recommendation pending.	33	RN	pending	pending
21	Discharge management time	33	RN	15	0
22	End: Patient leaves site of service				
23	POST-SERVICE PERIOD CLINICAL STAFF TIME				
24	Start: Patient leaves site of service				
25	99211 16 minutes			0 0	0 0
26	99212 27 minutes			0 0	0 0
27	99213 36 minutes		2	72 0	0 0
28	99214 53 minutes		3	159 0	0.0
29	99215 63 minutes			0 0	0.0
30	Total Office Visit Time:	33	RN	231.0	0
31	End: at completion of global period				
32	MEDICAL SUPPLIES - POST-OP OFFICE VISITS				
33	Multispecialty Minimum Visit Package	peac	pack	5	0
34	Post-op Incision Care Kit:	peac	pack	1	0
35	Additional OFFICE VISIT Supplies (specify):				
36	EQUIPMENT				
37	exam lamp	E30006		1.0	0
38	exam table	E11001		1.0	0

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

February 2002

Elbow Surgery

Two new elbow surgery codes were established to identify newly developed surgical techniques, codes 24344 *Reconstruction lateral collateral ligament, elbow, with tendon graft (includes harvesting of graft)* and 24346 *Reconstruction medial collateral ligament, elbow, with tendon graft (includes harvesting of graft)*. At the April 2001 RUC meeting, the RUC assigned interim value recommendations due to the lack of survey data. The specialty societies then collected survey data for these codes and presented their results at the February 2002 RUC meeting. The RUC believed the physician work associated with code 24344 and code 24346 were similar to the work associated with code 27428 *ligamentous reconstruction (augmentation), knee; intraarticular (open)* (work RVU = 14.00). the knee and elbow ligament reconstructions have the following elements in common:

- Indicated for major joint instability
- Harvesting of a tendon graft
- Precise positioning and creation of periarticular bone tunnels
- Passage of tendon graft through bone tunnels
- Precise tensioning of the graft
- Close monitoring postoperative therapy
- CPT code 24346 and 27428 both require an arthrotomy. CPT code 24344 is extra-articular, but an arthrotomy is routinely performed to assess the joint.
- Major neurovascular structures are at risk for both the knee and elbow reconstructions. The popliteal structures are at risk with the knee reconstruction, while the radial and ulnar nerves are at risk in the elbow reconstruction.

In addition, previous RUC survey data for 24343 *Repair lateral collateral ligament, elbow, with local tissue* (work RVU= 8.64) and 24345 *Repair medial collateral ligament, elbow, with local tissue* (work RVU = 8.64) indicated the physician work values are appropriate for these primary repairs. These values are the same as code 27405 *Repair, primary, torn ligament and/or capsule, knee; collateral* (work RVU=8.64). However the increase in complexity inherent in the reconstruction of the collateral ligament of the elbow and knee are similar. **The RUC therefore recommends relative work values of 14.00 for CPT codes 24344 and 24346.**

Practice Expense

The RUC is recommending using the RUC approved practice expense standard packages for CPT codes 24344 and 24346. Only inputs for the facility setting is provided since these procedures are not performed in the office. Specifically, for all codes with 90 day

global periods, the RUC is recommending 60 minutes of pre-service time, and E/M clinical staff time for the number and level of post operative office visits included in the summary of recommendation form. Additionally, the staff blend of RN/LPN/MTA is recommended. For medical supplies the RUC is recommending the standard minimum supply packages for each post operative office visit as well as one post operative incision care kit. The specific practice expense inputs are attached to these recommendations.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 24344	JJ6	Reconstruction lateral collateral ligament, elbow, with tendon graft (includes harvesting of graft)	090	14.00
● 24346	JJ8	Reconstruction medial collateral ligament, elbow, with tendon graft (includes harvesting of graft)	090	14.00

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

CPT Code: 24344 (JJ6)

Global: 090

RUC Recommended RVW: 14.00

Descriptor: Reconstruction lateral collateral ligament, elbow, with tendon graft (includes harvesting of graft)

Survey Vignette (Typical Patient)

A 40-year-old male has a post-traumatic lateral instability of the elbow requiring lateral collateral ligament reconstruction with a palmaris longus tendon graft.

CLINICAL DESCRIPTION OF SERVICE:

Preoperative work:

- Imaging studies are carefully reviewed including X-rays, CT scans, and MRIs.
- Pre-operative laboratory tests are reviewed.
- Consultation is completed with the referring physician and other healthcare professionals
- The family and patient are apprised of the proposed surgery.
- The risks and complications associated with the surgery are discussed with the patient and family.
- Informed consent is obtained.
- The surgeon goes to the operating room and verifies that all appropriate equipment is available
- The patient is brought to the operating room and placed on the operating table in the supine position.
- The patient's bony prominences are padded.
- Thermal regulation drapes are applied
- The position of the extremities and head are checked and adjusted.
- The patient's involved arm is prepped and draped.
- A sterile tourniquet is applied to the proximal arm.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- The patient's arm is brought across the chest.

INTRA-SERVICE WORK: The joint capsule is exposed through Kocher's interval reflecting the anconeus posteriorly. The ulnar attachment of the lateral ulnar collateral ligament is palpated. The triceps and anconeus are reflected from the posterior margin of the lateral column. The common extensor tendon is elevated to expose the anterior capsule. The common extensor is carefully reflected from the epicondyle. Care is taken to preserve the capsule and lateral ulnar collateral ligament. A transverse incision is made in the anterior capsule of the radiohumeral joint. A similar incision is made posteriorly behind the lateral collateral complex. An incision is made at the wrist and the palmaris longus tendon is harvested using a tendon stripper. Care is taken to protect the median nerve during this maneuver. The tendon donor site incision is closed using a subcuticular suture. The insertion site of the lateral ulnar collateral ligament on the tubercle of the supinator crest is identified. A 3-4 mm hole is made in the ulna with a burr just posterior to this point. Another hole is made proximally near the anular ligament. A tunnel is created between these two holes with a curved awl. A suture is passed through the holes and tied to itself. The suture loop is then pulled proximally using a snap until the isometric point on the epicondyle is identified. The elbow is taken through a full range of motion to determine the exact position of the isometric point. The cortex is burred superficially at the isometric point. The correct position of the isometric point is once again verified. The burr-hole is then deepened and placed slightly proximal and slightly posterior to the exact isometric point. An exit hole is created with a burr just posterior to the supracondylar ridge. A tunnel is created between the isometric hole and the proximal hole. A second hole is made anterior to the posterior hole. This too is connected to the point of isometry using an awl. The tendon graft is then passed through the tunnel in the ulna. Its two ends of the tendon graft are sutured to themselves. The two ends are then pulled through the anterior tunnel and tension is maintained on the graft. The elbow is held in full pronation and 40 degrees of flexion. The graft is then passed through the posterior hole and through the tunnel to the point of isometry again. The end of the graft is then sewn to itself at the ulna. The capsule is closed such that the tendon will not rub directly on the lateral margin of the capitellum. The three limbs of the collateral ligament reconstruction that pass between the capitellum and ulna are sewn together using PDS suture. The fascia is closed and the skin is closed in layers.

Postoperative work: in hospital

- Application of dressing and splint.
- Monitoring patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative imaging studies are reviewed
- Postoperative laboratory studies are reviewed
- Preparation of discharge records

Postoperative work: in office

- Post-discharge office visits for this procedure for 90 days
- Assessment of circulation, sensation and motor function of the operated extremity
- Removal of splint
- Assessment of surgical wound
- Redress wound
- Order physical / occupational therapy
- Supervision of rehabilitation
- Ordering and reviewing radiographs.
- Antibiotic and pain medication management.
- Removal of sutures
- Evaluation laboratory reports
- Communication with other health care professionals
- Communication with patient and family regarding progress.

SURVEY DATA

Presenter(s): Daniel J. Nagle, MD, FACS

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

CPT: 24344

Sample Size: 70 **Resp n:** 37 **Resp %:** 53%

Sample Type: Random via fax/email

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	9.00	13.50	14.00	14.00	20.00
Pre-Service			60		
Intra-Service	90	120	120	120	180

Post-Service	<u>Total Min</u>	<u>CPT code / # of visits</u>
<i>Day of Surgery:</i>		
Immediate	30	
Other	19	99231
<i>After Day of Surgery:</i>		
Critical Care	0	
Other Hospital	0	
Dischg Day Mgmt	36	99238
Office Visits	114	99213x3 99212x3

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
27428	Ligamentous reconstruction (augmentation), knee; intra-articular (open)	14.00	090

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

	Svy CPT	Ref CPT
TIME ESTIMATES (MEDIAN)	24344	27428 RUC
Pre-service time	60	60
Intra-service time	120	120
Same Day Immediate Post-service time	30	30
Same Day Other Post-service time	19	0
Post Total critical care time (not same day)	0	0
Post Total other hospital visit time (not same day)	0	0
Discharge management time	36	36
Total office visit time	114	115

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	4.23	3.82
Intra-service	4.49	4.06
Post-service	4.09	3.76

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.65
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.89	3.60
Urgency of medical decision making	3.37	3.35

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.54	4.29
Physical effort required	4.11	4.06

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.37	4.00
Outcome depends on the skill and judgment of physician	4.51	4.35
Estimated risk of malpractice suit with poor outcome	3.94	3.71

RATIONALE:

The work associated with the reconstruction of the elbow ulnar (2434X2) or elbow radial (2434X4) collateral ligament is similar to the work associated with the reconstruction of the anterior cruciate ligament of the knee (27428). The knee and elbow ligament reconstructions have the following elements in common:

- Indicated for major joint instability
- Harvesting of a tendon graft
- Precise positioning and creation of periarticular bone tunnels
- Passage of tendon graft through bone tunnels
- Precise tensioning of the graft
- Close monitoring postoperative therapy
- Reconstruction of RCL (24346) and reconstruction of ACL both require an arthrotomy. Reconstruction of MCL (24344) is extra-articular, but an arthrotomy is routinely performed to assess the joint.
- Major neurovascular structures are at risk for both the knee and elbow reconstructions. The popliteal structures are at risk with the knee reconstruction, while the radial and ulnar nerves are at risk in the elbow reconstruction.

Additionally, previous RUC survey data for 24343 and 24345 indicated that a RVW of 8.65 is appropriate for these primary repairs. This value is the same as that assigned to the primary repair of a knee collateral ligament (27405). As demonstrated above, the increase in complexity inherent in the reconstruction of the collateral ligament of the elbow and knee is similar.

We therefore recommend that 24344 and 24346 be given an RVW of 14.00 which is equal to the current RVW for 27428.

FREQUENCY INFORMATION

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

24999 Unlisted procedure, humerus or elbow (Medicare frequency = 167)

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

Specialty: hand/elbow/orthopaedic surgery Commonly ~~_____~~ Sometimes Rarely

3. 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: hand/elbow/orthopaedic surgery Frequency: 200

4. 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: hand/elbow/orthopaedic surgery Frequency: 6 (3% or less of national frequency)

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to a few medical centers.

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

CPT Code: 24346 (JJ8)

Global: 090

RUC Recommended RVW: 14.00

CPT Descriptor: Reconstruction medial collateral ligament, elbow, with tendon graft (includes harvesting of graft)

Survey Vignette (Typical Patient)

A baseball pitcher develops elbow medial collateral ligament laxity requiring reconstruction with a tendon graft.

CLINICAL DESCRIPTION OF SERVICE:

Preoperative work:

- Imaging studies are carefully reviewed including X-rays, CT scans, and MRIs.
- Pre-operative laboratory tests are reviewed.
- Consultation is completed with the referring physician and other healthcare professionals
- The family and patient are apprised of the proposed surgery.
- The risks and complications associated with the surgery are discussed with the patient and family.
- Informed consent is obtained.
- The surgeon goes to the operating room and verifies that all appropriate equipment is available
- The patient is brought to the operating room and placed on the operating table in the supine position.
- The patient's bony prominences are padded.
- Thermal regulation drapes are applied
- The position of the extremities and head are checked and adjusted.
- The patient's involved arm is prepped and draped.
- A sterile tourniquet is applied to the proximal arm.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- The patient's arm is brought across the chest.

INTRA-SERVICE WORK: A 10 cm incision is centered over the medial epicondyle. Care is taken to protect the medial antebrachial cutaneous nerve. The ulnar nerve is identified and protected. A longitudinal split is made in the fascia and the underlying flexor pronator aponeurosis. The muscle mass is retracted out of the field and the anterior portion of the ulnar collateral ligament is exposed. Convergent drill holes are made in the ulna at the level of the tubercle at the medial aspect of the coronoid process. The holes are separated by approximately 1cm. The humeral attachment of the reconstructed collateral ligament is then repaired. The isometric point of attachment of the ulnar collateral ligament on the humerus is identified and marked. A point is made 10 mm proximal to this on the medial column. Another hole is made 10 mm proximal to the second hole. These holes are deepened and then a gouge is used to create a tunnel from each hole oriented towards each of the two proximal holes, oriented towards the isometric point. The palmaris longus is then harvested through a transverse incision at the wrist using a tendon stripper. Care is taken to not injure the median nerve. The wound at this level is closed using a subcuticular stitch. The tendon graft is then passed through the bone tunnels in a figure "8" fashion. A suture is placed through one of the free ends of the tendon graft to facilitate this process. With the elbow held at 45 degrees of flexion and neutral varus-valgus position, the graft is pulled taught and sutured to itself. The graft is also sutured to the fascia near the intermuscular septum and the remnants of the ulnar collateral ligament. The elbow is taken through a full range of motion and gently stressed. The flexor pronator muscle group is reattached to the medial epicondyle. The wound is closed in layers.

Postoperative work: in hospital

- Application of dressing and splint.
- Monitoring patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative imaging studies are reviewed
- Postoperative laboratory studies are reviewed

- Preparation of discharge records

Postoperative work: in office

- Post-discharge office visits for this procedure for 90 days
- Assessment of circulation, sensation and motor function of the operated extremity
- Removal of splint
- Assessment of surgical wound
- Redress wound
- Order physical / occupational therapy
- Supervision of rehabilitation
- Ordering and reviewing radiographs.
- Antibiotic and pain medication management.
- Removal of sutures
- Evaluation laboratory reports
- Communication with other health care professionals
- Communication with patient and family regarding progress.

SURVEY DATA

Presenter(s): Daniel J. Nagle, MD, FACS

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

CPT: 24346

Sample Size: 70 **Resp n:** 41 **Resp %:** 59%

Sample Type: Random via fax/email

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	9.00	13.30	14.00	15.00	20.00
Pre-Service			60		
Intra-Service	90	120	120	130	200
Post-Service	<u>Total Min</u>	<u>CPT code / # of visits</u>			
<i>Day of Surgery:</i>					
Immediate	30				
Other	19	99231			
<i>After Day of Surgery:</i>					
Critical Care	0				
Other Hospital	0				
Dischg Day Mgmt	36	99238			
Office Visits	114	99213x3	99212x3		

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
27428	Ligamentous reconstruction (augmentation), knee; intra-articular (open)	14.00	090

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

	Svy CPT	Ref CPT
TIME ESTIMATES (MEDIAN)	24346	27428 RUC
Pre-service time	60	60
Intra-service time	120	120
Same Day Immediate Post-service time	30	30
Same Day Other Post-service time	19	0
Post Total critical care time (not same day)	0	0
Post Total other hospital visit time (not same day)	0	0
Discharge management time	36	36
Total office visit time	114	115

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	4.15	4.10
Intra-service	4.44	4.10
Post-service	4.00	4.00

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.95	3.82
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.97	3.73
Urgency of medical decision making	3.54	3.91

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.59	4.09
Physical effort required	4.18	3.82

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.26	3.82
Outcome depends on the skill and judgment of physician	4.62	4.27
Estimated risk of malpractice suit with poor outcome	4.06	3.82

RATIONALE:

The work associated with the reconstruction of the elbow ulnar (2434X2) or elbow radial (2434X4) collateral ligament is similar to the work associated with the reconstruction of the anterior cruciate ligament of the knee (27428). The knee and elbow ligament reconstructions have the following elements in common:

- Indicated for major joint instability
- Harvesting of a tendon graft
- Precise positioning and creation of periarticular bone tunnels
- Passage of tendon graft through bone tunnels
- Precise tensioning of the graft
- Close monitoring postoperative therapy
- Reconstruction of RCL (24346) and reconstruction of ACL both require an arthrotomy. Reconstruction of MCL (24344) is extra-articular, but an arthrotomy is routinely performed to assess the joint.
- Major neurovascular structures are at risk for both the knee and elbow reconstructions. The popliteal structures are at risk with the knee reconstruction, while the radial and ulnar nerves are at risk in the elbow reconstruction.

Additionally, previous RUC survey data for 24343 and 24345 indicated that a RVW of 8.65 is appropriate for these primary repairs. This value is the same as that assigned to the primary repair of a knee collateral ligament (27405). As demonstrated above, the increase in complexity inherent in the reconstruction of the collateral ligament of the elbow and knee is similar.

We therefore recommend that 2434X2 and 2434X4 be given an RVW of 14.00 which is equal to the current RVW for 27428.

FREQUENCY INFORMATION

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

24999 Unlisted procedure, humerus or elbow (Medicare frequency = 167)

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

Specialty: hand/elbow/orthopaedic surgery Commonly ~~_____~~ Sometimes Rarely

3. 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: hand/elbow/orthopaedic surgery Frequency: 300

4. 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: hand/elbow/orthopaedic surgery Frequency: 9 (3% or less of national frequency)

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to a few medical centers.

AMA/Specialty Society RVS Update Committee Recommendation

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
1	Clinical Labor, Medical Supplies, and Procedure Equipment Practice Expense Data							CPT			24344	24344	24346	24346
2							Global			090	090	090	090	
3							Number/Level of Post OV:			N/A	99213x3 99212x3	N/A	99213x3 99212x3	
4	CLINICAL LABOR						Code	staff desc	Price	IN Off	OUT off	IN Off	OUT off	
5	TOTAL TYPICAL TIME						1130	RN/LPN/MA	\$ 0.317	0	249	0	249	
6	PRE-service time						1130	RN/LPN/MA	\$ 0.317	0	60	0	60	
7	SERVICE time						1130	RN/LPN/MA	\$ 0.317	0	0	0	0	
8	POST-service time						1130	RN/LPN/MA	\$ 0.317	0	189	0	189	
9	PRE-SERVICE													
10	BEGINS after procedure consult. (in/out)									Min	Min	Min	Min	
11	Complete pre-service diagnostic & referral forms (5/5)						1130	RN/LPN/MA	\$ 0.317	0	5	0	5	
12	Coord pre-proc services/review test/exam results (10/20)						1130	RN/LPN/MA	\$ 0.317	0	20	0	20	
13	Schedule space and equipment in facility (0/8)						1130	RN/LPN/MA	\$ 0.317	0	8	0	8	
14	OV before surgery/procedure - review test/exam results (0/0)						1130	RN/LPN/MA	\$ 0.317	0	0	0	0	
15	Provide pre-service education/obtain consent (10/20)						1130	RN/LPN/MA	\$ 0.317	0	20	0	20	
16	Follow-up phone calls & prescriptions (10/7)						1130	RN/LPN/MA	\$ 0.317	0	7	0	7	
17	Other Pre-Service Activities (please specify):													
18							1130	RN/LPN/MA	\$ 0.317	0	0	0	0	
19	ENDS with admission to facility/office													
20	SERVICE PERIOD													
21	Starts with admission to facility/office									Min	Min	Min	Min	
22							1130	RN/LPN/MA	\$ 0.317	0	0	0	0	
23							1130	RN/LPN/MA	\$ 0.317	0	0	0	0	
24	Ends with discharge from facility/office													
25	POST-SERVICE													
26	Begins after discharge from facility/office									Min	Min	Min	Min	
27	Postop OV total time (E/M standards)		-211 (16)	-212 (27)	-213 (36)	-214 (53)	-215 (63)	1130	RN/LPN/MA	\$ 0.317	0	189	0	189
39	Other Activities (please specify):													
40							1130	RN/LPN/MA	\$ 0.317	0	0	0	0	
41	ENDS after 90 days from day of procedure.													
42	MEDICAL SUPPLIES						Code	Unit Size	Unit Cnt	Price	Out Off QTY	Out Off QTY	Out Off QTY	Out Off QTY
43	PEAC Minimum visit package (multi-specialty):						PEAC	PKG	1	\$ 1,310	0	6	0	6
45	exam table paper (7 ft)						11111	foot	1	\$ 0.015				
46	gloves, non-sterile (2 pair)						11302	pair	1	\$ 0.120				
47	patient gown, disposable						11107	item	1	\$ 0.570				
48	pillow case, disposable						11112	item	1	\$ 0.320				
49	thermometer probe cover, disposable						11509	item	1	\$ 0.069				
50	Add'l per visit supplies:													
51														
52														
53														
54	PEAC Postop incision care kit:						PEAC	PKG	1	\$ 15.034	0	1	0	1
55	betadine						52310	ml	20	\$ 0.140				
56	gauze, sterile 4x4 (10 pack)						31505	pack	2	\$ 2.940				
57	gloves, sterile						14005	pair	1	\$ 0.890				
58	staple remover kit						31702	item	1	\$ 6.830				
59	sten-strip						31513	strip	12	\$ 3.580				
60	swab Alcohol						11302	item	2	\$ 0.034				
61	tape						31514	inch	12	\$ 0.300				
62	tincture benzoin swab						52308	item	1	\$ 0.320				
63	Add'l misc. supplies:													
64														
65														
66														
67										0	0	0	0	
68	PROCEDURE SPECIFIC EQUIPMENT													
69	Exam table						E11001	1		\$ 1,360	0	1	0	1

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2002

Ablation of Hepatic Tumors

Three new surgery codes, two new laproscopic codes, and three new radiologic guidance codes were created for the ablation of hepatic tumors. The RUC recommends that the work for code 47382 *Ablation, one or more liver tumor(s), percutaneous, radiofrequency* should be evaluated as follows:

Pre-Service	30 minutes x 0.0224	0.66
Intra-Service	180 minutes x 0.071	12.78
Same day post	30 minutes x 0.0224	0.66
½ discharge day management		0.64
Office visit (99212)		<u>0.45</u>
Total Work RVU		15.19

The committee agreed that this service was as least as intense as cryosurgical ablation of the prostate (IWPUT=0.71) and that the total work of code 55873 (February 2001 RUC recommendation = 19.19) is comparable to (or less than) the total work of the ablation of the liver tumor 47382, when the radiologic guidance code (76362, 76394, or 76490) is added to this code. **The RUC recommends a relative work value of 15.19 for CPT code 47382.**

Using a building block method for all other codes, values were determined using the 15.19 work RVU for 47382. The code 47370 *Laprosopy, surgical, ablation of one or more liver tumor(s); radiofrequency*, has a 090 day global period, and therefore requires 3 full hospital visits (99232, 99231, and 99238), and two additional office visits (2x 99213) when compared to 47382. Code 47371, *Laprosopy, surgical ablation of one or more liver tumor(s); cryosurgical* also has three full hospital visits, and two additional office visits (2x 99213). The median intra-operative time for both procedures is 180 minutes, and the resulting IWPUT for both procedures

is 0.071. Therefore, the RUC determined that the work RVU for 47370 and 47371 should be the same. **The RUC recommends a relative work value of 19.69 for both CPT codes 47370 and 47371.**

In addition to the two laproscopy codes, the RUC discussed and reviewed open ablation codes, 47380 *Ablation, open, of one or more liver tumor(s); radiofrequency* and 47381 *Ablation, open, of one or more liver tumor(s); cryosurgical*. Surgical procedures 47380 and 47381 are also 90 global procedures. Based on the survey results, the RUC believed that the intra service work intensity for these open ablation codes was slightly less than the above mentioned laproscopy ablation codes (IWPUT = 0.061). However, the RUC agreed that these procedures required 5 full hospital visits (2 x 99232, 2 X 99231, and 1 x 99238), and 2 additional office visits (2x 99213 and 1x 99212) when compared to 47382. To maintain relativity among the group of codes and with similar procedures, **the RUC recommends a relative work value of 23.00 for CPT code 47380 and 23.27 for CPT code 47381.**

The RUC reviewed radiologic guidance codes 76362, 76394, and 76490, and determined that the relative values as presented by the specialty societies (SCVIR, ACR, and ACS) are appropriate. The RUC agreed that a second physician may perform the radiologic guidance and that the intensity is less than an E/M intensity of 0.31. The RUC also compared an intensity of 0.026 per minute with the time fore each of these services. **The RUC recommends a relative work value of 4.00 RVUs for CPT code 76362, 4.25 RVUs for CPT code 76394, and 4.00 RVUs for CPT code 76490.**

Practice Expense

The practice expenses for 47370- 47381 were approved with the removal of the patient education booklet. The practice expense for 47382 has been modified to compare to the standard packages developed by the PEAC and approved by the RUC. There are no direct practice expense inputs for 76362-76490, as these services are performed in a facility setting only. For medical supplies for the RUC is recommending the standard minimum supply packages for each post operative office visit as well as one post-operative incision care kit. The specific practice expense inputs are attached to these recommendations.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 47370	F1	Laparoscopy, surgical, ablation of one or more liver tumor(s); radiofrequency (For imaging guidance, use 76490)	090	19.69
● 47371	F2	cryosurgical (For imaging guidance, use 76490)	090	19.69
● 47380	F3	Ablation, open, of one or more liver tumor(s); radiofrequency (For imaging guidance, use 76490)	090	23.00
● 47381	F4	cryosurgical (For imaging guidance, use 76490)	090	23.27
● 47382	F5	Ablation, one or more liver tumor(s), percutaneous, radiofrequency (For imaging guidance and monitoring, see codes 76362, 76394, or 76490)	010	15.19
● 76362	F6	Computerized axial tomography guidance for, and monitoring of, tissue ablation (For percutaneous radiofrequency ablation, use 47382)	XXX	4.00

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 76394	F7	Magnetic resonance guidance for, and monitoring of, tissue ablation (For percutaneous radiofrequency ablation, use 47382)	XXX	4.25
● 76490	F8	Ultrasound guidance for, and monitoring, of tissue ablation <u>(Do not report 76490 in addition to 76986)</u> <u>(For ablation, see codes 47370-47382)</u>	XXX	4.00

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

CPT Code: 47370 (F1)

Global: 090

RUC Recommended RVW: 19.69

CPT Descriptor: Laparoscopy, surgical, ablation of one or more liver tumor(s); radiofrequency
(For imaging guidance, use 76490)

Survey Vignette (Typical Patient)

The patient is a 51-year-old man who underwent a right colon resection for adenocarcinoma one year ago. At that time, he had positive lymph nodes and two palpable liver metastases. Following the right colon resection, he received systemic chemotherapy. After one year of treatment, the tumors increased in size, and two additional separate lesions were visible on spiral CT scan of the abdomen. The two lesions in the right lobe were 3 cm and 2 cm, and the two lesions in the left lobe were 3.5 cm and 2 cm. All four lesions were confirmed on ultrasound examination and were felt to be superficial and accessible by laparoscopy. The patient underwent laparoscopy and radiofrequency ablation of all four liver tumors. NOTE: The ultrasound guidance, supervision, and interpretation are separately reportable. Do not consider this work to complete this survey.

CLINICAL DESCRIPTION OF SERVICE:

Pre-service work – Day before surgery:

- Write pre-operative orders, including fasting after midnight, type and screen for two units of blood, and pre-operative parenteral antibiotic infusion
- Review pre-operative work-up, including: History and physical examination; chest x-ray; prior pathology reports; CT or MRI scans of liver, baseline sonogram of liver, and other films;
- Review planned trocar placement, incisions and procedure

Pre-service work – Day of surgery:

- Change into scrub clothes
- Check with lab on availability of blood and/or cross match
- Review the surgical procedure, length and type of anesthesia, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions
- Obtain informed consent if not already obtained
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient, positioning of monitors and laparoscopic/video equipment
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite, with special attention to availability of radiofrequency ablation unit
- Assure compliance with universal precautions relating to body substance isolation policies as required by JCAHO and OSHA
- Monitor patient positioning and draping, and assist with positioning as needed
- Oversee the placement of support stockings and sequential compression stockings on the patient, to provide prophylaxis for deep venous thrombosis.
- Directions are given to the nursing regarding wide prepping for a laparoscopic and possible open abdominal procedure.
- Scrub and gown

Intra-service work – Skin to skin:

- All laparoscopic and RF ablation equipment is hooked up, connected, and confirmed to be in working order by the surgeon.
- Under general anesthesia, the surgeon performs a diagnostic laparoscopic exam and found no evidence of extrahepatic disease (malignancy).
- The liver is mobilized.
- The largest lesion is biopsied using a Tru-Cut biopsy needle.

- The radiofrequency thermal ablation probe is placed within the first lesion. RF energy heats an area of tissue to 100 degrees centigrade (monitored by thermocouples within the device) and the temperature is maintained at that level for ten minutes. When the ablation cycle is complete, the "cool down temperature" is monitored for an additional 5 minutes to insure the entire lesion had been adequately heated.
- Each subsequent tumor is treated in the same manner, with the largest tumor requiring three overlapping ablations to ensure that the necessary margin of normal liver has been ablated around the tumor. A total of six ablation cycles are performed in the treatment of the four tumors. Each ablation cycle requires 30 minutes.
- The liver is examined for any sign of bleeding.
- The laparoscopic probes are removed.
- The CO₂ gas is allowed to escape from the abdominal cavity.
- The incisions are sutured.

Post-op work, same day work:

- Sterile dressings are applied to the incisions
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Write orders for post-op labs, chest x-ray, medications, diet, and patient activity
- Write brief operative note for patient's chart documenting in the daily progress notes pre-and postoperative diagnoses, operation performed, findings, blood loss, intraoperative IV fluids administered, complications, specimens sent to pathology, and condition of patient at the end of the procedure
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Examine patient, check wounds and patient progress

Post-op other hospital work, postop day 1 through discharge day:

- Examine and talk with patient
- Review labs
- Check wounds and patient progress
- Chart patient progress notes
- As appropriate, write discharge order to telemetry unit or general care ward
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, handling of wound, return appointment to office, etc.
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op office work – After discharge from hospital through 90 day global period:

- Obtain and review CT scan
 - Examine and talk with patient
 - Check wounds and patient progress
 - Discuss findings with patient and family
 - Answer patient/family questions
 - Answer insurance staff questions
 - Discuss patient progress with referring physician (verbal and written)
 - Coordinate care with other physicians
 - Write orders for medications
 - Dictate patient progress notes for medical chart
-

SURVEY DATA**Presenter(s).** Charles D. Mabry, MD, FACS**Specialty(s):** American College of Surgeons**Sample Size:** 70 **Response n:** 24 **Response %:** 34%**Type of Sample:** Random / Panel (surgeons trained to use ablation equipment)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	8.51	18.00	21.25	28.50	35.00
Pre-Service			80		
Intra-Service	120	170	180	221	360
Post-Service	<u>Total Time</u>	<u>CPT code / # of visits</u>			
Immediate	30				
Critical Care	0				
Other Hospital	49	99231x1, 99232 x 1			
Discharge Day Mgmt	36	99238			
Office Visits	61	99213x2 99212x1			

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
47120	Hepatectomy, resection of liver; partial lobectomy	35.50	090
47125	Hepatectomy, resection of liver; total left lobectomy	49.19	090

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

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT	Ref CPT
	47370	47120	47125
Count	24	11	9
Pre-service time	80	75	75
Intra-service time	180	225	225
Same Day Immediate Post-service time	30	30	45
Same Day Other Post-service time (*critical care)	0	0	0
Post Total critical care time (not same day)	0	60	120
Post Total other hospital visit time (not same day)	49	210	210
Discharge management time	36	36	36
Total office visit time	61	91	61

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	4.10	3.60	4.50
Intra-service	4.15	4.00	4.50
Post-service	3.10	4.00	3.75

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.20	4.00	4.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.45	4.20	4.50
Urgency of medical decision making	3.25	3.60	3.50

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.45	4.00	4.63
Physical effort required	3.90	4.20	4.50

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.75	3.80	4.63
Outcome depends on the skill and judgment of physician	4.50	4.20	4.63
Estimated risk of malpractice suit with poor outcome	3.40	3.80	3.75

ADDITIONAL RATIONALE

Radiofrequency ablation cycles typically take 30 minutes (this does not include time for the ultrasound guidance). More time is necessary for larger lesions for repeat ablations cycles. Intraoperatively, in addition to the ablation, the surgeon must place the trocars, perform a diagnostic laparoscopy, and control bleeding at the ablation sites prior to closing. The typical patient described had four lesions. The median intra-operative time of 180 minutes is conservative for this typical patient. The resulting IWPUT of 0.078 (see Appendix A), is also conservative for this procedure and comparable to the reference services.

Additionally, on the survey we asked two questions. 1) Where is this service performed? and 2) Do you perform BOTH the surgical ablation procedure AND the ultrasound guidance (answer choice: always, sometimes, or never)? The response to the first question was 100 percent "inpatient hospital." With respect to the second question, the majority response was "always." One respondent indicated "sometimes." Zero respondents indicated "never."

FREQUENCY INFORMATION

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

This is a new procedure using new technology. Any reporting would have used an "unlisted" code.
47379 Unlisted laparoscopic procedure, liver (new CPT 2001 – no frequency data available)

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

Specialty: general surgery ~~Commonly~~ Sometimes Rarely

3. 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: general surgery Frequency: 600

4. 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: general surgery Frequency: 300

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to a few medical centers.

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

CPT Code: 47371 (F2)

Global: 090

RUC Recommended RVW: 19.69

CPT Descriptor: Laparoscopy, surgical, ablation of one or more liver tumor(s); cryosurgical (For imaging guidance, use 76490)

Survey Vignette (Typical Patient)

The patient is a 44-year-old man who underwent a left colon resection for adenocarcinoma one and one-half years ago. Following the left colon surgery, he received systemic chemotherapy. After six months of treatment, the patient's CEA began to rise. CT imaging of the liver reveals three lesions along the anterior, inferior surface of the right lobe of the liver. All three lesions were confirmed on ultrasound examination and were felt to be superficial and accessible by laparoscopy. The lesions measures 4 cm, 2.0 cm, and 2.5 cm in diameter. The patient undergoes laparoscopy and cryosurgical ablation of all three liver tumors. NOTE: The ultrasound guidance, supervision, and interpretation are separately reportable. Do not consider this work to complete this survey.

CLINICAL DESCRIPTION OF SERVICE:

Pre-service work – Day before surgery:

- Write pre-operative orders, including fasting after midnight, type and screen for two units of blood, and pre-operative parenteral antibiotic infusion
- Review pre-operative work-up, including: History and physical examination; chest x-ray; prior pathology reports; CT or MRI scans of liver, baseline sonogram of liver, and other films;
- Review planned trocar placement, incisions and procedure

Pre-service work – Day of surgery:

- Change into scrub clothes
- Check with lab on availability of blood and/or cross match
- Review the surgical procedure, length and type of anesthesia, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions
- Obtain informed consent if not already obtained
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient, positioning of monitors and laparoscopic/video equipment
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite, with special attention to availability of liquid nitrogen and the cryoablation unit
- Assure compliance with universal precautions relating to body substance isolation policies as required by JCAHO and OSHA
- Monitor patient positioning and draping, and assist with positioning as needed
- Oversee the placement of support stockings and sequential compression stockings on the patient, to provide prophylaxis for deep venous thrombosis.
- Directions are given to the nursing regarding wide prepping for a laparoscopic and possible open abdominal procedure.
- Scrub and gown

Intra-service work – Skin to skin:

- All laparoscopic and RF ablation equipment was hooked up and confirmed to be in working order by the surgeon.
- Under general anesthesia, the surgeon performs a diagnostic laparoscopy and there was no evidence of extrahepatic tumors (malignancy).
- The liver is mobilized.
- The largest lesion is biopsied using a Tru-Cut biopsy needle.
- A 5 mm cryosurgical probe is placed in the larger lesion in the right lobe of the liver.

- A 2.5 cm portion of the 4 cm lesion is cryoablated using a 15 minute freeze cycle, a 10 minute thaw cycle, and an additional 15 minute freeze cycle. This cycle is repeated for the adjacent portion of this lesion
- The cryoprobe is subsequently placed in the two remaining 2.0 and 2.5 cm lesions. The 15-10-15 minute freeze-thaw-freeze cycles are used again.
- On removal of the 5-mm probe, bleeding from the liver parenchyma is controlled with the application of thrombin-soaked gelfoam and liberal use of the argon beam coagulator.
- The rest of the abdominal cavity is examined for bleeding.
- The abdomen is irrigated.
- The liver is examined for any sign of bleeding and the laparoscopic cannulas are removed and the CO₂ gas is allowed to escape from the abdominal cavity.
- The incisions are sutured

Post-op work, same day work:

- Sterile dressings are applied to the incisions
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Write orders for post-op labs, chest x-ray, medications, diet, and patient activity
- Write brief operative note for patient's chart documenting in the daily progress notes pre-and postoperative diagnoses, operation performed, findings, blood loss, intraoperative IV fluids administered, complications, specimens sent to pathology, and condition of patient at the end of the procedure
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Examine patient, check wounds and patient progress

Post-op other hospital work, postop day 1 through discharge day:

- Examine and talk with patient
- Review labs
- Check wounds and patient progress
- Chart patient progress notes
- As appropriate, write discharge order to telemetry unit or general care ward
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, handling of wound, return appointment to office, etc.
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op office work – After discharge from hospital through 90 day global period:

- Obtain and review CT scan
 - Examine and talk with patient
 - Check wounds and patient progress
 - Discuss findings with patient and family
 - Answer patient/family questions
 - Answer insurance staff questions
 - Discuss patient progress with referring physician (verbal and written)
 - Coordinate care with other physicians
 - Write orders for medications
 - Dictate patient progress notes for medical chart
-

SURVEY DATA**Presenter(s):** Charles D. Mabry, MD, FACS**Specialty(s):** American College of Surgeons**Sample Size:** 70 **Response n:** 17 **Response %:** 24%**Type of Sample:** Random / Panel (surgeons trained to use ablation equipment)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	12.00	18.50	20.00	24.00	34.50
Pre-Service			80		
Intra-Service	120	160	180	180	300
Post-Service	<u>Total Time</u>	<u>CPT code / # of visits</u>			
Day of Surgery:					
Immediate	35				
Critical Care	0				
Other Hospital	49	99231x1, 99232x1			
Discharge Day Mgmt	36	99238			
Office Visits	61	99213x2 99212x1			

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
47120	Hepatectomy, resection of liver; partial lobectomy	35.50	090
47125	Hepatectomy, resection of liver; total left lobectomy	49.19	090

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

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT	Ref CPT
	47371	47120	47125
Count	17	6	3
Pre-service time	80	75	75
Intra-service time	180	225	225
Same Day Immediate Post-service time	35	30	45
Same Day Other Post-service time (*critical care)	0	0	0
Post Total critical care time (not same day)	0	60	120
Post Total other hospital visit time (not same day)	49	210	210
Discharge management time	36	36	36
Total office visit time	61	91	61

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	4.15	3.00	4.75
Intra-service	4.23	4.00	4.50
Post-service	3.23	4.00	4.00

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.15	4.00	4.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.46	4.50	4.75
Urgency of medical decision making	3.31	4.00	4.00

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.46	4.00	4.75
Physical effort required	3.77	4.50	4.75

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.77	4.00	4.75
Outcome depends on the skill and judgment of physician	4.54	4.50	4.50
Estimated risk of malpractice suit with poor outcome	3.08	4.50	3.25

ADDITIONAL RATIONALE

Cryosurgical ablation of hepatic tumors requires a 15-10-15 minute freeze-thaw-freeze cycle prior to incising the lesion (this does not include time for the ultrasound guidance). Intraoperatively, in addition to the ablation, the surgeon must place the trocars, perform a diagnostic laparoscopy, and control bleeding at the ablation sites prior to closing. More time is necessary for larger lesions for repeat ablations cycles. The median intra-operative time of 180 minutes is conservative for this typical patient. The resulting IWP/PUT of 0.071 (see Appendix A), is also conservative for this procedure and comparable to the reference services.

Additionally, on the survey we asked two questions. 1) Where is this service performed? and 2) Do you perform BOTH the surgical ablation procedure AND the ultrasound guidance (answer choice: always, sometimes, or never)? The response to the first question was 100 percent "inpatient hospital." With respect to the second question, the majority response was "always." One respondent indicated "sometimes." Zero respondents indicated "never."

FREQUENCY INFORMATION

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

This is a new procedure using new technology. Any reporting would have used an "unlisted" code.
47379 Unlisted laparoscopic procedure, liver (new CPT 2001 – no frequency data available)

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

Specialty: general surgery ~~Commonly~~ ~~Sometimes~~ Rarely

3. 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: general surgery Frequency: 50

4. 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: general surgery Frequency: 25

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to a few medical centers.

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

CPT Code: 47380 (F3)

Global: 090

Recommended RVW: 23.00

CPT Descriptor: Ablation, open, of one or more liver tumor(s); radiofrequency
(For imaging guidance, use 76490)

Survey Vignette (Typical Patient)

An 82-year-old man was diagnosed with colon cancer and underwent a right hemi-colectomy in May of 1994. He had a Dukes C2 lesion with positive lymph nodes. Recently, he was seen in follow-up and found to have an elevated CEA of 34. A CT scan revealed two hepatic metastases in the right lobe of the liver and one in the medial segment of the left lobe. The two lesions in the right lobe were 3 cm and 2 cm, and the lesion in the left lobe was 3.5 cm. These findings were confirmed by ultrasound. The remainder of the metastatic workup revealed no other spread in the abdomen, retroperitoneum, lung, bone, or brain. A recent follow-up colonoscopy was also negative for recurrent cancer.

Because of the bilaterality and multiplicity of the lesions, biopsy and radiofrequency thermal ablation was determined most appropriate. The patient underwent an exploratory laparotomy and one of the liver lesions was proven malignant by core needle biopsy. No extra-hepatic disease was found. All three lesions were ablated with radiofrequency thermal technique, using sonographic guidance and confirmation of lesion destruction. NOTE: The ultrasound guidance, supervision, and interpretation are separately reportable. Do not consider this work to complete this survey.

CLINICAL DESCRIPTION OF SERVICE:

Pre-service work – Day before surgery:

- Write pre-operative orders, including fasting after midnight, type and screen for two units of blood, and pre-operative parenteral antibiotic infusion
- Review pre-operative work-up, including: History and physical examination; chest x-ray; prior pathology reports; CT or MRI scans of liver, baseline sonogram of liver, and other films;
- Review planned trocar placement, incisions and procedure

Pre-service work – Day of surgery:

- Change into scrub clothes
- Check with lab on availability of blood and/or cross match
- Review the surgical procedure, length and type of anesthesia, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions
- Obtain informed consent if not already obtained
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite, with special attention to availability of radiofrequency ablation unit
- Assure compliance with universal precautions relating to body substance isolation policies as required by JCAHO and OSHA
- Monitor patient positioning and draping, and assist with positioning as needed
- Oversee the placement of support stockings and sequential compression stockings on the patient, to provide prophylaxis for deep venous thrombosis.
- Directions are given to the nursing regarding wide prepping for a bilateral subcostal incision
- Scrub and gown

Intra-service work – Skin to skin:

- A bilateral subcostal incision is made.
- A thorough manual and visual exploration of the abdomen, peritoneum, and retroperitoneum is performed.
- Appropriate biopsies outside the liver are performed based on the findings, and the tissue is sent to the pathologist for frozen section examination. No extra-hepatic metastatic deposits are found.
- Upon visualizing the liver, two metastases in the right lobe of the liver and one lesion in the medial segment of the left lobe are found.
- A tru-cut needle biopsy of one lesion is performed confirming a mucin-producing metastatic adenocarcinoma.
- The right and left lobes of the liver are then mobilized by taking down the right and left triangular ligaments and the falciform ligament.
- A radiofrequency needle is inserted individually in each of the lesions.
- The lesions are heated to a temperature of 100 degrees Celsius for five minutes.
- The two lesions of 3 cm and 3.5 cm diameter each require two heatings with re-positioning of the RF needle. The 2.0 cm lesion requires one heating, for a total of 5 ablations cycles.
- The heat ablation is monitored
- The rest of the abdominal cavity is examined for bleeding.
- The abdomen is irrigated.
- The sponge, needle, and instrument counts is reconciled with the nursing staff.
- The abdominal wound is closed in layers.
- The skin is carefully closed with a skin stapler.

Post-op work, same day work:

- Sterile dressings are applied to the incisions
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Write orders for post-op labs, chest x-ray, medications, diet, and patient activity
- Write brief operative note for patient's chart documenting in the daily progress notes pre-and postoperative diagnoses, operation performed, findings, blood loss, intraoperative IV fluids administered, complications, specimens sent to pathology, and condition of patient at the end of the procedure
- Order transfer of patient to the ICU
- Discuss procedure outcome with patient and family
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Examine patient, check wounds and patient progress
- Monitor urinary output and vital signs.

Post-op other hospital work, postop day 1 through discharge day:

- The patient is extubated on postop day 1 after 8 hours of ventilator management by the surgeon.
- On postop day 2, the patient is assessed by the surgeon and is transferred to the floor, begins a liquid diet and advance on diet and physical activity.
- Examine and talk with patient
- Review labs
- Check wounds and patient progress
- Chart patient progress notes
- As appropriate, write discharge order to telemetry unit or general care ward
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, handling of wound, return appointment to office, etc.
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op office work – After discharge from hospital through 90 day global period:

- Obtain and review CT scan
- Examine and talk with patient
- Check wounds and patient progress
- Remove staples
- Discuss findings with patient and family
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Write orders for medications
- Dictate patient progress notes for medical chart

SURVEY DATA**Presenter(s):** Charles D. Mabry, MD, FACS**Specialty(s):** American College of Surgeons**Sample Size:** 70 **Response n:** 26 **Response %:** 37%**Type of Sample:** Random / Panel (surgeons trained to use ablation equipment)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	14.00	21.25	23.00	29.25	34.00
Pre-Service			85		
Intra-Service	150	180	200	240	390
Post-Service	<u>Total Time</u>	<u>CPT code / # of visits</u>			
Immediate	45				
Critical Care	0				
Other Hospital	98	99232x2	99231x2		
Discharge Day Mgmt	36	99238			
Office Visits	61	99213x2	99212x1		

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
47120	Hepatectomy, resection of liver; partial lobectomy	35.50	090
47125	Hepatectomy, resection of liver, total left lobectomy	49.19	090

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

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT	Ref CPT
	47380	47120	47125
Count	26	13	11
Pre-service time	85	75	75
Intra-service time	200	225	225
Same Day Immediate Post-service time	45	30	45
Same Day Other Post-service time (*critical care)	0	0	0
Post Total critical care time (not same day)	0	60	120
Post Total other hospital visit time (not same day)	98	210	210
Discharge management time	36	36	36
Total office visit time	61	91	61

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	4.23	4.00	4.44
Intra-service	4.14	4.30	4.44
Post-service	3.41	3.70	3.89

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.27	4.10	4.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.45	4.40	4.56
Urgency of medical decision making	3.36	3.20	3.67

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.27	4.30	4.67
Physical effort required	4.00	4.30	4.44

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.05	4.20	4.56
Outcome depends on the skill and judgment of physician	4.59	4.40	4.67
Estimated risk of malpractice suit with poor outcome	3.50	3.50	3.89

ADDITIONAL RATIONALE

Radiofrequency ablation cycles typically take 30 minutes (this does not include time for the ultrasound guidance). More time is necessary for larger lesions for repeat ablations cycles. The median intra-operative time of 200 minutes is conservative for this typical patient. The resulting IWPUT of 0.065 (see Appendix A), is also conservative for this procedure and comparable to the reference services.

Additionally, on the survey we asked two questions. 1) Where is this service performed? and 2) Do you perform BOTH the surgical ablation procedure AND the ultrasound guidance (answer choice: always, sometimes, or never)? The response to the first question was 100 percent "inpatient hospital." With respect to the second question, the majority response was "always." One respondent indicated "sometimes." Zero respondents indicated "never."

FREQUENCY INFORMATION

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

This is a new procedure using new technology. Any reporting would have used an "unlisted" code.
47399 Unlisted procedure, liver (1999 Medicare frequency for general surgery was 125)

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

Specialty: general surgery Commonly Sometimes Rarely

3. 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: general surgery Frequency: 250

4. 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: general surgery Frequency: 125

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to a few medical centers.

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

CPT Code: 47381 (F4)

Global: 090

RUC Recommended RVW: 23.27

CPT Descriptor: Ablation, open, of one or more liver tumor(s); cryosurgical
(For imaging guidance, use 76490)

Survey Vignette (Typical Patient)

A 65-year-old male was diagnosed with colon cancer and underwent a sigmoid colon resection in 1999. He had a Dukes C2 lesion with positive lymph nodes. He was recently seen in follow-up and found to have an elevated CEA of 34. A CT scan revealed two hepatic metastases in the liver; one in the medial segment of the left lobe of the liver and one in the posterior segment of the right lobe of the liver. The lesion in the right lobe was 4.5 cm, and the lesion in the left lobe was 3.5 cm. These findings were confirmed by ultrasound. The remainder of the metastatic workup revealed no other spread in the abdomen, retroperitoneum, lung, bone, or brain. A recent follow-up colonoscopy was also negative for recurrent cancer.

Because of the bilaterality and multiplicity of the lesions, and proximity to the biliary tree, open cryosurgical ablation was determined most appropriate. The patient underwent an exploratory laparotomy and one of the liver lesions was proven malignant by core needle biopsy. No extra-hepatic disease was found. An additional 1.5 cm. lesion was found in the anterior segment of the right lobe of the liver. All three lesions were ablated with cryosurgical thermal technique using sonographic guidance and confirmation of lesion destruction. NOTE: The ultrasound guidance, supervision, and interpretation are separately reportable. Do not consider this work to complete this survey.

CLINICAL DESCRIPTION OF SERVICE:

Pre-service work – Day before surgery:

- Write pre-operative orders, including fasting after midnight, type and screen for two units of blood, and pre-operative parenteral antibiotic infusion
- Review pre-operative work-up, including: History and physical examination; chest x-ray; prior pathology reports; CT or MRI scans of liver, baseline sonogram of liver, and other films;
- Review planned trocar placement, incisions and procedure

Pre-service work – Day of surgery:

- Change into scrub clothes
- Check with lab on availability of blood and/or cross match
- Review the surgical procedure, length and type of anesthesia, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions
- Obtain informed consent if not already obtained
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite, with special attention to availability of radiofrequency ablation unit
- Assure compliance with universal precautions relating to body substance isolation policies as required by JCAHO and OSHA
- Monitor patient positioning and draping, and assist with positioning as needed
- Oversee the placement of support stockings and sequential compression stockings on the patient, to provide prophylaxis for deep venous thrombosis.
- Directions are given to the nursing regarding wide prepping for a bilateral subcostal incision
- Scrub and gown

Intra-service work – Skin to skin:

- A bilateral subcostal incision is made.
- A thorough manual and visual exploration of the abdomen, peritoneum, and retroperitoneum is performed.
- Appropriate biopsies are performed based on the findings, and the tissue is sent to the pathologist for frozen section examination. No extra-hepatic metastatic deposits are found.
- Upon visualizing the liver, two metastases in the right lobe of the liver and one lesion in the medial segment of the left lobe are noted.
- A Tru-Cut needle biopsy of one lesion is performed confirming a mucin-producing metastatic adenocarcinoma.
- The right and left lobes of the liver were then mobilized by taking down the right and left triangular ligaments and the falciform ligament.
- Two 5 mm cryosurgical probes are placed in the larger lesion in the posterior right liver. Both probes are used simultaneously, using a 15 minute freeze cycle, a 10 minute thaw cycle, and an additional 15 minute freeze cycle.
- The anterior lesion in the right liver lobe is ablated using a single 10 mm probe, again with ultrasound documentation of the adequacy of the ice-ball formation and by obtaining at least 10 mm margins of ice around the lesion. The 15-10-15 minute freeze-thaw-freeze cycles are used again.
- Similarly, the lesion in the left liver lobe is ablated
- On removal of the 10 mm probe, the liver parenchyma cracked and brisk bleeding ensued. This was controlled with the application of thrombin-soaked Gelfoam and liver sutures.
- The rest of the abdominal cavity is examined for bleeding.
- The abdomen is then irrigated.
- The sponge, needle, and instrument counts are reconciled with the nursing staff.
- The abdominal wound is closed in layers.
- The skin is carefully closed with a skin stapler.

Post-op work, same day work:

- Sterile dressings are applied to the incisions
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Write orders for post-op labs, chest x-ray, medications, diet, and patient activity
- Write brief operative note for patient's chart documenting in the daily progress notes pre-and postoperative diagnoses, operation performed, findings, blood loss, intraoperative IV fluids administered, complications, specimens sent to pathology, and condition of patient at the end of the procedure
- Order transfer of patient to the ICU
- Discuss procedure outcome with patient and family
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Examine patient, check wounds and patient progress
- Monitor urinary output and vital signs.

Post-op other hospital work, postop day 1 through discharge day:

- The patient is extubated on postop day 1 after 8 hours of ventilator management by the surgeon.
- On postop day 2, the patient is assessed by the surgeon and is transferred to the floor, begins a liquid diet and advance on diet and physical activity.
- Examine and talk with patient
- Review labs
- Check wounds and patient progress
- Chart patient progress notes
- As appropriate, write discharge order to telemetry unit or general care ward
- Carefully explain to patient and a family member dietary management, activities permitted, bathing, handling of wound, return appointment to office, etc.
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op office work – After discharge from hospital through 90 day global period:

- Obtain and review CT scan
- Examine and talk with patient
- Check wounds and patient progress
- Remove staples
- Discuss findings with patient and family
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Write orders for medications
- Dictate patient progress notes for medical chart

SURVEY DATA**Presenter(s):** Charles D. Mabry, MD, FACS**Specialty(s):** American College of Surgeons**Sample Size:** 70 **Response n:** 21 **Response %:** 30%**Type of Sample:** Random / Panel (surgeons trained to use ablation equipment)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	14.00	21.00	22.79	27.00	34.00
Pre-Service			85		
Intra-Service	180	200	210	240	330
Post-Service	<u>Total Time</u>	<u>CPT code / # of visits</u>			
Immediate	45				
Critical Care	0				
Other Hospital	98	99232x2	99231x2		
Discharge Day Mgmt	36	99238			
Office Visits	61	99213x2	99212x1		

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
47120	Hepatectomy, resection of liver; partial lobectomy	35.50	090
47125	Hepatectomy, resection of liver; total left lobectomy	49.19	090

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

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT	Ref CPT
	4737X1	47120	47125
Count	21	10	8
Pre-service time	85	75	75
Intra-service time	210	225	225
Same Day Immediate Post-service time	45	30	45
Same Day Other Post-service time (*critical care)	0	0	0
Post Total critical care time (not same day)	0	60	120
Post Total other hospital visit time (not same day)	98	210	210
Discharge management time	36	36	36
Total office visit time	61	91	61

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	4.18	3.88	4.50
Intra-service	4.24	4.25	4.50
Post-service	3.59	3.75	3.83

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.24	4.00	4.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.47	4.38	4.67
Urgency of medical decision making	3.41	3.13	4.00

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.41	4.25	4.67
Physical effort required	3.94	4.25	4.67

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.24	4.13	4.67
Outcome depends on the skill and judgment of physician	4.53	4.38	4.33
Estimated risk of malpractice suit with poor outcome	3.35	3.38	3.83

ADDITIONAL RATIONALE

Cryosurgical ablation of hepatic tumors requires a 15-10-15 minute freeze-thaw-freeze cycle prior to incising the lesion (this does not include time for the ultrasound guidance). More time is necessary for larger lesions for repeat ablations cycles. The median intra-operative time of 210 minutes is conservative for this typical patient. The resulting IWPOT of 0.061 (see Appendix A), is also conservative for this procedure and comparable to the reference services.

Additionally, on the survey we asked two questions. 1) Where is this service performed? and 2) Do you perform BOTH the surgical ablation procedure AND the ultrasound guidance (answer choice: always, sometimes, or never)? The response to the first question was 100 percent "inpatient hospital." With respect to the second question, the majority response was "always." One respondent indicated "sometimes." Zero respondents indicated "never."

FREQUENCY INFORMATION

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

This is a new procedure using new technology. Any reporting would have used an "unlisted" code.
47399 Unlisted procedure, liver (1999 Medicare frequency for general surgery was 125)

2. 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

3. 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: general surgery Frequency: 100

4. 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: general surgery Frequency: 50

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to a few medical centers.

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

CPT Code: 47382 Tracking Number: F5 Global Period: 010 RUC Recommended RVW: 15.19

CPT Descriptor: **Ablation, percutaneous, one or more liver tumor(s), radiofrequency
(For imaging guidance and monitoring, see codes 76362, 76394, or 76490)**

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 73 year old man with colon cancer developed two metastatic lesions to the liver. Lesions were 2 cm x 2 cm and 4 cm by 4 cm. Because the lesions were not surgically resectable due to their location, the patient's oncologist referred him for evaluation for radiofrequency (RF) ablation. The patient was evaluated by the treating physician, and the lesions were determined to be amenable to percutaneous RF ablation.

Description of Pre-Service Work:

In addition to the standard pre-service activities as defined by RUC, Code 47382 includes the following pre-service work:

- Obtain and review pertinent imaging studies and lab results
- Discuss procedure with patient and family; answer questions
- Obtain informed consent
- Plan operative approach
- Check equipment, supplies, and instruments
- Supervise patient positioning and placement of ground pads
- Prep and drape upper abdomen into a sterile field

Description of Intra-Service Work:

Physician work associated with imaging guidance should be excluded from your evaluation of code 4737X5, since imaging guidance is separately reportable. The intra-service period includes all "skin-to-skin" work that is a necessary part of the procedure.

- After imaging localization of the lesion (coded separately), local anesthesia is injected and a small incision is made to facilitate RF needle electrode placement
- The RF needle electrode is placed into the lesion
- RF power is applied until satisfactory core heating is achieved
- Overlapping ablations are performed as needed to assure complete tumor necrosis and satisfactory margins
- After satisfactory necrosis, the RF needle is withdrawn to the liver capsule and cauterization is performed to achieve hemostasis along the needle tract

After adequate hemostasis of the first lesion, the additional lesion is treated in turn using the same process

Description of Post-Service Work:

In addition to the standard post-service activities as defined by RUC, Code 47382 includes the following pre-service work:

- Discuss results with patient's family
- Observe patient in holding area to assure hemodynamic stability
- Dictate, review, and sign report of the procedure
- Discuss outcome with referring physician
- Follow patient with telephone calls

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
37204	Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve homeostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck	18.14

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

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

TIME ESTIMATES (Median)

	New/Revis. CPT Code:	Key Reference CPT Code:
	47382	37204
Median Pre-Time	30 minutes	
Median Intra-Time	180 minutes	
Median Immediate Post-service Time		
Median of Aggregate Critical Care Times	18 minutes	
Median of Aggregate Other Hospital Visit Times	15 minutes	
Median Discharge Day Management Time	30 minutes	
Median of Aggregate Office Visit Times	15 minutes	

370 total

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.13	3.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.19	3.95
Urgency of medical decision making	3.31	3.48

Technical Skill/Physical Effort (Mean)

Technical skill required	4.56	4.29
Physical effort required	4.31	3.95

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.22	4.29
Outcome depends on the skill and judgement of physician	4.66	4.10
Estimated risk of malpractice suit with poor outcome	3.66	3.67

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

CPT Code: 76362 Tracking Number: F6 Global Period: XXX Recommended RVW: 4.0

CPT Descriptor: **Computerized tomography guidance for, and monitoring of, tissue ablation
(For percutaneous radiofrequency ablation, use 47382)**

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 73 year old man with colon cancer developed two metastatic lesions to the liver. Lesions were 2 cm x 2 cm and 4 cm x 4 cm. Because the lesions were not surgically resectable due to their location, the patient's oncologist referred him for evaluation for radiofrequency (RF) ablation. The patient was evaluated by the treating physician, and the lesions were determined to be amenable to percutaneous RF ablation.

Description of Pre-Service Work:

- Review of any previous imaging studies
- Confirmation of patient positioning and imaging setup
- Determine need for intravascular contrast to identify liver masses

Description of Intra-Service Work:

- Preliminary CT images acquired to assess appropriate approach to the tumor(s)
- CT guidance to direct RF needle electrode to tumor(s)
- CT monitoring for needle electrode repositioning within lesion, if and as necessary for multiple ablations to coagulate the lesion
- CT to confirm satisfactory coagulative necrosis of the lesion(s) and comparison to pre-ablation images
- CT of liver for post-ablation bleeding

Description of Post-Service Work:

- Dictate, review and sign CT report

KEY REFERENCE SERVICE:

<u>CPT Code</u> 76360	<u>CPT Descriptor</u> Computerized tomography guidance for needle placement 1.16 (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation	<u>RVW</u>
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RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

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

<u>TIME ESTIMATES (Median)</u>	New/Revis. CPT Code:	Key Reference CPT Code:
	<u>76362</u>	<u>76360</u>
Median Pre-Time	20 minutes	
Median Intra-Time	120 minutes	
Median Immediate Post-service Time	15 minutes	
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.88	2.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.13	2.61
Urgency of medical decision making	3.29	2.72

Technical Skill/Physical Effort (Mean)

Technical skill required	4.54	3.00
Physical effort required	4.08	2.78

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.33	2.72
Outcome depends on the skill and judgement of physician	4.83	2.83
Estimated risk of malpractice suit with poor outcome	3.70	2.78

INTENSITY/COMPLEXITY MEASURES

CPT Code: Reference Service 1

76362 76360

Time Segments (Mean)

Pre-Service intensity/complexity	3.75	2.61
Intra-Service intensity/complexity	4.67	2.67
Post-Service intensity/complexity	3.17	2.61

ADDITIONAL RATIONALE

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

The process used consisted of a survey of physicians (panel sample) who typically perform this service. Final recommendation and work values were reviewed by physicians representing SCVIR and ACR. These physicians reviewed all components of work for the newly proposed CPT code, 7637X, as well as the information provided for the reference procedure. The recommended RVW (4.0) is the median RVW of the polled respondents (n=24) from SCVIR and ACR surveys.

FREQUENCY INFORMATION

How was this service previously reported? **76360-22** (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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 **Interventional 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.

There are approximately 100,000 patients per year who have metastatic disease and/or primary hepatic tumors, who would be candidates for treatment. An estimated 5 to 15 percent of these patients would be candidates for percutaneous radiofrequency ablation (PRA). CT is one of three guidance modalities used for guidance and monitoring of PRA. At this time, we are unable to ascertain accurate percentages of utilization by guidance modality for PRA procedures.

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.

Unable to quantify. (See estimate of services for general population, above.)

Do many physicians perform this service across the United States? X Yes ___ No

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

CPT Code: 76394 Tracking Number: F7 Global Period: XXX Recommended RVW: 4.25

CPT Descriptor: **Magnetic resonance guidance for, and monitoring of, tissue ablation
(For percutaneous radiofrequency ablation, use 4737X5)**

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 73 year old man with colon cancer developed two metastatic lesions to the liver. Lesions were 2 cm x 2 cm and 4 cm by 4 cm. Because the lesions were not surgically resectable due to their location, the patient's oncologist referred him for evaluation for radiofrequency (RF) ablation. The patient was evaluated by the treating physician, and the lesions were determined to be amenable to percutaneous RF ablation.

Description of Pre-Service Work:

- Review of any previous imaging studies
- Confirmation of patient positioning and imaging setup
- Determine need for intravascular contrast to identify liver masses

Description of Intra-Service Work:

- Preliminary MRI images acquired to access appropriate approach to the tumor(s)
- MRI guidance to direct RF needle electrode to tumor(s)
- MRI monitoring for needle electrode repositioning within lesion, if and as necessary for multiple ablations to coagulate the lesion
- MRI to confirm satisfactory coagulative necrosis of the lesion(s) and comparison to pre-ablation images
- MRI of liver for post-ablation bleeding

Description of Post-Service Work:

- Dictate, review and sign MRI report

SURVEY DATA:

Presenter(s): **James P. Borgstede, MD, ACR RUC advisor**
Bibb Allen, Jr., MD, ACR Alternate RUC advisor
Robert L. Vogelzang, MD, SCVIR RUC advisor

Specialty(s): **American College of Radiology**
Society of Cardiovascular & Interventional Radiology

Sample Size: **108** Response Rate: (%): **16% (n=18)** Median RVW: **4.25**

Type of Sample (Circle One): random, **panel**, convenience.

Explanation of sample size: **The panel of survey recipients included both SCVIR and ACR members.**

25th Percentile RVW: **3.00** 75th Percentile RVW: **8.12** Low: **1.60** High: **12**

Median Pre-Service Time: **20 minutes** Median Intra-Service Time: **165 minutes**

25th Percentile Intra-Svc Time: **120 minutes** 75th Percentile Intra-Svc Time: **180 minutes** Low: **30 minutes** High: **210 minutes**

Median Post-Service Time:

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

KEY REFERENCE SERVICE:

<u>CPT Code</u> 76360	<u>CPT Descriptor</u> Computerized tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation	<u>RVW</u> 1.16
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RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

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

TIME ESTIMATES (Median)

	New/Revis. CPT Code:	Key Reference CPT Code:
	<u>7639X</u>	<u>76360</u>
Median Pre-Time	20 minutes	
Median Intra-Time	165 minutes	
Median Immediate Post-service Time	15 minutes	
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.92	3.17
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.46	3.17
Urgency of medical decision making	3.46	3.17

Technical Skill/Physical Effort (Mean)

Technical skill required	4.94	3.33
Physical effort required	4.06	2.67

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.44	3.33
Outcome depends on the skill and judgement of physician	4.94	3.33
Estimated risk of malpractice suit with poor outcome	3.72	3.50

INTENSITY/COMPLEXITY MEASURESCPT Code: Reference
Service 17639X 76360**Time Segments (Mean)**

Pre-Service intensity/complexity	4.08	3.17
Intra-Service intensity/complexity	5	3.17
Post-Service intensity/complexity	3.54	3

ADDITIONAL RATIONALE

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

The process used consisted of a survey of physicians (panel sample) who typically perform this service. Final recommendation and work values were reviewed by physicians representing SCVIR and ACR. These physicians reviewed all components of work for the newly proposed CPT code, 7639X, as well as the information provided for the reference procedure. The recommended RVW (4.25) is the median RVW of the polled respondents (n=18) from SCVIR and ACR surveys.

FREQUENCY INFORMATION

How was this service previously reported? **74181-22** (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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 **Interventional 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.

There are approximately 100,000 patients per year who have metastatic disease and/or primary hepatic tumors, who would be candidates for treatment. An estimated 5 to 15 percent of these patients would be candidates for percutaneous radiofrequency ablation (PRA). MR is one of three guidance modalities used for guidance and monitoring of PRA. At this time, we are unable to ascertain accurate percentages of utilization by guidance modality for PRA procedures.

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.

Unable to quantify. (See estimate of services for general population, above.)

Do many physicians perform this service across the United States? ___ Yes X No

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

CPT Code:	<u>76490</u>	Tracking Number:	<u>F8</u>	Global Period:	<u>XXX</u>	Recommended RVW:	<u>4.0</u>
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CPT Descriptor: **Ultrasound guidance for, and monitoring of, tissue ablation**
(Do not report 7649X in addition to 76986)
(For ablation, see codes 47370-47382)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The three clinical vignettes below describe typical patients referred for laparoscopic, open, and percutaneous procedures. Patients undergoing open or laproscopic procedures may receive either radiofrequency or cryosurgical ablation.

Typical Patient Treated By Laparoscopic Cryosurgical Ablation

The patient is a 44-year old man who underwent a left colon resection for adenocarcinoma one and one-half years ago. Following the left colon surgery, he received systemic chemotherapy. After six months of treatment, the patient's CEA begins to rise. CT imaging of the liver reveals three lesions along the anterior, inferior surface of the right lobe of the liver. All three lesions were confirmed on ultrasound examination and were felt to be superficial and accessible by laparoscopy. The lesions measure 4 cm, 2.0 cm and 2.5 cm in diameter. The patient undergoes laparoscopy and cryosurgical ablation of all three liver tumors. NOTE: The ultrasound guidance, supervision and interpretation are separately reportable. Do not consider this work to complete this survey.

Typical Patient Treated By Open Radiofrequency Ablation

An 82-year-old gentleman was diagnosed with colon cancer and underwent a right hemi-colectomy in May of 1994. He had a Dukes C2 lesion with positive lymph nodes. Recently he was recently seen in follow-up and found to have an elevated CEA of 34. A CT scan revealed two hepatic metastases in the right lobe of the liver and one in the medial segment of the left lobe. The two lesions in the right lobe were 3 cm and 2 cm, and the lesion in the left lobe was 3.5 cm. These findings were confirmed by ultrasound. The remainder of the metastatic workup revealed no other spread in the abdomen, retroperitoneum, lung, bone, or brain. A recent follow-up colonoscopy was also negative for recurrent cancer. Because of the bilaterality and multiplicity of the lesions, biopsy and radiofrequency thermal ablation was determine most appropriate. The patient underwent an exploratory laparotomy and one of the liver lesions was proven malignant by core needle biopsy. No extra-hepatic disease was found. All three lesions were ablated with radiofrequency thermal technique, using sonographic guidance and confirmation of lesion destruction. NOTE: The ultrasound guidance, supervision and interpretation, are separately reportable. Do not consider this work to complete this survey.

Typical Patient Treated By Percutaneous Radiofrequency Ablation

A 73 year old man with colon cancer developed two metastatic lesions to the liver. Lesions were 2 cm x 2 cm and 4 cm x 4 cm. Because the lesions were not surgically resectable due to their location, the patient's oncologist referred him for evaluation for radiofrequency (RF) ablation. The patient was evaluated by the treating physician, and the lesions were determined to be amenable to percutaneous RF ablation.

Description of Pre-Service Work:

- Review of any previous imaging studies
- Supervise transport and set up of the ultrasound equipment in the OR, when necessary, assuring all necessary, transducers are available
- Confirmation of patient positioning and imaging setup

Description of Intra-Service Work:

- Preliminary ultrasound to assess percutaneous or the various intraoperative transhepatic approach(es) to the tumor(s)
- Perform intraoperative ultrasound examination of each hepatic segment until satisfactory exposure has been achieved to confirm expected location(s) of the lesion(s)
- Ultrasound guidance to direct RF or cryosurgical needle electrode(s) to tumor(s), percutaneous or intraoperative transhepatic
- Ultrasound monitoring of needle electrode repositioning within lesion, if and as necessary for each of the multiple ablations or freeze-thaw cycles required to completely ablate the lesion
- Ultrasound to confirm satisfactory ablation of the lesion(s) and comparison to pre-ablation images
- Imaging of liver for post-ablation bleeding

Description of Post-Service Work:

- Dictate, review and sign ultrasound report

SURVEY DATA:

Presenter(s): **James P. Borgstede, MD, ACR RUC advisor**
Bibb Allen, Jr., MD, ACR Alternate RUC advisor
Robert L. Vogelzang, MD, SCVIR RUC advisor

Specialty(s): **American College of Radiology**
Society of Cardiovascular & Interventional Radiology

Sample Size: 178 Response Rate: (%): 29.2% (n=52) Median RVW: 3.00

Type of Sample (Circle One): random, **panel**, convenience.

Explanation of sample size: The panel of survey recipients included both SCVIR and ACR members.

25th Percentile RVW: 2.15 75th Percentile RVW: 4.75 Low: .75 High: 15.49

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

25th Percentile Intra-Svc Time: 60 minutes 75th Percentile Intra-Svc Time: 150 minutes
Low: 10 minutes High: 240 minutes

Median Post-Service Time:

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

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	.67

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)

	<u>CPT Code</u> 76490	<u>Reference Service 1 CPT</u> 76942
Median Pre-Time	20 minutes	
Median Intra-Time	120 minutes	
Median Immediate Post-service Time	15 minutes	
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		
Total Time	155 minutes	30 minutes

Source of time for 76942 is RUC

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.54	2.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.71	2.45
Urgency of medical decision making	3.38	2.50

Technical Skill/Physical Effort (Mean)

Technical skill required	4.48	2.77
Physical effort required	3.75	2.45

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.77	2.59
Outcome depends on the skill and judgement of physician	4.63	2.68
Estimated risk of malpractice suit with poor outcome	3.37	2.73

monitoring of PRA. At this time, we are unable to ascertain accurate percentages of utilization by guidance modality for PRA procedures.

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.

Unable to quantify. (See estimate of services for general population, above.)

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

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Clinical Labor, Medical Supplies, and Procedure Equipment Practice Expense Data						CPT				47370	47370	47371	47371	47380	47380	47381	47381
2							Global				090	090	090	090	090	090	090	090
3							Number/Level of Post OV:				N/A	99213x2 99212x1	N/A	99213x2 99212x1	N/A	99213x2 99212x1	N/A	99213x2 99212x1
4	CLINICAL LABOR						Code	staff desc	Price	IN Off	OUT off	IN Off	OUT off	IN Off	OUT off	IN Off	OUT off	
5	TOTAL TYPICAL TIME						1130	RN/LPN/MA	\$ 0.317	0	159	0	159	0	159	0	159	
6	PRE-service time						1130	RN/LPN/MA	\$ 0.317	0	60	0	60	0	60	0	60	
7	SERVICE time						1130	RN/LPN/MA	\$ 0.317	0	0	0	0	0	0	0	0	
8	POST-service time						1130	RN/LPN/MA	\$ 0.317	0	99	0	99	0	99	0	99	
9	PRE-SERVICE																	
10	BEGINS after procedure consult. (in off/out off)									Min	Min	Min	Min	Min	Min	Min	Min	
11	Complete pre-service diagnostic & referral forms (5/5)						1130	RN/LPN/MA	\$ 0.317	0	5	0	5	0	5	0	5	
12	Coord pre-proc services/review test/exam results (10/20)						1130	RN/LPN/MA	\$ 0.317	0	20	0	20	0	20	0	20	
13	Schedule space and equipment in facility (0/8)						1130	RN/LPN/MA	\$ 0.317	0	8	0	8	0	8	0	8	
14	OV before surgery/procedure - review test/exam results (0/0)						1130	RN/LPN/MA	\$ 0.317	0	0	0	0	0	0	0	0	
15	Provide pre-service education/obtain consent (10/20)						1130	RN/LPN/MA	\$ 0.317	0	20	0	20	0	20	0	20	
16	Follow-up phone calls & prescriptions (10/7)						1130	RN/LPN/MA	\$ 0.317	0	7	0	7	0	7	0	7	
17	Other Pre-Service Activities (please specify):																	
18	Obtain/review previous imaging studies (CPT 7649X)						1130	RN/LPN/MA	\$ 0.317	0	0	0	0	0	0	0	0	
19	ENDS with admission to facility/office																	
20	SERVICE PERIOD																	
21	Starts with admission to facility/office									Min	Min	Min	Min	Min	Min	Min	Min	
22							1130	RN/LPN/MA	\$ 0.317	0	0	0	0	0	0	0	0	
23							1130	RN/LPN/MA	\$ 0.317	0	0	0	0	0	0	0	0	
24	Ends with discharge from facility/office																	
25	POST-SERVICE																	
26	Begins after discharge from facility/office									Min	Min	Min	Min	Min	Min	Min	Min	
27	Postop OV total time (E/M standards)		-211 (16)	-212 (27)	-213 (36)	-214 (53)	-215 (63)	1130	RN/LPN/MA	\$ 0.317	0	99	0	99	0	99	0	99
39	Other Activities (please specify):																	
40							1130	RN/LPN/MA	\$ 0.317	0	0	0	0	0	0	0	0	
41	ENDS after 90 days from day of procedure.																	
42	MEDICAL SUPPLIES						Code	Unit Size	Unit Cnt	Price	Out Off QTY							
44	PEAC Minimum visit package (multi-specialty):						PEAC	PKG	1	\$ 1.310	0	3	0	3	0	3	0	3
45	exam table paper (7 ft)						11111	foot	1	\$ 0.015								
46	gloves, non-sterile (2 pair)						11302	pair	1	\$ 0.120								
47	patient gown, disposable						11107	item	1	\$ 0.570								
48	pillow case, disposable						11112	item	1	\$ 0.320								
49	thermometer probe cover, disposable						11509	item	1	\$ 0.069								
50	Add'l per visit supplies:																	
51																		
52																		
53	PEAC Postop incision care kit:						PEAC	PKG	1	\$ 15.034	0	1	0	1	0	1	0	1
54	betadine						52310	ml	20	\$ 0.140								
55	gauze, sterile 4x4 (10 pack)						31505	pack	2	\$ 2.940								
56	gloves, sterile						14005	pair	1	\$ 0.890								
57	staple remover kut						31702	item	1	\$ 6.830								
58	steri-stnp						31513	stnp	12	\$ 3.580								
59	swab Alcohol						11302	item	2	\$ 0.034								
60	tape						31514	inch	12	\$ 0.300								
61	tincture benzoin swab						52308	item	1	\$ 0.320								
62	Add'l misc. supplies:																	
63											0	0	0	0	0	0	0	

**AMA/Specialty Society Update Process
RUC Summary of Recommendation
010 or 090 Day Global Periods
Out-Of-Office Direct Inputs**

Sample Size: **consensus** Response Rate: (%): **n/a** Global Period: **10-day**

Tracking Number: **F5** 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:

Consensus on direct inputs for 47382 was reached via a conference call with representation from ACR's Practice Expense Committee and SCVIR's Economic's Committee. (SCVIR's Economics Committee serves as its RUC/Practice Expense Committee.) Both the ACR's Practice Committee and SCVIR's Economics Committee consist of broad representation of geographic regions and practice types.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Completes pre-service diagnostic and referral forms
- Coordinates pre-surgery services and scheduling
- Obtains necessary medical records
- Provides education and obtains consent

Intra-Service Clinical Labor Activities:

- Coordinates post procedural care

Post-Service Clinical Labor Activities:

- Conducts phone calls and calls in prescriptions
- Coordinates home and outpatient care

HCFA's Staff Type Code***	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	Cost Estimate and Source (if applicable)
	RN, LPN, MTA	60 min	0 min	6 min		1	27 min	

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

**Excluding Time of Office Visits

*** From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	Multi-specialty minimum supply package	1	Item	

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
E11001	Exam table	4	20	40	

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

**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	5 minutes	RN, LPN, MA, Other _____
Coordinate pre-surgery services	20 minutes	RN, LPN, MA, Other _____
Schedule space and equipment in facility	8 minutes	RN, LPN, MA, Other _____
Office visit before surgery/procedure Review test and exam results	_____	RN, LPN, MA, Other _____
Provide pre-service education/obtain consent	20 minutes	RN, LPN, MA, Other _____
Follow-up phone calls & prescriptions	7 minutes	RN, LPN, MA, Other _____
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 _____
<i>Intra-service</i>		
Assist physician in performing surgery/procedure	_____	RN, LPN, MA, Other _____

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	_ 6 min _	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	_____	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		
	A 27 minutes	RN, LPN, MTA, Other _
List total number of office visits	B 1	99212
Total office visit time (A * B)	27 minutes	
Conduct phone calls between office visits	_____	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 2002

Digitization of Mammographic Filming

In *CPT 2002*, a code was created to describe the additional work of digitization of film radiographic images with computer analysis for lesion detection. CPT code 76085 is appended to 76092 *Screening mammography, bilateral (two view film study of each breast)* when this new technology is utilized. The RUC agreed that there is minimal additional physician work related to this service and agreed with the specialty's recommendation of 0.06. This work relative value is consistent with the work relative value implemented for this code by the Centers for Medicare and Medicaid Services on January 1, 2002. **The RUC recommends a work relative value of 0.06 for CPT code 76085.**

The RUC also reviewed the direct practice expense inputs associated with this service and made no modifications to the inputs as proposed by the specialty and appended to this recommendation. There are no direct practice expense inputs when this service is performed in an out-of-office setting.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•76085	AC1	Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, screening mammography (List separately in addition to code for primary procedure) (Use 76085 in conjunction with code 76092)	ZZZ	0.06

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

CPT Code: 76085 Tracking Number: AC1 Global Period: ZZZ Recommended RVW: 0.06

CPT Descriptor: **Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, screening mammography (List separately in addition to code for primary procedure).**

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A screening mammogram has been performed on an asymptomatic woman at least 40 years of age. The radiographic images are further processed using computer aided detection. (For screening mammography, use code 76092).

Description of Pre-Service Work:

The screening mammogram is reviewed and a preliminary interpretation performed prior to review of the CAD data. There is no physician work for CAD in the pre-service period as this service is performed and reported with the screening mammogram.

Description of Intra-Service Work:

1. Compare and correlate the result of CAD analysis with the screening mammogram.
2. Determine the significance of potential abnormalities indicated by CAD and formulate recommendations.
3. Integrate the result of CAD analysis with the interpretation of the screening mammogram.

Description of Post-Service Work:

No additional post-service work is performed. The result of the CAD is integrated with the report of the screening mammogram and not reported separately.

SURVEY DATA:

Presenter(s) Bibb Allen, Jr., M.D., ACR RUC advisor
 Specialty(s) American College of Radiology

Sample Size: 80 Response Rate: (%): 22 (28%) Median RVW: 0.36

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

25th Percentile RVW: 0.21 75th Percentile RVW: 0.74 Low: 0.10 High: 1.76

Median Pre-Service Time: 0 Median Intra-Service Time: 1.0

25th Percentile Intra-Service Time: 1.00 75th Percentile Intra-Svc Time: 3.38 Low: 0.30 High: 7.00

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	<u>0</u>	_____
Critical Care:	_____	_____
Other Hospital Visits:	_____	_____
Discharge Day Mgmt.:	_____	_____
Office Visits:	_____	_____

KEY REFERENCE SERVICE:

CPT Code
76091

CPT Descriptor
Mammography; bilateral

RVW
0.69

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)

	<u>CPT Code</u>	<u>Reference Service 1 CPT (Taken from RUC Database – 2nd 5-year review)</u>
Median Pre-Time	0.00	5.00
Median Intra-Time	1.13	10.00
Median Immediate Post-service Time	0.00	8.00
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	3.82	3.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.09	3.55
Urgency of medical decision making	3.36	3.50

Technical Skill/Physical Effort (Mean)

Technical skill required	3.91	3.95
Physical effort required	2.27	2.37

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.41	3.45
Outcome depends on the skill and judgement of physician	4.50	4.25

Estimated risk of malpractice suit with poor outcome	4.68	4.20
------------------------------------------------------	------	------

INTENSITY/COMPLEXITY MEASURES

CPT Code

Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	N/A	N/A
----------------------------------	-----	-----

Intra-Service intensity/complexity	3.36	3.43
------------------------------------	------	------

Post-Service intensity/complexity	N/A	N/A
-----------------------------------	-----	-----

ADDITIONAL RATIONALE

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

The ACR RUC committee met, reviewed the data and is recommending 0.06 RVUs for this digitization of film radiographic images with computer analysis for lesion detection procedure. The committee determined that they survey respondents had difficulty separating out the incremental increase in physician work, in addition to the base code, screening mammography. The committee felt that the recent CMS rationale published in the Proposed Rule on the 2002 Medicare Fee Schedule, stating that the physician work associated with this code was comparable per unit of time with the physician work in CPT code 76375 was appropriate.

FREQUENCY INFORMATION

How was this service previously reported? G0203, Screen mammogram, film to digital

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 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 7,800

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 2,500

Specialty _____ Frequency _____

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

AMA/Specialty Society Update Process
RUC Summary of Recommendation
ZZZ Global Period
In Office Direct Inputs

CPT Descriptor: **Digitization of film radiograph images with computer analysis for lesion detection and further physician review for interpretation, screening mammography (List separately in addition to code for primary procedure).**

Sample Size _____ Response Rate (%) _____ Global Period ZZZ

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:

The ACR conducted a standard Practice Expense survey and then utilized a consensus panel process to develop recommended direct inputs. The ACR Practice Expense Committee was assembled using representatives from each of the ACR sub-specialty Economics Committees, thus assuring a broad representation of all of the multiple radiology sub-specialties, general radiology and radiation oncology. Attention was paid to the geographic distribution, practice type (academic, private practice) and practice size of the representatives. This Committee was the final common pathway of all the recommendations that are submitted.

Please describe the clinical activities of your staff:

Intra-Service Clinical Labor Activities:

The Registered Technologist (RT) arranges the films for each case in the correct loading order for the site. For each case, the RT places the corresponding separator sheet on top of the case. The RT arranges the films into a stack. The stack of film with the separator sheets is loaded into the input tray. The films are scanned and converted into digital images that are analyzed. RT then separates the films from the stack into patient jackets. The films are hung on the ImageChecker Display Unit for review by the radiologist.

Total Staff Time In Office: 5 Minutes

Visits in Global Period:

HCFA's Staff Type Code*	Clinical Labor	Service Period	Cost Estimate and Source (if applicable)
	Registered Technologist (RT)	5	

*From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	Separator sheet	1	Each	\$0.37

*From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed provide full description, estimated cost, and cost source.

HCFA Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	CAD Processor Unit	1	5	20	\$210K

*From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed provide full description, estimated cost, and cost source.

CPT Code 76085
Specialty Society('s) ACR

TYPE OF SERVICE: ZZZ Global Period

SITE OF SERVICE: In-OFFICE

Clinical Services

Minutes

Staff Type – Circle

Intra-service

Assist physician in performing procedure

RN, LPN, MA, Other _____

Other Clinical Activity (please specify)

Digitize images, scan bar code, hang and organize digitized images, hang on special mammography rotator, code properly, paste CAD label on patient's folder.

5

RN, LPN, MA, Other RT _____

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE AND
SUMMARY OF RECOMMENDATIONS

February 2002

Gait and Motion Analysis

Rapid improvements in technology have made motion analysis accessible to many more physicians over the past ten years. With this greater accessibility there has been a great deal of variability in how these procedures are currently coded. The CPT codes that are currently being used do not reflect the services that are actually being performed. Therefore, these codes were created to describe more accurately a comprehensive motion analysis study. The Health Care Professional Advisory Committee will review and make recommendations on the first four codes of this series while the RUC will review the last code, 96004

96004 Physician review and interpretation of comprehensive computer based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report

The RUC examined the survey results for code 96004 and had some concerns about the difference between the specialty society's recommended work value and their reference service code 99205, *Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family* (work relative value of 2.67). The RUC noted that the reference code and new code had similar physician work. In addition, the RUC noted that the reference code had additional time. The RUC then made a recommendation to use a ratio of the new code's total time to the reference code's total time and then multiply this ratio by the reference code's RVW to get the recommended work value for this code. Therefore, **the RUC recommends a work relative value of 2.14 for 96004.**

Practice Expense:

There are no direct practice expense inputs related to this service.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period		Work RVU Recommendation
95860		Medicine Neurology and Neuromuscular Procedures Sleep Testing (Do not report codes 95860-95875 in addition to 96001-96005) <i>Needle electromyography, one extremity with or without related paraspinal areas</i>			
95861		<i>Needle electromyography, two extremities with or without related paraspinal areas</i> (For dynamic electromyography performed during motion analysis studies, see 96002-96003)			

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period		Work RVU Recommendation
<p>Medicine Neurology and Neuromuscular Procedures <u>Motion Analysis</u></p> <p><u>Codes 96001-96004 describe services performed as part of a major therapeutic or diagnostic decision making process. Motion analysis is performed in a dedicated motion analysis laboratory (ie, a facility capable of performing videotaping from the front, back and both sides, computerized 3-D kinematics, 3-D kinetics, and dynamic electromyography). Code 96001 may include 3-D kinetics and stride characteristics. Codes 96002-96003 describe dynamic electromyography. Do not report codes 95860-95875 in addition to the motion analysis codes.</u></p> <p><u>(Code 96004 should only be reported once regardless of the number of study(ies) reviewed/interpreted.)</u></p> <p><u>(For performance of needle electromyography procedures, see 96860-95875)</u></p> <p><u>(For gait training, use 97116)</u></p>					
●96000	XX1	Comprehensive computer-based motion analysis by video-taping and 3-D kinematics	XXX		1.80
●96001	XX2	with dynamic plantar pressure measurements during walking	XXX		2.15
●96002	XX3	Dynamic surface electromyography, during walking or other functional activities, 1-12 muscles	XXX		0.41
●96003	XX4	Dynamic fine wire electromyography, during walking or other functional activities, 1 muscle <u>(Do not report codes 95860-95875 in addition to 96002-96003)</u>	XXX		0.37

●96004	XX5	Physician review and interpretation of comprehensive computer based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report	XXX		2.14
<p>97110 Medicine Physical Medicine and Rehabilitation Therapeutic Procedures</p> <p><i>Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility</i></p> <p>97116 <i>gait training (include stair climbing)</i></p> <p><u>(Use 96001-96004 to report comprehensive gait and motion analysis procedures)</u></p>					

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

(April 2001)

CPT Code: 96004 (XX5)

Global: XXX

~~Recommended RVW: 3.00~~
RUC Recommended RVW: 2.14

CPT Descriptor: Physician review and interpretation of comprehensive computer based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report

Survey Vignette (Typical Patient)

A 10-year-old boy with cerebral palsy, spastic diplegia type, has multiple gait abnormalities that cannot be accurately assessed with the human eye. The patient is referred for a comprehensive motion analysis test to improve planning for orthopaedic surgery and orthotic management. The physician assesses the patient and collaborates with the motion lab staff to plan the computerized motion analysis, plantar pressure and electromyography tests. The tests are performed. The results of all of the following aspects of the study that were performed are reviewed by the physician including: slow motion video from the front, back and sides, 3-D kinematic measurements of joint motion, 3-D kinetic measurements of joint forces, measurements of stride characteristics, plantar pressure measurements and electromyography testing. The results are integrated and interpreted by the physician who then makes recommendations for medical or surgical treatment to improve the patient's walking ability based on the integrated results of the study.

CLINICAL DESCRIPTION OF SERVICE:

- **Review patient's clinical history, physical examination, and imaging studies (such as x-rays, CT scans, and MRI scans).**
 - Plan and order the computerized motion analysis, plantar pressure and electromyography tests
 - Obtain and review the results of the computerized motion analysis, plantar pressure, and electromyography tests. Specifically:
 - Computerized 3D kinematic information is obtained and reviewed to accurately evaluate joint motion in three planes and to accurately assess abnormalities occurring at all levels of the extremities simultaneously.
 - Joint kinetic information is obtained and reviewed to see abnormal forces that occur at the joints in three planes simultaneously as the patient moves, to provide information about the causes of the movement abnormalities detected by kinematics.
 - Stride characteristic measurements are obtained and reviewed, including velocity, cadence, stride length, gait cycle time, double limb stance time and single limb stance to allow the physician to quantify gait and assess the quality of pathological gait when compared to age-matched normals.
 - Dynamic plantar pressure information is obtained and reviewed to measure the magnitude and distribution of pressure that is occurring under the feet as the patient walks. This helps the physician to identify where the deforming forces are coming from and what can be done medically or surgically to improve them.
 - Dynamic EMG information is obtained and reviewed to evaluate the timing and magnitude of muscle activity as the patient performs functional activities. Abnormalities in muscle timing are noted to help with determining the causes of movement abnormalities detected by kinematics and kinetics.
 - After review, the study data are integrated, analyzed and interpreted by the physician who **summarizes the gait disorders, reviews treatment options, and then makes medical and/or surgical treatment recommendations which are documented for the medical record and communicated to the referring physician, patient, and family.**
-

SURVEY DATA

Presenter(s): David Martin, MD
Jon Davids, MD

Specialty(s): American Association of Orthopaedic Surgeons
Gait and Clinical Movement Analysis Society

CPT: 96004

Sample Size: 58 **Resp n:** 22 **Resp %:** 38%

Sample Type: random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	1.00	2.75	3.00	5.00	14.00
Total-Service Time	50	60	73	121	180

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. usually, the presenting problem(s) are of moderate to high severity. physicians typically spend 60 minutes face-to-face with the patient and/or family.	2.67	XXX

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

TIME ESTIMATES (MEDIAN)	Svy CPT 96004	Ref CPT 99205
Total Time	73	89

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

	Svy CPT 96004	Ref CPT 99205
Pre-service	3.50	3.29
Intra-service	4.25	4.18
Post-service	4.25	3.71

MENTAL EFFORT AND JUDGMENT

	Svy CPT 96004	Ref CPT 99205
The number of possible diagnosis and/or the number of management options that must be considered	4.30	4.32
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.65	4.21
Urgency of medical decision making	2.95	3.39

TECHNICAL SKILL/PHYSICAL EFFORT

	Svy CPT 96004	Ref CPT 99205
Technical skill required	4.10	3.63
Physical effort required	2.90	3.00

PSYCHOLOGICAL STRESS

	Svy CPT 96004	Ref CPT 99205
The risk of significant complications, morbidity and/or mortality	3.40	3.42
Outcome depends on the skill and judgment of physician	4.50	4.00
Estimated risk of malpractice suit with poor outcome	2.75	3.37

ADDITIONAL RATIONALE

96004 is valued slightly more than 99205 because of the level of biomechanical complexity associated with these gait disorders and the data integration required to identify, categorize, and describe the gait deviations. Typically, 6 distinct data sets (clinical history and physical examination, imaging studies, kinematics, kinetics, EMG, and dynamic pedal pressure) are interpreted and integrated for each patient. The physician interpreter must be familiar with possible treatment options that cover several fields, including orthopaedic surgery, neurosurgery, neurology, physiatry, physical therapy, orthotics, and prosthetics.

FREQUENCY INFORMATION

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

Outpatient consultation codes, like 99205, have been used in the past to report this service.

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

Specialty: Pediatric orthopaedic surgery *Commonly* Sometimes *Rarely*

3. 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: Pediatric orthopaedic surgery **Frequency: 25,000**

4. 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: Pediatric orthopaedic surgery **Frequency: 1,250**

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to a few medical centers

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

February 2002

**Intracardiac Electrophysiology – Mapping, Comprehensive EP, &
Analysis of Pacing Cardioverter Defibrillators**

The CPT Editorial Panel for CPT 2002 deleted 3 codes, revised 3 codes to be add-on codes, editorially changed 2 codes, and created 1 new code, in order to provide further clarification of the use of certain cardiac electrophysiology procedures, update current terminology related to the technology involved, and to accurately depict the continued technologic changes. All of these codes were reviewed by the RUC in April, 2001. At that time, codes 93609 and 93613 were referred back to CPT for clarification and the CPT Editorial Panel clarified that these services should be add-on codes. CMS valued these codes for 2001 without input from the RUC.

93609 Intraventricular and/or intra-atrial mapping of tachycardia site(s) with 3 dimensional mapping or catheter manipulation to record from multiple sites to identify origin of trachycardia (List separately in addition to code for primary procedure)

The RUC discussion focused on ensuring that these codes were appropriately valued as add on codes and did not contain any pre and post service work. The RUC was concerned that the survey respondents inappropriately included additional work in their estimates and therefore adjusted the recommended values to reflect only the intra-service work. The intra-service time of the base code 93620 *Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia* (11.59 RVW) was examined to determine the incremental time of mapping attributed to 93609 that is separate from the base code. The RUC felt that the proposal of 7.20 RVUs for 93609 was based on the inclusion of some of the work of the base code 93620, and therefore was an overestimation of the work.

The RUC also examined the CMS rationale for valuing this code at 4.81 RVUs, which is equal to code 93624 *Electrophysiologic follow-up study with pacing and recording to test effectiveness of therapy, including induction or attempted induction of arrhythmia* (4.81 RVW) with an intra-service time of 60 minutes. The committee felt that that 93624 had less intensity than 93609 and was not an appropriate comparison. However, code 93618 *Induction of arrhythmia by electrical pacing* has time of 90 minutes with work RVU of 4.26 was a better comparison but also was determined to have less intensity.

The RUC felt that another methodology for reducing the recommended RVU so that it only includes intra-service work is to assign an IWPUT of .066 to 93609, which is less than the IWPUT of .07 and .08 for other codes in the family. Using this IWPUT and the survey time of 90 minutes, results in the following value: $90 \times .066 = 5.94$

The value is then reduced by 15% to account for duplication of time with the base code, resulting in an RVU of 5.00. **The RUC recommends a work RVU of 5.00 for 93609.**

93613 Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)

The RUC reviewed this code in conjunction with 93609 and had the same concerns described above. The RUC therefore felt that the survey 25th percentile of 7.00 RVUs is appropriate since this is more intense than 93609 and the resulting work RVU accounted for any duplication with the base code. This value also places the code in proper rank order. **The committee recommends a work RVU of 7 for 93613.**

Practice Expense

Since codes 93609 and 93613 are add on codes performed in the facility setting there are no direct practice expense inputs for these codes.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
93607		Left ventricular recording <u>(93607 has been deleted. To report, use 93622)</u>	000	N/A
93609	VV4	Intraventricular and/or intra-atrial mapping of tachycardia site(s) with 3 dimensional mapping or catheter manipulation to record from multiple sites to identify origin of trachycardia <u>(List separately in addition to code for primary procedure)</u> <u>(Use 93609 in conjunction with codes 93620, 93651, 93652)</u>	ZZZ* change in global	5.00
● 93613	VV3	Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure) (Use 93613 in conjunction with codes 93620, 93651, 93652)	ZZZ	7.00
▲ 93619		Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular	000	7.32

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		<p> pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters; without induction or attempted induction of arrhythmia (This code is to be used when 93600 is combined with 93602, 93610, 93612)</p> <p><u>(Do not report 93619 in conjunction with 93600, 93602, 93610, or 93612, 93618, or 93620-93622)</u></p>		(No change)
▲93620		<p>Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters; with induction or attempted induction of arrhythmia (This code is to be used when 93618 is combined with 93619)</p> <p><u>(Do not report 93620 in conjunction with 93600, 93602, 93610, 93612, 93618 or 93619)</u></p>	000	11.59 (No change)
▲93621	VV1	<p>with left atrial pacing and recordings from coronary sinus or left atrium, with or without pacing, with induction or attempted induction of arrhythmia <u>(List separately in addition to code for primary procedure)</u></p> <p><u>(Use 93621 in conjunction with 93620)</u></p>	<p>ZZZ*</p> <p>*change in global</p>	2.10 (Approved at the April 2001 RUC Meeting) (No change)
▲93622	VV2	<p>with left ventricular pacing and recordings, with or without pacing with induction or attempted induction of arrhythmia <u>(List separately in addition to code for primary procedure)</u></p>	<p>ZZZ*</p> <p>*change in global</p>	3.10 (Approved at the April 2001 RUC Meeting)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		<u>(Use 93622 in conjunction with 93620)</u>		(No Change)
93737		Other Vascular Studies Electronic analysis of single or dual chamber pacing cardioverter defibrillator only (interrogation, evaluation of pulse generator status); without reprogramming <u>(93737 has been deleted. To report, use 93741 or 93743)</u>	XXX	N/A
93738		— with reprogramming <u>(93738 has been deleted. To report, use 93742 or 93744)</u>	XXX	N/A

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

CPT Code: 93609 Tracking Number: VV4 Global Period: ZZZ **Recommended RVW:** 7.2
RUC Recommended RVW: 5.00

CPT Descriptor:

Intraventricular and/or intra-atrial mapping of tachycardia site(s) with catheter manipulation to record from multiple sites to identify origin of tachycardia (List separately in addition to code for primary procedure)

(Use 93609 in conjunction with codes 93620, 93651, 93652)

CLINICAL DESCRIPTION OF SERVICE:Vignette Used in Survey:

A 67 year old man with a prior myocardial infarction is undergoing radiofrequency ablation (93652, billed separately) for treatment of ventricular tachycardia. A tachycardia that is hemodynamically stable is induced with a QRS morphology similar to his clinical tachycardia. The left ventricle is mapped to determine the tachycardia origin."

Intraservice work:

During the course of an electrophysiology procedure (93620, 93651, 93652, billed separately), an arrhythmia is induced that requires intracardiac mapping to localize the arrhythmia origin. The mapping electrode catheter is placed using standard percutaneous techniques. Mapping of the endocardial surface from within the chamber(s) is performed. The mapping catheter is moved from point to point to record endocardial activation during tachycardia or during sinus rhythm (voltage map identifying scar) to identify an early point of activation, mid-diastolic potential, Kent potential and/or similar paced maps. The map is displayed and analyzed. When a reentrant circuit is identified, entrainment mapping studies are performed and evaluated to confirm the catheter location is within the reentrant circuit. Additional mapping is performed when new arrhythmias occur and at the procedure conclusion. At the conclusion of the procedure, the catheter is removed, hemostasis obtained, and the mapping procedures and findings are included in the final report.

SURVEY DATA: (Update Data)

Presenter(s) James Maloney, M.D.

Specialty(s): Cardiology/Electrophysiology

Sample Size: 95 Response Rate: (31): (33%) Median RVW: 10.0

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

The survey was sent to a random sample of members of the North American Society of Pacing and Electrophysiology, a subspecialty of cardiology.

25th Percentile RVW: 7 75th Percentile RVW: 12.0 Low: 2.2 High: 21

Median Pre-Service Time: N/A Median Intra-Service Time: 90

25th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 155 Low: 30 High: 360

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

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Global</u>
93619	Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters, without induction or attempted induction of arrhythmia (This code is to be used when 93600 is combined with 93602, 93603, 93610, 93612)	7.32	000

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

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

<u>TIME ESTIMATES (Median)</u>	<u>New/Revis. CPT Code: <u>93609</u></u>	<u>Key Reference CPT Code: <u>93619</u> RUC time</u>
Median Pre-Time (day of procedure)	<u>N/A</u>	<u>60</u>
Median Intra-Time	<u>90</u>	<u>90</u>
Median Immediate Post-service Time	<u>N/A</u>	<u>53</u>
Median of Aggregate Critical Care Times	<u>N/A</u>	<u>N/A</u>
Median of Aggregate Other Hospital Visit Times	<u>N/A</u>	<u>N/A</u>
Median Discharge Day Management Time	<u>N/A</u>	<u>N/A</u>
Median of Aggregate Office Visit Times	<u>N/A</u>	<u>N/A</u>

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	4.48	3.76
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.45	3.59
Urgency of medical decision making	4.42	3.59

Technical Skill/Physical Effort (Mean)

Technical skill required	4.81	3.41
Physical effort required	4.35	3.41

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.74	3.18
Outcome depends on the skill and judgement of physician	4.90	3.53
Estimated risk of malpractice suit with poor outcome	4.42	3.71

INTENSITY/COMPLEXITY MEASURES**Time Segments (Mean)**

Pre-Service intensity/complexity	N/A	N/A
Intra-Service intensity/complexity	4.68	3.41
Post-Service intensity/complexity	N/A	N/A

ADDITIONAL RATIONALE

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

The American College of Cardiology has a Cardiovascular RUC Committee, representing general cardiology and the cardiology subspecialties, which met by phone conference to discuss the recommended work RVU.

Code 93609 is currently a 000 global period with 10.07 RVUs (until January 1, 2002). The ACC brought forward survey results on a newly approved code for 3D mapping to the April 2001 RUC meeting which

was surveyed as a 000 global period. At that time, the RUC determined that the 3D mapping code should be a ZZZ global period (add-on code). The RUC also determined that current code 93609 should be changed to ZZZ global status, necessitating that it be surveyed for the September RUC meeting.

Although the current value for 93609 of 10.07 work RVUs is similar to the median work RVU from our survey results of 10.0 work RVUs, we are requesting 7.2 work RVUs. This equates to an IWPUT of .08 and takes into account the change to add-on status. This recommendation puts code 93609 in proper rank order to the more difficult 3D mapping code, of which we are recommending 9.5 RVUs, with an IWPUT of .079.

FREQUENCY INFORMATION

How was this service previously reported? 93609 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

Note – code is the same, global period has been changed from 000 to ZZZ.

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 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 17,100

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 Cardiology _____ Frequency 5,700

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

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

CPT Code: 93613 Tracking Number: VV3 Global Period: ZZZ

Recommended RVW: 9.5**RUC Recommended RVW:** 7.00

* New code for 2002

CPT Descriptor:

Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)

(Use 93613 in conjunction with codes 93620, 93651, 93652)

CLINICAL DESCRIPTION OF SERVICE:Vignette Used in Survey:

A 71 year old woman is undergoing radiofrequency ablation (93651, billed separately) to treat atrial tachycardia. Two distinct atrial tachycardias are induced each with a morphology similar to her tachycardia that has been documented clinically. Neither tachycardia is sustained. The right atrium is mapped to determine the origin of each tachycardia.

Intraservice work :

During the course of an electrophysiology procedure (93620, 93651, 93652), an arrhythmia is induced that requires use of an advanced three-dimensional computer-assisted mapping system to localize the arrhythmia origin. The physician places the mapping system in the cardiac chamber of interest using standard percutaneous techniques. The system is calibrated, and recordings are made during sinus rhythm to identify normal activation and the location of scar and during each distinct tachycardia. The computer-generated map is displayed, modifications in the computer parameters and display are performed, and the tachycardia origin is identified. The ablation catheter is moved to the point of early activation localized by the mapping system to identify a mid-diastolic potential, Kent potential and/or similar paced maps. When a reentrant circuit is identified, entrainment mapping studies are performed and evaluated to confirm the catheter location is within the reentrant circuit. Additional mapping acquisitions are made to confirm arrhythmia origin and study additional arrhythmias and at the procedure conclusion. At the conclusion of the procedure, the catheter is removed, hemostasis obtained, and the mapping procedure and findings are included in the final report.

SURVEY DATA:

Presenter(s) James Maloney, M.D.

Specialty(s): Cardiology/Electrophysiology

Sample Size: 95 Response Rate: (32): (34%) Median RVW: 9.5Type of Sample (Circle One): random, panel, convenience. Explanation of sample size:

The survey was sent to a random sample of members of the North American Society of Pacing and Electrophysiology, a subspecialty of cardiology.

25th Percentile RVW: 7 75th Percentile RVW: 16.09 Low: 2.2 High: 25

Median Pre-Service Time: N/A Median Intra-Service Time: 120

25th Percentile Intra-Svc Time: 71.25 75th Percentile Intra-Svc Time: 180 Low: 30 High: 360

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

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW	Global
93619	Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters; without induction or attempted induction of arrhythmia (This code is to be used when 93600 is combined with 93602, 93603, 93610, 93612)	7.32	000

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

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

<u>TIME ESTIMATES (Median)</u>	New/Revis. CPT Code: <u>93613</u>	Key Reference CPT Code: <u>93619</u> RUC Time
Median Pre-Time (day of procedure)	<u> N/A </u>	<u> 60 </u>
Median Intra-Time	<u> 120 </u>	<u> 90 </u>
Median Immediate Post-service Time	<u> N/A </u>	<u> 53 </u>
Median of Aggregate Critical Care Times	<u> N/A </u>	<u> N/A </u>
Median of Aggregate Other Hospital Visit Times	<u> N/A </u>	<u> N/A </u>
Median Discharge Day Management Time	<u> N/A </u>	<u> N/A </u>
Median of Aggregate Office Visit Times	<u> N/A </u>	<u> N/A </u>

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	4.75	3.90
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.56	3.75
Urgency of medical decision making	4.47	3.65

Technical Skill/Physical Effort (Mean)

Technical skill required	4.84	3.45
Physical effort required	4.22	3.35

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.41	3.26
Outcome depends on the skill and judgement of physician	4.84	3.63
Estimated risk of malpractice suit with poor outcome	4.13	3.74

INTENSITY/COMPLEXITY MEASURES**Time Segments (Mean)**

Pre-Service intensity/complexity	N/A	N/A
Intra-Service intensity/complexity	4.84	3.55
Post-Service intensity/complexity	N/A	N/A

ADDITIONAL RATIONALE

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

The American College of Cardiology has a Cardiovascular RUC Committee, representing general cardiology and the cardiology subspecialties, which met by phone conference to discuss the recommended work RVU.

The ACC originally surveyed this 3D mapping code for the April 2001 RUC meeting as a 000 global code. The RUC determined that it should be a ZZZ global period, necessitating that it be resurveyed for

CPT 2002 RUC Recommendations

<i>CPT Code</i>	<i>Global Coding</i>	<i>CPT Main</i>	<i>Change</i>	<i>Date</i>	<i>Tab</i>	<i>Issue</i>	<i>Tracking Number</i>	<i>RUC Date</i>	<i>RUC Tab</i>	<i>Specialty Rec</i>	<i>RUC Rec</i>	<i>RVU as last yr?</i>	<i>Same Rec last yr?</i>	<i>MFS?</i>	<i>Comments</i>
00797	XXX	N	Feb01	Q		Anesthesia for Gastric Restrictive Procedure for Morbid Obesity	DD1	Apr01	13	9.00	9.00		Yes		
00850	XXX	D	Feb01	S		Anesthesia for Obstetrical Procedures		Deletion						Yes	
00851	XXX	N	Feb01	S		Anesthesia for Obstetrical Procedures	FF1	Apr01	15	6.00	6.00		Yes		
00855	XXX	D	Feb01	S		Anesthesia for Obstetrical Procedures		Deletion						Yes	
00857	XXX	D	Feb01	S		Anesthesia for Obstetrical Procedures		Deletion						Yes	
00869	XXX	N	Feb01	S		Anesthesia for Obstetrical Procedures	FF2	Apr01	15	3.00	3.00		Yes		
00884	XXX	D	Feb01	R		Anesthesia for Interventional Radiology Procedures		Deletion						Yes	
00946	XXX	D	Feb01	S		Anesthesia for Obstetrical Procedures		Deletion						Yes	
00955	XXX	D	Feb01	S		Anesthesia for Obstetrical Procedures		Deletion						Yes	
01904	XXX	D	Feb01	R		Anesthesia for Interventional Radiology Procedures		Deletion						Yes	
01905	XXX	N	Feb01	R		Anesthesia for Interventional Radiology Procedures	EE1	Apr01	14	6.00	5.00		Yes		
01906	XXX	D	Feb01	R		Anesthesia for Interventional Radiology Procedures		Deletion						Yes	
01908	XXX	D	Feb01	R		Anesthesia for Interventional Radiology Procedures		Deletion						Yes	
01910	XXX	D	Feb01	R		Anesthesia for Interventional Radiology Procedures		Deletion						Yes	
01912	XXX	D	Feb01	R		Anesthesia for Interventional Radiology Procedures		Deletion						Yes	
01914	XXX	D	Feb01	R		Anesthesia for Interventional Radiology Procedures		Deletion						Yes	
01916	XXX	R	Feb01	R		Anesthesia for Interventional Radiology Procedures	EE2	Apr01	14	5.00	5.00		Yes		

<i>CPT Global Coding</i>	<i>CPT Main</i>	<i>Code</i>	<i>Period</i>	<i>Change</i>	<i>Date</i>	<i>Tab</i>	<i>Issue</i>	<i>Tracking RUC</i>	<i>RUC</i>	<i>Specialty</i>	<i>RUC</i>	<i>RVU as</i>	<i>Same</i>	<i>MFS?</i>	<i>Comments</i>	
								<i>Number</i>	<i>Date</i>	<i>Tab</i>	<i>Rec</i>	<i>Rec last yr?</i>				
01918	XXX	D	Feb01	R			Anesthesia for Interventional Radiology Procedures								Deletion	Yes
01921	XXX	D	Feb01	R			Anesthesia for Interventional Radiology Procedures								Deletion	Yes
01924	XXX	N	Feb01	R			Anesthesia for Interventional Radiology Procedures	EE3	Apr01	14	7.00	5.00				Yes
01925	XXX	N	Feb01	R			Anesthesia for Interventional Radiology Procedures	EE4	Apr01	14	8.00	7.00				Yes
01926	XXX	N	Feb01	R			Anesthesia for Interventional Radiology Procedures	EE5	Apr01	14	10.00	8.00				Yes
01930	XXX	N	Feb01	R			Anesthesia for Interventional Radiology Procedures	EE6	Apr01	14	5.00	5.00				Yes
01931	XXX	N	Feb01	R			Anesthesia for Interventional Radiology Procedures	EE7	Apr01	14	7.00	7.00				Yes
01932	XXX	N	Feb01	R			Anesthesia for Interventional Radiology Procedures	EE8	Apr01	14	7.00	6.00				Yes
01933	XXX	N	Feb01	R			Anesthesia for Interventional Radiology Procedures	EE9	Apr01	14	8.00	7.00				Yes
01951	XXX	R	Nov00	G			Anesthesia Services - Burn	S1	Feb01	17	3.00	3.00	Yes			Yes
01952	XXX	R	Nov00	G			Anesthesia Services - Burn	S2	Feb01	17	5.00	5.00				Yes
01960	XXX	N	Feb01	S			Anesthesia Obstetrical Procedures	FF3	Apr01	15	5.00	5.00				Yes
01961	XXX	N	Feb01	S			Anesthesia Obstetrical Procedures	FF4	Apr01	15	7.00	7.00				Yes
01962	XXX	N	Feb01	S			Anesthesia Obstetrical Procedures	FF5	Apr01	15	8.00	8.00				Yes
01963	XXX	N	Feb01	S			Anesthesia Obstetrical Procedures	FF6	Apr01	15	9.00	8.00				Yes
01964	XXX	N	Feb01	S			Anesthesia Obstetrical Procedures	FF10	Apr01	15	4.00	4.00				Yes
01967	XXX	N	Feb01	S			Anesthesia Obstetrical Procedures	FF7	Apr01	15	5.00	5.00				Yes
01968	XXX	N	Feb01	S			Anesthesia Obstetrical Procedures	FF8	Apr01	15	3.00	3.00				Yes
01969	XXX	N	Feb01	S			Anesthesia Obstetrical Procedures	FF9	Apr01	15	5.00	5.00				Yes

<i>CPT Global Coding</i>	<i>CPT Main</i>				<i>Tracking RUC</i>	<i>RUC</i>	<i>Specialty RUC</i>	<i>Same RUC RVU as</i>		<i>MFS?</i>	<i>Comments</i>		
<i>Code</i>	<i>Period</i>	<i>Change</i>	<i>Date</i>	<i>Tab</i>	<i>Issue</i>	<i>Number</i>	<i>Date</i>	<i>Tab</i>	<i>Rec</i>	<i>Rec last yr?</i>			
10021	XXX	N	Nov00	22	Fine Needle Aspiration			Editorial	1.27	1.27	Yes	Yes	Moved existing code 88170
10022	XXX	N	Nov00	22	Fine Needle Aspiration			Editorial	1.27	1.27	Yes	Yes	Moved existing code 88171
11755	000	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	1.31	1.31	Yes	Yes	
11981	XXX	N	Feb01	V	Nonbiodegradable Androgen Suppression Implant	GG1	Apr01	16	1.48	1.48		Yes	Interim recommendations. RUC to review at a future meeting
11982	XXX	N	Feb01	V	Nonbiodegradable Androgen Suppression Implant	GG2	Apr01	16	1.78	1.78		Yes	Interim recommendations. RUC to review at a future meeting.
11983	XXX	N	Feb01	V	Nonbiodegradable Androgen Suppression Implant	GG3	Apr01	16	3.30	3.30		Yes	Interim recommendations. RUC to review at a future meeting.
17000	010	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	0.60	0.60	Yes	Yes	
17003	ZZZ	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	0.15	0.15	Yes	Yes	
17004	010	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	2.79	2.79	Yes	Yes	
17110	010	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	0.65	0.65	Yes	Yes	
17111	010	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	0.92	0.92	Yes	Yes	
17260	010	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	0.91	0.91	Yes	Yes	
17261	010	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	1.71	1.71	Yes	Yes	
17262	010	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	1.58	1.58	Yes	Yes	
17263	010	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	1.79	1.79	Yes	Yes	
17264	010	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	1.94	1.94	Yes	Yes	
17266	010	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	2.34	2.34	Yes	Yes	
17270	010	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	1.32	1.32	Yes	Yes	
17271	010	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	1.49	1.49	Yes	Yes	
17272	010	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	1.77	1.77	Yes	Yes	
17273	010	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	2.05	2.05	Yes	Yes	

<i>CPT Global Coding</i>	<i>CPT Main</i>								<i>Same</i>			
<i>Code</i>	<i>Period</i>	<i>Change</i>	<i>Date</i>	<i>Tab</i>	<i>Issue</i>	<i>Tracking RUC</i>	<i>RUC</i>	<i>Specialty RUC</i>	<i>RVU as</i>	<i>Rec last yr?</i>	<i>MFS?</i>	<i>Comments</i>
						<i>Number</i>	<i>Date</i>	<i>Tab</i>	<i>Rec</i>	<i>Rec last yr?</i>		
17274	010	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	2.59	2.59	Yes	Yes
17276	010	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	3.20	3.20	Yes	Yes
17280	010	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	1.17	1.17	Yes	Yes
17281	010	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	1.72	1.72	Yes	Yes
17282	010	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	2.04	2.04	Yes	Yes
17283	010	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	2.64	2.64	Yes	Yes
17284	010	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	3.21	3.21	Yes	Yes
17286	010	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	4.44	4.44	Yes	Yes
20225	000	R	Feb01	15	Radiology Revisions		Apr01	10	1.87	1.87	Yes	Yes
20526	000	N	Feb01	Fax	Therapeutic Injections	ZZ1	Apr01	24	0.86	0.86		Yes Interim - RUC to review in Sept. 2001
20550	000	R	Feb01	Fax	Therapeutic Injections	ZZ2	Apr01	24	0.86	0.86	Yes	Yes Interim - RUC to review in Sept. 2001
20551	000	N	Feb01	Fax	Therapeutic Injections	ZZ3	Apr01	24	0.86	0.86		Yes Interim - RUC to review in Sept. 2001
20552	000	N	Feb01	Fax	Therapeutic Injections	ZZ4	Apr01	24	0.86	0.86		Yes Interim - RUC to review in Sept. 2001
20553	000	N	May01	EC	Therapeutic Injections	ZZ5					Yes	No RUC Rec - RUC to review in Sept. 2001
23000	090	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	4.36	4.36	Yes	Yes
23350	000	R	Feb01	15	Radiology Revisions		Apr01	10	1.00	1.00	Yes	Yes
24075	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures		Apr01	25	3.92	3.92	Yes	Yes
24076	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures		Apr01	25	6.30	6.30	Yes	Yes
24300	090	N	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	JJ9	Apr01	25	3.75	3.75		Yes
24332	090	N	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	JJ4	Apr01	25	7.45	7.45		Yes

<i>CPT Global Coding</i>	<i>CPT Main</i>														
<i>Code</i>	<i>Period</i>	<i>Change</i>	<i>Date</i>	<i>Tab</i>	<i>Issue</i>	<i>Tracking RUC Number</i>	<i>RUC Date</i>	<i>Tab</i>	<i>Specialty RUC Rec</i>	<i>RVU as Rec last yr?</i>	<i>Same</i>	<i>MFS?</i>	<i>Comments</i>		
24343	090	N	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures JJ5	Apr01	25	25	8.65	8.65		Yes			
24344	090	N	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures JJ6	Apr01	25	25	14.00	14.00		Yes	Interim - RUC to review in Sept. 2001		
24345	090	N	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures JJ7	Apr01	25	25	8.65	8.65		Yes			
24346	090	N	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures JJ8	Apr01	25	25	14.00	14.00		Yes	Interim - RUC to review in Sept. 2001		
25001	090	N	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures JJ10	Apr01	25	25	3.38	3.38		Yes			
25020	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	Apr01	25	25	5.92	5.92	Yes	Yes			
25023	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	Apr01	25	25	12.96	12.96	Yes	Yes			
25024	090	N	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures JJ11	Apr01	25	25	9.50	9.50		Yes			
25025	090	N	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures JJ12	Apr01	25	25	18.48	16.54		Yes			
25075	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	Apr01	25	25	3.74	3.74	Yes	Yes			
25076	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	Apr01	25	25	4.92	4.92	Yes	Yes			
25259	090	N	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures JJ18	Apr01	25	25	3.75	3.75		Yes			
25274	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	Apr01	25	25	8.75	8.75	Yes	Yes			
25275	090	N	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures JJ13	Apr01	25	25	8.50	8.50		Yes			
25394	090	N	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures JJ14	Apr01	25	25	10.40	10.40		Yes			
25405	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	Apr01	25	25	14.38	14.38	Yes	Yes			

<i>CPT Global Coding</i>	<i>CPT Main</i>								<i>Same</i>		
<i>Code</i>	<i>Period</i>	<i>Change</i>	<i>Date</i>	<i>Tab</i>	<i>Issue</i>	<i>Tracking RUC</i>	<i>RUC</i>	<i>Specialty RUC</i>	<i>RVU as</i>		
						<i>Number</i>	<i>Date</i>	<i>Tab</i>	<i>Rec</i>	<i>Rec last yr?</i>	<i>MFS?</i>
											<i>Comments</i>
25420	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	Apr01	25	16.33	16.33	Yes	Yes
25430	090	N	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	JJ15	Apr01	25	9.25	9.25	Yes
25431	090	N	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	JJ16	Apr01	25	10.44	10.44	Yes
25440	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	JJ17	Apr01	25	10.44	10.44	Yes
25520	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	Apr01	25	6.26	6.26	Yes	Yes
25526	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	Apr01	25	12.98	12.98	Yes	Yes
25645	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	Apr01	25	7.25	7.25	Yes	Yes
25651	090	N	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	JJ19	Apr01	25	5.36	5.36	Yes
25652	090	N	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	JJ20	Apr01	25	7.60	7.60	Yes
25671	090	N	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	JJ21	Apr01	25	6.00	6.00	Yes
26115	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	Apr01	25	3.86	3.86	Yes	Yes
26116	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	Apr01	25	5.53	5.53	Yes	Yes
26160	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	Apr01	25	3.15	3.15	Yes	Yes
26250	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	Apr01	25	7.55	7.55	Yes	Yes
26255	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	Apr01	25	12.43	12.43	Yes	Yes
26340	090	N	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	JJ25	Apr01	25	2.50	2.50	Yes

<i>CPT Global Coding</i>	<i>CPT Main</i>												
<i>Code</i>	<i>Period</i>	<i>Change</i>	<i>Date</i>	<i>Tab</i>	<i>Issue</i>	<i>Tracking RUC Number</i>	<i>RUC Date</i>	<i>Specialty RUC Tab</i>	<i>Rec</i>	<i>RVU as Rec last yr?</i>	<i>MFS?</i>	<i>Comments</i>	
26350	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	Apr01	25	5.99	5.99	Yes	Yes		
26352	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	Apr01	25	7.68	7.68	Yes	Yes		
26356	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	Apr01	25	8.07	8.07	Yes	Yes		
26357	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	Apr01	25	8.58	8.58	Yes	Yes		
26358	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	Apr01	25	9.14	9.14	Yes	Yes		
26390	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	Apr01	25	9.19	9.19	Yes	Yes		
26392	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	Apr01	25	10.26	10.26	Yes	Yes		
26415	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	Apr01	25	8.34	8.34	Yes	Yes		
26416	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	Apr01	25	9.37	9.37	Yes	Yes		
26426	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	Apr01	25	6.15	6.15	Yes	Yes		
26428	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	Apr01	25	7.21	7.21	Yes	Yes		
26445	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	Apr01	25	4.31	4.31	Yes	Yes		
26510	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	JJ22 Apr01	25	5.43	5.43	Yes	Yes		
26585	090	D	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	Deletion					Yes		
26587	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	JJ23 Apr01	25	14.05	14.05		Yes	This code was previously carrier-priced	
26590	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	JJ24 Apr01	25	17.96	17.96	Yes	Yes		

<i>CPT Code</i>	<i>Global Coding</i>	<i>CPT Main</i>	<i>Change</i>	<i>Date</i>	<i>Tab</i>	<i>Issue</i>	<i>Tracking Number</i>	<i>RUC Date</i>	<i>RUC Tab</i>	<i>Specialty Rec</i>	<i>RUC Rec last yr?</i>	<i>RVU as</i>	<i>MFS?</i>	<i>Comments</i>	
26597	090	D	Feb01	2		Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures								Deletion	Yes
26607	090	R	Feb01	X		Closed Treatment Metacarpal Fracture	QQ1	Apr01	26	5.36	5.36	Yes	Yes	Interim Recommendation - AAOS will be working on further coding revisions	
26608	090	R	Feb01	X		Closed Treatment Metacarpal Fracture	QQ2	Apr01	26	5.36	5.36	Yes	Yes	Interim Recommendation - AAOS will be working on further coding revisions	
26670	090	R	Feb01	2		Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures		Apr01	25	3.69	3.69	Yes	Yes		
26675	090	R	Feb01	2		Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures		Apr01	25	4.64	4.64	Yes	Yes		
26676	090	R	Feb01	2		Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures		Apr01	25	5.52	5.52	Yes	Yes		
26685	090	R	Feb01	2		Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	JJ26	Apr01	25	6.98	6.98	Yes	Yes		
26843	090	R	Feb01	2		Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	JJ27	Apr01	25	7.61	7.61	Yes	Yes		
26844	090	R	Feb01	2		Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	JJ28	Apr01	25	8.73	8.73	Yes	Yes		
27096	000	R	Nov00	3		Sacroiliac Joint Arthrography				1.40	1.40	Yes	Yes	Editorial	
28299	090	R	Feb01	Y		Hallux Valgus Repair		Apr01	27	11.85	10.58		Yes		
29086	000	N	Feb01	2		Hand/Finger/Wrist/Forearm/Musculoskeletal/ Vascular/Nerve Procedures	JJ29	Apr01	25	0.62	0.62		Yes		
29805	090	N	Feb01	1		Arthroscopic Shoulder Procedures		Apr01	28	5.89	5.89	Yes	Yes	Code was renumbered from 29815	
29806	090	N	Feb01	1		Arthroscopic Shoulder Procedures	II1	Apr01	28	15.00	14.37		Yes		
29807	090	N	Feb01	1		Arthroscopic Shoulder Procedures	II2	Apr01	28	14.37	13.90		Yes		
29815	090	D	Feb01	1		Arthroscopic Shoulder Procedures							Yes	Deletion	
29819	090	R	Feb01	1		Arthroscopic Shoulder Procedures		Apr01	28	7.62	7.62	Yes	Yes		
29820	090	R	Feb01	1		Arthroscopic Shoulder Procedures		Apr01	28	7.07	7.07	Yes	Yes		

<i>CPT Global Coding</i>	<i>CPT Main</i>														
<i>Code</i>	<i>Period</i>	<i>Change</i>	<i>Date</i>	<i>Tab</i>	<i>Issue</i>	<i>Tracking RUC Number</i>	<i>RUC Date</i>	<i>RUC Tab</i>	<i>Specialty Rec</i>	<i>RUC Rec</i>	<i>RVU as last yr?</i>	<i>MFS?</i>	<i>Comments</i>		
44126	090	N	Aug00	L	Repair Small Intestine Atresia	E1	Apr01	A	35.50	35.50		Yes			
44127	090	N	Aug00	L	Repair Small Intestine Atresia	E2	Apr01	A	41.00	41.00		Yes			
44128	ZZZ	N	Aug00	L	Repair Small Intestine Atresia	E3	Apr01	A	5.00	4.45		Yes			
44140	090	R	Aug00	T	Laparoscopic Colon Procedures		Apr01	C	18.35	18.35	Yes	Yes	The RUC recommends that its previous 5 yr rec. of 18.35 created a rank order anomaly with 44160. 44140 should be valued higher than 44160.		
44160	090	R	Aug00	T	Laparoscopic Colon Procedures		Apr01	C	18.62	18.62		Yes			
44202	090	R	Aug00	T	Laparoscopic Colon Procedures	P1	Apr01	C	22.04	22.04	Yes	Yes			
44203	ZZZ	N	Aug00	T	Laparoscopic Colon Procedures	P2	Apr01	C	4.45	4.45		Yes			
44204	090	N	Aug00	T	Laparoscopic Colon Procedures	P3	Apr01	C	22.00	22.00		Yes			
44205	090	N	Aug00	T	Laparoscopic Colon Procedures	P4	Apr01	C	19.50	19.50		Yes			
44366	000	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	4.41	4.41	Yes	Yes			
44378	000	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	5.26	5.26	Yes	Yes			
44391	000	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	3.82	3.82	Yes	Yes			
45136	090	N	Nov00	U	Placement of Anal Seton and Excision of Ileoanal Reservoir	Q2	Feb01	23	27.30	27.30		Yes			
45190	090	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	8.28	8.28	Yes	Yes			
45303	000	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	0.44	0.44	Yes	Yes			
45317	000	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	1.50	1.50	Yes	Yes			
45334	000	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	2.73	2.73	Yes	Yes			
45382	000	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	5.69	5.69	Yes	Yes			
46020	010	N	Nov00	U	Placement of Anal Seton and Excision of Ileoanal Reservoir	Q1	Feb01	23	2.90	2.90		Yes			
46604	000	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	1.31	1.31	Yes	Yes			

<i>CPT Code</i>	<i>Global</i>	<i>Coding</i>	<i>CPT Main</i>	<i>Change</i>	<i>Date</i>	<i>Tab</i>	<i>Issue</i>	<i>Tracking RUC Number</i>	<i>RUC Date</i>	<i>Specialty RUC Tab</i>	<i>RVU as Rec</i>	<i>RVU as Rec last yr?</i>	<i>MFS?</i>	<i>Comments</i>
52347	000	N	Nov00	X	Cystoscopy/Cystourethroscopy Procedures	J2	Apr01	17	5.28	5.28	Yes			
52510	090	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	6.72	6.72	Yes	Yes		
53431	090	N	Feb01	G	Urethral Sphincter Procedures		Renumbered Code		19.89	19.89	Yes	Yes	Renumbered from code 53443	
53443	090	D	Feb01	G	Urethral Sphincter Procedures		Deletion						Yes	
53444	090	N	Nov00	Y	Insertion of Tandem Cuff	K1	Apr01	18	13.40	13.40		Yes		
53445	090	R	Feb01	G	Urethral Sphincter Procedures	X1	Apr01	19	14.06	14.06	Yes	Yes		
53446	090	N	Feb01	G	Urethral Sphincter Procedures	X2	Apr01	19	10.23	10.23		Yes		
53447	090	R	Feb01	G	Urethral Sphincter Procedures	X3	Apr01	19	14.08	13.49		Yes		
53448	090	N	Feb01	G	Urethral Sphincter Procedures	X4	Apr01	19	24.86	21.15		Yes		
53449	090	R	Feb01	G	Urethral Sphincter Procedures	X5	Apr01	19	9.70	9.70	Yes	Yes		
53853	090	N	May00	J	Transurethral Destruction of Prostate by Water-induced Thermotherapy	A1	Apr01	20	8.75	6.41		Yes		
54065	010	R	Feb01	N	Any Method/Any Approach/Any Technique		Apr01	9	2.42	2.42	Yes	Yes		
54162	010	N	Nov00	Z	Penile Procedures	L1	Apr01	21	3.44	3.00		Yes		
54163	010	N	Nov00	Z	Penile Procedures	L2	Apr01	21	3.70	3.00		Yes		
54164	010	N	Nov00	Z	Penile Procedures	L3	Apr01	21	3.10	2.50		Yes		
54400	090	R	Feb01	G	Penile Prosthesis		Apr01	22	8.99	8.99	Yes	Yes		
54401	090	R	Feb01	G	Penile Prosthesis		Apr01	22	10.28	10.28	Yes	Yes		
54402	090	D	Feb01	G	Penile Prosthesis		Deletion						Yes	
54405	090	R	Feb01	G	Penile Prosthesis	Y1	Apr01	22	13.43	13.43	Yes	Yes		
54406	090	N	Feb01	G	Penile Prosthesis	Y5	Apr01	22	12.10	12.10		Yes		
54407	090	D	Feb01	G	Penile Prosthesis		Deletion						Yes	
54408	090	N	Feb01	G	Penile Prosthesis	Y6	Apr01	22	13.30	12.75		Yes		



CPT Global Coding CPT Main
Code Period Change Date Tab Issue

Tracking RUC RUC Specialty RUC RVU as
Number Date Tab Rec Rec last yr? MFS? Comments

CPT Code	Period	Change	Date	Tab	Issue	Tracking Number	RUC Date	RUC Tab	Specialty Rec	RUC Rec last yr?	RVU as	MFS?	Comments
64575	010	R	Nov00	2	Implantation of Sacral Nerve Neuro-Stimulators		Apr01	23	4.53	4.53	Yes	Yes	
64581	010	N	Nov00	2	Implantation of Sacral Nerve Neuro-Stimulators	N2	Apr01	23	13.50	13.50		Yes	
64820	090	R	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/Vascular/Nerve Procedures		Apr01	25	10.37	10.37	Yes	Yes	
64821	090	N	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/Vascular/Nerve Procedures	JJ33	Apr01	25	9.50	8.75		Yes	
64822	090	N	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/Vascular/Nerve Procedures	JJ34	Apr01	25	9.50	8.75		Yes	
64823	090	N	Feb01	2	Hand/Finger/Wrist/Forearm/Musculoskeletal/Vascular/Nerve Procedures	JJ35	Apr01	25	10.37	10.37		Yes	
66982	090	R	Feb01	Fax	Complex Cataract		Editorial		13.50	13.50	Yes	Yes	
67225	ZZZ	N	Feb01	14	Ocular Photodynamic Therapy	PP1	Apr01	11				Yes	No RUC Rec. - RUC will review in 2-3 years
69990	ZZZ	R	Feb01	2	Operating Microscope		Apr01	25	3.47	3.47	Yes	Yes	
74230	XXX	R	Feb01	15	Radiology Revisions		Apr01	10	0.53	0.53	Yes	Yes	
74305	XXX	R	Feb01	15	Radiology Revisions		Apr01	10	0.42	0.42	Yes	Yes	
76066	XXX	R	Feb01	16	Joint Survey		Editorial		0.31	0.31	Yes	Yes	
76078	XXX	R	Feb01	15	Radiology Revisions		Apr01	10	0.20	0.20	Yes	Yes	
76085	ZZZ	N		EC	Computer-Aided Mammographic Lesion Detection							Yes	No RUC Recommendation - RUC will review in Sept. 2001
76120	XXX	R	Feb01	15	Radiology Revisions		Apr01	10	0.38	0.38	Yes	Yes	
76125	XXX	R	Feb01	15	Radiology Revisions		Apr01	10	0.27	0.27	Yes	Yes	
76362	XXX	N	Feb01	F	Ablation of Hepatic Tumors		Apr01	E	4.00			Yes	No RUC Rec. See Specialty Society info. Attached. RUC to Review in Sept. 2001
76394	XXX	N	Feb01	F	Ablation of Hepatic Tumors		Apr01	E	4.25			Yes	No RUC Rec. See Specialty Society info. Attached. RUC to Review in Sept. 2001

<i>CPT Global Coding CPT Main</i>					<i>Tracking RUC</i>		<i>RUC Specialty RUC RVU as</i>		<i>Same</i>		<i>MFS? Comments</i>		
<i>Code</i>	<i>Period</i>	<i>Change</i>	<i>Date</i>	<i>Tab</i>	<i>Issue</i>	<i>Number</i>	<i>Date</i>	<i>Tab</i>	<i>Rec</i>	<i>Rec</i>	<i>last yr?</i>	<i>MFS?</i>	<i>Comments</i>
76490	XXX	N	Feb01	F	Ablation of Hepatic Tumors		Apr01	E	4.00			Yes	No RUC Rec. See Specialty Society info. Attached. RUC to Review in Sept. 2001
76819	XXX	R	Nov00	EC-	Fetal Biophysical Profile			Editorial	0.63	0.63	Yes	Yes	
76885	XXX	R	Feb01	15	Radiology Revisions		Apr01	10	0.74	0.74	Yes	Yes	
76886	XXX	R	Feb01	15	Radiology Revisions		Apr01	10	0.62	0.62	Yes	Yes	
77300	XXX	R	Feb01	15	Radiology Revisions		Apr01	10	0.62	0.62	Yes	Yes	
77301	XXX	N	Nov00	5	Radiotherapy	V1	Apr01	H	9.00	8.00		Yes	
77418	XXX	N	Nov00	6	Radiation Treatment Delivery	W1	Apr01	I	0.00	0.00		Yes	No physician work - practice expense inputs only
80072	XXX	D	Nov00	H	Arthritis Panel			Deletion				No	
82270	XXX	R	Nov00	EC-	Blood, occult			CLFS				No	
82273	XXX	R	Nov00	EC-	Blood, occult			CLFS				No	
82274	XXX	R	Nov00	EC-	Blood, occult			CLFS				No	
83013	XXX	R	Feb01	21	H Pylori Detection			CLFS				No	
83950	XXX	N	Feb01	26	Oncoprotein			CLFS				No	
85095	XXX	D	Nov00	22	Bone Marrow aspiration/biopsy			Deletion				Yes	Moved to code 38220
85097	XXX	R	Nov00	22	Bone Marrow aspiration/biopsy			Editorial	0.94	0.94	Yes	Yes	
85102	XXX	D	Nov00	22	Bone Marrow aspiration/biopsy			Deletion				Yes	Moved to code 38221
85535	XXX	D	Feb01	22	Iron Stain			Deletion				No	
86140	XXX	R	Feb01	12	C-reactive protein			CLFS				No	
86141	XXX	N	Feb01	12	C-reactive protein			CLFS				No	
86336	XXX	N	Aug00	F	Inhibin A			CLFS				No	
86683	XXX	D	Nov00	D	Hemoglobin, fecal			Deletion				No	
87198	XXX	N	Aug00	F	Cytomegalovirus			CLFS				No	

<i>CPT Code</i>	<i>Global</i>	<i>Coding</i>	<i>CPT Main</i>	<i>Change</i>	<i>Date</i>	<i>Tab</i>	<i>Issue</i>	<i>Tracking RUC Number</i>	<i>RUC Date</i>	<i>Specialty Tab</i>	<i>RUC Rec</i>	<i>Specialty Rec</i>	<i>RUC RVU as last yr?</i>	<i>MFS?</i>	<i>Comments</i>
87199	XXX	N	Aug00	F	Enterovirus			CLFS						No	
87802	XXX	N	Aug00	N	Visually read immunoassay for infectious disease antigen			CLFS						No	
87803	XXX	N	Aug00	N	Visually read immunoassay for infectious disease antigen			CLFS						No	
87804	XXX	N	Aug00	N	Visually read immunoassay for infectious disease antigen			CLFS						No	
87902	XXX	N	Feb01	25	Hepatitis C Virus			CLFS						No	
87903	XXX	R	Feb01	23	Microbiology Infectious Agent Antigen Detection			CLFS						No	
87904	XXX	N	Feb01	23	Microbiology Infectious Agent Antigen Detection			CLFS						No	
88170	XXX	D	Nov00	22	Fine Needle Aspiration			Deletion						Yes	Code moved to 10021
88171	XXX	D	Nov00	22	Fine Needle Aspiration			Deletion						Yes	Code moved to 10022
88380	XXX	N	Nov00	EC-	Microdissection (mechanical, laser capture)									Yes	Carrier Price. RUC to review in Sept. 2001
90471	XXX	R	May00	U	Immunization Administration	B1	Feb01	21	0.17	0.17	Yes				
90472	XXX	R	May00	U	Immunization Administration	B2	Feb01	21	0.15	0.15	Yes				
90473	XXX	N	May00	U	Immunization Administration	B3	Feb01	21	0.17	0.17	Yes				
90474	XXX	N	May00	U	Immunization Administration	B4	Feb01	21	0.15	0.15	Yes				
90732	XXX	R	Feb01	27	Pneumococcal Vaccine			Vaccine						No	
90939	XXX	N	Feb01	28	Revised Hemodialysis Access Flow Measurement	SS1	Feb01	12	0.00	0.00	Yes				Per HCFA - bundled into MCP Payment
91123	XXX	N	May00	EC1	Pulsed Irrigation of the Bowel	C1	Apr01	J	0.00	0.00	Yes				No Physician work - PE inputs only
92136	XXX	N	Feb01	19	Noninvasive Anterior Chamber Biometry	RR1	Apr01	K	0.54	0.54	Yes				
92973	ZZZ	N	Feb01	29	Percutaneous Transluminal Coronary Thrombectomy	TT1	Apr01	M	3.28	3.28	Yes				

<i>CPT Global Coding</i>	<i>CPT Main</i>					<i>Tracking RUC</i>	<i>RUC</i>	<i>Specialty</i>	<i>RUC</i>	<i>RVU as</i>	<i>Same</i>	<i>MFS?</i>	<i>Comments</i>
<i>Code</i>	<i>Period</i>	<i>Change</i>	<i>Date</i>	<i>Tab</i>	<i>Issue</i>	<i>Number</i>	<i>Date</i>	<i>Tab</i>	<i>Rec</i>	<i>Rec last yr?</i>			
95250	XXX	N	Feb01	K	Continuous Glucose Monitoring System	BB1	Apr01	U	0.00	0.00		Yes	No Physician work - PE inputs only
95875	XXX	R	Feb01	C1	Neurology Procedures	WW1	Apr01	R	1.50	1.10		Yes	
95904	XXX	R	Nov00	L	Nerve Conduction Studies		Editorial		0.34	0.34	Yes	Yes	
95965	XXX	N	Feb01	C1	Neurology Procedures	WW2	Apr01	R	9.50	8.00		Yes	
95966	XXX	N	Feb01	C1	Neurology Procedures	WW3	Apr01	R	5.00	4.00		Yes	
95967	ZZZ	N	Feb01	C1	Neurology Procedures	WW4	Apr01	R	4.50	3.50		Yes	
96004	XXX	N	Feb01	E1	Gait and Motion Studies	XX5	Apr01	29	3.00			Yes	Carrier Price - RUC to Review in Sept. 2001
96567	XXX	N	Feb01	G1	Photodynamic Therapy Destruction of Skin Lesions	YY1	Apr01	S	3.15	0.00		Yes	No Physician work - PE inputs only
99090	XXX	R	Feb01	J	Analysis of Computer Transmitted Data		Apr01	T	0.00	0.00	Yes	Yes	HCFA considers this a bundled service
99091	XXX	N	Feb01	J	Analysis of Computer Transmitted Data	AA1	Apr01	T	1.73	1.10		Yes	
99289	XXX	N	Feb01	L	Patient Transport		Apr01	V	6.00	4.80		Yes	
99290	XXX	N	Feb01	L	Patient Transport		Apr01	V	3.00	2.40		Yes	
99374	XXX	R	Feb01	EC1	Care Plan Oversight Services		Editorial		1.10	1.10	Yes	Yes	
99375	XXX	R	Feb01	EC1	Care Plan Oversight Services		Editorial		1.73	1.73	Yes	Yes	
99377	XXX	R	Feb01	EC1	Care Plan Oversight Services		Editorial		1.10	1.10	Yes	Yes	
99378	XXX	R	Feb01	EC1	Care Plan Oversight Services		Editorial		1.73	1.73	Yes	Yes	
99379	XXX	R	Feb01	EC1	Care Plan Oversight Services		Editorial		1.10	1.10	Yes	Yes	
99380	XXX	R	Feb01	EC1	Care Plan Oversight Services		Editorial		1.73	1.73	Yes	Yes	
99381	XXX	R	Nov00	N	Preventive Medicine		Editorial		1.19	1.19	Yes	Yes	
99382	XXX	R	Nov00	N	Preventive Medicine		Editorial		1.36	1.36	Yes	Yes	
99383	XXX	R	Nov00	N	Preventive Medicine		Editorial		1.36	1.36	Yes	Yes	
99384	XXX	R	Nov00	N	Preventive Medicine		Editorial		1.53	1.53	Yes	Yes	

<i>CPT Global Coding CPT Main</i>					<i>Tracking RUC</i>	<i>RUC Specialty</i>	<i>Same RUC RVU as</i>		<i>MFS?</i>	<i>Comments</i>		
<i>Code</i>	<i>Period</i>	<i>Change</i>	<i>Date</i>	<i>Tab</i>	<i>Issue</i>	<i>Number</i>	<i>Date</i>	<i>Tab</i>	<i>Rec</i>	<i>Rec last yr?</i>		
99385	XXX	R	Nov00	N	Preventive Medicine			Editorial	1.53	1.53	Yes	Yes
99386	XXX	R	Nov00	N	Preventive Medicine			Editorial	1.88	1.88	Yes	Yes
99387	XXX	R	Nov00	N	Preventive Medicine			Editorial	2.06	2.06	Yes	Yes
99391	XXX	R	Nov00	N	Preventive Medicine			Editorial	1.02	1.02	Yes	Yes
99392	XXX	R	Nov00	N	Preventive Medicine			Editorial	1.19	1.19	Yes	Yes
99393	XXX	R	Nov00	N	Preventive Medicine			Editorial	1.19	1.19	Yes	Yes
99394	XXX	R	Nov00	N	Preventive Medicine			Editorial	1.36	1.36	Yes	Yes
99395	XXX	R	Nov00	N	Preventive Medicine			Editorial	1.36	1.36	Yes	Yes
99396	XXX	R	Nov00	N	Preventive Medicine			Editorial	1.53	1.53	Yes	Yes
99397	XXX	R	Nov00	N	Preventive Medicine			Editorial	1.71	1.71	Yes	Yes
99500	XXX	N	Aug00	3	Home Health Procedures/Services			HHA				No
99501	XXX	N	Aug00	3	Home Health Procedures/Services			HHA				No
99502	XXX	N	Aug00	3	Home Health Procedures/Services			HHA				No
99503	XXX	N	Aug00	3	Home Health Procedures/Services			HHA				No
99504	XXX	N	Aug00	3	Home Health Procedures/Services			HHA				No
99505	XXX	N	Aug00	3	Home Health Procedures/Services			HHA				No
99506	XXX	N	Aug00	3	Home Health Procedures/Services			HHA				No
99507	XXX	N	Aug00	3	Home Health Procedures/Services			HHA				No
99508	XXX	N	Aug00	3	Home Health Procedures/Services			HHA				No
99509	XXX	N	Aug00	3	Home Health Procedures/Services			HHA				No
99510	XXX	N	Aug00	3	Home Health Procedures/Services			HHA				No
99511	XXX	N	Aug00	3	Home Health Procedures/Services			HHA				No

CPT Global Coding CPT Main
Code Period Change Date Tab Issue

Tracking RUC RUC Specialty RUC RVU as
Number Date Tab Rec Rec last yr? MFS? Comments

Code	Period	Change	Date	Tab	Issue	Tracking RUC Number	RUC Date	Specialty Tab	RUC Rec	RVU as Rec last yr?	MFS?	Comments
99512	XXX	N	Aug00	3	Home Health Procedures/Services			HHA			No	
99539	XXX	N	Aug00	3	Home Health Procedures/Services			HHA			No	
99551	XXX	N	Nov00	25	Home Infusion Procedures			HHA			No	
99552	XXX	N	Nov00	25	Home Infusion Procedures			HHA			No	
99553	XXX	N	Nov00	25	Home Infusion Procedures			HHA			No	
99554	XXX	N	Nov00	25	Home Infusion Procedures			HHA			No	
99555	XXX	N	Nov00	25	Home Infusion Procedures			HHA			No	
99556	XXX	N	Nov00	25	Home Infusion Procedures			HHA			No	
99557	XXX	N	Nov00	25	Home Infusion Procedures			HHA			No	
99558	XXX	N	Nov00	25	Home Infusion Procedures			HHA			No	
99559	XXX	N	Nov00	25	Home Infusion Procedures			HHA			No	
99560	XXX	N	Nov00	25	Home Infusion Procedures			HHA			No	
99561	XXX	N	Nov00	25	Home Infusion Procedures			HHA			No	
99562	XXX	N	Nov00	25	Home Infusion Procedures			HHA			No	
99563	XXX	N	Nov00	25	Home Infusion Procedures			HHA			No	
99564	XXX	N	Nov00	25	Home Infusion Procedures			HHA			No	
99565	XXX	N	Nov00	25	Home Infusion Procedures			HHA			No	
99566	XXX	N	Nov00	25	Home Infusion Procedures			HHA			No	
99567	XXX	N	Nov00	25	Home Infusion Procedures			HHA			No	
99568	XXX	N	Nov00	25	Home Infusion Procedures			HHA			No	
99569	XXX	N	Nov00	25	Home Infusion Procedures			HHA			No	

**AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS**

April 2001

Anesthesia for Gastric Restrictive Procedure for Morbid Obesity

A new CPT code 00797 *Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; gastric restrictive procedure for morbid obesity* was developed to describe anesthesia for gastric restrictive procedures for morbid obesity.

The RUC examined the survey results, which supported a base unit value greater than the reference service 00790 *Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified* (base unit value = 7). The RUC discussed the increased complexity involved in this code such as the increased work of positioning the patient, maintaining the airway and maintaining cardiovascular ventilation. Due to the increased difficulty of providing anesthesia to this type of patient with a number of health problems, the RUC agreed that an increase of 2 base units over the reference service is warranted. Since Anesthesia base units include practice expense as well as work recommendations, a separate practice expense recommendation does not apply for this code.

The RUC recommends a base unit of 9.00 for CPT code 00797.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Base Unit Recommendation
00790		<i>Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified</i>	XXX	7 (No change)
●00797	DD1	gastric restrictive procedure for morbid obesity	XXX	9

CPT Code: 00798 Tracking Number: DD1 Global Period: XXX Recommended Base Units: 9.0

CPT Descriptor: Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; gastric restrictive procedure for morbid obesity.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 38-year-old female has had a life-long history of obesity. She has failed numerous dietary regimens and presents for gastric bypass surgery. Her height is 5'4" and her weight is 325 lbs. She has mild, untreated hypertension, diabetes managed with oral hypoglycemics and chronic asthma for which she uses bronchodilators

SERVICE DESCRIPTION:

Pre-Anesthesia:

She is evaluated one week prior to the planned surgery. A medical history is taken, a systems review conducted, and a physical examination is performed emphasizing cardiorespiratory elements, assessment of her upper airway (in anticipation of endotracheal intubation), and room air oxygen saturation is measured. Background medical information from her physicians is obtained and reviewed, including prior pulmonary function tests, electrocardiograms, and chest x-ray reports. She is counseled about the plans for general anesthesia and the possibility of postoperative mechanical ventilation. Informed consent is obtained. On the day of surgery, the record is reviewed and any interim data assessed. A peripheral intravenous catheter is inserted with some difficulty because of her obesity. Intravenous sedatives are administered with continuous pulse oximetry monitoring and oxygen administration prior to transport to the operation room.

Intra-Operative:

She is transferred to the special heavy capacity operating table and non-invasive blood pressure monitoring begun, EKG leads applied and oximetry resumed. If the blood pressure is excessive, intravenous beta blockers are cautiously administered to attenuate the response to intubation. She is pre-oxygenated with 100% oxygen and anesthesia is induced with intravenous agents and muscle relaxants and positive pressure mask ventilation begun to attempt to maintain oxygenation. When she has been adequately paralyzed, endotracheal intubation is performed and positive pressure ventilation with 100% oxygen rapidly initiated to correct the desaturation which has occurred during anesthetic induction. Mechanical ventilation is initiated to maintain adequate oxygenation, normocarbia and acceptable tidal volumes and inflation pressures. Because of the patient's body habitus and asthma, peak airway pressures are likely to be excessive and manipulation of tidal volume and rate to produce adequate gas exchange with minimal risk of barotrauma are required. Inhaled volatile anesthetic and intravenous narcotic is titrated to blood pressure and heart rate parameters. The patient is positioned for surgery in the supine, reverse Trendelenburg position with attention to protecting peripheral nerves and pressure points, including the olecranon fossae, brachial plexus and the heels. A warm air blanket is positioned over the patient, avoiding the surgical field, to maintain normothermia. Because of tenuous peripheral venous access, a central venous catheter is inserted (separately reported) to assure reliable access during the intra-operative and post-operative periods. Neuromuscular blockade is regularly monitored using peripheral nerve stimulation and additional paralytic agents administered to maintain adequate surgical relaxation. Intravenous fluids are administered at a rapid rate to replace substantial insensible losses and surgical blood loss. Urinary output and temperature are monitored. Serial blood glucose determinations are made and an intravenous insulin infusion is begun as needed. A nasogastric tube is inserted and subsequently a calibrated bougie is passed into the proximal stomach under manual guidance to assist the surgeon. As the operation draws to an end, the dosage of narcotic is assessed and supplemented as needed to assure adequate postoperative analgesia. Inhaled anesthetic is withdrawn gradually and neuromuscular blockade reversed by administration of anticholinesterase and anticholinergic drugs. Inhaled bronchodilators are administered through the anesthetic breathing circuit and endotracheal tube. The patient's level of consciousness, ventilatory efforts, capnogram and oximetry are assessed to determine the adequacy of spontaneous respiration. If these parameters appear satisfactory, the trachea is extubated and mask oxygen administered. A period of careful observation is undertaken while still in the operating room to allow swift reintubation if respiratory decompensation occurs. If doubt exists about the adequacy of respiration, additional sedatives are administered and a period of postoperative mechanical ventilatory support is planned. The patient is then transported to the PACU with continuous EKG and oximetry monitoring. In the PACU, a patient history and synopsis of intraoperative events, including fluids administered, blood loss, urinary output, drugs administered, vital sign trends is provided to the nursing staff. The anesthesiologist continues to participate in the management of postoperative analgesia, fluid balance and respiratory care while the patient is cared for in the PACU. When the patient is stable, the anesthesiologist discharges the patient to the surgical floor or intensive care unit.

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Base Units</u>
00790	Anesthesia for intraperitoneal procedures in the upper abdomen including laparoscopy, not otherwise specified	7.0

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 existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

TIME ESTIMATES (Median)

	<u>New/ Revised CPT Code: 00798</u>	<u>Key Reference CPT Code: 00790</u>
Median Pre-Time	30	20
Median Intra-Time	180	180
Median Immediate Post-service Time	30	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	3.95	3.14
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.0
Urgency of medical decision making	3.41	3.05

Technical Skill/Physical Effort (Mean)

Technical skill required	4.09	3.10
Physical effort required	3.91	2.95

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.32	3.43
Outcome depends on the skill and judgement of physician	4.0	3.33
Estimated risk of malpractice suit with poor outcome	4.0	3.29

INTENSITY/COMPLEXITY MEASURES

CPT Code

Reference
Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.57	3.04
Intra-Service intensity/complexity	3.83	3.35
Post-Service intensity/complexity	3.61	2.83

ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after deliberation of the procedure by the ASA COE, evaluation of the results of this survey by the ASA RVS committee, a subcommittee of the ASA COE, and consideration of the similarities and dis-similarities of this procedure with the key reference service. Evaluation of the results of the survey intensity/complexity measures supports a base unit value greater than the reference service base unit value.

FREQUENCY INFORMATION

How was this service previously reported? 00790 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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 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 3000-5000

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 < 100

Specialty _____ Frequency _____

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

AMA/SPECIALTY SOCIETY JOINTS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
February 2001

Anesthesia Services

The RUC reviewed the following anesthesia services for burn excisions and debridement at their April 2000 meeting. At that time, the RUC was concerned that percent of burn area should be clarified for codes 01951 and 01952 to report less than four percent in code 01951 and between four and nine percent in code 01952. The CPT Editorial Panel has included these changes in CPT 2002 as outlined below. **The RUC has reviewed this issue again and recommends that the base unit for 01952 be changed from 3 to 5.**

CPT Code (●New) (▲Revised) (D Deleted) (E Editorial)	Tracking Number	CPT Descriptor	Global Period	Base Unit Recommendation
▲01951	BB8	<u>Burn Excisions or Debridement</u> 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 four percent total body surface area	XXX	3 (no change)
▲01952	BB9	one percent to nine <u>between four and nine percent of total body surface area</u>	XXX	5* *RUC had previously agreed to accept higher base value if coding change were made to 01952. These changes will occur for CPT 2002.
01953	BB10	each additional nine percent total body surface area or part thereof (List separately in addition to code for primary procedure) (Use 01951 in conjunction with code 01953)	ZZZ	1 (no change)

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

April 2001

Anesthesia for Interventional Radiology Procedures

To redefine anesthesia for interventional radiology, eight new codes were created along with the revision of one code and the deletion of nine codes. In each instance the RUC examined the survey results but also placed additional emphasis on examining the rank order of codes within the family of interventional radiology anesthesia procedures. This was necessary since the ASA base units can not be examined in exactly the same way as physician work relative values

01905 (EE 1)

The RUC examined the survey results for CPT code 01905 *Anesthesia for myelography, discography, vertebroplasty* in comparison to the reference code 01906 *Anesthesia for injection procedure for myelography; lumbar*. The RUC agreed that the new code was sufficiently similar to the reference code, which is being deleted, that the new code should be valued the same at 5 base units. **The RUC recommends a base unit of 5 for CPT code 01905**

01916 (EE 2)

The RUC agreed with the ASA recommendation to crosswalk the value from the reference code 01918 *Anesthesia for arteriograms, needle; retrograde, brachial or femoral* (base unit =5) to the new code 01916 *Anesthesia for diagnostic arteriography/venography*. The RUC agreed that the two codes should be valued the same since the reference code was previously used to report this procedure and due to the survey results that support equivalent base units between the two codes. **The RUC recommends a base unit of 5 for CPT code 01916**

01924 (EE 3)

Although the ASA survey results recommended a base unit of 7 for CPT code 01924 *Anesthesia for therapeutic interventional radiologic procedures involving the arterial system, not otherwise specified*, the RUC concluded that the value of the code should be two base units less than the reference service CPT code 01920 *Anesthesia for cardiac catheterization including coronary arteriography and ventriculography (not to include Swan-Ganz catheter)* (Base unit = 7) in order to preserve proper rank order within the family of codes. **The RUC recommends a base unit of 5 for CPT code 01924**

01925 (EE 4)

01926 (EE 5)

Codes 01925 Anesthesia for therapeutic interventional radiologic procedures involving the arterial system; carotid or coronary, and code 01926 *Anesthesia for therapeutic interventional radiologic procedures involving the arterial system; intracranial, intracardiac, or aortic*, were examined together. The patient population for these codes has significant comorbidities that complicates the anesthesia work. Since 01925 is currently billed as code 01920 *Anesthesia for cardiac catheterization including coronary arteriography and ventriculography (not to include Swan-Ganz catheter)* (Base unit = 7), the RUC concluded that a straight crosswalk would be appropriate and would maintain proper rank order with the family. Code 01926 was examined in relation to 01925 and the additional work for providing anesthesia when considering the physiological consequences of occluding the aorta or cardiac chamber and placing a multi-piece stent. The RUC concluded that a one base unit increment above 01925 reflected the incremental work between these two codes. **The RUC recommends a base unit of 7 for CPT code 01925.**
The RUC recommends a base unit of 8 for CPT code 01926.

01930 (EE6)

The RUC agreed with the ASA recommendation to crosswalk the value from the reference code 01918 Anesthesia for arteriograms, needle, retrograde, brachial or femoral (base unit =5) to the new code 01930 Anesthesia for therapeutic interventional radiologic procedures involving the venous/lymphatic system (not to include access to the central circulation), not otherwise specified. The RUC agreed that the two codes should be valued the same since the ASA survey median value of 5 base units was the same as the value for the reference service. **The RUC recommends a base unit of 5 for CPT code 01930.**

01931 (EE7)

The RUC agreed with the ASA recommendation to crosswalk the value from the reference code 00790 *Anesthesia for intraperitoneal procedures in upper abdomen, including laparoscopy; not otherwise specified* (base unit =7) to the new code 01931 *Anesthesia for therapeutic interventional radiologic procedures involving the venous/lymphatic system (not to include access to the central circulation); intrahepatic or portal circulation (eg, Transcatheter Porto- Caval Shunt (TIPS))*. The typical patient is usually unstable and there are often problems relating to venous access. The RUC agreed that the two codes should be valued the same since the reference code was previously used to report this procedure, and due to the survey results that support equivalent base units between the two codes. **The RUC recommends a base unit of 7 for CPT code 01931.**

01932 (EE8)

The RUC examined code 01932 *Anesthesia for therapeutic interventional radiologic procedures involving the venous/lymphatic system (not to include access to the central circulation); intrathoracic or jugular* to the reference code 00534 *Anesthesia for transvenous insertion or replacement of pacing cardioverter-defibrillator* (base unit = 7). This was described as an uncommon procedure and although the ASA recommended that the work between the two procedures was similar, the RUC felt that a base unit of 6 would more appropriately place this code in the proper rank order within the family of codes. **The RUC recommends a base unit of 6 for CPT code 01932.**

01933 (EE9)

The RUC examined code 01933 *Anesthesia for therapeutic interventional radiologic procedures involving the venous/lymphatic system (not to include access to the central circulation); intracranial* to the reference code 00214 *Anesthesia for intracranial procedures; burr holes, including ventriculography* (base unit = 9) as well as code 01932 *Anesthesia for therapeutic interventional radiologic procedures involving the venous/lymphatic system (not to include access to the central circulation, intrathoracic or jugular)* (recommended base unit 6). Although the ASA recommended a median base unit value of 8, the RUC concluded that the work involved in this procedure was slightly lower and that a base unit of 7 would be more appropriate and place the code in the proper rank order, especially in relation to code 01932. **The RUC recommends a base unit of 7 for CPT code 01933.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
00884		Anesthesia for procedures on major lower abdominal Blood vessels; transvenous umbrella insertion (00884 has been deleted. To report, use 01930)	XXX	N/A
01904		Anesthesia for injection procedure for Pneumoencephalography (01904 has been deleted. To report, use 01905)	XXX	N/A
●01905	EE1	Anesthesia for myelography, discography, Vertebroplasty	XXX	5
01906		Anesthesia for injection procedure for myelography; Lumbar (01906 has been deleted. To report, use 01905)	XXX	N/A
01908		—Cervical (01908 has been deleted. To report, use 01905)	XXX	N/A
01910		—Posterior fossa (01910 has been deleted. To report, use 01905)	XXX	N/A
01912		—Anesthesia for injection procedure for —Discography; lumbar (01912 has been deleted. To report, use 01905)	XXX	N/A

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
01914		—Cervical (01914 has been deleted. To report, use 01905)	XXX	N/A
▲01916	EE2	Anesthesia for <u>diagnostic arteriography/venography</u> Arteriograms, needle; carotid or vertebral (Do not report 01916 in conjunction with therapeutic codes 01924-01926, 01930-01933)	XXX	5
01918		—Retrograde, brachial and femoral (01918 has been deleted. To report, use 01916)	XXX	N/A
01921		Anesthesia for angioplasty (01921 has been deleted. To report, see 01924-01926)	XXX	N/A
●01924	EE3	Anesthesia for therapeutic interventional radiologic Procedures involving the arterial system; not Otherwise specified	XXX	5
●01925	EE4	Carotid or coronary	XXX	7
●01926	EE5	Intracranial, intracardiac, or aortic	XXX	8
●01930	EE6	Anesthesia for therapeutic interventional radiologic Procedures involving the venous/lymphatic system (not to include access to the central circulation); not otherwise specified	XXX	5

●01931	EE7	Intrahepatic or portal circulation (eg, Transcutaneous Porto- Caval Shunt (TIPS))	XXX	7
●01932	EE8	Intrathoracic or jugular	XXX	6
●01933	EE9	Intracranial	XXX	7

01905

CPT Code: 0190X5 Tracking Number: EE1 Global Period: XXX Recommended Base Units: 6
RUC recommendation = 5

CPT Code Descriptor: Anesthesia for myelography, discography, vertebroplasty.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 63-year-old male with COPD, hypertension, and severe back and radicular pain secondary to possible herniated lumbar disks presents for diskography of the L3/L4, L4/L5, and L5/S1 disks in the prone position under monitored anesthesia

SERVICE DESCRIPTION:

Pre-Anesthesia: Preoperative assessment by the anesthesiologist includes a thorough history and physical examination with special attention to the patient's COPD and hypertension, his past surgical and medical history, current medications, and allergies. The physical examination pays special attention to pulmonary and cardiac status. The anesthesiologist reviews pertinent laboratory data and ECG and chest radiograph. He then discusses in detail the plan for anxiolysis, analgesia and sedation with the patient and his family. The anesthesiologist then obtains informed consent for anesthetic management of the procedure.

Intra-Operative: Preparations for intubation, mechanical ventilation, and general anesthesia are made should such intervention become necessary. After a small amount of IV sedation and IV analgesia in pre-operative area, the patient is brought to the radiology suite. Routine monitors (ECG, pulse oximetry) and nasal cannula are positioned in place and the patient is placed prone on the operating table with care to ensure patient comfort and adequate padding of extremities. Blood pressure is monitored intermittently at least every five minutes; respiration, pulse, ECG, pulse oximetry and end tidal CO₂ are monitored continuously and recorded. IV sedation with midazolam, fentanyl and a low-dose propofol is used to achieve anxiolysis while still maintaining hemodynamic stability and spontaneous respiration. However the patient is kept very lightly sedated for the actual diskography since he will have to be able to describe the presence or absence of duplication of pain during the diskography of individual intervertebral disks. At the end of the procedure, the patient is placed supine on his bed/cart, transferred to the post anesthetic care unit and placed in the care of the recovery room personnel until discharge from the unit. The anesthesiologist orders IV analgesia as needed for the patient's radicular pain.

Post Anesthesia:

The anesthesiologists makes a postoperative evaluation in the post anesthesia care unit to determine satisfactory recovery from anesthetic care and determine if any anesthetic related complications have occurred; he then discharges the patient from the unit.

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Base Units</u>
01906	Anesthesia for injection procedure for myelography; lumbar	5.0

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 existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

TIME ESTIMATES (Median)

	New/ Revised CPT Code: 0190X5	Key Reference CPT Code: 01906
Median Pre-Time	15	15
Median Intra-Time	60	60
Median Immediate Post-service Time	15	10
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	2.52	2.63
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.61	2.67
Urgency of medical decision making	2.5	2.48

Technical Skill/Physical Effort (Mean)

Technical skill required	2.61	2.56
Physical effort required	2.36	2.41

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.75	2.56
Outcome depends on the skill and judgement of physician	2.61	2.52
Estimated risk of malpractice suit with poor outcome	3.04	2.89

INTENSITY/COMPLEXITY MEASURES

CPT Code

**Reference
Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.23	2.61
Intra-Service intensity/complexity	2.90	2.83
Post-Service intensity/complexity	2.23	1.97

ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after deliberation of the this procedure by the ASA COE, evaluation of the results of this survey by the ASA RVS committee, a subcommittee of the ASA COE, and consideration of the similarities of this procedure with the key reference service. Further evaluation of the results of the survey intensity/complexity measures support a base unit value somewhat greater than the reference service base unit value

FREQUENCY INFORMATION

How was this service previously reported? 01904, 01906, 01908, 01910, 01912, 01914
(if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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 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 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 Anesthesiology Frequency 3,000

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

CPT Code: ▲ 01916 Tracking Number: EE2 Global Period: XXX Recommended Base Units: 5.0

CPT Code Descriptor: Anesthesia for diagnostic arteriography/venography arteriograms, needle; carotid or vertebral.
(Do not report 01916 in conjunction with therapeutic codes 0193X1 - 0193X3, 0194X1 - 0194X4)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72-year-old female with hypertension, insulin dependent diabetes and COPD and a history of severe claudication in both lower extremities is scheduled for diagnostic femoral arteriography and venography under general anesthesia.

SERVICE DESCRIPTION:

Pre Anesthesia: Preoperative assessment by the anesthesiologist includes a thorough history and physical examination with special attention to the patient's COPD, diabetes mellitus, ASPVD and probable ASCVD. She reviews the patient's past surgical and medical history, current medications, and allergies. The physical examination pays special attention to pulmonary and cardiac and vascular status. The anesthesiologist reviews pertinent laboratory data, including a recent blood sugar, ECG and chest radiograph. She then discusses in detail the plan for general anesthesia with the patient and her family. The anesthesiologist obtains informed consent for anesthetic management of the procedure.

Intra-Operative: Preparations for intubation, mechanical ventilation, and general anesthesia are made prior to the patient entering the radiology suite. After a small amount of IV sedation and IV analgesia in pre-operative area, the patient is brought to the radiology suite. Routine monitors (ECG, pulse oximetry, blood pressure cuff) are positioned in place after positioning the patient on the operating table with care to ensure patient comfort and adequate padding of extremities. Blood pressure is monitored intermittently at least every five minutes; respiration, pulse, ECG, pulse oximetry and end tidal CO₂ are monitored continuously and recorded.

After adequate pre-oxygenation, anesthesia is induced with propofol and fentanyl. Muscle relaxation is achieved with a non-depolarizing neuromuscular blocking agent. The patient is intubated and anesthesia is maintained with oxygen, nitrous oxide, and desflurane. Since the patient is a diabetic and since contrast agent is used for the arteriography and venography, adequate hydration is essential. Vital signs, fluid status and blood sugar levels are all carefully monitored. Depth of anesthesia is carefully titrated to assure adequate anesthesia and amnesia while still maintaining physiologically appropriate vital signs. At the end of the procedure, muscle relaxation is reversed, anesthetic agents are discontinued, the patient is awakened and transferred to the post anesthesia care unit (PACU). When the patient is stable, the care of the patient is turned over to the PACU personnel with instructions to check the patient's blood sugar and to notify the anesthesiologist of the result.

Post Anesthesia: The anesthesiologist makes a postoperative evaluation in the post anesthesia care unit to determine satisfactory recovery from anesthetic care and determine if any anesthetic related complications have occurred; he then discharges the patient from the unit, after ascertaining that the patient's vital signs and metabolic status are stable.

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Base Units</u>
01918	Anesthesia for arteriograms, needle; retrograde, brachial or femoral	5.0

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 existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

TIME ESTIMATES (Median)

	New/ Revised CPT Code: 01916	Key Reference CPT Code: 01918
Median Pre-Time	19	19
Median Intra-Time	46.5	45
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	3.21	3.26
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.38	3.43
Urgency of medical decision making	3.08	3.17

Technical Skill/Physical Effort (Mean)

Technical skill required	2.79	2.91
Physical effort required	2.72	2.74

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.08	3.17
Outcome depends on the skill and judgement of physician	2.96	3.04

INTENSITY/COMPLEXITY MEASURES

CPT Code

Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.27	3.35
Intra-Service intensity/complexity	3.23	3.31
Post-Service intensity/complexity	2.50	2.62

ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after consideration of the similarities of this procedure with the key reference service, which previously was often used to report this procedure, and after considering the results of the survey which support a base unit value similar to the reference service base unit value.

FREQUENCY INFORMATION

How was this service previously reported? 01916 (this is a revision), 01918
 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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 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 16,000-20,000

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 Anesthesiology Frequency 8,500

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

01924

CPT Code: 0193X1 Tracking Number: EE3 Global Period: XXX Recommended Base Units: 6
RUC Recommendation = 5

CPT Code Descriptor: Anesthesia for therapeutic interventional radiologic procedures involving the arterial system; not otherwise specified.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year-old male presents for percutaneous transluminal atherectomy and stenting of the right renal artery. He is an ex-smoker with severe emphysema requiring home oxygen therapy. He has recently been admitted with malignant hypertension.

SERVICE DESCRIPTION:

Pre-Anesthesia: A preoperative assessment is made the afternoon prior to the scheduled procedure and the patient is seen on the medical ward. An extensive review is made of the past medical records as well as the current chart. The consultation reports by the pulmonologist as well as the cardiologist are reviewed in addition to the work up of the admitting internist and interventional radiologist scheduled to perform the procedure. Recent laboratory data, PFTs, ECG, chest x-rays, and echo results are reviewed. The patient is interviewed and a history taken. Past anesthetic experiences and current complaints are discussed. The patient is examined with particular attention to the airway, cardiopulmonary system, and vascular access. A detailed discussion of the plan for analgesia and sedation is undertaken. The patient is counseled that his cardiopulmonary compromise may require intubation, general anesthesia, and post op ventilation. Informed consent for anesthetic management is obtained. On the day of the procedure, the medical record is reviewed for updated information and the patient's current clinical status re-evaluated.

Intra-Operative: While pulse oximetry is monitored, a peripheral intravenous line is placed and oxygen per mask administered. Intravenous sedation is carefully titrated and a left radial arterial line placed (separately reported). The patient is transported to the radiology suite and transferred to the procedure table. The patient is carefully positioned and all monitoring reestablished. Oxygen and intravenous medications are carefully titrated to provide sedation, amnesia, analgesia, and hemodynamic stability while maintaining adequate ventilation. Point of care lab analysis of ABGs, electrolytes, and hematocrit is performed at regular intervals. Warm blankets and a forced air warming system are utilized to maintain normothermia. Preparations for intubation, mechanical ventilation, and general anesthesia are made should the patient's condition require such intervention. Vasoactive medications are prepared and utilized to treat hemodynamic changes as they occur during the procedure. At the conclusion of the procedure, the patient is transferred to the PACU and monitored as the sedatives and analgesics wear off. He is hemodynamically monitored and vasoactive medications adjusted as required. A report is made to the PACU RN as to the procedure, anesthetic care and expectations for recovery in the PACU.

Post -Anesthesia: The anesthesiologist remains involved in the management of the patient's analgesia, cardiopulmonary status, anxiety, and level of consciousness while the patient is in the PACU. When the patient is stable, the anesthesiologist discharges the patient to the ward or ICU. A postoperative evaluation is made to determine if any anesthetic related complication have occurred.

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Base Units</u>
01920	Anesthesia for cardiac catheterization including coronary arteriography and ventriculography (not to include Swan-Ganz catheter).	7.0

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 existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

TIME ESTIMATES (Median)

	New/ Revised CPT Code: 0193X1	Key Reference CPT Code: 01920
Median Pre-Time	20	17
Median Intra-Time	90	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	3.72	3.46
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.92	3.63
Urgency of medical decision making	3.92	3.71

Technical Skill/Physical Effort (Mean)

Technical skill required	3.40	3.32
Physical effort required	3.24	3.08

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.96	3.52
Outcome depends on the skill and judgement of physician	3.72	3.52

Estimated risk of malpractice suit with poor outcome	3.48	3.20
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INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.92	3.46
Intra-Service intensity/complexity	3.85	3.64
Post-Service intensity/complexity	3.19	3.04

ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after consideration of the similarities of this procedure to the key reference service and the service (01921) which this code partially replaces and after considering the results of the survey which support a base unit value similar to the reference service base unit value.

FREQUENCY INFORMATION

How was this service previously reported? 01921 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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 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 24,000-30,000

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 Anesthesiology Frequency 13,000

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

01925

CPT Code: 0193X2 Tracking Number: EE4 Global Period: XXX Recommended Base Units 8
RUC Recommendation= 7

CPT Code Descriptor: Anesthesia for therapeutic interventional radiologic procedures involving the arterial system; carotid or coronary.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Seventy-one-year-old female with a history of adult onset diabetes, thirty plus years of smoking, angina and hypertension. Possible past history of allergy to "iodine". She is scheduled for cardiac catheterization and probable stenting of coronary vessels.

SERVICE DESCRIPTION:

Pre-Anesthesia: The Anesthesia Department receives a consultation request for evaluation of a seventy-one year old female by a cardiologist for anticipated cardiac catheterization in three days. The patient presents to the pre-anesthesia holding area for evaluation two days prior to the anticipated procedure. The anesthesiologist interviews the patient who presents with her husband and daughter. The "iodine allergy" is related as being a feeling of warmth and tachycardia during an IVP performed twenty years ago. There is no other drug allergy. The patient stopped smoking three years ago after significant bouts of bronchitis, one requiring hospitalization. The patient was diagnosed with diabetes about fifteen years ago and has been treated with the same oral hypoglycemic agent as well as some dietary restrictions. She checks her blood sugars about twice a week and they are never over "150". She has been on a variety of antihypertensive agents over the years but her most recent therapy has been in place for two years and the referring cardiologist has provided treatment. Additional history includes a tonsillectomy as a child, a cholecystectomy about thirty years ago and total abdominal hysterectomy ten years ago. The patient has never had hormonal therapy,. All surgeries were without anesthesia problems except nausea and vomiting with the tonsillectomy. The patient has no kidney problems as the IVP was to rule out a kidney stone and subsequent diagnosis was mild diverticulosis. The patient has only recently developed angina and has not had any angina since last seeing the cardiologist two days ago. She has not had any additional medications ordered by the cardiologist. The only medications are the oral hypoglycemic and the antihypertensive agent. The remaining review of systems is unremarkable. The patient is a retired schoolteacher who enjoys traveling in their recreational vehicle. Her other activities include bridge and church socials. She used to swim two to three times a week but stopped that about two years ago. On physical examination, the lungs are clear. The heart is in regular rhythm with no murmurs or gallops. A bruit was heard over the left carotid artery. Pulses were full in all extremities. Abdomen was benign except for well-healed scars. The neurologic and musculoskeletal systems were within normal limits. Electrocardiogram (ECG) was consistent with left ventricular hypertrophy and a PVC was noted. Chemistry profile was normal except the blood glucose was 160 mg/ml. The anesthesiologist contacts the cardiologist especially relating to the carotid bruit. The upcoming procedure was discussed with the patient and family. The anesthesiologist then discusses the anesthetic options. The patient and anesthesiologist mutually agree that local anesthetic by the cardiologist and sedative agents and cardiopulmonary monitoring provided by the anesthesiologist would be the most efficient and least invasive anesthetic regimen. The anesthesiologist also reviews the possibility of endotracheal intubation as well as treatment for the "iodine allergy" if it occurs. NPO plan is discussed. The patient and her husband then sign the anesthesia consent. The patient presents on the day of the procedure. The anesthesiologist reviews the chart, examines the patient and again discusses the anesthesia plan.

Intra-Operative: An intravenous catheter is placed and the patient is taken to the cardiac catheterization suite and positioned. Oxygen via nasal cannula, ECG and blood pressure cuff are placed. Capnography tubing is adjusted to provide a waveform. Sedation is provided to the level of patient comfort. The nursing staff prepares the patient for the procedure including sterile scrub and draping. The cardiologist then injects local anesthetic. The vascular system is accessed with the patient being comfortably responsive. Additional medication is provided to maintain patient comfort and compliance. The procedure is completed with stenting of two coronary vessels. The patient is taken to the post anesthesia holding area for recovery and is awake and conversant upon arrival. Vital signs are

recorded, a report is given by the anesthesiologist to the post anesthesia care unit (PACU) nurse. Orders are written. After reassessing the patient, the anesthesiologist "signs off" the patient to the PACU nurse.

Post-Anesthesia: The next day, the anesthesiology department contacts the patient at her home to see if there are any anesthesia related questions or problems.

SURVEY DATA:

Presenter(s) Dr Karl E Becker

Specialty(s): American Society of Anesthesiologists

Sample Size: 22 Response Rate: (%): 4% Median Base Units: 8

Type of Sample (Circle One): **random**, panel, convenience. Explanation of sample size: 500 e-mails directing physicians to a web site

25th Percentile Base Units: 7 75th Percentile Base Units: 9 Low: 6 High: 15

Median Pre-Service Time: 25 Median Intra-Service Time: 90

25th Percentile Intra-Svc Time: 75 75th Percentile Intra-Svc Time: 120 Low: 75 High: 180

Median Post-Service Time: 20

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>15</u>	<u>Included</u>
Critical Care:	<u></u>	<u></u>
Other Hospital Visits:	<u>5</u>	<u>Included</u>
Discharge Day Mgmt.:	<u></u>	<u></u>
Office Visits:	<u></u>	<u></u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Base Units</u>
01920	Anesthesia for cardiac catheterization including coronary arteriography and ventriculography (not to include Swan-Ganz catheter).	7.0

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 existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

TIME ESTIMATES (Median)

	<u>New/ Revis. CPT Code: 0193X2</u>	<u>Key Reference CPT Code: 01920</u>
Median Pre-Time	25	20
Median Intra-Time	90	75
Median Immediate Post-service Time	20	17.5
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.	3.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.05	3.75
Urgency of medical decision making	4.35	3.95

Technical Skill/Physical Effort (Mean)

Technical skill required	3.75	3.65
Physical effort required	3.25	3.20

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.20	3.80
Outcome depends on the skill and judgement of physician	3.95	3.70

Estimated risk of malpractice suit with poor outcome	3.55	3.50
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INTENSITY/COMPLEXITY MEASURES

CPT Code

Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.95	3.77
Intra-Service intensity/complexity	4.41	3.82
Post-Service intensity/complexity	3.23	3.14

ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after deliberation of the this procedure by the ASA COE, evaluation of the results of this survey by the ASA RVS committee, a subcommittee of the ASA COE, and consideration of the similarities and dissimilarities of this procedure with the key reference service. Furthermore evaluation of the results of the survey intensity/complexity measures support a base unit value greater than the reference service base unit value.

FREQUENCY INFORMATION

How was this service previously reported? 01921 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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 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 24,000

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 Anesthesiology Frequency 12,000

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

01926

CPT Code: 0193X3 Tracking Number: EE5 Global Period: XXX Recommended Base Units: 9
RUC Recommendation= 8

CPT Code Descriptor: Anesthesia for therapeutic interventional radiologic procedures involving the arterial system; intracranial, intracardiac, or aortic.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 77-year-old male with a long history of hypertension and coronary artery disease, five years status post inferior wall myocardial infarction with subsequent triple coronary artery bypass grafting. During routine periodic examination by his primary care physician, he is found to have a pulsatile abdominal mass. Computerized axial tomography demonstrates a seven-centimeter, infrarenal abdominal aortic aneurysm, extending to the aortic bifurcation. Vascular surgery consultation has recommended the placement of an abdominal aortic stent graft through a femoral artery approach under fluoroscopic guidance.

SERVICE DESCRIPTION:

Pre Anesthesia: The patient has been seen in the pre-operative screening clinic, where an anesthesia questionnaire has been completed and where the results of laboratory tests and other studies have been assembled. Having been admitted on the day of the procedure, the patient is seen in the holding area of the Operating room, where the chart is reviewed including the history and physical examination by the vascular surgeon, cardiology consultation, and various laboratory tests. Pertinent history is taken, and a physical examination is performed with particular attention to the airway, neck, lungs, heart, and peripheral blood vessels. Alternatives to anesthesia management are explained to the patient. Based on advice from the anesthesiologist, a lumbar epidural will be placed and general anesthesia will be provided.

Intra-Operative: Non-invasive blood pressure, EKG, and pulse oximetry monitors are placed and oxygen is provided by mask. A large bore intravenous cannula and an intra-arterial cannulae (separately reported) are inserted in the forearm. With the patient in the lateral decubitus position, a lumbar epidural catheter is placed using local anesthesia, and a test dose of 1.5% lidocaine is given. With the patient in the supine position, vital signs including blood pressure, pulse rate, and pulse oximetry are reassessed. General anesthesia is induced using intravenous narcotics and hypnotics. With the use of muscle relaxants, the trachea is intubated and the endotracheal tube is secured to the face with tape. Positive pressure ventilation using 100% oxygen is initiated. Inhalation anesthesia agents are introduced and titrated to maintain hemodynamic stability. The chest is auscultated and the capnograph assessed to ensure proper tube placement. While the nursing staff inserts a urinary drainage catheter, a flow directed pulmonary artery catheter is inserted through the right internal jugular vein (separately reported). Peripheral and coronary vasodilatory drugs as well as inotropic and vasopressive drugs are available as infusions, when needed. The patient is positioned on the operating table, fluoroscopic equipment is arranged, and the patient is prepped and draped for the procedure. Intravenous fluids are administered to satisfy maintenance requirements and to replace surgical blood loss. Hemodynamic fluctuations are anticipated. A time based anesthesia record is maintained to document anesthesia drugs and intravenous fluids administered, as well as the various vital signs that are followed on a continuous basis. Particular attention is needed at the time of stent deployment which may increase afterload pressures on the myocardium. Administration of vasodilators and inotropic agents may be necessary. Failure of proper stent placement or vascular perforation may warrant immediate trans-abdominal surgical exploration. Following the procedure, the patient is allowed to emerge from general anesthesia by discontinuance of the inhalation agents. The activity of muscle relaxant drugs is assessed by the use of a neuromuscular blockade monitor, reversal of these drugs is achieved if necessary, and the trachea is extubated when adequate ventilation by the patient is assured. The patient is transferred to a bed, and transported to the post-anesthesia care unit. Vital signs, level of consciousness, oxygen saturation, and adequacy of ventilation are determined. A verbal report of the patient's condition is provided to the post-anesthesia care nurse. Post-operative analgesia is initially provided with intravenous narcotics, and the epidural is utilized for managing pain.

Post-Operative: The anesthesiologist supervises the recovery of the patient, checking hematocrit and arterial blood gases as needed. Fluids are administered as necessary to maintain adequate blood pressure and urine output. After stabilization and achievement of adequate analgesia, the patient is discharged to the intensive care unit. A follow-up note is recorded later that day, and additional care provided as indicated or requested by the surgeon.

SURVEY DATA:

Presenter(s) Dr Karl E Becker

Specialty(s): American Society of Anesthesiologists

Sample Size: 23 Response Rate: (%): 4% Median Base Units: 10

Type of Sample (Circle One): **random**, panel, convenience. Explanation of sample size: 500 e-mails directing physicians to web site

25th Percentile Base Units: 10 75th Percentile Base Units: 12.5 Low: 7 High: 30

Median Pre-Service Time: 30 Median Intra-Service Time: 120

25th Percentile Intra-Svc Time: 97.5 75th Percentile Intra-Svc Time: 165 Low: 60 High: 420

Median Post-Service Time: 20

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>15</u>	<u>Included</u>
Critical Care:	<u> </u>	<u> </u>
Other Hospital Visits:	<u>5</u>	<u>Included</u>
Discharge Day Mgmt.:	<u> </u>	<u> </u>
Office Visits:	<u> </u>	<u> </u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Base Units</u>
00770	Anesthesia for all procedures on major abdominal blood vessels	15.0

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 existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

TIME ESTIMATES (Median)

	New/ Revised CPT Code: 0193X3	Key Reference CPT Code: 00770
Median Pre-Time	30	25
Median Intra-Time	120	180
Median Immediate Post-service Time	20	25
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	3.91	3.68
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.14	3.81
Urgency of medical decision making	4.09	4.09

Technical Skill/Physical Effort (Mean)

Technical skill required	3.95	4.09
Physical effort required	3.68	3.77

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.36	4.18
Outcome depends on the skill and judgement of physician	4.09	4.0
Estimated risk of malpractice suit with poor outcome	3.55	5.24

INTENSITY/COMPLEXITY MEASURES

CPT Code

**Reference
Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	4.30	4.04
Intra-Service intensity/complexity	4.22	4.22
Post-Service intensity/complexity	3.65	3.70

ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after deliberation of the this procedure by the ASA COE, evaluation of the results of this survey by the ASA RVS committee, consideration of the similarities of this procedure with the key reference service; all of which support a base unit value less than the reference service base unit value.

FREQUENCY INFORMATION

How was this service previously reported? 00770
(if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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 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 4,000

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 Anesthesiology Frequency 3,500

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

CPT Code: 0194X1 Tracking Number: EE6 Global Period XXX Recommended Base Units: 5.0

CPT Code Descriptor: Anesthesia for therapeutic interventional radiologic procedures involving the venous/lymphatic system (not to include access to the central circulation); not otherwise specified.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year-old male presents for percutaneous thrombectomy of the femoral vein. The patient has recently been extubated following prolonged abdominal and extremity surgery to repair injuries and fractures sustained in a motor vehicle accident. The patient is felt to be a high risk for pulmonary embolism from his femoral vein thrombosis and the use of systemic thrombolytics is contraindicated.

SERVICE DESCRIPTION:

Pre-Anesthesia: The patient is assessed by the anesthesiologist in the intensive care unit prior to transport to the radiology suite. The recent anesthesia record, the past medical record, the notes by the intensivist and trauma surgeon are reviewed along with the note by the interventional radiologist scheduled to perform the procedure. Recent laboratory data, ECG, and imaging studies are reviewed. The patient is interviewed and current symptoms explored. The patient is examined with particular attention to his airway and cardiopulmonary systems. A detailed discussion of the plan for anxiolysis, analgesia and sedation is undertaken with the patient and his family. The patient is counseled that the procedure may result in pulmonary emboli that may require reintubation and mechanical ventilation. Informed consent for anesthetic management is obtained.

Intra-Operative: While oxygen is administered by mask and pulse oximetry is monitored, the patient is transported to the radiology suite. Intravenous sedation is carefully titrated to reduce anxiety while preserving adequate ventilation and allowing patient cooperation. The patient is positioned to comfort and carefully padded for the procedure. Pulse oximetry monitoring is reestablished as well as ECG and non-invasive blood pressure monitoring. Intravenous medications are administered to ensure anxiolysis, analgesia, amnesia, and hemodynamic stability while maintaining adequate spontaneous ventilation. Preparations for intubation, mechanical ventilation, and general anesthesia are made should such intervention become necessary. Vasoactive medications are prepared to deal with hemodynamic compromise should it occur during the procedure. Communication with the interventional radiologist is maintained in order to anticipate and respond to the demanding aspects of the procedure. At the conclusion of the procedure the patient is transferred to an ICU bed and transported back to the intensive care unit with oxygen administered by facemask and pulse oximetry and ECG monitoring. A report is made to the ICU CCRN as to the procedure, anesthetic care and expectations for recovery from the medications administered. Care is transferred to the ICU staff.

Post-Anesthesia: A postoperative evaluation is made to determine satisfactory recovery from anesthetic care and determine if any anesthetic related complications have occurred.

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Base Units</u>
01918	Anesthesia for arteriograms, needle; retrograde, brachial or femoral	5.0

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 existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

TIME ESTIMATES (Median)

	New/ Revised CPT Code: 0194X1	Key Reference CPT Code: 01918
Median Pre-Time	18	15.5
Median Intra-Time	60	60
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	3.37	2.68
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.53	2.95
Urgency of medical decision making	3.21	2.74

Technical Skill/Physical Effort (Mean)

Technical skill required	2.95	2.79
Physical effort required	2.68	2.68

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.32	2.79
Outcome depends on the skill and judgement of physician	3.26	2.74

INTENSITY/COMPLEXITY MEASURES

CPT Code

Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.55	2.85
Intra-Service intensity/complexity	3.45	2.90
Post-Service intensity/complexity	2.90	2.45

ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after consideration of the similarities of this procedure with the key reference service, which previously was often used to report this procedure, and after considering the results of the survey which support a base unit value similar to the reference service base unit value.

FREQUENCY INFORMATION

How was this service previously reported? 01260 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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 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 4000

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 3000

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

01931

CPT Code: 0194X2 Tracking Number: EE7 Global Period: XXX Recommended Base Units: 7.0

CPT Code Descriptor: Anesthesia for therapeutic interventional radiologic procedures involving the venous/lymphatic system (not to include access to the central circulation); intrahepatic or portal circulation (e.g. Transcutaneous Porto-Caval Shunt (TIPS))

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Forty-three-year old male with a history of cirrhosis, esophageal varices and pancreatitis. Coagulation studies are normal. Scheduled for transcutaneous intrahepatic porto-caval shunt.

SERVICE DESCRIPTION:

Pre-Anesthesia: The anesthesiology department is consulted by the radiology department for evaluation of a forty-three year old male for an upcoming Transcutaneous Intrahepatic Porto-caval Shunt (TIPS) procedure. The patient presents to the pre-anesthesia area for evaluation six days before the scheduled procedure. The patient relates that he has had a history of significant alcohol abuse since his teenage years. The abuse included regular drinking as well as "binge" drinking. He also relates a history of intravenous and transnasal drug abuse. He relates that he stopped both habits about five years ago. He has had many hospitalizations relating to gastrointestinal bleeding. The most recent was about one month ago, which also required several units of blood and fresh frozen plasma. He has received blood and blood products on several occasions. He has also developed chronic pancreatitis. He has presented to the Emergency Room several times for treatment and hospitalization. He has had gastroscopy and has been diagnosed with esophageal varices. The patient has a twenty plus year history of smoking. He has had fracture of several bones as well as multiple lacerations/scars from fighting. He also has had several concussions. The remaining review of systems is unremarkable. He knows of no drug allergies. He presently takes only digestive supplements. Past surgical/anesthesia history is unremarkable including an ORIF of the left tibia and, on another occasion, ORIF of the left radius and ulna. The patient has been divorced once and has been remarried for the last eight years. He has two children and is employed as an automobile mechanic. Physical examination reveals multiple well healed scars over several areas of the body. There are several concentric one half centimeter or less healing sores on both upper arms. The veins are poorly defined. The lungs are clear except for mild bibasilar rhonchi clearing with cough. The heart is in regular rhythm with no murmurs or gallops. The pulses are full in the carotids and the extremities. The abdomen is slightly pendulous with no fluid wave. Laboratory findings are reviewed with the CBC, coagulation profile and electrolytes being within normal limits. The liver function studies are also normal except for mild elevation of the alkaline phosphatase. Electrocardiogram and chest x-rays are within normal limits except for multiple healed rib fractures. The anesthesiologist then discusses the anesthetic options. The patient and anesthesiologist mutually agree that local anesthetic by the cardiologist and sedative agents and cardiopulmonary monitoring provided by the anesthesiologist would be the most efficient and least invasive. The patient expresses some concerns over bleeding. Because of possible lack of venous access, the possibility of a central venous line is discussed. Anesthesia consent, including placement of a central venous line is signed. NPO orders are discussed. The anesthesiologist contacts the radiologist. Two units of packed red blood cells (PRBCs) are typed and crossed and two units of PRBCs are screened. The patient presents to the radiologic holding area on the day of the procedure. The chart is reviewed and the patient is examined. The anesthesia plan is again discussed.

Intra-Operative: An intravenous catheter is attempted to be placed, but is unsuccessful. After again discussing this with the patient a left subclavian catheter is placed under sterile conditions (separately reported). The patient was then taken into the radiologic suite. Oxygen was provided via a nasal cannula, ECG and blood pressure cuff are placed. Capnography tubing is adjusted to provide a waveform. Sedation is provided to the level of patient comfort. The nursing staff prepares the patient for the procedure including sterile scrub and draping. The radiologist then injects local anesthetic. The vascular system is accessed with the patient being comfortably responsive. Additional medication is provided to maintain patient comfort and compliance. The procedure is

completed with a satisfactory placing of the shunt. The patient is taken to the post anesthesia holding area for recovery and is awake and conversant upon arrival. Vital signs are recorded; a report is given by the anesthesiologist to the post anesthesia care unit (PACU) nurse. Orders are written. After reassessing the patient, the anesthesiologist "signs off" the patient to the PACU nurse.

Post-Anesthesia: The next day, the anesthesiology department contacts the patient to see if there are any anesthesia related questions or problems.

SURVEY DATA:

Presenter(s) Dr Karl E Becker

Specialty(s): American Society of Anesthesiologists

Sample Size: 18 Response Rate: (%): 3.6% Median Base Unit: 8

Type of Sample (Circle One): **random**, panel, convenience. Explanation of sample size: 500 e-mails directing physicians to a web site

25th Percentile Base Unit; 7 75th Percentile Base Unit: 10 Low: 7 High: 15

Median Pre-Service Time: 20 Median Intra-Service Time: 105

25th Percentile Intra-Svc Time: 90 75th Percentile Intra-Svc Time: 180 Low: 60 High: 420

Median Post-Service Time: 20

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>17</u>	<u>Included</u>
Critical Care:	<u> </u>	<u> </u>
Other Hospital Visits:	<u>3</u>	<u>Included</u>
Discharge Day Mgmt.:	<u> </u>	<u> </u>
Office Visits:	<u> </u>	<u> </u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Base Units</u>
00790	Anesthesia for intraperitoneal procedures in upper abdomen, including laparoscopy; not otherwise specified	7.0

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 existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

TIME ESTIMATES (Median)

	<u>New/ Revised CPT Code: 0194X2</u>	<u>Key Reference CPT Code: 00790</u>
Median Pre-Time	20	20
Median Intra-Time	105	90
Median Immediate Post-service Time	20	17.5
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	3.56	3.35
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.94	3.59
Urgency of medical decision making	3.88	3.82

Technical Skill/Physical Effort (Mean)

Technical skill required	3.53	3.53
Physical effort required	3.41	3.35

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.18	3.59
Outcome depends on the skill and judgement of physician	3.71	3.71

Estimated risk of malpractice suit with poor outcome	3.12	3.18
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INTENSITY/COMPLEXITY MEASURES

CPT Code

Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.06	3.67
Intra-Service intensity/complexity	3.89	3.78
Post-Service intensity/complexity	3.28	3.22

ADDITIONAL RATIONALE

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

While the results of the survey which support a base unit value greater than the reference service base unit value, the ASA reached its final conclusion after consideration of the similarities of this procedure to the key reference service.

FREQUENCY INFORMATION

How was this service previously reported? 00790
 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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 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 ~3000

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 <500

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

01932

CPT Code: 0194X3 Tracking Number: EE8 Global Period: XXX Recommended Base Units: 7
RUC Recommendation= 7

CPT Code Descriptor: Anesthesia for therapeutic interventional radiologic procedures involving the venous/lymphatic system (not to include access to the central circulation); intrathoracic or jugular.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 56 year old female presents with superior vena caval syndrome characterized by flushing of the face, edema of the arms and neck, and mild shortness of breath. A left supraclavicular lymph node biopsy done six months earlier revealed metastatic bronchogenic carcinoma. With large mediastinal lymph nodes on chest x-ray, the patient had received a course of radiation therapy and chemotherapy. Other than a forty-pack year history of smoking, her medical history was otherwise unremarkable. She is scheduled to have a balloon dilatation and stent placement in the innominate vein and superior vena cava, using a two-site approach through the basilic and femoral veins, the procedure to be conducted in the Interventional Radiology Department

SERVICE DESCRIPTION:

Pre-Anesthesia: The patient is seen on the medical-surgical floor in the evening prior to the planned procedure. The current chart and past medical records are carefully reviewed including the most recent history and physical examination as well as relevant consultations, laboratory tests, x-rays and EKG. The patient is interviewed and examined with particular attention to airway integrity, ventilatory efforts, and peripheral venous access sites. Alternatives to various anesthetic techniques are explained, emphasizing the particular risks of general anesthesia involving airway collapse and immediate upper body venous return. Patient is advised that local anesthesia supplemented by intravenous sedation and analgesia with appropriate monitoring is preferable to the administration of general anesthesia. Informed consent is obtained. On the day of surgery, the chart is again reviewed and the patient examined.

Intra-Operative: Intravenous access is established in a lower extremity. The patient is lightly sedated and positioned on the procedure table. Oxygen is established by nasal cannula. Monitors are applied including EKG, non-invasive blood pressure, and pulse oximetry. Intravenous sedatives, hypnotics, and analgesics are administered in sufficient amounts to achieve comfort, sedation, and compliance with the procedure being provided under local anesthesia. Particular attention is paid to airway integrity, with constant attention being given to the patient's voluntary efforts to maintain adequate ventilation and oxygenation. Drugs and equipment to control the airway by intubation are immediately available. Additional drugs are prepared to treat hemodynamic changes should they occur. A time based anesthesia record is maintained to document anesthesia drugs and intravenous fluids administered, as well as the various vital signs that are followed on a continuous basis. Following the procedure, the patient is transported to the Post-Anesthesia Care Unit, portable monitors and oxygen being provided, and with the anesthesiologist in attendance. A report on the patient's status is provided to the responsible recovery room nurse. Initial vital signs are obtained..

Post-Anesthesia: Analgesics are provided as needed under the anesthesiologists care. Ongoing vital signs are closely monitored, and the anesthesiologist remains available to provide immediate treatment for any untoward hemodynamic and respiratory changes, until it is determined that the patient can be transported back to the patient's room. After stabilization and achievement of adequate analgesia, the patient is discharged to the medical surgical floor. A follow-up note is recorded later that day, and additional care provided as indicated.

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Base Units</u>
00534	Anesthesia for transvenous insertion or replacement of pacing cardioverter-defibrillator	7.0

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 existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

TIME ESTIMATES (Median)

	<u>New/ Revised CPT Code: 0194X3</u>	<u>Key Reference CPT Code: 00534</u>
Median Pre-Time	27.5	20
Median Intra-Time	90	90
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	3.82	3.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.82	3.71
Urgency of medical decision making	3.88	3.76

Technical Skill/Physical Effort (Mean)

Technical skill required	3.76	3.47
Physical effort required	3.24	3.24

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.06	3.94
Outcome depends on the skill and judgement of physician	4.0	3.88

INTENSITY/COMPLEXITY MEASURES

CPT Code

Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.11	3.56
Intra-Service intensity/complexity	4.06	3.89
Post-Service intensity/complexity	3.28	3.28

ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after consideration of the similarities of this procedure with the key reference service and after considering the results of the survey which support a base unit value similar to the reference service base unit value.

FREQUENCY INFORMATION

How was this service previously reported? 00520
 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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 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 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 Anesthesiology Frequency 1000

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

01933

CPT Code: 0194X4 Tracking Number: EE9 Global Period: XXX Recommended Base Units: 8
RUC Recommendation= 7

CPT Code Descriptor: Anesthesia for therapeutic interventional radiologic procedures involving the venous/lymphatic system (not to include access to the central circulation); intracranial.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 42-year-old female presents with the onset of a severe headache, nausea and decreased mental status. Neurological evaluation followed by diagnostic imaging studies reveals a thrombosis of the superior sagittal sinus. She is scheduled for thrombolysis

SERVICE DESCRIPTION:

Pre-Anesthesia: The patient is seen in the Neurological Intensive Care Unit where she is being closely monitored. Particular attention is being paid to her mental status and blood pressure, which is being maintained between 120 and 140 mm HG systolic by intravenous medications. Her past medical history is reviewed with her family and her gynecologist, who has long served as her primary care physician. Except for the usual childhood diseases and two uneventful pregnancies, her past history is unremarkable. Physical examination reveals a healthy appearing woman weighing 60 kg., who is somewhat lethargic, but does respond to loud questioning. Her airway is considered a Mallampati Class III, but this may be due to her decreased mental status and inability to fully cooperate with the physical exam. There are no other physical findings that would suggest the potential for a difficult airway. She has a peripheral intravenous line in place, through which she is receiving medication to maintain her systolic pressure between 120 and 140 mm hg. Laboratory data reveals a normal hemoglobin and basic metabolic panel profile. An EKG was read as being normal. Blood was sent to the Blood Bank for a "Type and Screen". The patient and her family were counseled about the need for general anesthesia including the use of an endotracheal tube. The need for vascular access with a central venous catheter and direct monitoring of her arterial pressure with an intra-arterial catheter were discussed. The possibility of the need for post-procedure mechanical ventilation was also presented. A discussion of the patient's wishes as expressed in her living will and the requirements inherent in a general anesthetic was held with the family and their minister, with the charge nurse from the ICU present. Informed consent was obtained from the patient and agreed to by her husband, who holds a Durable Power of Attorney for his wife.

Intra-Operative: To lessen the likelihood of aspiration of acid gastric contents, an H2 blocker and metoclopramide were given intravenously. The patient was taken to the Radiology Special Procedures Suite, being monitored during transport. After being moved to the special procedures table, ECG monitoring was continued, and the other usual non-invasive monitors were attached. One milligram of intravenous midazolam was given to sedate her, and an intra-arterial catheter was inserted in her left radial artery (separately reported). She was still receiving intravenous phenylephrine for blood pressure maintenance. Pre-oxygenation via mask was carried out for approximately two minutes, and then anesthesia was gradually induced with intravenous fentanyl and propofol. Neuromuscular paralysis was achieved with intravenous rocuronium. Easy mask ventilation for approximately two minutes was carried out; when the nerve stimulator showed that the patient was completely paralyzed, her trachea was intubated orally without difficulty. Close attention was paid to the blood pressure in order to keep it in the desired range. Proper placement of the tube was ensured by auscultation and a satisfactory waveform on the end-tidal CO2 monitor. An esophageal stethoscopy with temperature monitoring and esophageal temperature monitoring capability was placed, and a multi-lumen left subclavian central venous catheter was inserted (separately reported) to assure adequate venous access while a urinary catheter was inserted. Proper positioning of the patient was confirmed prior to prepping for the procedure. During the procedure, there was constant communication between the anesthesiologist and the interventional radiologist concerning the status of the patient and the need for blood pressure manipulation. The patient was kept paralyzed to prevent undesirable movement during the procedure. When adequate thrombolysis of the thrombosed superior sagittal sinus was accomplished, the patient was allowed to emerge from the anesthetic, while close monitoring was maintained. The intravenous infusion of phenylephrine was continued to maintain the desired pressure.

When the peripheral nerve stimulator showed a satisfactory train-of-four response, neosigmine and glycopyrolate were given. When the patient's respiratory rate and depth were judged adequate and the patient responded to painful and verbal stimuli, the endotracheal tube was removed. The patient was kept in the special procedures room for a few additional minutes to allow for neurological assessment which might have indicated the need for further immediate diagnostic imaging. The patient was then taken back to the Neurological Intensive Care Unit where the monitoring of her mental status and hemodynamic parameters were continued. The anesthesiologist made a report and care of the patient was transferred to the ICU team.

Post-Anesthesia: The anesthesiologist gave instructions as to his availability, and left the ICU. He checked on the patient by phone twice over the next few hours and visited the patient before leaving the hospital that day, and again upon arrival at the hospital the next morning, prior to starting his first case of the day. After evaluating the patient, with special attention to her recovery from the anesthetic, a post-anesthesia note was made in the medical record.

SURVEY DATA:

Presenter(s) Dr Karl E Becker

Specialty(s): American Society of Anesthesiologists

Sample Size: 17 Response Rate: (%): 3.4% Median Base Units: 8

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: 500 e-mails directing physicians to a web site

25th Percentile Base Units: 7 75th Percentile Base Units: 10 Low: 6 High: 24

Median Pre-Service Time: 25 Median Intra-Service Time: 77.5

25th Percentile Intra-Svc Time: 50 75th Percentile Intra-Svc Time: 120 Low: 45 High: 180

Median Post-Service Time: 15

Level of Service by CPT Code
Total Time (List CPT Code & # of Visits)

Immediate Post Service Time: 13 Included

Critical Care: _____ _____

Other Hospital Visits: 2 Included

Discharge Day Mgmt.: _____ _____

Office Visits: _____ _____

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Base Units</u>
00214	Anesthesia for intracranial procedures; burr holes, including ventriculography	9.0

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 existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

TIME ESTIMATES (Median)

	New/ Revised CPT Code: 0194X4	Key Reference CPT Code: 00214
Median Pre-Time	25	20
Median Intra-Time	77.5	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	3.31	3.25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.38	3.25
Urgency of medical decision making	3.56	3.38

Technical Skill/Physical Effort (Mean)

Technical skill required	3.40	3.33
Physical effort required	3.07	3.0

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.88	3.56
Outcome depends on the skill and judgement of physician	3.50	3.31
Estimated risk of malpractice suit with poor outcome	3.38	3.44

INTENSITY/COMPLEXITY MEASURES

CPT Code

**Reference
Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.88	3.35
Intra-Service intensity/complexity	3.82	3.65
Post-Service intensity/complexity	3.06	3.0

ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after deliberation of the this procedure by the ASA COE, evaluation of the results of this survey by the ASA RVS committee and consideration of the similarities of this procedure with the key reference service. While evaluation of the results of the survey intensity/complexity measures support a base unit value somewhat greater than the reference service base unit value, the ASA agree with the survey median base unit value.

FREQUENCY INFORMATION

How was this service previously reported? 00210
(if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

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 ~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 Anesthesiology Frequency ~200

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

**AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS**

April 2001

Anesthesia for Obstetrical Procedures

Ten new codes were added to CPT to redefine anesthesia for obstetrical and non-obstetrical procedures. This also included the deletion of five codes. In each instance the RUC examined the survey results but also placed additional emphasis on examining the rank order of codes within the family of interventional radiology anesthesia procedures. This was necessary since the ASA base units can not be examined in exactly the same way as physician work relative values.

00851 (FF1)

The RUC examined the survey results for code 00851 *Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transection* in comparison to the reference code 00840 *Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified* (base unit = 6). The RUC agreed that the skill and anesthesia risk for these codes was similar and therefore should have the same base units. Additionally, code 00851 was previously reported using the reference code 00840. **The RUC recommends a base unit of 6 for CPT code 00851.**

00869 (FF 2)

The RUC agreed with the ASA recommendation of 3 base units, which was also the median survey value for code 00869 *Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; vasectomy, unilateral/bilateral*. This code was valued in relation to code 00920 *Anesthesia for procedures on male genitalia (including open male urethral procedures); not otherwise specified* (base unit = 3) and was felt to be the most valid comparison since both codes involved similar work. Therefore, the RUC concluded that the work involved in both codes was the same and should have the same base units. **The RUC recommends a base unit of 3 for CPT code 00869.**

01960 (FF3)

Code 01960 *Anesthesia for vaginal delivery only* essentially replace code 00946 *Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); vaginal delivery* (base unit = 5), which is the code previously used to report this service. The RUC felt that a base unit of 5 was appropriate for anesthesia for vaginal delivery as described by this code where an epidural was not previously in place. Although the median survey value was 7 base units the RUC concluded that the vignette may have been atypical in that it described a breech delivery while more typically an epidural anesthetic is used for an uncomplicated vaginal delivery. **The RUC recommends a base unit of 5 for CPT code 01960.**

01961 (FF4)

Code 01961 *Anesthesia for cesarean delivery only* replaces code 00850 *Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; cesarean section* (base unit = 7). This code describes the provision of anesthesia for a cesarean delivery where no other anesthesia had been used previously. Therefore the RUC agreed to crosswalk the base unit value of 7 to the new code. Also, this value was appropriate in comparison to the previous code for vaginal delivery since the increment of 2 base units reflected the additional work involved in a cesarean section. **The RUC recommends a base unit of 7 for CPT code 01961.**

01962 (FF5)

Code 01962 *Anesthesia for urgent hysterectomy following delivery* is a stand alone code that was compared to reference code 00850 *Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; cesarean section* (base unit = 7). The ASA recommended a base unit of 8 to reflect the complications involved in this type of case as compared to a cesarean section or hysterectomy. This code covers the provision of anesthesia for an urgent hysterectomy following delivery where up until this point the anesthesiologist had not been involved. Therefore, this is a stand alone code. The RUC agreed that this value of 8 base units would place the code in proper rank order within the family. **The RUC recommends a base unit of 8 for CPT code 01962.**

01963 (FF6)

Code 01963 *Anesthesia for cesarean hysterectomy without any labor analgesia/anesthesia care* describes an urgent cesarean section where severe blood loss occurs and a hysterectomy is required. The median survey results of 9 base units was based on the higher intensity for the new code in comparison to reference code 00855 *Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; cesarean hysterectomy* (base unit = 8). However, after discussing the code and the work involved the RUC concluded that the anesthesia work was sufficiently similar to the reference code especially since the reference code was previously used to report this service. The RUC concluded that a base unit of 8 would properly place this code in the correct rank order with this family of codes. **The RUC recommends a base unit of 8 for CPT code 01963.**

01967 (FF7)

Code 01967 *Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)* is essentially the same as the reference code 00955 *Neuroaxial analgesia/anesthesia for labor ending in a vaginal delivery (includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)* (base unit = 5) the RUC therefore agreed with applying the same value to the new code since it was previously used to report this procedure. **The RUC recommends a base unit of 5 for CPT code 01967**

01968 (FF8)

The new code 01968 *Cesarean delivery following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure)* describes a situation where code 01305 *Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)* (recommended base unit = 5) is billed for a planned vaginal delivery, but when an unplanned cesarean section occurs, the new add on code 01968 is also billed. The RUC agreed with the ASA recommendation of 3 base units. This reflects the additional intensity and work involved in changing anesthetic techniques in the middle of the delivery that represents the work involved in changing from vaginal delivery to cesarean section. **The RUC recommends a base unit of 3 for CPT code 01968.**

01969 (FF9)

Code 01969 *Cesarean hysterectomy following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure)* describes a situation where the patient previously has a cesarean section but is currently undergoing vaginal delivery, but the vaginal delivery is unsuccessful due to fetal distress and therefore an urgent cesarean section occurs. During the cesarean delivery, the obstetrical discovers a tear in the mothers uterus through the previous cesarean scar. The ruptured uterus resulted in uncontrolled bleeding and an emergency hysterectomy was performed. Code 01305 *Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)* (recommended base unit = 5) accounts for the anesthesia work during the planned vaginal delivery such as the epidural. The new add on code 01969 then describes the work involved in providing anesthesia for the urgent cesarean delivery and also for the hysterectomy. The presenters stated that this code would be rarely used and the anesthesia work involves switching from an epidural to general anesthetic with significant blood loss, requiring an urgent hysterectomy. The RUC agreed that the work involved with a cesarean section and hysterectomy is significant and the recommended value of 5 base units correctly places the code within the proper rank order. **The RUC recommends a base unit of 5 for CPT code 01969.**

01964 (FF10)

Code 01964 *Anesthesia for abortion procedures* is rarely used and was created at the request of CPT. The ASA recommended a value of 4 based on a comparison to reference code 00946 *Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); vaginal delivery (base unit=5)*. **The RUC recommends a base unit of 4 for CPT code 01964**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Current Base Unit	Work RVU Recommendation
00840		<i>Anesthesia for intraperitoneal procedures in lower Abdomen including laparoscopy; not other specified</i>	XXX	2001 Unit = 6	6 (No change)
00850		Cesarean section (00850 has been deleted. To report, use 01961)	XXX	2001 Unit = 7	N/A
•00851	FF1	Tubal ligation/transection	XXX	N/A	6
00855		Cesarean hysterectomy (00855 has been deleted. To report, use 01963)	XXX	2001 Unit = 8	N/A

00857		Neruoaxial analgesia/anesthesia for labor ending in a Cesarean delivery (includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor) (00857 has been deleted. To report, see 01968, 01969)	XXX	2001 Unit = 7	N/A
00860		<i>Anesthesia for extraperitoneal procedures in lower Abdomen, including urinary tract; not otherwise Specified</i>	XXX	2001 Unit = 6	6 (No change)
●00869	FF2	Vasectomy, unilateral/bilateral	XXX		3
00940		<i>Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); not otherwise specified.</i>	XXX	2001 Unit = 3	3 (No change)
00946		—Vaginal delivery (00946 has been deleted. To report, see 01960)	XXX	2001 Unit = 5	N/A
00955		Neruoaxial analgesia/anesthesia for labor ending in a vaginal delivery (includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor) (00955 has been deleted. To report, use 01967)	XXX	2001 Unit = 5	N/A
●01960	FF3	Anesthesia for; vaginal delivery only	XXX	N/A	5

●01961	FF4	cesarean delivery only	XXX	N/A	7
●01962	FF5	urgent hysterectomy following delivery	XXX	N/A	8
●01963	FF6	cesarean hysterectomy without any labor analgesia/anesthesia care	XXX	N/A	8
●01967	FF7	Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor);	XXX	N/A	5
+●01968	FF8	Cesarean delivery following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure) (Use 01968 in conjunction with code 01967)	ZZZ	N/A	3
+●01969	FF9	Cesarean hysterectomy following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure) (Use 01969 in conjunction with code 01967)	ZZZ	N/A	5
●01964	FF10	Anesthesia for abortion procedures	XXX	N/A	4

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 00851 Tracking Number: FF1 Global Period: XXX Recommended Base Units: 6

CPT Descriptor: Anesthesia for intraperitoneal procedures in lower abdomen, including laparoscopy; tubal ligation/transection.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 36-year-old female with two children, ages 6 and 2, desires permanent sterilization. She no longer wants to take oral contraceptives or use any mechanical birth control techniques; her husband has chosen not to have a vasectomy. She is otherwise in good health.

SERVICE DESCRIPTION:

Pre-Anesthesia:

The patient was seen in the "holding area" approximately 30 minutes prior to the scheduled time of her surgery. She reported that she was in good general health, with only seasonal allergic rhinitis and occasional headaches, for which she took over the counter medication. She denied taking any herbal agents and had no known drug allergies. She had received an epidural for each of her deliveries, and general anesthesia for an appendectomy at age 14. Her family history was negative. Physical examination revealed a healthy appearing woman weighing 65 kg; her airway was rated a Mallampati Class I. No lab work had been ordered. She had been given an H2 blocker and metoclopramide by mouth on arrival, and a 20 gauge intravenous catheter had been inserted into her left forearm. After being given 2mg of midazolam in the holding area, she was taken to the operating room, and moved to the OR table.

Intra-Operative:

The usual monitors (EKG, non-invasive blood pressure and pulse oximeter) were applied, and she was given oxygen by mask for 90 seconds. General anesthesia was induced intravenously (IV) with 150mcg of fentanyl and 160 mg of propofol and 30 mg of rocuronium was given for muscle paralysis. She was ventilated with 100% oxygen for 45 seconds, then a size 7 french endotracheal tube was inserted into her trachea. Proper placement of the endotracheal tube was assured by condensation in the tube, movement of the chest, auscultation of the lungs and a satisfactory wave form and numerical value on the end-tidal CO2 monitor. Desflurane was added to the inspired oxygen. As prophylaxis against nausea and vomiting, she was given 0.625mg of droperidol intravenously.

She was then placed in the lithotomy position, her abdomen and vagina prepped, and the surgical field was draped. The surgeon requested that the patient be placed in a significant Trendelenberg position. The surgeon then insufflated the patient's abdomen with carbon dioxide. When the surgeon was satisfied with the volume of the carbon dioxide in the abdominal cavity, the anesthesiologist noted that the airway pressures increased from 18 to approximately 36 cm of water, and the end-tidal CO2 had increased from 36 to 48 mm Hg. To compensate for the increased end tidal CO2, the patient's respiratory rate was increased from 8 to 14 per minute.

After the second fallopian tube had been cauterized and the surgeon inspected the cervix, and no bleeding was noted; the patient was then taken out of the lithotomy position.

The desflurane had been discontinued, and as the peripheral nerve stimulator showed some fade and post tetanic facilitation, 3mg of neostigmine and 0.6 mg of glycopyrrolate were given IV.

Two minutes later the patient was breathing spontaneously, her end-tidal CO2 was 38mm Hg; after another minute, she opened her eyes. Her oro-pharynx was suctioned and the endotracheal tube removed.

The patient was moved to a recovery stretcher, and taken to the Post Anesthesia Care Unit (PACU). The anesthesiologist gave report to the PACU nurse, as the vital signs were being taken. The patient was responsive, and denied any pain or nausea. The anesthesiologist gave instructions concerning pain management, left his pager number to the PACU nurse, and went to see his next patient.

Post-Anesthesia:

00851 ff1

The patient was seen approximately two hours later in the second stage recovery area. She was awake, alert and oriented, except for some mild lower abdominal discomfort, she reported no problems, including nausea. She had been given 30 mg of ketorolac intra-muscularly 10 minutes earlier. She was judged ready for discharge.

SURVEY DATA:

Presenter(s) Dr. Karl E. Becker

Specialty(s): American Society of Anesthesiologists

Sample Size: 42 Response Rate: (%): 7% Median Base Units: 6

Type of Sample (Circle One): **random**, panel, convenience. Explanation of sample size: 583 emails directing physician to a web site

25th Percentile Base Units: 6 75th Percentile Base Units: 6 Low: 4 High: 8

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

25th Percentile Intra-Svc Time: 53.75 75th Percentile Intra-Svc Time: 80 Low: 30 High: 125

Median Post-Service Time: 10

Level of Service by CPT Code

Total Time (List CPT Code & # of Visits)

Immediate Post Service Time: 10 Included

Critical Care: _____

Other Hospital Visits: _____

Discharge Day Mgmt.: _____

Office Visits: _____

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Base Units</u>
00840	Anesthesia for intraperitoneal procedures in lower abdomen; not otherwise specified	6.0

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 existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

TIME ESTIMATES (Median)

	New/ Revised CPT Code: <u>00851</u>	Key Reference CPT Code: <u>00840</u>
Median Pre-Time	15	15
Median Intra-Time	60	60
Median Immediate Post-service Time	10	10
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	1.98	2.39
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.16	2.16
Urgency of medical decision making	1.88	2.11

Technical Skill/Physical Effort (Mean)

Technical skill required	2.48	2.47
Physical effort required	2.21	2.28
<u>Psychological Stress (Mean)</u>		
The risk of significant complications, morbidity and/or mortality	2.12	2.31
Outcome depends on the skill and judgement of physician	2.42	2.53
Estimated risk of malpractice suit with poor outcome	3.32	3.39

INTENSITY/COMPLEXITY MEASURES

CPT Code

**Reference
Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	1.78	2.07
Intra-Service intensity/complexity	2.50	2.56
Post-Service intensity/complexity	1.85	1.98

ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after consideration of the similarities of this procedure with the key reference service, which previously was used to report this procedure, and after considering the results of the survey which support a base unit value similar to the reference service base unit value.

FREQUENCY INFORMATION

How was this service previously reported? 00840 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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 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 > 400,000 per year

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 <1000/yr

Specialty _____ Frequency _____

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

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

CPT Code: 00869 Tracking Number: FF2 Global Period: XXX Recommended Base Units: 3.0

CPT Descriptor: Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; vasectomy, unilateral/bilateral.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 42-year-old married male with three children, ages 11,8, and 3, desires permanent sterilization. He and his wife prefer not to use mechanical means of contraception. They have chosen vasectomy for him, preferring to avoid general anesthesia necessary for a tubal ligation. He is in excellent health, exercising 45 minutes or so five days a week.

SERVICE Description:

Pre-Anesthesia:

The patient had been seen in the office of his urologist one week earlier. His medical history reveals no current medications or known allergies. He had had general anesthesia for an arthroscopic meniscectomy 4 years previously; his family history was unremarkable. Physical exam revealed a healthy appearing man weighing 72kg, no lab work had been ordered.

Although the patient wanted his wife to avoid having general anesthesia for a tubal ligation, he was quite anxious about having a vasectomy. The surgeon usually does his vasectomies in his office under local anesthesia without any sedation. However, this was unacceptable to this patient, who requested the procedure be done in an out-patient surgical center with an anesthesiologist in attendance.

The anesthesiologist saw the patient in the holding area of the outpatient surgery center; he had already been given an H2blocker and metoprolol orally on arrival, and the holding room nurse had inserted a 20 gauge intravenous (IV) line in the dorsum of his left hand. The patient's past medical and anesthetic history were quickly reviewed, his last oral intake was 10 hours previously, and his airway was rated a Mallampati Class I. The anesthetic management discussed with the patient included intravenous sedation with midazolam and fentanyl.

Intra-Operative:

The patient was taken to the operating room, placed on the table in the supine position, and had the usual monitoring devices attached (EKG, non-invasive blood pressure, and pulse oximetry). Supplemental oxygen was given via a face mask, to which had been attached an end-tidal CO2 sampling tube.

The patient was sedated with 2mg midazolam and 100 mcg fentanyl. His scrotum was prepped, and just prior to the surgeon injecting local anesthesia, the patient was given 50mg of propofol. When the patient stopped responding to verbal stimulation, the surgeon injected a local anesthetic into each side of the patient's upper scrotum, after having identified the spermatic cord.

During the procedure, the patient was given an additional 50mg of propofol. After 20 minutes, the bilateral incisions had been closed; and the patient was easily arousable. The monitors were removed, and the patient moved himself to the recovery stretcher. His mental status was sufficient to allow him to be taken to the second stage recovery area.

Report was given to the recovery area nurse, and after assuring that the patient was awake and comfortable the anesthesiologist gave his pager number to the nurse and left to do his next case.

Post-Anesthesia:

The patient was seen approximately one hour later. He was awake, alert and oriented and reported no pain. He had taken 8oz of fluid and denied any nausea. He was judged ready for discharge.

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Base Units</u>
00860	Anesthesia for extraperitoneal procedures in the lower abdomen, including urinary tract; not otherwise specified	6.0

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 existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

TIME ESTIMATES (Median)

	<u>New/ Revised CPT Code: 00869</u>	<u>Key Reference CPT Code: 00860</u>
Median Pre-Time	15	15
Median Intra-Time	30	45
Median Immediate Post-service Time	10	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	1.37	1.89
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.21	1.61
Urgency of medical decision making	1.26	1.67

Technical Skill/Physical Effort (Mean)

Technical skill required	1.37	1.78
Physical effort required	1.33	1.65

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.32	1.61
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Outcome depends on the skill and judgement of physician	1.53	1.94
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Estimated risk of malpractice suit with poor outcome	3.11	2.61
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INTENSITY/COMPLEXITY MEASURES

CPT Code

**Reference
Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	1.32	1.74
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Intra-Service intensity/complexity	1.47	1.84
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Post-Service intensity/complexity	1.11	1.53
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ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after consideration of the similarities of this procedure with the key reference service and after evaluation of the results of the survey which support a base unit value less than the reference service base unit value.

FREQUENCY INFORMATION

How was this service previously reported? 00920 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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 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 10,000-20,000

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 <100

Specialty _____ Frequency _____

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

01960
CPT Code: 03100 Tracking Number: FF3 Global Period: XXX Recommended Base Units: 5.0

CPT Descriptor: Anesthesia for; vaginal delivery only.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 27-year-old gravida 3 para 2 female at 36 weeks gestation arrives in labor and delivery in active labor and fully dilated. Vaginal exam shows that she is complete with breech presentation. The obstetrician believes that is too late for an epidural anesthetic. The patient cannot be delivered vaginally with local analgesia and general anesthesia is required for delivery

SERVICE DESCRIPTION:

Pre-Anesthesia:

The patient is on the delivery table in the lithotomy position, and has an 18 gauge intravenous line in her left forearm through which she is receiving Ringer's Lactate solution. She is awake and alert and experiencing significant pain (pain score of 10). As the usual monitors are being attached (EKG, non-invasive blood pressure and pulse oximeter) a quick history is elicited. She denies any significant medical problems, she has been taking only a pre-natal vitamin and denies any drug allergies. Her last oral intake - a bowl of breakfast cereal with about four ounces of milk and eight ounces of orange juice - was six hours ago. The need for general anesthesia was quickly discussed with her.

Intra-Operative:

The patient was given 100% oxygen via the anesthesia mask/circuit for approximately ninety seconds; general anesthesia was induced intravenously with 5mg. rocuronium followed by 300. mg of sodium pentothal and 120 mg. of succinylcholine, while cricoid pressure was being applied. After the patient was asleep and with adequate muscle relaxation, the trachea was intubated with a 7 mm cuffed endotracheal tube. Proper placement of the tube was assured by condensation in the tube, chest movement, auscultation of the lungs and a satisfactory wave form and numerical value on the end-tidal CO2 monitor. The tube was taped as were the eyes. Via the endotracheal tube, the patient was given oxygen, nitrous oxide and desflurane. The obstetrician, after infiltrating the perineum with a local anesthetic and performing an episiotomy, proceeded to deliver the breech presentation vaginally over the next 10 minutes. During this time the anesthesiologist passed an 18 gauge oro-gastric tube to decompress the stomach.

After delivery of the baby, and prior to delivery of the placenta, another 150 mg. of pentothal as well as 100 mcg. of fentanyl were administered intravenously. After delivery of the placenta, pitocin was added to the intravenous infusion. After the episiotomy had been repaired, the patient was taken out of the lithotomy position, and her uterus massaged. The nitrous oxide and desflurane were discontinued, and the patient began to arouse. When her level of consciousness and respiratory effort were judged to be adequate, the endotracheal tube was removed.

The patient was moved to a recovery stretcher, and taken to the Post Anesthesia Care Unit (PACU). Report was given to the PACU nurse as the usual PACU monitors and an oxygen mask were being applied. After vital signs were taken, and the PACU nurse's questions answered, the anesthesiologist left the PACU.

Post-Anesthesia:

The patient was seen in follow-up the next day, and reported no adverse sequelae, including intra-operative awareness, to the anesthetic.

SURVEY DATA:

03100 ff3

Presenter(s) Dr. Karl E. Becker
Specialty(s): American Society of Anesthesiologists

Sample Size: 38 Response Rate: (%): 6.5% Median Base Units: 7

Type of Sample (Circle One): **random**, panel, convenience. Explanation of sample size: 583 e-mails directing physician to a web site

25th Percentile Base Units: 6 75th Percentile Base Units: 8 Low: 4 High: 12

Median Pre-Service Time: 10 Median Intra-Service Time: 45

25th Percentile Intra-Svc Time: 30 75th Percentile Intra-Svc Time: 60 Low: 12 High: 225

Median Post-Service Time: 15

Level of Service by CPT Code
Total Time (List CPT Code & # of Visits)

Immediate Post Service Time: 15 Included

Critical Care: _____ _____

Other Hospital Visits: 5 Included

Discharge Day Mgmt.: _____ _____

Office Visits: _____ _____

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Base Units</u>
00946	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); vaginal delivery	5.0

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 existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

TIME ESTIMATES (Median)

	<u>New/ Revised CPT Code: 03100</u>	<u>Key Reference CPT Code: 00946</u>
Median Pre-Time	10	10
Median Intra-Time	45	47.5
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	3.31	2.97
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.33	2.33
Urgency of medical decision making	4.36	3.54

Technical Skill/Physical Effort (Mean)

Technical skill required	3.56	3.41
Physical effort required	3.31	3.31

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.23	3.54
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Outcome depends on the skill and judgement of physician	3.90	3.56
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Estimated risk of malpractice suit with poor outcome	4.56	4.41
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INTENSITY/COMPLEXITY MEASURES

CPT Code

**Reference
Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.33	2.97
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Intra-Service intensity/complexity	3.79	3.44
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Post-Service intensity/complexity	2.41	2.23
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ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after consideration of the similarities of this procedure with the key reference service, which previously was used to report this procedure, and after considering the results of the survey which support a base unit value similar to the reference service base unit value.

FREQUENCY INFORMATION

How was this service previously reported? 00946 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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 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 2.5 to 2.9 Million

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 1000

Specialty _____ Frequency _____

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

01961
CPT Code: 03101 Tracking Number: FF4 Global Period: XXX Recommended Base Units: 7.0

CPT Descriptor: Anesthesia for; cesarean delivery only.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25-year-old gravida 1 para 0 presents to the obstetrical suite with prolonged active labor and failure to progress. The patient did not want neuraxial analgesia for labor. A non-reassuring fetal heart rate tracing is noted. A cesarean section is planned.

SERVICE DESCRIPTION:

Pre-Anesthesia:

The patient was seen in the labor room along with her husband; she rated her labor pain at 10 on a 0 - 10 scale. She was in bed, with her head elevated about 40 degrees, a roll was under her right hip for left uterine displacement, and her abdomen was being shaved by the labor room nurse. She had an 18 gauge intravenous catheter in her left wrist, through which she was receiving Ringer's Lactate solution. Over the past hour, she had received 400ccs of the fluid. Except for ice chips, she had not had any oral intake for the past eight hours. She had just been given 30ccs of sodium citrate solution.

Her past medical history was unremarkable, and she denied any drug allergies; during the pregnancy she had been taking prenatal vitamins and occasionally some acetaminophen for lower backaches. Her only previous anesthetic was a general anesthetic for a tonsillectomy at age 8; she knew of no family history of problems with anesthetics. On physical examination, she was noted to be 5'4" tall, and weighing 72kg. Her airway was assessed to be a Mallampati Class II. Her hematocrit was reported to be 36%.

She and her husband wanted him to be with her in the delivery room; it was explained to them that that would be possible only with a regional technique. So although she had chosen not to have a neuraxial analgesic for her labor, after her options were explained, including the risks, she opted for a spinal anesthetic.

Intra-Operative:

After having received an additional 800ccs of the Ringer's Lactate, the patient was taken to the delivery room, and moved to the operating table. She was helped to sit on the table with her legs over the side, and the usual monitors (EKG, non-invasive blood pressure and a pulse oximeter) were applied. After having been positioned by the labor nurse, who was helping her maintain that position, her lower back was prepped with an iodine solution and alcohol. Approximately 3cc. of 1% lidocaine was infiltrated into the skin and subcutaneous tissue, and an 18 gauge introducer needle inserted at the L 3-4 interspace. Through the introducer needle, a 24 gauge pencil point spinal needle was inserted into the subarachnoid space; no paresthesia was noted by the patient, and the cerebrospinal fluid was clear. 20mcg. of fentanyl (0.4ml) in 1.4 ml of "spinal bupivacaine" (0.75% bupivacaine in 8.25% dextrose) was injected intrathecally for surgical anesthesia. After 30 seconds, the patient was placed in the supine position, with her head elevated approximately 15 degrees, and a roll was placed under her right hip to provide left uterine displacement. An oxygen mask was placed on the patient, and she was given 10 mg of ephedrine intravenously, as prophylaxis against hypotension.

After the fetal heart tones were checked and a urinary catheter inserted, the patient's abdomen was prepped and draped. The sensory level of the spinal anesthetic had been continuously checked during this time, and her blood pressure was being checked every 3 minutes. A satisfactory level of the anesthetic was once again assured, and the patient's husband was brought into the room and placed at the head of the table. As had been discussed in the labor room, what the patient was likely to experience during the surgical procedure was explained to her and her husband. The patient's hand grip strength was checked from time to time, as was the appearance and affect of her husband. Although she was aware of "something going on" in her abdomen, she denied any discomfort.

As the baby was being delivered through the uterine incision, she did comment on some pressure in her upper abdomen, which ended with the delivery of her baby. At the time of delivery, the father was given the opportunity to stand up and witness the delivery. After the delivery, the oxygen mask was removed from the patient, and the drapes were briefly lowered so that she could see her baby before it was given to the neonatologist in attendance. Pitocin was added to the intravenous fluid bag, and 1 gm of cefazolin was given intravenously.

The vital signs continued to be monitored as is usual for operative procedures during the remainder of the operation, and the patient was kept apprised of the progress of the procedure. After having been evaluated by the neonatologist, the baby was brought to the patient for several minutes before being taken to the nursery. After the incision was closed and a dressing applied, the patient was moved to a recovery stretcher and taken to the Post Anesthesia Care Unit (PACU).

Report was given to the PACU nurse, including the drugs given and the orders pertaining to post-operative pain management. After the vital signs were taken, and any questions by the patient and the PACU nurse were answered, the anesthesiologist left his pager number and returned to the Labor and Delivery Suite.

Post-Anesthesia:

The patient was checked on approximately one hour later; she reported the surgical anesthetic was waning, and her pain score was 2 to 3. She was seen in follow up the next day. She denied any headache, and remarked that she had only some mild lower back discomfort and adequate pain control. She was reassured that the back discomfort had several possible causes, and would likely pass in a few days.

SURVEY DATA:

Presenter(s) Dr Karl E. Becker

Specialty(s): American Society of Anesthesiologists

Sample Size: 38 Response Rate: (%): 6.5% Median Base Units: 7

Type of Sample (Circle One): **random**, panel, convenience. Explanation of sample size: 583 e-mails directing physicians to a website

25th Percentile Base Units: 7 75th Percentile Base Units: 8 Low: 7 High: 12

Median Pre-Service Time: 15 Median Intra-Service Time: 75

25th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 88.75 Low: 35 High: 120

Median Post-Service Time: 11

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>11</u>	<u>Included</u>
Critical Care:	<u></u>	<u></u>
Other Hospital Visits:	<u>5-10</u>	<u>Included</u>
Discharge Day Mgmt.:	<u></u>	<u></u>
Office Visits:	<u></u>	<u></u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Base Units</u>
00850	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; cesarean section	7.0

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 existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

TIME ESTIMATES (Median)

	New/ Revised CPT Code: 03101	Key Reference CPT Code: 00850
Median Pre-Time	15	15
Median Intra-Time	75	75
Median Immediate Post-service Time	11	11
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	3.11	2.97
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.61	2.53
Urgency of medical decision making	3.97	3.56

Technical Skill/Physical Effort (Mean)

Technical skill required	3.73	3.63
Physical effort required	3.34	3.28

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.68	3.44
Outcome depends on the skill and judgement of physician	4.	3.86

Estimated risk of malpractice suit with poor outcome	4.74	4.56
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INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.08	2.92
Intra-Service intensity/complexity	3.55	3.42
Post-Service intensity/complexity	2.45	2.42

ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after consideration of the similarities of this procedure with the key reference service, which is currently used to report this procedure, and after considering the results of the survey which support a base unit value similar to the reference service base unit value.

FREQUENCY INFORMATION

How was this service previously reported? 00850 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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 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 800,000 to 850,000/year

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 250-2000

Specialty _____ Frequency _____

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

01/16/2

CPT Code: 03102 Tracking Number: FF5 Global Period: XXX Recommended Base Units: 8.0

CPT Descriptor: Anesthesia for; urgent hysterectomy following delivery.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

The patient, a 37-year-old gravida 5 female, presents to the labor and delivery suite in active labor at 39 weeks gestation. Her obstetric history is remarkable for 3 uncomplicated vaginal deliveries that did not require labor analgesia services. Her fourth pregnancy was complicated by a Cesarean section for breech presentation. This labor reveals a reassuring fetal heart rate tracing and rapid progression to the second stage of labor, without augmentation. The patient tolerated the discomfort of labor and delivery without any anesthetic intervention. After uneventful delivery of a healthy male neonate, adherent placenta (placenta accreta) complicates delivery of the placenta. Due to increasing hemorrhage and partial inversion of the uterus during attempted manual extraction of retained placenta, the obstetrician decides to perform an emergent laparotomy for control of hemorrhage. The obstetrician administers oxytocin intravenously and methergine intramuscularly without apparent improvement

SERVICE DESCRIPTION:

Pre-Anesthesia:

After receiving a "stat" page to the obstetric suite, the anesthesiologist promptly arrives and is directed to the delivery room. On arrival, she receives a brief report from the obstetrician and obstetric nurse summarizing the events leading to the current situation. The anesthesiologist quickly obtains pertinent history focusing on medications, allergies, previous anesthetic experiences, family history of anesthetic problems and a review of systems concentrating on the cardiac and pulmonary systems. Simultaneously, she begins giving the patient 100% oxygen after performing a check of the anesthetic circuit, applies monitoring devices, (ECG, non-invasive blood pressure monitoring, and pulse oximetry), assures adequate intravenous access, and performs an examination of the airway. The patient is on no medications, develops hives from penicillin, had no anesthetic problems from her cesarean section, has no knowledge of anesthetic problems in the family, and is otherwise in excellent health.

While the nurse administers oxygen to the patient, via a face mask, the anesthesiologist gathers the induction medications, checks that the wall suction is operating, and determines that the laryngoscope and endotracheal tube are readily accessible. The anesthesiologist briefly informs the patient of the need for general anesthesia. Due to the emergent nature of the procedure, the anesthesiologist chooses not to discuss the risks of general anesthesia. Vital signs immediately before induction of anesthesia reveal a blood pressure of 70/42, a heart rate of 120, and oxygen saturation of 99%. The patient has received 1700 cc of crystalloid solution intravenously during labor, and 1000 cc since delivery via a 16 gauge peripheral venous catheter. The obstetrician estimates that the blood loss is 1000 cc.

Intra-Operative:

The anesthesiologist instructs the nurse to apply and maintain cricoid pressure, Etomidate .02 mg/kg and succinylcholine 1.5 mg/kg are administered intravenously. After uncomplicated rapid sequence intubation, the anesthesiologist confirms endotracheal tube placement via auscultation and presence of end-tidal carbon dioxide. Vital signs demonstrate continued hypotension and tachycardia; peripheral nerve stimulator indicates the need for additional muscle relaxation. The anesthesiologist also administers incremental doses of fentanyl and low dose (less than 0.5 MAC) inhalational anesthesia to achieve analgesia and amnesia, adjusting the anesthetic depth to minimize hypotension. While the surgical team rapidly prepares the patient's abdomen and applies sterile drapes, the anesthesiologist places a 14 gauge, antecubital intravenous catheter, which she connects to a rapid infusion device (Level One). She also places an arterial catheter (separately reportable) in the left radial artery for continuous blood pressure monitoring and access for laboratory studies. The anesthesiologist obtains an arterial blood gas, complete blood count, and coagulation profile.

The obstetrician makes the skin incision. Due to the continuing hemorrhage and associated hypotension, the anesthesiologist rapidly infuses 1000 cc of hydroxyethyl starch. Arterial blood gas demonstrates metabolic acidosis and adequate oxygenation. Hemoglobin is 6 g/dl and platelet count is 80,000/cc³. The anesthesiologist orders appropriate blood products and administers sodium bicarbonate intravenously. The surgeon quickly exposes the uterus, which demonstrates atony. Clamping the uterine arteries only minimally reduces the ongoing hemorrhage. A nurse delivers four units of crossmatched packed red blood cells to the operating room. The anesthesiologist begins a rapid infusion of the red cells after confirming with the nurse that the unit is in date and that the crossmatch is correct. Given the ongoing hemorrhage, the obstetrician decides to proceed with urgent hysterectomy. Despite continued rapid infusion of blood and crystalloid, the patient's

hypotension only minimally improves. The obstetrician reports increasing bleeding from serosal surfaces, and the anesthesiologist notes bleeding around the intravenous catheter sites. The platelets arrive and the anesthesiologist administers the platelets after confirming the blood bank tag with the nurse. Oxygen saturation declines from 99% to 93% despite administration of 100% oxygen. Lung auscultation demonstrates diffuse rales. A nurse delivers the results of the coagulation panel, which demonstrate low fibrogen, elevated D-dimers, prothrombin time of 25 seconds (INR 2.3), and activated thromboplastin time of 60 seconds. The anesthesiologist makes a diagnosis of disseminated intravascular coagulation and possible adult respiratory distress syndrome. The anesthesiologist orders additional platelets, cryoprecipitate and fresh frozen plasma. To address the respiratory compromise, the anesthesiologist adds positive end-expiratory pressure (PEEP); however, the patient's hypotension worsens, and the PEEP is discontinued. To help support blood pressure, the anesthesiologist initiates an infusion of dopamine, which increases the blood pressure to 80-90/35-45. At the end of surgery, the anesthesiologist and the nurse transfer the patient to the ICU bed. The anesthesiologist connects the transport monitor and observes ECG, oxygen saturation and arterial blood pressure. Using an ambu bag, the anesthesiologist ventilates the patient manually during transport to the ICU.

On arrival, the anesthesiologist orders initial ventilator settings, reviews hemodynamics on arrival, orders sedatives and analgesics for patient comfort, and provides a detailed report to the admitting nurse. In addition, the anesthesiologist orders admitting laboratory studies - including complete blood count and arterial blood gas, reviews the results of the coagulation profile obtained at the end of surgery, reviews the chest x-ray obtained after pulmonary artery catheter placement, and provides a detailed report to the intensivist, who will be assuming care of the patient. The anesthesiologist and the surgeon then visit with the patient's family to discuss the anesthetic and the surgery, the patient's condition and to answer the family's questions.

Post-Anesthesia:

The anesthesiologist returns later in the day as well as the next morning to check on the patient's progress, assure adequate analgesia, and to provide input into the patient's care. She makes a medical record entry on both visits. The patient's condition gradually improves with extubation on the second post-operative day and discharge from the ICU on the third post-operative day. The patient has no recall of intraoperative events.

SURVEY DATA:

Presenter(s) Dr Karl E. Becker

Specialty(s): American Society of Anesthesiologists

Sample Size: 38 Response Rate: (%): 6.5% Median Base Units: 7.0

Type of Sample (Circle One): **random**, panel, convenience. Explanation of sample size: 583 e-mails directing physicians to a web site

25th Percentile Base Units: 7 75th Percentile Base Units: 8 Low: 7 High: 12

Median Pre-Service Time: 15 Median Intra-Service Time: 75

25th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 80 Low: 35 High: 120

Median Post-Service Time: 15

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

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Base Units</u>
00850	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; cesarean section	7.0

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 existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

TIME ESTIMATES (Median)

	<u>New/ Revised CPT Code: <u>03102</u></u>	<u>Key Reference CPT Code: <u>00850</u></u>
Median Pre-Time	15	15
Median Intra-Time	75	75
Median Immediate Post-service Time	11	11
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	3.14	2.92
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.57	2.42
Urgency of medical decision making	3.97	3.56

Technical Skill/Physical Effort (Mean)

Technical skill required	3.70	3.54
Physical effort required	3.32	3.22

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.73	3.44
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Outcome depends on the skill and judgement of physician	4.05	3.85
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Estimated risk of malpractice suit with poor outcome	4.81	4.56
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INTENSITY/COMPLEXITY MEASURES

CPT Code

**Reference
Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.03	2.84
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Intra-Service intensity/complexity	3.54	3.41
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Post-Service intensity/complexity	2.43	2.41
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ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after deliberation of the procedure by the ASA COE, evaluation of the results of this survey by the ASA RVS committee, a subcommittee of the ASA COE, and consideration of the similarities of this procedure with the key reference service. Further evaluation of the results of the survey intensity/complexity measures support a base unit value somewhat greater than the reference service base unit value.

FREQUENCY INFORMATION

How was this service previously reported? 00840 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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 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 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 Anesthesiology Frequency <50

Specialty _____ Frequency _____

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

07/16/03

CPT Code: 03103 Tracking Number: FF6 Global Period: XXX Recommended Base Units: 9.0
RUC Recommendation = 8.0

CPT Descriptor: Anesthesia for; cesarean hysterectomy without any labor analgesia/anesthesia care.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old gravida 4 para 3 female presents to the delivery suite in active labor. A non-reassuring fetal heart rate is noted and an urgent cesarean section is planned under general anesthesia. After delivery of the infant, separation of the placenta is incomplete, and severe on-going blood loss occurs. A cesarean hysterectomy is required

SERVICE DESCRIPTION:

Pre-Anesthesia:

The patient was seen in the labor room, along with her husband. She supine in the bed, with her head elevated about 40 degrees, she had a roll under her right hip to provide some left uterine displacement and she was receiving supplemental oxygen through nasal cannulae. She had an 18 gauge intravenous catheter in her left wrist, through which she had received 500 cc of Ringer's Lactate solution, and her abdomen was being shaved by the labor nurse. She was having significant discomfort with her contractions, reporting a pain score of 9 - 10 on a 10 scale. She had eaten a full meal 5 hours previously.

She reported that her past medical history was remarkable only for seasonal allergic rhinitis (which was not a current problem) and a dilation and curettage under general anesthesia six years previously. Her only medications were pre-natal vitamins and occasionally acetaminophen for low back discomfort. She denied any drug allergies or family history of problems with anesthesia. Physical exam revealed her to be 5'1" tall, a weight of 80 kg and a Mallampati Class II to III airway. Her hematocrit was 34%; blood for "type and screen" had been sent to the blood bank.

She was given 30cc of sodium citrate while the anesthetic management was discussed. Before being taken to the delivery room, a urinary catheter was inserted. Because of the emergent nature of the situation, the obstetrician felt that there was not time for a neuraxial anesthetic.

Intra-Operative:

She was taken to the operating room and placed on the table in the supine position, with a roll under her right hip. While the usual monitors (EKG, non-invasive blood pressure and a pulse oximeter) were being applied, the patient was given oxygen via a mask and the anesthesia breathing circuit. The patient's abdomen was prepped and draped, and when the obstetrician and the surgical team were ready, general anesthesia was induced with 5mg of rocuronium, 300mg of sodium pentothal followed by 120mg of succinylcholine while cricoid pressure was being applied. After approximately 45 seconds, the trachea was intubated with a 7 mm oral endotracheal tube with some slight difficulty because of the patient's body habitus and airway architecture. Proper position was assured by seeing condensation in the tube, movement of the chest, auscultation of the lungs and a satisfactory wave form and numerical value on the end-tidal CO2 monitor. Oxygen, nitrous oxide and desflurane were administered via the endotracheal tube.

The operative delivery was accomplished within approximately 5 minutes; the baby was given to the attending neonatologist. An additional 200mg of pentothal, 150 mg of fentanyl and 20 mg of rocuronium were administered intravenously, and pitocin was added to the intravenous solution. An 18 gauge oro-gastric tube was inserted to decompress the stomach.

The obstetrician reported that the uterine tone was not satisfactory, and 4mg of methergine was administered intramuscularly. More than the usual amount of bleeding was occurring and the obstetrician was concerned that in trying to separate the placenta, a tear in the lateral wall of the uterus had occurred. Except for a slight increase in the patient's pulse rate, the vital signs remained stable. 250mcg of carboprost were given intramuscularly, and the blood bank was called and 4 units of packed red blood cells (PRBC) ordered. Another 18 gauge intravenous catheter was inserted in the patient's right forearm, and an esophageal stethoscope/temperature probe was inserted into her esophagus.

Over the next 10 minutes the bleeding continued and the exact origin could not be identified. The obstetrician asked a colleague who happened to be finishing a vaginal delivery to scrub in; they agreed that in the face of not being able to control the bleeding, a hysterectomy was necessary. While the second obstetrician remained scrubbed, the patient's obstetrician stepped outside to explain the situation to the patient's husband.

The anesthesiologist had called for two fluid warming devices and an upper body forced air warming blanket; when they arrived, they were immediately employed.

The patient's blood pressure had dropped into the 80's and her pulse rate was 110-120. The blood loss at this time was estimated to be 2000cc, and she had been given 3000cc of Ringer's Lactate. The four units of PRBC arrived, and after being checked by the circulator and the anesthesiologist, two units were immediately hung. The blood bank was asked to stay four units on PRBC ahead.

The primary obstetrician had returned, and an emergency hysterectomy was initiated. Once the blood supply to the uterus had been identified and ligated, the bleeding was controlled; by this time the blood loss was thought to be approximately 2500cc. An additional two units of PRBC were administered. The blood pressure had stabilized at 104 - 112 systolic, and the pulse rate was in the low 90s. The anesthetic continued to be a combination of intravenous drugs and desflurane.

The hysterectomy was completed, and a posterior lateral tear in the uterine wall was seen; this was felt to be the site of the bleeding. The abdomen was explored to be sure that no surgical packs/sponges were being overlooked, and the abdomen was closed.

The patient's temperature was 35.5 degrees, and her other vital signs were stable. Her urine, somewhat pink in color, was flowing at about 60cc per hour. Following closure of the abdomen, the desflurane was discontinued and the residual paralysis reversed with 3mg of neostigmine, accompanied by 0.6mg of glycopyrrolate. When the patient's mental status, respiratory effort and head lift were judged adequate, the endotracheal tube was removed.

The patient was moved to a recovery stretcher and taken to the Post Anesthesia Care Unit (PACU) while being administered oxygen via a face mask. The anesthesiologist gave report to the PACU nurse, including reviewing the blood products (four units of PRBC) and fluids (4000cc of Ringer's Lactate and 400cc of Normal Saline) she had received, and told her of the four units of PRBC remaining in the blood bank. The patient's vital signs were taken and were acceptable. After discussing the plans for pain management (IV PCA) and the next few hours monitoring and fluid administration plans with the obstetrician, the anesthesiologist left word with the PACU nurse as to how he would be reached, and returned to the labor and delivery suite.

Post-Anesthesia:

Before leaving for the evening, the anesthesiologist passed on to his partner who would be covering labor and delivery/post-partum that night about the events of the case.

The next day the patient was seen on post-anesthesia follow-up rounds. She reported no recall, a mild sore throat, and reasonably satisfactory pain control with the IV PCA utilizing morphine.

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Base Units</u>
00855	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; cesarean hysterectomy	8.0

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 existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

TIME ESTIMATES (Median)

	New/ Revised CPT Code: 03103	Key Reference CPT Code: 00855
Median Pre-Time	10.5	15
Median Intra-Time	120	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	2.36	2.92
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.34	2.34
Urgency of medical decision making	4.34	3.50

Technical Skill/Physical Effort (Mean)

Technical skill required	3.53	3.37
Physical effort required	3.29	3.29

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.21	3.553
Outcome depends on the skill and judgement of physician	3.87	3.53

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	4.18	3.55
Intra-Service intensity/complexity	4.58	4.11
Post-Service intensity/complexity	3.58	3.32

ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after deliberation of the procedure by the ASA COE, evaluation of the results of this survey by the ASA RVS committee, a subcommittee of the ASA COE, and consideration of the similarities of this procedure with the key reference service. Further evaluation of the results of the survey intensity/complexity measures support a base unit value somewhat greater than the reference service base unit value.

FREQUENCY INFORMATION

How was this service previously reported? 00855 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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 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 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 Anesthesiology Frequency < 50

Specialty _____

Frequency _____

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



19167

CPT Code: 03105 Tracking Number: FF7 Global Period: XXX Recommended Base Units: 5.0

CPT Descriptor: Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural during labor).

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 32-year-old primiparous female admitted for induction of labor and planned vaginal delivery at 41 weeks gestation. She and her husband have attended childbirth classes, and she is interested in having an epidural if and when her labor pains exceed what she feels she can tolerate.

SERVICE DESCRIPTION:

Pre-Anesthesia:

The patient was admitted at 0600 to the labor and delivery (L/D) suite for elective induction. She has had no solid food intake for 8 hours, and had about 240cc of water at 0500 when she awoke. She is admitted to a Labor and Delivery/Post Partum (LDRP) by the nurse who will see her throughout her labor and delivery and immediate recovery. The L/D inserts an 18 gauge indwelling intravenous catheter in the patient's forearm, at the same time sending blood for a CBC and Type and Screen. The patient's obstetrician checks her, and determines that she is 2 to 3 cm dilated and somewhat effaced, at which time the amniotic sac membranes are artificially ruptured and pitocin is begun.

Two hours later the patient is 4 to 5 cm dilated, and in an active labor pattern as demonstrated on the fetal monitors. The obstetrician has been informed, and states the patient can have pain relief administered by the anesthesiologist whenever the patient wants it. The anesthesiologist is called by the nurse who reports that the patient is reaching her pain tolerance threshold.

The anesthesiologist arrives, and quickly reviews the patient's past medical history and her prenatal history. Her past medical history is unremarkable, and her prenatal course is notable only in that she had some nausea and vomiting early in the pregnancy, which subsided by the twelfth week. A discussion of pain management alternatives, including combined spinal epidural analgesia ensues, and the patient and her husband, being familiar with the various techniques because of their childbirth classes and conversations with friends, give their consent for a combined spinal epidural.

Intra-Operative:

The patient is assisted in sitting up, with her feet off the side of the bed; her husband sits on a stool in front of her to support her while the neuraxial technique is undertaken. The lumbar area back is cleaned with an iodine containing solution followed by isopropyl alcohol. The L3-4 interspace is identified, and the skin and subcutaneous tissues infiltrated with 1% lidocaine. The skin was punctured in the midline at the L3-4 interspace, and then using the loss of resistance technique, the epidural space was identified at that level with a 17-gauge tuohy needle. A 25-gauge pencil pointed spinal needle was passed through the epidural needle into the subarachnoid space, with the return of clear cerebrospinal fluid; the patient felt no paresthesias. 2.5 mg of preservative free bupivacaine and 20 mcg of fentanyl were injected through the spinal needle, which was then removed. An 18-gauge bullet tipped epidural catheter was then passed through the epidural needle approximately 5 cm into the epidural space. A transient paresthesia to the left thigh was noted by the patient.

Within 2 minutes the patient reported significant relief of her pain. The anesthesiologist filled out the anesthetic record and left the room, having been called to see another laboring patient. Twenty minutes later he checked on this patient, who was still quite comfortable, and had had no significant changes in her vital signs, nor had there been any significant change in the course of her labor or in the condition of the baby.

An epidural infusion of 10cc/hour of .125% bupivacaine with 2 mcg of fentanyl/cc was begun an hour later. Over the next 5 hours the anesthesiologist checked on the patient twice, once in person and once by phone. The anesthesiologist was then called by the L/D nurse and informed that delivery was imminent. The patient was checked, and was comfortable. She

delivered 10 minutes later. Approximately 30 minutes after delivery she was seen again by the anesthesiologist, who asked the nurse to remove the epidural catheter.

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Base Units</u>
00955	Neuraxial analgesia/anesthesia for labor ending in vaginal delivery (includes any repeat subarachnoid needle placement and drug injection and/or any replacement of an epidural catheter during labor)	5.0

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 existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

TIME ESTIMATES (Median)

	<u>New/ Revised CPT Code: 03105</u>	<u>Key Reference CPT Code: 00955</u>
Median Pre-Time	15	15
Median Intra-Time	97.5	82.5
Median Immediate Post-service Time	10	10
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	2.62	2.53
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.50	2.55
Urgency of medical decision making	2.67	2.76

Technical Skill/Physical Effort (Mean)

Technical skill required	2.89	2.97
Physical effort required	2.72	2.82

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.81	2.97
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Outcome depends on the skill and judgement of physician | 5.0 | 2.95

Estimated risk of malpractice suit with poor outcome | 2.97 | 3.03

INTENSITY/COMPLEXITY MEASURES

CPT Code

Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity | 2.18 | 2.18

Intra-Service intensity/complexity | 2.84 | 2.87

Post-Service intensity/complexity | 1.68 | 1.71

ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after consideration of the similarities of this procedure with the key reference service, which is currently used to report this procedure, and after evaluating the results of the survey which support a base unit value similar to the reference service base unit value.

FREQUENCY INFORMATION

How was this service previously reported? 00955 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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 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 2.0-2.3 Million

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 800

Specialty _____ Frequency _____

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

03106

CPT Code: **+** 03106 Tracking Number: FF8 Global Period: ZZZ Recommended Base Units: 3.0

CPT Descriptor: Cesarean delivery following neuraxial labor analgesia/anesthesia
(List separately in addition to code for primary procedure)
(Use 03106 in conjunction with 03105)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 30-year-old primiparous female estimated fetal age of 41 weeks is admitted for induction of labor following spontaneous rupture of membranes. At the request of both the obstetrician and the patient herself, the anesthesiologist has been consulted for additional pain management of labor. A lumbar epidural has been placed. The patient's labor, augmented by pitocin infusion, has progressed to a complete dilation of the cervix. After three hours of pushing, the presence of a fever of 101F, failure of the fetal head to descend adequately into the pelvis and a loss of fetal heart tone variability, the obstetrician has decided to perform a Cesarean section.

SERVICE DESCRIPTION:

Pre-Anesthesia:

Having been assessed by her obstetrician in the office, the patient is admitted to the hospital at 1100 hours for the purpose of inducing labor. Her past medical history is unremarkable, and she has had no previous anesthetic experience. Following maternal and fetal assessment by the nursing staff, intravenous access is established. After several hours of observation and no sign of active labor, intravenous pitocin stimulation is initiated. Initial labor pain is treated with intravenous butorphanol. Because of increased discomfort and a lack of relief from butorphanol, the anesthesiologist is requested to see the patient who at this point is 3-4 centimeters dilated, 80% effaced, the fetal vertex is palpable at a minus 1-2 station, and the fetal heart tones reflect healthy variability. The patient's chart, including pertinent laboratory data, is reviewed; the patient is examined with particular attention to the airway, heart, lungs, and spine. Alternatives and relative risks to anesthesia management are discussed with the patient, and the anesthesiologist recommends the placement of a lumbar epidural through which a continuous infusion of local anesthetic and narcotic can be employed to provide analgesia for labor and anticipated vaginal delivery. All questions are answered.

Intra-Operative:

While monitoring maternal blood pressure and fetal heart rate, the patient is positioned for epidural insertion. In the lumbar area, the skin is prepped with an antiseptic solution, sterile drapes are applied, and the skin is infiltrated with 1% plain lidocaine. Using delicate technique, an #18 gauge epidural needle is inserted at the L2-3 interspace and, using a loss of resistance technique, the epidural space is identified. A #20 gauge epidural catheter is passed through the needle and advanced into the epidural space. The introducer needle is then withdrawn, and the catheter is taped into position. A 3 cc test dose of 1.5% lidocaine with epinephrine 1:200,000 is injected through the epidural catheter, and the patient is observed for onset of anesthesia or the development of maternal tachycardia. An initial dose of 8 cc's of 0.125% bupivacaine and fentanyl 5 micrograms/cc is given, and an infusion pump is programmed to deliver 0.1% bupivacaine plus fentanyl 2.3 micrograms per cc at the rate of 10 cc's per hour. Blood pressure, fetal heart rate, and dermatome level of analgesia are regularly checked. A time based anesthesia record is developed to record expected and unexpected changes in blood pressure and fetal heart rates. The progress of labor is monitored. The patient is visited regularly by the anesthesiologist, and the infusion adjusted to meet the analgesic needs of the patient. After seven hours of epidural infusion, the patient is noted to be completely dilated; though the fetal vertex remains high. The labor nurse reports that there is a moderate amount of meconium staining. Maternal efforts to push the baby out are begun. After three hours of excellent maternal efforts at pushing, the fetal heart tones are noted to have increased to 190 beats per minute with a loss of variability, and the fetal vertex remains high in the pelvis. The maternal temperature is 101.6 F. The obstetrician advises the parents that delivery by Cesarean section is indicated. The anesthesiologist again reviews the notes of the labor nurse, and discusses the alternatives of anesthesia for the planned Cesarean section with the patient. Epidural anesthesia, using the already functioning epidural catheter, is recommended. The consent for surgery having been signed, the epidural infusion and the pitocin infusion are discontinued, while 30 cc of antacid is given orally to the patient. The surgical suite is checked to ensure proper functioning of the anesthesia machine, the adequacy of the oxygen supply, the presence of suction equipment, and the preparation of anesthesia drugs, especially those to induce general anesthesia should it be necessary. The patient is then transferred to the operating suite, using care to protect dislodgment of the epidural

patient. The patient moves easily to the operating table, where blood pressure, ECG, and pulse oximetry monitors are applied. Oxygen is provided by mask. Fetal heart tones are checked. 2% lidocaine is injected through the epidural catheter to achieve a level of surgical anesthesia. A rolled towel is placed under the patient's right flank to achieve lateral displacement of the uterus from the vena cava. The patient is prepped and draped for surgery. Intravenous fluids are administered in amounts to meet surgical blood loss and maintenance requirements. Lower blood pressure is anticipated due to the sympathetic blockage as a part of the epidural anesthesia. Upon delivery of the baby, intravenous pitocin and antibiotics are given. Following cessation of surgery, preservative free morphine and fentanyl are injected through the epidural catheter to enhance postoperative analgesia. The patient is transferred to a bed, and transported to the post-anesthesia care unit.

Vital signs, dermatome level of anesthesia, oxygen saturation, and adequacy of ventilation are determined. A verbal report of the patient's condition is provided to the post-anesthesia care nurse. Supplemental analgesia is provided with intravenous narcotics. Fluids and vasopressors are administered as necessary to maintain adequate blood pressure and urine output. After the level of epidural anesthesia has subsided, and after stabilization and achievement of adequate analgesia, the patient is discharged to the postpartum unit.

Post-Anesthesia:

Management of peridural narcotics and supplemental analgesia is continued for 24 hours (separately reported). A follow-up note is recorded later that day, and additional care provided as indicated or requested by the obstetrician.

SURVEY DATA:

Presenter(s) Dr Karl E. Becker

Specialty(s): American Society of Anesthesiologists

Sample Size: 37 Response Rate: (%): 6.4% Median Base Units: 7.0

Type of Sample (Circle One): **random**, panel, convenience. Explanation of sample size: 583 e-mails directing physicians to a web site

25th Percentile Base Units: 5.25 75th Percentile Base Units: 8.0 Low: 3.0 High: 14.0

Median Pre-Service Time: 10 Median Intra-Service Time: 75

25th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 135 Low: 12 High: 420

Median Post-Service Time: 10

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

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Base Units</u>
00857	Neuraxial analgesia/anesthesia for labor ending in a cesarean delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)	7.0

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 existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

TIME ESTIMATES (Median)

	<u>New/ Revised CPT Code: 03106</u>	<u>Key Reference CPT Code: 00857</u>
Median Pre-Time	10	12
Median Intra-Time	75	105
Median Immediate Post-service Time	10	10
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	2.69	2.76
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.53	2.54
Urgency of medical decision making	3.69	3.54

Technical Skill/Physical Effort (Mean)

Technical skill required	3.66	3.61
Physical effort required	2.83	2.74

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.89	3.83
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Outcome depends on the skill and judgement of physician | 4.25 | 4.14

Estimated risk of malpractice suit with poor outcome | 4.64 | 4.53

INTENSITY/COMPLEXITY MEASURES

CPT Code

Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity | 2.44 | 2.53

Intra-Service intensity/complexity | 3.31 | 3.36

Post-Service intensity/complexity | 2.24 | 2.19

ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after deliberation of the procedure by the ASA COE, evaluation of the results of this survey by the ASA RVS committee, a subcommittee of the ASA COE, and consideration of the similarities of this procedure with the key reference service. Further evaluation of the results of the survey intensity/complexity measures support a base unit value somewhat greater than the reference service base unit value. In addition, the concept of an "add-on" code was not well understood by the survey respondents and they did not evaluate the add-on code appropriately.

FREQUENCY INFORMATION

How was this service previously reported? 00857 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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 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 200,000 - 400,000

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 100-200

Specialty _____

Frequency _____

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

CPT Code: **+** 03107 Tracking Number: FF9 Global Period: ZZZ Recommended Base Units: 5.0

CPT Descriptor: Cesarean hysterectomy following neuraxial labor analgesia/anesthesia.
(List separately in addition to code for primary procedure).
(Use 03107 in conjunction with 03105)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

The patient is a 34-year-old woman who is pregnant for the third time. Her first child was delivered vaginally, but because of dysfunctional labor and a non-reassuring fetal heart rate, the second child was delivered by Cesarean section. For both deliveries, she had an epidural. After considering the advantages, disadvantages and risks, the patient and her obstetrician decided that she was a reasonable candidate for a Vaginal Birth after Cesarean Section (VBAC).

SERVICE DESCRIPTION:

Pre-Anesthesia:

The patient was admitted at 0500 in anticipation of an elective induction. She had not had any solid food intake since 2200 the previous evening.

Her past medical history was unremarkable, as was her family history. She had a general endotracheal anesthetic for a Dilaiton and Curettage 18 months prior to this admission because of a spontaneous miscarriage at 14 weeks.

On arrival in the Labor and Delivery Suite, the nurses had started an 18 gauge intravenous line, and sent blood for a Complete Blood Count (including a platelet count) as well as to the Blood Bank for a type and screen. She was seen by her obstetrician at 0645 and judged to be ready for induction. Fetal monitoring was initiated and an infusion of pitocin was started.

The anesthesiologist was called to see the patient; on arrival at 0750, the patient's medical, obstetric and anesthetic history were reviewed. A focused physical exam revealed a Mallampati Class II airway and reasonable additional peripheral venous access. Anesthetic options were discussed, and a continuous epidural was decided upon as the patient had had epidurals for her previous two deliveries. The remote possibility of a general anesthetic was discussed in the highly unlikely event of a uterine rupture necessitating an extremely emergent Cesarean section. The patient and her husband had all their questions answered, and gave their informed consent for the necessary anesthetic interventions. At 0915 the anesthesiologist was called by the OB nurse, who reported that the patient was experiencing more discomfort than she wanted. She had received a total of 1050 cc of Ringer's Lactate intravenously, she was 4 to 5 cm dilated, and had a good active labor pattern.

Intra-Operative:

The anesthesiologist arrived shortly after being called, and positioned and prepped the patient for the initiation of an epidural analgesic. After prepping the lumbar area, a local anesthetic was injected at the L3-4 interspace to lessen the discomfort of the epidural needle. A 17 gauge epidural needle was inserted into the epidural space, using the loss of resistance technique to identify the space. A 2 cc test dose of 1.5% lidocaine with 1:400000 epinephrine was injected through the needle. When no sign of an intravenous or sub-arachnoid injection appeared, 2 cc then 4 cc of 0.18% bupivacaine were injected through the needle. An 18 gauge, bullet-tipped, multi-orifice catheter was then passed through the needle so that approximately 4 cm was in the epidural space. An additional 4cc and 2cc of the bupivacaine were injected, along with 100 mcg of fentanyl. A continuous infusion of 0.12% bupivacaine with 2 mcg of fentanyl/cc was started at 12 cc/hr. The patient's vital signs were monitored every 5 minutes for 30 minutes; the patient began to experience after about 3 contractions, and was quite comfortable within about 12 minutes.

Over the next 3 hours, the patient's labor progressed without incident. However, at about 1300, the character of the contractions changed, and the fetal heart rate began to show late decelerations, and the base line rate began to slow. The obstetrician was called, and based on the changes in the monitors, it was decided that an urgent Cesarean section was indicated. While awaiting transfer to the Labor and Delivery operating room, a urinary catheter was inserted, and another large bore peripheral IV catheter was inserted. The Blood Bank was called and 4 units of packed red blood cells were ordered. It was decided that since the exact cause of the fetal distress was unclear, and because of the need for delivery as quickly as possible, the epidural would not be "topped up" for delivery but that a general anesthetic would be administered.

The patient was moved to the operating room and placed on the OR table. As the monitors were being placed and the abdomen prepped, supplemental oxygen was administered by mask. When the patient had been draped and the obstetricians ready to make the incision, general anesthesia was induced with sodium pentothal and the patient paralyzed with succinylcholine, while an assistant was applying cricoid pressure. The trachea was intubated and proper placement of the tube assured by auscultation of both lungs and the presence of a satisfactory end-tidal CO2 wave form. Oxygen, nitrous oxide and isoflurane were given via the endotracheal tube.

The obstetrician, upon entering the abdominal cavity, discovered that there was a tear in the uterus through the previous Cesarean scar. The uterine tear was extended and the baby delivered into the wound. The baby's oropharynx was suctioned while the umbilical cord was cut, and the baby was given to the neonatologist in attendance. The baby's 1 minute Apgar score was 6 and the 5 minute score 9. An additional dose of pentothal as well as 100 mcg of fentanyl and 2 mg of midazolam were given. Pitocin was added to one of the IV solutions which was being rapidly infused.

The uterus remained relatively flacid, and methergine was given intramuscularly. The state of the uterus did not change, and the patient was losing significant amounts of blood. The obstetrician, unable to stop the hemorrhage, and with the agreement of the obstetrician who was assisting, decided to do an emergency hysterectomy. The charge nurse, who was in the operating room assisting the circulating nurse, was sent to inform the husband of the problem and the plan to resolve it.

The patient's blood pressure was in the 70-80 mm Hg systolic range, inspite having received approximately 3000 cc of a balanced salt solution and 500 cc of a hetastarch in saline solution. As she was still bleeding and her losses were estimated to be about 3500cc, she was given a total of 6 units of PRBC's, in addition to more balanced salt solution. The hysterectomy was accomplished, and the bleeding stopped. The hemodynamic status of the patient stabilized, and there were no further bleeding nor signs of clotting problems. Arterial blood gas analysis showed no problems with oxygenation or ventilation, and the hematocrit was 29%. Blood sent for clotting studies showed only a slightly prolonged PT and PTT; the platelet count was normal. The fluids and blood had been run through a warmer, and the patient's temperature was 36 degrees.

The abdomen was closed, and the patient emerged from the anesthetic. When her spontaneous respirations were judged adequate and she was able to respond to verbal commands, the endotracheal tube was removed. She was observed in the operating room for approximately 10 minutes, then transferred to the Intensive Care Unit for close monitoring.

The anesthesiologist accompanied the patient to the ICU, reported to the ICU staff the information they needed to assume care of the patient and initial post-operative pain management orders using the indwelling epidural were left.

Post-Anesthesia:

The anesthesiologist saw the patient again twice that afternoon, and checked her out to his partner who was covering the OB service that night. He saw her again the next morning, and discussed the previous day's events. She reported no recall of the post-induction or intra-operative events, and stated she was anxious to be transferred to the post-partum unit so she could begin breast feeding her baby. All this was noted by the anesthesiologist in the progress note, as well as the absence of any other anesthesia related problems.

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Base Units</u>
00855	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; cesarean hysterectomy	8.0

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 existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

TIME ESTIMATES (Median)

	New/ Revised CPT Code: 03107	Key Reference CPT Code: 00855
Median Pre-Time	15	15
Median Intra-Time	150	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	3.36	3.36
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.24	4.15
Urgency of medical decision making	3.67	3.55

Technical Skill/Physical Effort (Mean)

Technical skill required	3.73	3.71
Physical effort required	2.91	2.88

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.12	4.09
Outcome depends on the skill and judgement of physician	4.30	4.21

Estimated risk of malpractice suit with poor outcome	4.42	4.53
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INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.42	3.03
Intra-Service intensity/complexity	4.21	4.06
Post-Service intensity/complexity	3.21	3.12

ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after deliberation of the this procedure by the ASA COE, evaluation of the results of this survey by the ASA RVS committee, a subcommittee of the ASA COE, and consideration of the similarities of this procedure with the key reference service. Further evaluation of the results of the survey intensity/complexity measures support a base unit value somewhat greater than the reference service base unit value. In addition, the concept of an "add-on" code was not well understood by the survey respondents and they did not evaluate the add-on code appropriately.

FREQUENCY INFORMATION

How was this service previously reported? 00855 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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 <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 Anesthesiology Frequency <50

Specialty _____ Frequency _____

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 03104 Tracking Number: FF10 Global Period: XXX Recommended Base Units: 4.0

CPT Descriptor: Anesthesia for abortion procedures.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 22-year-old unmarried female discovers she is pregnant. For a variety of reasons, she does not wish to have a child at this point in her life. At approximately eight weeks estimated gestational age, she consults her obstetrician about an elective termination of the pregnancy. Except for some seasonal reactive airway disease, she is in otherwise good health.

SERVICE DESCRIPTION:

Pre-Anesthesia:

The patient was seen in the pre-operative holding area of an out patient day surgery center at 0700. She was a healthy appearing young woman who was somewhat anxious. Her past medical history was unremarkable; she was on no medications and had no known drug allergies. She had never had a general anesthetic, and knew of no family history of problems with anesthesia Her last oral intake was at 2200hrs the previous day. She weighed 60kg, and her airway was a Mallampati Class I. The anesthetic options were discussed, and she chose to have a general anesthetic.

Intra-Operative:

An 18gauge intravenous (IV) catheter was inserted in her left forearm; she was given 2mg of midazolam and 10mg of metoclopramide and taken to the operating room (OR). After moving to the OR table, EKG, non-invasive blood pressure and pulse oximetry monitors were attached. She breathed 100% oxygen by mask, and anesthesia was induced with 100mcg of fentanyl and 150mg of propofol. Desflurane was added to the inspired oxygen, and she was ventilated by hand. After approximately 60 seconds, a # laryngeal mask airway (LMA) was inserted. Proper positioning was assured by chest movement and a satisfactory wave form and numerical value on the end-tidal CO2 monitor. The patient was gently ventilated by hand for an additional 4 to 5 minutes before spontaneous respirations resumed.

The patient was put in the lithotomy position, and after a vaginal prep, the procedure commenced. At the request of the surgeon, 20 units of pitocin were added to the Ringer's Lactate solution that was infusing via the IV. Also, as prophylaxis against nausea, 0.625 mg of droperidol was given IV.

The procedure lasted 20 minutes; at the conclusion of the procedure, the patient was taken out of the lithotomy position. The desflurane had been discontinued as the surgeon announced that she was through; the patient was still breathing spontaneously and the LMA was removed a minute or two later.

The patient was moved to a recovery stretcher and taken to the Post Anesthesia Care Unit (PACU). Report was given to the PACU nurse as the monitors were being applied. After assuring that the patient's condition was satisfactory, the anesthesiologist gave his pager number to the PACU nurse and left to see his next patient.

Post-Anesthesia:

The patient was seen approximately an hour and a half later in the second stage recovery area. She was awake, alert and oriented, and except for some mild cramping, she had no complaints. She was judged ready for discharge.

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Base Units</u>
00946	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); vaginal delivery	5.0

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 existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

TIME ESTIMATES (Median)

	<u>New/ Revised CPT Code: 03104</u>	<u>Key Reference CPT Code: 00946</u>
Median Pre-Time	10	10
Median Intra-Time	30	32.5
Median Immediate Post-service Time	10	10
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	2.03	2.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.20	2.17
Urgency of medical decision making	1.87	2.07

Technical Skill/Physical Effort (Mean)

Technical skill required	2.50	2.50
Physical effort required	2.30	2.33

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.17	2.28
-------------------------------------------------------------------	------	------

Outcome depends on the skill and judgement of physician | 2.40 | 2.46

Estimated risk of malpractice suit with poor outcome | 3.37 | 3.34

| | |

| | |

INTENSITY/COMPLEXITY MEASURES

CPT Code

Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity | 1.97 | 2.10

Intra-Service intensity/complexity | 2.27 | 2.40

Post-Service intensity/complexity | 1.70 | 1.80

ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after consideration of the similarities of this procedure with the key reference service and after evaluation of the results of the survey which support a base unit value less than the reference service base unit value.

FREQUENCY INFORMATION

How was this service previously reported? 00940 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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 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 Anesthesiology Frequency < 50

Specialty _____ Frequency _____

Do many physicians perform this service across the United States? ___ Yes X No

Any Method, Any Approach & Any Technique

The RUC recommends that the following CPT revisions are all editorial changes and do not reflect a change in physician work.

Integumentary System
Nails

▲11755 Biopsy of nail unit, ~~any method~~ (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)

Destruction
Destruction, Benign or Premalignant Lesions

▲17000 Destruction ~~by any method~~ (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), ~~including laser, with or without surgical curettement~~, all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions, ~~including local anesthesia~~; first lesion

17003 second through 14 lesions, each (List separately in addition to code for first lesion)

▲17004 Destruction ~~by any method~~ (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), ~~including laser, with or without surgical curettement~~, all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions, ~~including local anesthesia~~; 15 or more lesions

▲17110 Destruction ~~by any method~~ (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of flat warts, molluscum contagiosum, or milia; up to 14 lesions

17111 15 or more lesions

Destruction, Malignant Lesions, ~~Any Method~~

▲17260 Destruction, malignant lesion, ~~any method~~ (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 0.5 cm or less

17261 *lesion diameter 0.6-1.0 cm*

17262 *lesion diameter 1.1-2.0 cm*

17263 *lesion diameter 2.1-3.0 cm*

17264 *lesion diameter 3.1-4.0 cm*

17266 *lesion diameter over 4.0 cm*

▲17270 Destruction, malignant lesion, ~~any method~~ (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less

17271 *lesion diameter 0.6-1.0 cm*

17272 *lesion diameter 1.1-2.0 cm*

17273 *lesion diameter 2.1-3.0 cm*

17274 *lesion diameter 3.1-4.0 cm*

17276 *lesion diameter over 4.0 cm*

▲17280 Destruction, malignant lesion, ~~any method~~ (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less

17281 *lesion diameter 0.6-1.0 cm*

17282 *lesion diameter 1.1-2.0 cm*

17283 *lesion diameter 2.1-3.0 cm*

17284 *lesion diameter 3.1 to 4.0*

17286 *lesion diameter over 4.0 cm*

Musculoskeletal System

Shoulder

Incision

▲23000 Removal of subdeltoid (~~or intratendinous~~) calcareous deposits, ~~any method~~ open

Respiratory System

Nose

Excision

▲30117 Excision or destruction, ~~any method~~ (including eg, laser), intranasal lesion; internal approach

▲30118 Excision or destruction, ~~any method~~ (including eg, laser), intranasal lesion; external approach (lateral rhinotomy)

Trachea and Bronchi

Endoscopy

▲31641 Bronchoscopy, (rigid or flexible); with destruction of tumor or relief of stenosis by any method other than excision (eg laser therapy, cryotherapy)

Lungs and Pleura

Endoscopy

▲32650 Thoracoscopy, surgical; with pleurodesis, ~~any method~~ (eg, mechanical or chemical)

Digestive System
Esophagus
Endoscopy

- 43200 *Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*
- ▲43227 with control of bleeding, ~~any method~~ (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
- 43235 *Upper GI 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)*
- ▲43245 with dilation of gastric outlet for obstruction, ~~any method~~ (eg, balloon, guide wire, bougie)

Endoscopy, Small Bowel and Stomal

- 44360 *Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*
- ▲44366 with control of bleeding, ~~any method~~ (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
- 44376 *Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*
- ▲44378 with control of bleeding, ~~any method~~ (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
- 44388 *Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*
- ▲44391 with control of bleeding, ~~any method~~ (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)

Rectum
Destruction

- ▲45190 Destruction of rectal tumor, ~~any method~~ (eg, electrodesiccation, electrosurgery, laser ablation, laser resection, cryosurgery) ~~(eg, electrodesiccation)~~ transanal approach

Endoscopy

- 45300 *Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*
- ▲45303 with dilation, ~~any method~~ (eg, balloon, guidewire, bougie)
- ▲45317 with control of bleeding, ~~any method~~ (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
- 45330 *Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*
- ▲45334 with control of bleeding, ~~any method~~ (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
- 45378 *Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)*
- ▲45382 with control of bleeding, ~~any method~~ (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)

**Anus
Endoscopy**

46600 *Anoscopy, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*

▲46604 with dilation, ~~any method~~ (eg, balloon/ guidwire, bougie)

▲46614 with control of bleeding, ~~any method~~ (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)

Destruction

▲46924 Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive, ~~any method~~ (eg, laser surgery, electrocautery, cryosurgery, chemosurgery)

**Pancreas
Excision**

▲48100 Biopsy of pancreas, open, ~~any method~~ (eg, fine needle aspiration, needle core biopsy, wedge biopsy)

Urinary System

**Kidney
Excision**

▲50220 Nephrectomy, including partial ureterectomy, any open approach including rib resection;

50225 *complicated because of previous surgery on same kidney*

50230 *radical, with regional lymphadenectomy and/or vena caval thrombectomy*

**Bladder
Excision**

▲51596 Cystectomy, complete, with continent diversion, any open technique, using any segment of small and/or large ~~bowel~~ intestine to construct neobladder

Vesical Neck and Prostate

▲52510 Transurethral balloon dilation of the prostatic urethra, ~~any method~~

**Male Genital System
Destruction**

▲54065 Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive, ~~any method~~ (eg, laser surgery, electrocautery, cryosurgery, chemosurgery)

**Female Genital System
Vulva, Perineum, and Introitus
Destruction**

▲56501 Destruction of lesion(s), vulva; simple, ~~any method~~ (eg, laser surgery, electrocautery, cryosurgery, chemosurgery)

▲56515 extensive, ~~any method~~ (eg, laser surgery, electrocautery, cryosurgery, chemosurgery)

**Vagina
Destruction**

▲57061 Destruction of vaginal lesion(s); simple, ~~any method~~ (eg, laser surgery, electrocautery, cryosurgery, chemosurgery)

▲57065 extensive, ~~any method~~ (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)

**Corpus Uteri
Laparoscopy/Hysteroscopy**

58558 *Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D&C*

▲58563 with endometrial ablation (~~any method~~) (eg, endometrial resection, electrosurgical ablation, thermoablation)

**Medicine
Pulmonary**

▲94720 Carbon monoxide diffusing capacity, ~~any method~~ (eg, single breath, steady state)

▲94750 Pulmonary compliance study, ~~any method~~ (eg, plethysmography, ~~spirometric~~ spirometric volume and pressure measurements)

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

April 2001

**Insertion/Removal/Removal with Reinsertion
Nonbiodegradeable Androgen Suppression Implant**

Three new codes were developed specifically to describe services for the insertion and removal of non-biodegradable drug delivery implants that were not specific to a type of drug or a particular treatment. 11981 *Insertion, non-biodegradable drug delivery implant*, 11982 *Removal, non-biodegradable drug delivery implant*, and 11983 *Removal with reinsertion, non-biodegradable drug delivery implant*.

The RUC agreed with the specialty's recommendation that these three new codes have similar physician work as codes: 11975 *Insertion, implantable contraceptive capsules* (work relative value = 1.48); 11976 *Removal, implantable contraceptive capsules* (work relative value=1.78); and 11977 *Removal with reinsertion, implantable contraceptive capsules* (work relative value=3.30) The RUC therefore crosswalked, codes 11975, 11976, and 11977 to codes 11981, 11982, and 11983. The RUC agreed to recommend these values on an interim basis until the specialty returns with survey data. **The RUC recommends work values for CPT codes 11981, 11982, and 11983 of 1.48, 1.78, and 3.30 respectively.**

Practice Expense

The RUC recommended that the practice expense for codes 11975, 11976, and 11977 be applied to 11981, 11982, and 11983 respectively.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
• 11981	GG1	Insertion, non-biodegradable drug delivery implant	XXX	1.48 (Interim)
• 11982	GG2	Removal, non-biodegradable drug delivery implant	XXX	1.78 (Interim)
• 11983	GG3	Removal with reinsertion, non-biodegradable drug delivery implant	XXX	3.30 (Interim)

Insertion, im... e contraceptive capsules

Global Period XXX 2001 HCFA Total Physician Time 48
2001 HCFA Intraoperative Time

Most Frequently Performing Specialty in 98
Medicare Frequency 1998:

1999 HCFA Number and Level of Visits Data										
99211	99212	99213	99214	99215	99231	99232	99233	99238	ICU32	ICU33
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Yr 2001 Non-Facility PE:	1.46
Fully Impl Non-Facility PE:	1.56

Yr 2001 Facility PE:	0.73
Fully Impl Facility PE:	0.59

CLINICAL LABOR DIRECT INPUTS				CLINICAL STAFF TIME					HCFA PROFILED AS		
SOURCE CPEP	STAFF TYPE	DESCRIPTION	COMPENSATION PER MINUTE	PRE-SERV IN OFF	SERV IN-OFF	POST-OPS IN-OFF	SERV OUT-OFF	PRE-SERV OUT-OFF	POST-OPS OUT-OFF	IN OFFICE	OUT OF OFFICE
CPEP	C 4	4133 RN/MA	0.326	0	67	0				Y	N

MEDICAL SUPPLY DIRECT INPUTS-CPEP: C 4				QUANTITY	QUANTITY IN OFFICE	QUANTITY OUT OFFICE	COST IN OFFICE	COST OUT OF OFFICE
SOURCE CPEP	SUPPLY CODE	DESCRIPTION						
CPEP	C 4	11106	drape, sheet	1 item	1		0.26	
CPEP	C 4	11107	patient gown, disposable	1 item	1		0.57	
CPEP	C 4	11111	exam table paper	1 foot	7		0.11	
CPEP	C 4	11112	pillow case, disposable	1 item	1		0.32	
CPEP	C 4	11302	gloves, non-sterile	1 pair	2		0.24	
CPEP	C 4	31101	swab, alcohol	1 item	1		0.02	
CPEP	C 4	31105	KY jelly, single use foil pack, 5 grams	1 item	1		0.13	
CPEP	C 4	31105	KY jelly, single use foil pack, 5 grams	1 item	1		0.13	
CPEP	C 4	31505	Gauze, Sterile 4 x 4	1 item	1		0.22	
CPEP	C 4	31511	mini pad	1 item	1		0.17	
CPEP	C 4	31711	Vicryl suture 3-0	1 item	1		6.16	
CPEP	C 4	51502	lidocaine	30 ml	15		0.84	
CPEP	C 4	52301	Betadine	10 ml	50		0.35	
CPEP	C 4	52304	silver nitrate stick	1 item	4		0.20	
CPEP	C 4	91402	needle, 18 to 24 gauge	1 item	1		0.12	
CPEP	C 4	91407	syringe, 10 cc or 12 cc	1 item	1		0.23	

EQUIPMENT - CPEP:				MIN EQUIP IN USE, IN-OFFICE	MIN EQUIP IN USE, OUT-OFFICE	EQUIP COST IN-OFFICE	EQUIP COST OUT-OFFICE	EQUIP USEFUL LIFE (YRS)	PURCHASE PRICE
SOURCE CPEP	EQUIP CODE	DESCRIPTION							
CPEP	C 4	E11003	Power Table	67				10.00	6,939.00
CPEP	C 4	E11006	fiberoptic exam light	67				10.00	608.75
CPEP	C 4	E30020	minor surgical tray	67		0.13		4.00	572.20

11976 HCFA CPEP 2001 Data - Practice Expense Inp

Removal, im...e contraceptive capsules

Global Period XXX 2001 HCFA Total Physician Time 54 Most Frequently Performing Specialty in 98
 2001 HCFA Intraoperative Time Medicare Frequency 1998:

1999 HCFA Number and Level of Visits Data										
99211	99212	99213	99214	99215	99231	99232	99233	99238	ICU32	ICU33
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Yr 2001 Non-Facility PE:	1.51
Fully Impl Non-Facility PE:	1.55

Yr 2001 Facility PE:	0.89
Fully Impl Facility PE:	0.72

CLINICAL LABOR DIRECT INPUTS				CLINICAL STAFF TIME					HCFA PROFILED AS		
SOURCE CPEP	STAFF TYPE	DESCRIPTION	COMPENSATION PER MINUTE	PRE-SERV IN OFF	SERV IN-OFF	POST-OPS IN-OFF	SERV OUT-OFF	PRE-SERV OUT-OFF	POST-OPS OUT-OFF	IN OFFICE	OUT OF OFFICE
CPEP	C 4	4133 RN/MA	0.326	0	67	0				Y	N

MEDICAL SUPPLY DIRECT INPUTS-CPEP: C 4

SOURCE CPEP	SUPPLY CODE	DESCRIPTION	QUANTITY	QUANTITY IN OFFICE	QUANTITY OUT OFFICE	COST IN OFFICE	COST OUT OF OFFICE
CPEP	C 4	11106	drape, sheet	1 item	1	0.26	
CPEP	C 4	11107	patient gown, disposable	1 item	1	0.57	
CPEP	C 4	11111	exam table paper	1 foot	7	0.11	
CPEP	C 4	11112	pillow case, disposable	1 item	1	0.32	
CPEP	C 4	11302	gloves, non-sterile	1 pair	2	0.24	
CPEP	C 4	31101	swab, alcohol	1 item	1	0.02	
CPEP	C 4	31105	KY jelly, single use foil pack, 5 grams	1 item	1	0.13	
CPEP	C 4	31505	Gauze, Sterile 4 x 4	1 item	1	0.22	
CPEP	C 4	31511	mini pad	1 item	1	0.17	
CPEP	C 4	31711	Vicryl suture 3-0	1 item	1	6.16	
CPEP	C 4	51502	lidocaine	30 ml	15	0.84	
CPEP	C 4	52301	Betadine	10 ml	50	0.35	
CPEP	C 4	52304	silver nitrate stick	1 item	4	0.20	
CPEP	C 4	91402	needle, 18 to 24 gauge	1 item	1	0.12	
CPEP	C 4	91407	syringe, 10 cc or 12 cc	1 item	1	0.23	

EQUIPMENT - CPEP:

SOURCE CPEP	EQUIP CODE	DESCRIPTION	MIN EQUIP IN USE IN-OFFICE	MIN EQUIP IN USE OUT-OFFICE	EQUIP COST IN-OFFICE	EQUIP COST OUT-OFFICE	EQUIP USEFUL LIFE (YRS)	PURCHASE PRICE
CPEP	C 4	E11003	Power Table	67			10.00	6,939.00
CPEP	C 4	E30020	minor surgical tray	67	0.13		4.00	572.20
CPEP	C 4	E11006	fiberoptic exam light	67			10.00	608.75

11977 HCFA CPEP 2001 Data - Practice Expense Inc.

Removal with abortion, implantable contraceptive capsules

Global Period XXX 2001 HCFA Total Physician Time 85 Most Frequently Performing Specialty in 98
 2001 HCFA Intraoperative Time Medicare Frequency 1998:

1999 HCFA Number and Level of Visits Data										
99211	99212	99213	99214	99215	99231	99232	99233	99238	ICU32	ICU33
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Yr 2001 Non-Facility PE:	2.35
Fully Impl Non-Facility PE:	2.28

Yr 2001 Facility PE:	1.63
Fully Impl Facility PE:	1.32

CLINICAL LABOR DIRECT INPUTS				CLINICAL STAFF TIME					HCFA PROFILED AS		
SOURCE CPEP	STAFF TYPE	DESCRIPTION	COMPENSATION PER MINUTE	PRE-SERV IN OFF	SERV IN-OFF	POST-OPS IN-OFF	SERV OUT-OFF	PRE-SERV OUT-OFF	POST-OPS OUT-OFF	IN OFFICE	OUT OF OFFICE
CPEP	C 4	4133 RN/MA	0.326	0	67	0		0	0	Y	Y

MEDICAL SUPPLY DIRECT INPUTS-CPEP: C 4

SOURCE CPEP	SUPPLY CODE	DESCRIPTION	QUANTITY	QUANTITY IN OFFICE	QUANTITY OUT OFFICE	COST IN OFFICE	COST OUT OF OFFICE	
CPEP	C 4	11106	drape, sheet	1 item	1	0	0.26	0
CPEP	C 4	11107	patient gown, disposable	1 item	1	0	0.57	0
CPEP	C 4	11111	exam table paper	1 foot	7	0	0.11	0
CPEP	C 4	11112	pillow case, disposable	1 item	1	0	0.32	0
CPEP	C 4	11302	gloves, non-sterile	1 pair	2	0	0.24	0
CPEP	C 4	31101	swab, alcohol	1 item	1	0	0.02	0
CPEP	C 4	31105	KY jelly, single use foil pack, 5 grams	1 item	1	0	0.13	0
CPEP	C 4	31505	Gauze, Sterile 4 x 4	1 item	1	0	0.22	0
CPEP	C 4	31511	mini pad	1 item	1	0	0.17	0
CPEP	C 4	31711	Vicryl suture 3-0	1 item	1	0	6.16	0
CPEP	C 4	51502	lidocaine	30 ml	15	0	0.84	0
CPEP	C 4	52301	Betadine	10 ml	50	0	0.35	0
CPEP	C 4	52304	silver nitrate stick	1 item	4	0	0.20	0
CPEP	C 4	91402	needle, 18 to 24 gauge	1 item	1	0	0.12	0
CPEP	C 4	91407	syringe, 10 cc or 12 cc	1 item	1	0	0.23	0

EQUIPMENT - CPEP:

SOURCE CPEP	EQUIP CODE	DESCRIPTION	MIN EQUIP IN USE, IN-OFFICE	MIN EQUIP IN USE, OUT-OFFICE	EQUIP COST IN-OFFICE	EQUIP COST OUT-OFFICE	EQUIP USEFUL LIFE (YRS)	PURCHASE PRICE
CPEP	C 4	E11003 Power Table	67	0			10.00	6,939.00
CPEP	C 4	E11006 fiberoptic exam light	67	0			10.00	608.75
CPEP	C 4	E30020 minor surgical tray	67	0	0.13	0.00	4.00	572.20

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

April 2001

Injection of Trigger Points/Carpal/Tarsal Canal

Code 20550 was revised and three additional codes created to describe injection of the carpal canal, tendon at origin or insertion, and trigger point. The RUC received a report supported by seven specialty societies representing orthopedic surgery, rheumatology, podiatry, plastic surgery, hand surgery, and spine surgery pertaining to the following four codes: 20526 *Injection, therapeutic (eg, local anesthetic, corticosteroid); carpal canal*; 20550 *Injection, tendon sheath, ligament; ganglion cyst, ~~or trigger points~~*; 20551 *Injection, tendon origin/insertion*; 20552 *Injection, single or multiple trigger point(s), one or more muscle group(s)*. Due to the number of specialty societies involved, the specialties requested additional time to complete a survey and present a recommendation to the RUC. The specialties first had to identify the typical number of injections required and this differed by specialty. The RUC accepted an interim recommendation for these codes with the understanding that the specialty societies will present a recommendation at the September, 2001 RUC meeting. The RUC accepted the following interim recommendations:

The RUC recommends maintaining the current work RVU of 0.86 as an interim value for each of the four new/revised codes, keeping in mind that the survey data indicate one injection (unilateral) for 20526, 20550, and 20551, and two injections (unilateral) for 20552. The preliminary survey data suggest that there is not much difference in total work between the four codes as described (i.e., no compelling evidence to make changes). Even if slight work-RVU adjustments up or down could be determined for each of the four codes (relative to the current work RVU of 0.86), there is no way to determine the frequency distribution of typical patients, and, therefore, any effort at establishing family budget neutrality would be flawed. Establishing the codes in CPT 2002 and maintaining an interim work-RVU of 0.86 should result in near-term family budget neutrality (or even less than family budget neutral, taking into consideration the reporting restrictions being placed on 20552).

The RUC also recommends an interim total time of 20 minutes for 20526, 20550, and 20551, and an interim total time of 22 minutes for 20552, keeping in mind that the survey data indicate one injection (unilateral) for 20526, 20550, and 20551 and two injections (unilateral) for 20552.

Practice Expense

Crosswalk the PEAC-approved practice expense data for 20550, with adjustments to supplies for one injection (20526, 20550, 20551) versus three injections (20552). (see attached spreadsheet)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Interim Work RVU Recommendation
•20526	ZZ1	Injection, therapeutic (eg, local anesthetic, corticosteroid); carpal canel	000	.86 Interim Recommendation
▲20550	ZZ3	Injection, ; tendon sheath, ligament; ganglion cyst, or trigger points (if imaging guidance is performed, see 76003, 76393, 76942)	000	.86 Interim Recommendation
•20551	ZZ4	tendon origin/insertion	000	.86 Interim Recommendation
•20552	ZZ5	single or multiple trigger point(s), one or more <u>two</u> muscle group(s)	000	.86 Interim Recommendation
•20553	ZZ6	single or multiple trigger point(s), three or more muscle group(s)	000	RUC will review in September 2001

		PEAC APPROVED	
		20550	
HCFA CODE		Injection, tendon sheath, ligament, trigger points or ganglion cyst	
LOCATION		In Office	Out Office
GLOBAL PERIOD		000	000
TOTAL TIME		34	5
PRE-SERVICE	RN/LPN/MA	0	0
Start: Following visit when decision for surgery or procedure made			
End: When patient enters office for surgery/procedure			
SERVICE PERIOD	RN/LPN/MA	31	0
Start: When patient enters office for surgery/procedure			
Pre-service services			
Review charts	RN/LPN/MA	2	
Greet patient and provide gowning			
Obtain vital signs			
Provide pre-service education/obtain consent	RN/LPN/MA	3	
Prepare room, equipment, supplies	RN/LPN/MA	5	
Prepare and position patient/ monitor patient/ set up IV	RN/LPN/MA	2	
Sedate/apply anesthesia			
Intra-service			
Assist physician in performing procedure	RN/LPN/MA	10	
Monitor pt following service	RN/LPN/MA	3	
Clean room/equipment by physician staff	RN/LPN/MA	3	
Complete diagnostic forms, lab & X-ray requisitions			
Review/read X-ray, lab, and pathology reports			
Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	RN/LPN/MA	3	
Other Clinical Activity (please specify)			
End: Patient leaves office			
POST-SERVICE	RN/LPN/MA	3	5
Start: Patient leaves office			
Conduct phone calls/call in prescriptions	RN/LPN/MA	3	5
Other Activity (please specify)			
MEDICAL SUPPLIES			
Gloves (sterile)	14005	1 pair	
Betadine	52301	10ml	
Sterile drape	14001	1	
Sterile gauze (pack)	31508	1	
Needle (18/22)	91402	2	
Syringe	91407	1	
Lidocaine	51502	5ml	
Bandaid	31502	0	
PROCEDURE SPECIFIC EQUIPMENT		0	0

NEW CODE		REVISED CODE		NEW CODE		NEW CODE	
20526		20550		20551		20552	
Injection, therapeutic (eg, local anesthetic, corticosteroid); carpal canal		Injection; tendon sheath, ligament, ganglion cyst		Injection, tendon origin/insertion		Injection, single or multiple trigger point(s), one or more muscle groups	
In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office
000	000	000	000	000	000	000	000
34	5	34	5	34	5	34	5
0	0	0	0	0	0	0	0
31	0	31	0	31	0	31	0
2		2		2		2	
3		3		3		3	
5		5		5		5	
2		2		2		2	
10		10		10		10	
3		3		3		3	
3		3		3		3	
3		3		3		3	
3	5	3	5	3	5	3	5
3	5	3	5	3	5	3	5
1 pair		1 pair		1 pair		1 pair	
10ml		10ml		10ml		10ml	
1		1		1		1	
1		1		1		1	
1		1		1		2	
1		1		1		1	
5ml		5ml		5ml		5ml	
1		1		1		2	
0	0	0	0	0	0	0	0

*American Academy of Orthopaedic Surgeons
American Academy of Physical Medicine & Rehabilitation
American College of Rheumatology
American Podiatric Medical Association
American Society for Surgery of the Hand
American Association of Plastic Surgeons
North American Spine Society*

April 23, 2001

James E. Hoehn, M.D.
Chairman
AMA/Specialty Society RVS Update Committee (RUC)
515 North State Street
Chicago Illinois 60610

Subject: New/Revised Injection Codes - RUC Meeting Tab 24

Dear Jim:

On March 16th, CPT staff distributed the results of a "fax/e-mail ballot CPT Panel EC action memo" regarding revision of CPT 20550 and addition of new codes for injection of the carpal canal, tarsal canal, tendon at origin or insertion, and trigger point. These results were later modified to delete the proposed new code for tarsal canal. The final language that is scheduled for CPT 2002 is:

- 20526* Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal canal
- ▲ 20550* Injection, ~~in~~ tendon sheath, ligament, ganglion cyst, ~~or trigger points~~
(If imaging guidance is performed, see 76003, 76393, 76942)
- 20551* tendon origin/insertion
- 20552* single or multiple trigger point(s), one or more muscle group(s)

On March 29th, a conference call was held that included representatives from podiatry, plastic surgery, orthopaedic surgery, rheumatology, hand surgery, PM&R, neurology and NASS (multi-specialty society representing spine care providers including orthopaedic surgery, neurosurgery, neurology, neurology, physiatry, and pain management). Representatives from anesthesia and neurosurgery could not participate on the call, but were provided with pre- and post-call materials. The new/revised codes and the variability of use between specialties was discussed extensively. Hand surgery representatives noted that ASSH had already conducted a RUC survey for carpal tunnel injection in *anticipation* of the new code, but did not survey any of the other codes because the nomenclature was still being discussed at CPT.

By the end of the call, it was decided that it would not be possible to conduct a traditional RUC survey for all of the new/revised codes because of time constraints and the number of specialties that needed to be involved in vignette and service descriptor development. However, the call participants believed that it *would* be possible to gather *some* data about pre-service, intra-service, and post-service time and intensity/complexity, along with physician experience in the previous 12 months and typical number of injections per patient at each visit. The group believed that these data may be useful in determining "relativity" between the new codes. A cover letter and one-page survey were drafted that could be broadcast faxed by each specialty for a fax-back return by April 17th (see Attachment A). [Note that the original survey included tarsal canal injection, however, this code was withdrawn.]

Tables 1 through 8 present the survey response distribution and summary data. Tables 9 and 10 present 1999 Medicare allowed frequency data from HCFA's 1999 utilization file. These data were reviewed during a conference call on April 19th that included representatives from podiatry, plastic surgery, orthopaedic surgery, rheumatology, hand surgery, PM&R, neurology and NASS (multi-specialty society representing spine care providers including orthopaedic surgery, neurosurgery, neurology, neurology, physiatry, and pain management). Representatives from anesthesia and neurosurgery could not participate on the call, but were provided with pre- and post-call materials.

Based on the discussion of survey results, it can be stated that:

1. CPT 20526, 20550, and 20551 would typically involve one injection.
2. For 20552, anesthesiology, neurology, pain medicine, and PM&R typically use three or more injections per visit, while orthopaedic surgery, plastic surgery, hand surgery and rheumatology typically use one to two injections. Some respondents from all specialties indicated only one injection as typical. Therefore, CPT 20552 would typically involve more than one injection, but the actual "typical" number of injections may be very dependent on the specialty providing the service (ie, multi-modal rather than bell-shaped curve).
3. The slightly higher survey total time and slightly lower survey intra-service complexity/intensity for CPT 20552 compared with the survey data for the other three codes does not indicate a significant difference in "total" work.
4. There was no significant difference in total time between those respondents with more experience than those with less experience.
5. A majority of the respondents provided information for all four codes (76%). An additional 17% provided information for at least three codes. Therefore, the survey results may have some basis of relativity. However, because anesthesiology had only one survey response and because this specialty (which is a primary provider of this service) may typically provide more than two trigger point injections per patient at each visit, the data for 20552 may be understated.
6. Hand surgery independently surveyed carpal tunnel injection, as part of a larger RUC survey effort, using the standard RUC survey. The results of that survey (response of 37) confirm the median total time of 20 minutes (min/max range = 9 to 55 minutes). The survey vignette indicated only one injection. This total time compares with the current multispecialty survey median total time for 20526 of 20 minutes.

Historical note: The original valuation of 20550 code is based on a Harvard Phase I/II survey of 12 orthopaedic surgeons using a global period of 10 days. No specific vignette was used to indicate which type of injection was to be considered. Between the 1992 MFS and the 1993 MFS, the RVU was changed from 1.22 to 0.88 and the global period was changed from 010 to 000, however, the "total" time in the Harvard database was never changed to subtract the surveyed time for one post-service visit. As measured in the Harvard Study, the historical Harvard total time should be 27 minutes in contrast to the 37 minutes currently listed in both the HCFA and RUC databases.

Recommendation 1: Maintain the current work-RVU of 0.86 as an interim value for each of the four new/revised codes, keeping in mind that the survey data indicate one injection (unilateral) for 20526, 20550, and 20551, and two injections (unilateral) for 20552. **Discussion:** These preliminary survey data suggest that there is not much difference in total work between the four codes as described (ie, no compelling evidence to make changes). Even if slight work-RVU adjustments up or down could be determined for each of the four codes (relative to the current work-RVU of 0.86), there is no way to determine the frequency distribution of typical patients, and, therefore, any effort at establishing family budget neutrality would be flawed. Establishing the codes in CPT 2002 and maintaining an interim work-RVU of 0.86 should result in near-term family budget neutrality (or even less than family budget neutral,

taking into consideration the reporting restrictions being placed on 20552). Further, because the original valuation of 20550 was based solely on the response of one specialty and without a clear vignette, it is the opinion of the group reviewing these codes that the possibility of valuing each code individually, based on individual surveys, relative to other similar stable codes, and not based on family budget neutrality, should be explored during the next five-year review.

Recommendation 2. Recommend an interim total time of 20 minutes for 20526, 20550, and 20551, and an interim total time of 22 minutes for 20552, keeping in mind that the survey data indicate one injection (unilateral) for 20526, 20550, and 20551 and two injections (unilateral) for 20552.

Recommendation 3. Allow the use of modifier '-50' (bilateral) for all four new/revised codes. (eg, bilateral carpal canal injections).

Recommendation 4. Allow each code to be billed with one or more of the other codes at one visit (eg, 20526 carpal canal injection on right hand plus 20550 tendon injection left hand).

Recommendation 5. Crosswalk the PEAC-approved practice expense data for 20550, with adjustments to supplies for one injection (20526, 20550, 20551) versus three injections (20552).

Because representatives from all of the specialties that will utilize the four new codes are either members of the RUC or have advisors that should be at the RUC meeting in April, we recommend that this letter and attachments be offered as a starting point for questions, discussion, and action, in lieu of any formal presentation. We appreciate the opportunity to offer an interim solution to this issue.

Sincerely,

Keith Brandt, MD
RUC Advisor, ASPS

Ernie Found, MD
Alternate RUC Advisor, NASS

Ronald A. Henrichs, CAE
AAPM&R Executive Director

Ron Kaufman, MD
RUC Advisor, ACR

Mark D. Lenet, DPM
RUC Advisor, APMA

Dan Nagle, MD
RUC Advisor, ASHS

Bernie Pfeifer, MD
RUC Advisor, AAOS

Attachments: Tables 1 through 10
Survey Instrument
Practice Expense Recommendations

SURVEY RESULTS FOR NEW/REVISED CPT INJECTION CODES

**Table 1
Response Distribution By CPT Code (n=402)**

• 20526 Injection, Carpal tunnel	100	24.9%
20550 Injection, Tendon sheath, ligament, ganglion cyst	99	24.6%
• 20551 Injection, Tendon origin/insertion	91	22.6%
• 20552 Injection, Trigger point(s)	112	27.9%

**Table 2
Response Distribution: CPT Code by State**

	20526		20550		20551		20552			20526		20550		20551		20552	
Total	100	100%	99	100%	91	100%	112	100%	MS	1	1%	1	1%	1	1%	1	1%
AL	0	0%	1	1%	1	1%	1	1%	NC	5	5%	5	5%	4	4%	5	4%
AZ	3	3%	2	2%	2	2%	3	3%	NE	1	1%	1	1%	1	1%	1	1%
CA	13	13%	13	13%	13	14%	16	14%	NH	0	0%	0	0%	0	0%	1	1%
CO	3	3%	2	2%	2	2%	4	4%	NJ	2	2%	1	1%	1	1%	2	2%
CT	2	2%	2	2%	2	2%	2	2%	NM	2	2%	2	2%	2	2%	2	2%
DC	1	1%	1	1%	1	1%	1	1%	NV	0	0%	1	1%	0	0%	1	1%
DE	1	1%	1	1%	1	1%	1	1%	NY	8	8%	8	8%	6	7%	10	9%
FL	2	2%	2	2%	2	2%	4	4%	OH	7	7%	7	7%	7	8%	7	6%
GA	1	1%	1	1%	1	1%	2	2%	OR	1	1%	1	1%	1	1%	2	2%
HI	1	1%	1	1%	1	1%	1	1%	PA	4	4%	4	4%	4	4%	5	4%
IA	2	2%	2	2%	2	2%	2	2%	TN	1	1%	1	1%	0	0%	1	1%
ID	0	0%	0	0%	1	1%	1	1%	TS	1	1%	1	1%	1	1%	1	1%
IL	6	6%	5	5%	3	3%	4	4%	TX	6	6%	7	7%	6	7%	6	5%
KY	2	2%	2	2%	2	2%	2	2%	VA	2	2%	2	2%	2	2%	2	2%
LA	0	0%	0	0%	1	1%	1	1%	VT	1	1%	1	1%	1	1%	1	1%
MA	5	5%	5	5%	5	5%	4	4%	WA	2	2%	2	2%	2	2%	2	2%
MD	4	4%	5	5%	4	4%	5	4%	WI	3	3%	3	3%	3	3%	3	3%
MI	2	2%	1	1%	1	1%	3	3%	WV	1	1%	1	1%	1	1%	1	1%
MO	2	2%	2	2%	2	2%	0	0%	n/r	2	2%	2	2%	1	1%	0	1%

Table 3
Response Distribution: CPT Code by Specialty

	20526 (n=100)	20550 (n=99)	20551 (n=91)	20552 (n=112)
Anesthesiology	0 0.0%	0 0.0%	0 0.0%	1 0.9%
Neurology	4 4.0%	2 2.0%	3 3.3%	6 5.4%
Neurosurgery	6 6.0%	3 3.0%	3 3.3%	6 5.4%
Orthopaedic Surgery	29 29.0%	29 29.3%	26 28.6%	33 29.5%
Pain Medicine	4 4.0%	4 40.4%	4 44.0%	4 3.6%
Physical Medicine & Rehab.	28 28.0%	30 30.3%	31 34.1%	37 33.0%
Plastic Surgery	12 12.0%	14 14.1%	9 9.9%	7 6.3%
Rheumatology	17	17	15	18

Table 4
Response Distribution
CPT Code by Primary Geography Practice Setting

	20526 (n=100)	20550 (n=99)	20551 (n=91)	20552 (n=112)
Rural	7 7.0%	6 6.1%	7 76.9%	10 89.3%
Suburban	53 53.0%	50 50.5%	46 50.5%	60 53.6%
Urban	40 40.0%	43 43.4%	38 41.2%	42 37.5%

Table 5
Response Distribution
CPT Code by Primary Type of Practice

	20526 (n=100)	20550 (n=99)	20551 (n=91)	20552 (n=112)
Solo Practice	27 27.0%	27 27.3%	27 29.7%	31 27.7%
Single Specialty Group	37 37.0%	34 34.3%	32 35.2%	40 35.7%
Multispecialty Group	23 23.0%	25 25.2%	23 25.3%	26 23.2%
Med. School Practice Plan	13 13.0%	13 13.1%	9 9.9%	15 13.4%

Table 6
Survey Data: Total TIME by CPT Code

	Count	Min	10thpctl	25thpctl	Median	75thpctl	90thpctl	Max
20526	<i>100</i>	4	10	15	20	28	45	90
20550	<i>99</i>	3	9	15	20	29	41	90
20551	<i>91</i>	3	12	15	21	30	44	90
20552	<i>112</i>	4	11	16	25	35	50	90

Table 7
Survey Data: Typical NUMBER OF INJECTIONS per Patient Per Visit by CPT Code

	Count	Min	10thpctl	25thpctl	Median	75thpctl	90thpctl	Max
20526	<i>100</i>	1.0	1.0	1.0	1.0	1.0	1.0	3.0
20550	<i>99</i>	1.0	1.0	1.0	1.0	1.0	1.6	6.0
20551	<i>91</i>	1.0	1.0	1.0	1.0	1.0	1.5	2.5
20552	<i>112</i>	1.0	1.0	1.0	2.0	3.0	5.0	8.0

Table 8
Survey Data: Mean Complexity/Intensity

	Pre-	Intra-	Post-
20526	2.81	3.46	2.63
20550	2.55	2.94	2.38
20551	2.73	2.99	2.65
20552	2.67	2.78	2.49

Table 9
1999 Medicare Allowed Frequency by Modifier

Modifier	Allowed Frequency
(none)	827,609
-22 (unusual)	829
-50 (bilateral)	23
-51 (multiple)	334,726
-52 (reduced)	319

Table 10
1999 Medicare Allowed Frequency by Specialty

podiatry	202,160
anesthesiology	198,552
orthopaedic surgery	180,217
rheumatology	125,951
family practice	119,851
internal medicine	89,620
physical medicine and rehabilitation	86,635
general practice	42,772
neurology	34,858
clinic or group practice (not gppp)	15,987
hand surgery	13,220
general surgery	10,137
osteopathic manipulative therapy	7,131
plastic & reconstructive surgery	4,963
emergency medicine	3,163
neurosurgery	3,125
nurse practitioner	2,796
oral surgery (dentists only)	2,494
allergy/immunology	2,416
physician assistant	1,921
preventive medicine	1,888
cardiology	1,853
pulmonary disease	1,628
psychiatry	1,620
pathology	1,399
geriatric medicine	1,215
hematology/oncology	885
otolaryngology	822
obstetrics/gynecology	711
gastroenterology	588
diagnostic radiology	540
endocrinology	485
crna, anesthesia assistant	426
infectious disease	367
nephrology	251
pediatric medicine	193
addiction medicine	153
critical care (intensivists)	76
maxillofacial surgery	76
thoracic surgery	55
ophthalmology	54
medical oncology	53
dermatology	50
colorectal surgery	41
urology	39
peripheral vascular disease	35
vascular surgery	21
unknown physician specialty	13

[Attachment A]

**FOR YOUR IMMEDIATE ATTENTION AND REPLY
by Tuesday, April 17th**

To:

From: _____, AMA RUC Representative for

Subject: Data Collection for New/Revised Injection CPT Codes

Date: April XX, 2001 2 Pages Including Cover

YOUR TIME AND EXPERTISE IS NEEDED!

Whether you have experience with one or more of the listed injection procedures, please complete the following survey form with the information for the procedure(s) you currently perform. If you do not have experience with a particular injection, please list NA in the appropriate column. All information is critical to this process, as the survey results will be used to determine actual physician work relative value unit per code at the upcoming April AMA Relative Value Update Committee (RUC) Meeting.

The reason for this survey is the *Injection; tendon sheath, ligament, ganglion cyst, or trigger points* (20550) was separated into five separate codes by the AMA CPT Editorial Panel unexpectedly last month. In order for these codes to be included in the 2002 AMA CPT Publication, the AMA has placed these codes on the AMA RUC agenda in April for valuation.

If you have any questions/concerns when completing this survey, please contact _____ at _____.

**Please Complete the information below before Tuesday April 17TH and return
BY FAX to J. Martin - Health Data Management - FAX No: 734-944-1006**

Please utilize the following guidelines when completing the survey.

- The pre-service period includes physician services related to the procedure provided from the day before the procedure until the time of the procedure.
- The intra-service period includes only the injection itself.
- The post-service period includes services provided on the day of the procedure after the injection.
- For each code, rate the AVERAGE pre-, intra-, and post service *complexity/intensity* on a scale of 1 to 5 (circle one: 1 = low; 3 medium; 5 = high). Please base your rankings on how these codes relate to each other.

Please Complete the information below before Tuesday April 17TH
 and return BY FAX to J. Martin - Health Data Management - FAX No: 734-944-1006

Physician's Name: _____
 Physician's Primary Office: State: _____ E-mail address or Phone number: _____
 Physician's Specialty: _____ Years Practicing Specialty: _____
 Primary Geographic Practice Setting: ___Rural ___Suburban ___Urban
 Primary Type of Practice: ___Solo Practice ___Single Spec. Group ___Multispec. Group ___Med School Fac Practice Plan

	ZZ1	ZZ2	ZZ3	ZZ4	ZZ5
	Injection, therapeutic (eg, local anesthetic, corticosteroid); carpal canal	Injection, therapeutic (eg, local anesthetic, corticosteroid); tarsal canal	Injection; tendon sheath, ligament, ganglion cyst	Injection; tendon origin/insertion	Injection; single or multiple trigger point(s), one or more muscle group(s)
Pre-service minutes ¹					
Pre-service rank complexity/intensity ⁴	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Intra-service minutes ²					
Intra-service rank complexity/intensity ⁴	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Post-service minutes ³					
Post-service rank complexity/intensity ⁴	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Number of patients in past 12 months					
Typical number of injections per patient, each visit					

¹ The pre-service period includes physician services related to the procedure provided from the day before the procedure until the time of the procedure.
² The intra-service period includes only the injection itself.
³ The post-service period includes services provided on the day of the procedure after the injection.
⁴ For each code, rate the AVERAGE pre-, intra-, and post service *complexity/intensity* on a scale of 1 to 5 (**circle one**: 1 = low; 3 medium; 5 = high). Please base your rankings on how these codes relate to each other.

**AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS**

April 2001

Hand/Finger/Wrist/ Forearm Musculoskeletal/Vascular/Nerve Procedures

Numerous revisions, additions and deletions were made to the hand surgery codes. These changes were made to add clarity to this section of CPT to allow more accurate coding and to reduce ambiguity. The RUC is submitting recommendations for 32 codes, two of these codes have interim recommendations.

GROUP 1

24343 (JJ5)

The total work for 24343 *Repair lateral collateral ligament, elbow, with local tissue* is equivalent to that of the reference code 27405 *Repair, primary, torn ligament and/or capsule, knee; collateral* (work RVU = 8.65) This was supported by the median survey value of 8.65 and a description that the work involved with this procedure on the elbow was similar to the reference code that involved the knee. The RUC agreed that five post-operative office visits was appropriate due to the need to meet frequently with the patient to evaluate the patient's progress with a range of motion program for the elbow. **The RUC recommends a work relative value of 8.65 for CPT code 24343.**

24344 (JJ6) Interim Recommendation and **24346 (JJ8)** Interim Recommendation

the RUC assigned interim value recommendations to these two codes due to a lack of survey data. The specialty societies will collect survey data for these codes and present their results at the next RUC meeting. The work associated with code 24344 *Reconstruction lateral collateral ligament, elbow, with tendon graft (includes harvesting of graft)* and code 24346 *Reconstruction medial collateral ligament, elbow, with tendon graft (includes harvesting of graft)* is similar to the work associated with code 27428 *Ligamentous reconstruction (augmentation), knee; intra-articular (open)* (work RVU = 14.00). The knee and elbow ligament reconstructions have the following elements in common:

- Indicated for major joint instability
- Harvesting of a tendon graft
- Precise positioning and creation of periarticular bone tunnels
- Passage of tendon graft through bone tunnels
- Precise tensioning of the graft
- Close monitoring postoperative therapy
- Reconstruction of RCL (2434X4) and reconstruction of ACL both require an arthrotomy. Reconstruction of MCL (2434X2) is extra-articular, but an arthrotomy is routinely performed to assess the joint.
- Major neurovascular structures are at risk for both the knee and elbow reconstructions. The popliteal structures are at risk with the knee reconstruction, while the radial and ulnar nerves are at risk in the elbow reconstruction.

Survey data for 24343 and 24344 indicate that a work relative value of 8.65 is appropriate for these primary repairs. This value is the same as that assigned to code 27405 *Repair, primary, torn ligament and/or capsule, knee; intra-articular (open)* (work RVU = 8.65). Since the increase in complexity inherent in the reconstruction of the collateral ligament of the elbow and knee is similar, the RUC recommends that 24344 and 24346 be given an interim RVW of 14.00 which is equal to the current work relative value for code 27428. **The RUC recommends an interim work relative value of 14.00 for CPT codes 24344 and 24346.**

24345 (JJ7)

The total work for 24345 *Repair medial collateral ligament, elbow, with local tissue* is equivalent to reference code 27405 *Repair, primary, torn ligament and/or capsule, knee; collateral* (work RVU = 8.65). To place these code in proper rank order, the RUC agreed to accept the survey 25th percentile work RVU of 8.65 for 24345 instead of the survey median. The RUC agreed that five post-operative office visits were appropriate due to the need to meet frequently with the patient to evaluate the patient's progress. **The RUC recommends a work relative value of 8.65 for CPT code 24345.**

GROUP 2

29900 (JJ30)

The work involved in code 29900 *Arthroscopy, metacarpophalangeal joint, diagnostic, includes synovial biopsy* is similar to the reference code 29840 *Arthroscopy, wrist, diagnostic, with or without synovial biopsy* (work RVU = 5.54) Although 29900 requires the creation of two portals as compared to four portals for 29840, the insertion of a small arthroscope and instruments into the MCP joint is more difficult given the small size of the MCP joint. Furthermore, because of the small size of the MCP joint, there is an increased risk of iatrogenic joint surface damage. The RUC recommends the survey median RVW of 5.42 for 29900 to reflect the slightly lower total work for 29900 compared with 29840. **The RUC recommends a work relative value of 5.42 for CPT code 29900.**

29901 (JJ31)

The RUC compared 29901 *Arthroscopy, metacarpophalangeal joint, surgical; with debridement* to the reference service CPT code 29846 *Arthroscopy, wrist, surgical; excision and/or repair of triangular fibrocartilage and/or joint debridement* (work RVU = 6.75) and concluded that the work involved in both procedures is similar. Although code 29901 requires the creation of two portals as compared to four for 29846, the insertion of a small arthroscope and instruments into the MCP joint is more difficult given the small size of the MCP joint. Furthermore, because of the small size of the MCP joint, there is an increased risk of iatrogenic joint surface damage. However, the work needed to debride the radio-carpal or ulno-carpal joint is greater than that needed to debride the smaller MCP joint. Additionally, the intra-operative work to debride an MCP joint is greater than the intra-operative needed to perform a diagnostic wrist arthroscopy and biopsy as described in 29840. Using the survey median value of 6.13 work RVUs for 29901 correctly estimates the relatively lower total work for 29901 compared with 29846 and the relatively higher work compared with 29840. **The RUC recommends a work relative value of 6.13 for CPT code 29901.**

29902 (JJ32)

Total work for 29902 *Arthroscopy, metacarpophalangeal joint, surgical; with reduction of displaced ulnar collateral ligament (eg, Stener lesion)* is only slightly less than the work for reference code 29846 *Arthroscopy, wrist, surgical; excision and/or repair of triangular fibrocartilage and/or joint debridement*. Although code 29902 requires the creation of two portals as compared to four for 29846, the insertion of a small arthroscope and instruments into the MCP joint is more difficult given the small size of the MCP joint. Furthermore, because of the small size of the MCP

joint, there is an increased risk of iatrogenic joint surface damage. The work of 29902 involves the debridement of the ulnar aspect of the thumb MCP joint followed by the identification and reduction of the displaced ulnar collateral ligament. This work is slightly less complex than the work of 29846 which involves debridement of radio-carpal joint, ulno-carpal joint or triangular fibrocartilage. Additionally, the work to debride the MCP joint requires more intra-operative work than 29840 *Arthroscopy, wrist, diagnostic, with or without synovial biopsy* (work RVU = 5.54) The survey median value of 6.70 correctly estimates the slightly lower total work for CPT code 29902 compared with CPT code 29846 and the higher work when compared with CPT code 29840. **The RUC recommends a work relative value of 6.70 for CPT code 29902.**

GROUP 3

64821 (JJ33)

CPT code 64821 *Sympathectomy; radial artery* involves one artery, while the reference code 64820 *Sympathectomy, digital arteries, with magnification, each digit* (work RVU = 10.37) involves two arteries in each digit. There is 30 minutes less intra-operative time for code 64821 compared with the reference procedure code 64820, however, 64821 has more risk associated because damage to the radial artery may result in loss of several fingers. Therefore this procedure includes an overnight hospital stay for monitoring. Pre-service and post-service work are essentially the same for both procedures. Because the only difference is less intra-operative time (albeit slightly more intra-operative and postoperative intensity for 64821), both the survey median and the survey 25th percentile was judged by the specialty societies as too high relative to 64820. To develop a work RVU that would place this code in proper rank order, the RUC agreed to a work RVU of 8.75. This value was calculated by taking the estimated IWPOT of 0.054 for the reference code 64820 times 30 minutes (=1.62 RVUs) and subtracting this from the current value of 64820 (10.37-1.62=8.75). **The RUC recommends a work relative value of 8.75 for CPT code 64821.**

64822 (JJ34)

CPT code 64822 *Sympathectomy; ulnar artery* involves one artery, while the reference code 64820 *Sympathectomy, digital arteries, with magnification, each digit* (work RVU = 10.37) involves two arteries in each digit. There is 30 minutes less intra-operative time for 64822 compared with 64820, however, 64822 has more risk associated because damage to the ulnar artery may result in loss of several fingers. Pre-service and post-service work are essentially the same for both procedures. Therefore this procedure includes an overnight hospital stay for monitoring. Because the only difference is less intra-operative time (albeit slightly more intra-operative and postoperative intensity for 64822), both the survey median and the survey 25th percentile was judged by the specialty societies as too high relative to 64820. To develop a work RVU that would place this code in proper rank order, the RUC agreed to a work RVU of 8.75. This value was calculated by taking the estimated IWPOT of 0.054 for 64820 times 30 minutes (=1.62 RVUs) and subtracting this from the current value of 64820 (10.37-1.62=8.75). This would also be the same value as the recommendation for code 64821. **The RUC recommends a work relative value of 8.75 for CPT code 64822.**

64823 (JJ35)

The RUC agreed that the work involved with CPT code 64823 is equivalent to the reference code 64820 *Sympathectomy, digital arteries, with magnification, each digit* (work RVU 10.37). Intra-operatively, 64823 *Sympathectomy; superficial palmar arch* involves the exposure of the superficial palmar arch as it traverses the palm. The operative approach exposes the arch, the adjacent common and proper digital nerves and arteries and the underlying flexor tendons. The reference code 64820 involves the exposure of the two digital neurovascular bundles and the two tendons of the involved finger. Pre-service and post-service work are essentially the same for both procedures. The RUC recommends the survey median of 10.37 for 64823 to appropriately set these codes' relative values relative to each other. **The RUC recommends a work relative value of 10.37 for CPT code 64823.**

GROUP 4

25651 (JJ19)

Prior to the establishment of code 25651 *Percutaneous skeletal fixation of ulnar styloid fracture*, a CPT code to describe this procedure did not exist. The RUC concluded that the work for code 25651 is essentially equivalent to the reference code 26608 *Percutaneous skeletal fixation of metacarpal fracture, each bone* (work RVU = 5.36). Although there is no time and visit data for 26608, the survey respondents chose this code almost exclusively as the reference code, and the intensity/complexity measures validate the work equivalency. The RUC recommends the survey median RVW of 5.36 for 25651, which is equal to 26608. **The RUC recommends a work relative value of 5.36 for CPT code 25651.**

25652 (JJ20)

The RUC compared code 25652 *Open treatment of ulnar styloid fracture* to reference code 26665 *Open treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), with or without internal or external fixation* (work RVU = 7.60). Both procedures require an arthrotomy and mobilization of adjacent tendons and nerves. Both require the manipulation of small fracture fragments. A failure to repair the ulnar styloid fracture can lead to instability and arthrosis of the distal radio-ulnar joint while the failure to repair a Bennett fracture will lead to instability and arthrosis of the first CMC joint. The postoperative immobilization of a Bennett fracture includes a forearm based splint/cast while the postoperative immobilization of an ulnar styloid fracture requires a long arm splint/cast. The RUC agreed that the work was similar for both codes and recommends the survey median 7.60 for 25652. This value is equal to code 26665 and greater than the recommended value of 5.36 for code 25651 *Percutaneous skeletal fixation of ulnar styloid fracture*. **The RUC recommends a work relative value of 7.60 for CPT code 25652.**

25671 (JJ21)

The RUC compared CPT code 25671 *Percutaneous skeletal fixation of distal radioulnar dislocation* to the reference code 26706 *Percutaneous skeletal fixation of metacarpophalangeal dislocation, single, with manipulation* (work RVU = 5.12). Pre-operative evaluation for 25671 is more extensive than for 26706, as a distal radio-ulnar joint dislocation can be associated with injuries to the radius and/or ulna, the interosseous membrane, and the elbow joint. The percutaneous fixation of an MCP joint dislocation and a distal radio-ulnar joint dislocation are similar in that both place tendinous structures at risk. However, 25671 places the ulnar neurovascular bundle and its branches at risk, while 26706 is carried out through planes that are relatively free of significant neurovascular structures. The postoperative immobilization for 25671 includes a long arm splint/cast, while the postoperative immobilization for 26706 includes a hand based splint/cast. Therefore the RUC concluded that the survey median value of 6.00 for 25671 appropriately values the code greater than the reference procedure CPT code 26706, which involves less work. **The RUC recommends a work relative value of 6.00 for CPT code 25671.**

GROUP 5

25024 (JJ11) and 25025 (JJ12)

These two fasciotomy codes were examined together to determine proper rank order. The RUC initially examined the differences between the reference procedures, one that included debridement and one that did not. Since the frequency for code 25020 *Decompression fasciotomy, forearm and/or wrist; flexor or extensor compartment* (work RVU = 5.92) is less than code 25023 *Decompression fasciotomy, forearm and/or wrist; with debridement of nonviable muscle and/or nerve* (work RVU = 12.96) the RUC was not concerned that there might be an abuse of these codes when selecting between the code with debridement and the one without debridement. Code 25024 *Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment; without debridement of nonviable muscle and/or nerve* requires more pre-service, intra-service,

and post-service time and is intra-operatively and postoperatively more intense than 25020 (flexor OR extensor). Currently, it is possible to report 25999 (*unlisted*) or 25020-22 with 25020-51 for cases requiring decompression of both compartments, but this does not permit accurate tracking because 25020-51 may be secondary to another procedure. Also, using multiple procedure reporting does not account for the increased complexity of this patient (compared with a patient requiring 25020). The RUC agreed that the survey median value of 9.50 accurately accounted for the increased work involved in the typical patient requiring decompression of two compartments as compared with reference code 25020.

25025 *Decompression fasciotomy, forearm and/or wrist, flexor and extensor compartment; with debridement of nonviable muscle and/or nerve* requires more pre-service, intra-service, and post-service time and is intra-operatively and postoperatively more intense than the reference service code 25023 (flexor OR extensor). The RUC agreed that this procedure had more physician work than code 25024 due to the debridement, however, the RUC did not agree that the survey median of 18.48 reflected the increased work of debridement as compared to code 25024. The RUC attempted to determine a value for the debridement and reviewed codes 25020 *Decompression fasciotomy, forearm and/or wrist, flexor or extensor compartment; without debridement of nonviable muscle and/or nerve* (work RVU = 5.92) and code 25023 *Decompression fasciotomy, forearm and/or wrist, flexor or extensor compartment with debridement of nonviable muscle and/or nerve* (work RVU = 12.96). This comparison resulted in a difference of 7.04 RVUs for the debridement of nonviable muscle and/or nerve. Applying this differential to the recommended value of 9.50 for code 25024 the RUC recommends a total RVU of 16.54. This value would then properly rank both codes 25024 and 2525 by accounting for the additional work of debridement.

The RUC recommends a work relative value of 9.50 for CPT code 25024. The RUC recommends a work relative value of 18.48 for CPT code 25025.

GROUP 6

25394 (JJ14)

CPT code 25394 *Osteoplasty, carpal bone, shortening* is an intra-articular procedure that demands accurate restoration of the capitate articular surface. This precision requires more intra-operative work than the reference code 28302 *Osteotomy; talus*, (work RVU = 9.55) which is extra-articular. Both procedures are carried out near neurovascular and tendinous structures that must be protected. Both procedures require internal fixation and cast immobilization. Both procedures require management and monitoring of postoperative therapy. The survey median of 10.40 is slightly higher than the value for reference code 28302 to account for the additional intra-operative work. **The RUC recommends a work relative value of 10.40 for CPT code 25394.**

25430 (JJ15)

The specialty societies recommended using the 25th percentile value rather than the median value because the specialty society consensus committee reviewing the data for CPT code 25430 *Insertion of vascular pedicle into carpal bone (eg, Harii procedure)* believe the survey respondents overestimated the work relative value by comparing the work to CPT code 15740 *Flap; island pedicle* (work RVU = 10.25). Since code 15740 is "generic" in that the flap can be quite variable and the survey respondents to this survey were not offered the vignette that resulted in the value based on the original Harvard study, the specialty societies concluded that the respondents overestimated the value for code 25430. The RUC agreed that 25th percentile work relative value of 9.25 correctly places the procedure lower than code 15740. **The RUC recommends a work relative value of 9.25 for CPT code 25430.**

GROUP 7

24332 (JJ4)

The total work for code 24332 *Tenolysis, triceps* is equivalent to the reference code 24305 *Tendon lengthening, upper arm or elbow, each tendon* (work RVU = 7.45). Both of these procedures require the isolation of a myotendinous unit and place important neurovascular structures at risk. Both procedures require the prescription and monitoring of postoperative therapy. While code 24305 includes the incision and lengthening of a tendon, 24332 includes the lysis of adhesion from around the triceps tendon and muscle. The survey median value of 7.45 is the same value as the reference code 24305 and correctly sets these two codes relative to each other. **The RUC recommends a work relative value of 7.45 for CPT code 24332.**

25001 (JJ10)

The RUC agreed with the Specialty Society analysis, which concluded that the survey respondents overestimated the work RVU 25001 *Incision, flexor tendon sheath, wrist (eg, flexor carpi radialis)*, which requires a different approach than the reference code 25000 *Incision, extensor tendon sheath, wrist (eg, deQuervains disease)*, (work RVU = 3.38). Although code 25001 requires a different approach, it represents the same total work as the reference code. This new code was created to complement the reference code and allow correct coding for the less frequently performed incision of "flexor" tendon sheath. The RUC therefore agrees that the survey 25th percentile RVW of 3.38 for 25001 is appropriate since it is the same value as code 25000. **The RUC recommends a work relative value of 3.38 for CPT code 25001.**

25275 (JJ13)

The RUC compared code 25275 *Repair, tendon sheath, extensor, forearm and/or wrist, with free graft (includes obtaining graft) (eg, for extensor carpi ulnaris subluxation)* to the reference code 25274 *Repair, tendon or muscle, extensor, secondary, with tendon graft (includes obtaining graft), forearm and/or wrist, each tendon or muscle* (work RVU = 8.75). The RUC concluded that code 25275 is similar to the reference procedure but involves slightly less work. Although code 2527X1 requires slightly less intra-operative work than the reference code, code 25274 usually requires dissection of the injured tendon from scar as well as two tendinous anastomoses. The scaring at the sixth dorsal compartment associated with 25275 is usually mild and while the reconstruction of the tendon sheath must be precise, it is a bit less work than two tendinous anastomoses. Postoperative care for both procedures includes some form of immobilization and subsequent prescription and monitoring of therapy. The RUC recommends that the survey median value of 8.50 for 25275 correctly values the procedure in relation to code 25274. **The RUC recommends a work relative value of 8.50 for CPT code 25275.**

29086 (JJ29)

29086 *Application, cast; finger (eg, contracture)*, which includes fabrication of the case, is more total work than the reference code 29131 *Application of finger splint; dynamic* (work RVU = .55) as 29086 requires the application of casting material directly on the finger skin. This direct cutaneous contact carries more risk of cutaneous and neurovascular compromise than code 29131. This increased risk requires more pre and post service patient education and monitoring as reflected in the survey. Additionally, 29086 requires less time than 29075 therefore the Specialty Society recommended, and the RUC agreed that the survey 25th percentile value of 0.62 for 29086 is correct. This value is correctly placed between 29131 and 29075. **The RUC recommends a work relative value of .62 for CPT code 29086.**

GROUP 8

24300 (JJ9)

Pre-service and intra-service work of code 24300 *Manipulation, elbow, under anesthesia* is similar to the reference code 23700 *Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)* (work RVU = 2.52). Code 24300 includes more postoperative work because it has been assigned a 90-day global period (compared with 23700, which has a 10-day global). Patients requiring 24300 will be seen weekly for the first four weeks and then at 6 weeks and 12 weeks. The RUC concluded that the survey median value of 3.75 for code 24300 is appropriate since it is higher than code 23700 to account for the additional post-operative work for five additional office visits during the 90-day global. **The RUC recommends a work relative value of 3.75 for CPT code 24300.**

25259 (JJ18)

Pre-service and intra-service work of code 25259 *Manipulation, wrist, under anesthesia* is similar to 23700 *Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)* (work RVU = 2.52) and the previous code 24300 *Manipulation, elbow, under anesthesia* (recommended work RVU = 3.75). Code 25259 includes more postoperative work because it has been assigned a 90-day global period (compared with 23700, which has a 10-day global). Patients requiring 25259 will be seen weekly for the first four weeks and then at 6 weeks and 12 weeks. Total work for 25259 and 24300 is the same. The RUC concluded that the survey median value of 3.75 for code 25259 is appropriate since it is higher than code 23700 to account for the additional post-operative work for five additional office visits during the 90-day global. **The RUC recommends a work relative value of 3.75 for CPT code 25259.**

26340 (JJ25)

Code 26340 *Manipulation, finger joint, under anesthesia, each joint* requires more pre-service time than reference code 26600 *Closed treatment of metacarpal fracture, single; without manipulation, each bone* (work RVU = 1.96). Code 26340 will be used most often for post-traumatic contracture while code 26600 will be emergent and straightforward. The complications associated with manipulation of a finger joint include fracture, tendon rupture, skin laceration and neurovascular compromise. These complications are not associated with code 26600 and therefore the pre-service discussion with the patient is more complex with 26340 than with 26600. Additionally, the postop work for 26340 will be greater as the surgeon must carefully prescribe and closely monitor intensive postoperative therapy without which the procedure will fail. The treatment of an undisplaced metacarpal fracture requires far less vigilance. The RUC therefore concluded that the survey median value of 2.50 appropriately values the code in relation to 26600, and the slightly higher value accounts for the additional pre-service and post-service work. **The RUC recommends a work relative value of 2.50 for CPT code 26340.**

GROUP 9

25431 (JJ16)

The total work for code 25431 *Repair of nonunion of carpal bone (excluding carpal scaphoid (navicular)) (includes obtaining graft and necessary fixation)*, each bone is equivalent to reference code 25440 *Repair of nonunion, scaphoid (navicular) bone, with or without radial styloidectomy (includes obtaining graft and necessary fixation)* (work RVU = 10.44). Code 25431 was created to complement the nonunion repair of the scaphoid and allow correct coding for the less frequently performed nonunion repair of the carpal bone. The RUC agreed that the survey median value of 10.44, which is the same as code 25440 is appropriate. **The RUC recommends a work relative value of 10.44 for CPT code 25431.**

GROUP 10 Crosswalked values and editorial changes

25440 JJ17

Code 25440 *Repair of nonunion, scaphoid (navicular) bone, with or without radial styloidectomy (includes obtaining graft and necessary fixation)* (work RVU = 10.44) did not undergo a CPT revision but the code was sent to the RUC due to a possibility that the value of the code was affected by the revisions and creation of new codes. The RUC concluded that the code was not affected and recommends no change in value since code 2095X1 was deleted and therefore eliminated any possible overlap with this code. **The RUC recommends a work relative value of 10.44, no change in work relative value for CPT code 25440.**

26510 JJ22

CPT code 26510 *Cross intrinsic transfer, each tendon* (work RVU = 5.43) was surveyed during the Harvard study. Only intra-service time was surveyed and only three orthopedic surgeons provided information for the intra-time. The Harvard study report indicates that this code did not have a statistically significant response. The "vignette" for the survey of this code was "cross intrinsic transfer/thumb tendon transfer." The AMA CPT "short" descriptor for this code is "thumb tendon transfer." The orthopedic and plastic hand surgeons who use this code for reporting purposes believe that both the Harvard study and the CPT nomenclature never represented more than one tendon and this code is typically used to describe the transfer of one intrinsic tendon from one finger to the adjacent finger to limit ulnar drift. **The RUC recommends a work relative value of 5.43, no change in the work relative value for CPT code 26510 since the changes were deemed editorial and not a change in the service.**

26587 JJ23

In 1992 and 1993, HCFA asked the RUC to recommend work-RVUs for carrier priced codes. Specialty societies surveyed many replantation and reconstruction codes and while both code 26585 *Repair bifid digit* (work RVU = 14.05) and code 26587 *Reconstruction of polydactylous supernumerary digit, soft tissue and bone* were both surveyed, but the HCFA, RUC, and Society paper trail is not clear as to why only a recommendation for CPT 26585 proceeded to the RUC and why 26587 remained carrier priced. The specialty society proposed that code 26585 should be deleted since it is the same as 26587. Further, the term *supernumerary* is more correctly indicated as *polydactylous*. The CPT Editorial Panel accepted both of these changes based on this rationale. With respect to valuing 26587, which until now has been carrier priced, the RUC recommends crosswalking the value from 26585. A review of the vignette and service description from the RUC summary for 26587 supports the recommendation that both codes represent the same operation and that crosswalking is appropriate. **The RUC recommends a work relative value of 14.05 for CPT code 26587.**

26590 JJ24

Code 26590 *Repair macrodactylia, each digit* (work RVU = 17.96) has always referred to repair of one digit. The Harvard vignette was "repair macrodactylia/repair finger deformity," but the code was initially carrier priced. This code was reviewed by the specialty society and a recommendation was submitted to the RUC in 1994. The vignette used the intra-service description, and discussion at the RUC indicated that the value for this code is based on one digit. **The RUC recommends a work relative value of 17.96, no change in the work relative value for CPT code 26590 since the changes were deemed editorial and not a change in the service**

26685 JJ26

Code 26685 *Open treatment of carpometacarpal dislocation, other than thumb (Bennett fracture) ; single, with or without internal or external fixation, each joint*, (work RVU = 6.98) was judged by the RUC to be a straight forward editorial change. The nomenclature was revised to be consistent with CPT standards and "single" was changed to "each joint" and Bennett fracture was deleted because that fracture is specifically for a thumb only. **The RUC recommends a work relative value of 6.98, no change in the work relative value for CPT code 26685 since the changes were deemed editorial and not a change in the service**

26843 JJ27 and 26844 JJ28

Code 26843 *Arthrodesis, carpometacarpal joint, digits, other than thumb, each* (work RVU = 7.61) and code 26844 *Arthrodesis, carpometacarpal joint, digits, other than thumb, each with autograft (includes obtaining graft)* (work RVU = 8.73) underwent editorial changes. The "arthrodesis" procedure refers to the CMC "joint" and not to a digit (ie, an arthrodesis is performed on a joint, not a digit). It was poor grammar to indicate "digits" as plural when the arthrodesis was for one joint. For those surgeons who perform this operation, this code logically would never have been thought to include the work of arthrodesis of more than one CMC joint. Also, the Harvard vignette for this code was "Arthrodesis of carpometacarpal digits, not thumb/fusion of hand joint". Admittedly, this too was poor language - but clearly included only one joint and one arthrodesis procedure. The AMA CPT short descriptor is "fusion of hand joint" (ie, not plural). The addition of the word "each" was to clearly and unambiguously describe the procedure for those persons without a clear understanding of medical terminology. **The RUC recommends no change in the work relative value for CPT codes 26843 7.61, and 26844 8.73, since the changes were deemed editorial and not a change in the services.**

Practice Expense

The RUC is recommending using the RUC approved practice expense standard packages for these codes. Only inputs for the facility setting is provided since these procedures are not performed in the office. Specifically, for all codes with 90 day global periods, the RUC is recommending 60 minutes of pre-service time, and the E/M clinical staff time for the number and level of post operative office visits included in the summary of recommendation form. Additionally, the staff blend of RN/LPN/MA is recommended. For medical supplies the RUC is recommending the standard minimum supply packages for each post operative office visit as well as one post operative incision care kit. The specific practice expense inputs are attached to these recommendations. For code 2908X1, *Application, cast; finger (eg, contracture)*, which has a 000 day global period, the RUC is recommending a crosswalk of RUC refined inputs from code 29075 *Application; elbow to finger (short arm)*. The clinical staff time and other inputs are similar.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲24075		Excision, tumor, <u>soft tissue of</u> upper arm or elbow area; subcutaneous	090	3.92 (No change)
24076		deep; (subfascial or intramuscular)	090	6.30 (No change)
24330		<i>Flexor-plasty, elbow (eg, Steindler type advancement);</i>	090	9.60 (No change)
24331		<i>with extensor or advancement</i>	090	10.65 (No change)
✓ ●24332	JJ4	Tenolysis, triceps	090	7.45
✓ ●24343	JJ5	Repair lateral collateral ligament, elbow, with local tissue	090	8.65
✓ ●24344	JJ6	Reconstruction lateral collateral ligament, elbow, with tendon graft (includes harvesting of graft)	090	14.00 Interim Recommendation
✓ ●24345	JJ7	Repair medial collateral ligament, elbow, with local tissue	090	8.65
✓ ●24346	JJ8	Reconstruction medial collateral ligament, elbow, with tendon graft (includes harvesting of graft)	090	14.00 Interim Recommendation
24498		<i>Prophylactic treatment (nailing, pinning, plating or wiring), with or without methylmethacrylate, humera shaft)</i>	090	11.92 (No change)

✓ ● 24300	JJ9	Manipulation elbow, under anesthesia (For application of external fixation, see 20690 or 20692)	090	3.75
✓ ● 25001	JJ10	Incision, flexor tendon sheath, wrist (eg, flexor carpi radialis)	090	3.38
▲ 25020		Decompression fasciotomy, forearm and/or wrist, ; flexor or <u>OR</u> extensor compartment; <u>without</u> <u>debridement of nonviable muscle and/or nerve</u>	090	5.92 (No change)
25023		with debridement of nonviable muscle and/or nerve	090	12.96 (No change)
✓ ● 25024	JJ11	Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment; without debridement of nonviable muscle and/or nerve	090	9.50
✓ ● 25025	JJ12	with debridement of nonviable muscle and/or nerve	090	16.54
25065		<i>Biopsy, soft tissue of forearm and/or wrist; superficial</i>	010	1.99 (No change)
25066		<i>deep (subfascial or intramuscular)</i>	090	4.13 (No change)
▲ 25075		Excision, tumor, <u>soft tissue of</u> forearm and/or wrist area; subcutaneous	090	3.74 (No change)

▲25076		deep; (subfascial or intramuscular)	090	4.92 (No change)
25270		<i>Repair, tendon or muscle, extensor, forearm and/or wrist; primary, single, each tendon or muscle</i>	090	6.00 (No change)
25272		<i>secondary, single, each tendon or muscle</i>	090	7.04 (No change)
▲25274		Repair, tendon or muscle, extensor, secondary, with free tendon graft (includes obtaining graft), forearm and/or wrist, each tendon or muscle	090	8.75 (No change)
●25275	JJ13	Repair, tendon sheath, extensor, forearm and/or wrist, with free graft (includes obtaining graft) (eg, for extensor carpi ulnaris subluxation)	090	8.50
●25394	JJ14	Osteoplasty, carpal bone, shortening	090	10.40
25400		<i>Repair of nonunion or malunion, radius OR ulna; without graft (eg, compression technique)</i>	090	10.92 (No change)
▲25405		with iliac or other autograft (includes obtaining graft)	090	14.38 (No change)
25415		<i>Repair of nonunion or malunion, radius AND ulna; without graft (eg, compression technique)</i>	090	13.35 (No change)
▲25420		with iliac or other autograft (includes obtaining graft)	090	16.33 (No change)

● 25430	JJ15	Insertion of vascular pedicle into carpal bone (eg, Harii procedure)	090	9.25
● 25431	JJ16	Repair of nonunion of carpal bone (excluding carpal scaphoid (navicular)) (includes obtaining graft and necessary fixation), each bone	090	10.44
25440	JJ17	Repair of nonunion, scaphoid (navicular) bone, with or without radial styloidectomy (includes obtaining graft and necessary fixation)	090	10.44 (No change)
● 25259	JJ18	Manipulation wrist, under anesthesia (For application of external fixation, see 20690 or 20692)	090	3.75
25515		<i>Open treatment of radial shaft fracture, with or without internal or external fixation</i>	090	9.18 (No change)
▲ 25520		Closed treatment of radial shaft fracture, <u>with and</u> Closed treatment of dislocation of distal radioulnar Joint (Galeazzi fracture/dislocation)	090	6.26 (No change)
▲ 25526		Open treatment of radial shaft fracture, with internal And/or external fixation and open treatment, with or without internal or external fixation of distal radioulnar joint (Galeazzi fracture/dislocation), includes repair of triangular <u>fibrocartilage complex</u>	090	12.98 (No change)

▲25645		<i>Open treatment of carpal bone fracture (excluding other than carpal scaphoid (navicular)), each bone</i>	090	7.25 (No change)
●25651	JJ19	Percutaneous skeletal fixation of ulnar styloid fracture	090	5.36
●25652	JJ20	Open treatment of ulnar styloid fracture	090	7.60
●25671	JJ21	Percutaneous skeletal fixation of distal radioulnar dislocation	090	6.00
▲26115		Excision, tumor or vascular malformation, <u>soft tissue of hand or finger</u> ; subcutaneous	090	3.86 (No change)
26116		deep, (subfascial, <u>or</u> intramuscular)	090	5.53 (No change)
▲26160		Excision of lesion of tendon sheath or <u>joint capsule</u> (eg, cyst, mucous cyst, or ganglion), hand or finger	090	3.15 (No change)
26250		Radical resection, metacarpal ;-(eg, tumor);	090	7.55 (No change)
26255		<i>with autograft (includes obtaining graft)</i>	090	12.43 (No change)
▲26350		Repair or advancement, flexor tendon, not in <u>zone 2</u> digital flexor tendon sheath (eg, no man's land); primary or secondary without free graft, each tendon	090	5.99 (No change)

26352		<i>secondary with free graft (includes obtaining graft), each tendon</i>	090	7.68 (No change)
▲26356		Repair or advancement, flexor tendon, in <u>zone 2</u> digital flexor tendon sheath (eg, no man's land); primary or secondary without free graft, each tendon	090	8.07 (No change)
26357		<i>secondary, each tendon</i>	090	8.58 (No change)
26358		<i>secondary with free graft (includes obtaining graft), each tendon</i>	090	9.14 (No change)
▲26390		Excision flexor tendon, <u>with</u> implantation of <u>synthetic prosthetic</u> rod for delayed tendon graft, hand or finger, each tendon <u>each rod</u>	090	9.19 (No change)
▲26392		Removal of <u>synthetic prosthetic</u> rod and insertion of flexor tendon graft, hand or finger (includes obtaining graft), each tendon <u>each rod</u>	090	10.26 (No change)
▲26415		Excision of extensor tendon, <u>with</u> implantation of <u>synthetic prosthetic</u> rod for delayed tendon graft, hand or finger, <u>each rod</u>	090	8.34 (No change)
▲26416		Removal of <u>synthetic prosthetic</u> rod and insertion of extensor tendon graft (includes obtaining graft), hand or finger, each tendon <u>each rod</u>	090	9.37 (No change)

▲26426		Repair of extensor tendon, central slip, secondary (eg, boutonniere deformity); using local tissue(s), including lateral band(s), each tendon -finger	090	6.15 (No change)
▲26428		with free graft (includes obtaining graft), each tendon -finger	090	7.21 (No change)
▲26445		Tenolysis, extensor tendon, hand <u>OR</u> of finger; each Tendon	090	4.31 (No change)
▲26510	JJ22	Cross intrinsic transfer, <u>each tendon</u>	090	5.43 (No change)
26585		Repair bifid digit (26585 has been deleted. To report, use 26587)	090	N/A
▲26587	JJ23	Reconstruction of <u>polydactylous supernumerary</u> digit, soft tissue and bone (For excision of <u>supernumerary polydactylous</u> digit, soft tissue only, use 11200)	090	14.05
▲26590	JJ24	Repair macrodactylia, <u>each digit</u>	090	17.96 (No change)

26597		Release of scar contracture, flexor or extensor, with Skin grafts, rearrangement flaps, or Z-plasties, hand and/or finger (26597 has been deleted. To report, see 11041-11042 or 14040-14041, or 15120, 15240)	090	N/A
✓ ● 26340	JJ25	Manipulation, finger joint, under anesthesia, each Joint (For application of external fixation, see 20690 or 20692)	090	2.50
▲ 26670	✓	✓ Closed treatment of carpometacarpal dislocation, other than thumb (Bennett fracture), single, with manipulation, <u>each joint</u> ; without anesthesia	090	3.69 (No change)
26675		<i>requiring anesthesia</i>	090	4.64 (No change)
▲ 26676		Percutaneous skeletal fixation of carpometacarpal dislocation, other than thumb (Bennett fracture), single, with manipulation, <u>each joint</u>	090	5.52 (No change)
▲ 26685	JJ26	Open treatment of carpometacarpal dislocation, other than thumb (Bennett fracture); single, with or without internal or external fixation, <u>each joint</u> ,	090	6.98 (No change)

26841		<i>Arthrodesis, carpometacarpal joint, thumb, with or without internal fixation;</i>	090	7.13 (No change)
26842		<i>with autograft (includes obtaining graft)</i>	090	8.24 (No change)
▲26843	JJ27	Arthrodesis, carpometacarpal joint, digits , other than thumb, <u>each</u> ;	090	7.61 (No change)
26844	JJ28	with autograft (includes obtaining graft)	090	8.73 (No change)
●29086	JJ29	Application, cast; finger (eg, contracture)	000	0.62
29909		Unlisted procedure, arthroscopy <u>(29909 has been deleted, to report use ●29999)</u>		N/A
●29900	JJ30	Arthroscopy, metacarpal-phalangeal <u>metacarpophalangeal</u> joint; diagnostic, includes synovial biopsy <u>(Do not report 29900 with 29901, 29902)</u>	090	5.42

● 29901	JJ31	Arthroscopy, metacarpal-phalangeal <u>metacarpophalangeal</u> joint, surgical; with debridement	090	6.13
● 29902	JJ32	with reduction of displaced ulnar collateral ligament (eg, Stener lesion)	090	6.70
● 29999		Unlisted procedure, arthroscopy	YYY	N/A
▲ 64820		Sympathectomy; , digital arteries, with magnification, each digit <u>(Do not report 69990 in addition to code 64820)</u>	090	10.37 (No change)
● 64821	JJ33	radial artery <u>(Do not report 69990 in addition to code 64821)</u>	090	8.75
● 64822	JJ34	ulnar artery <u>(Do not report 69990 in addition to code 64822)</u>	090	8.75
● 64823	JJ35	superficial palmar arch <u>(Do not report 69990 in addition to code 64823)</u>	090	10.37
+ 69990		Microsurgical techniques, requiring of operating microscope (List separately in addition to code for primary procedure)	ZZZ	3.47 (No change)

A	C			D	E	F	G	H	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	Y	Z	AA				
1	Upper Limb Family Summary (Revised April 26, 2001)																												
2	Fam	CPT	Desc	Rec RVW		Ref	ref rvw	Pre RVW	Post RVW	Intra RVW	IWPUT	PRE	INTR	Im-SD	HV 33	HV 32	HV 31	HV 38	OV #	OV 15	OV 14	OV 13	OV 12	OV 11	Survey Times				
3	1	2434X1 JJ5	Repair lateral collateral ligament, elbow, with local tissue	8.65	med & 25th%	27405		1.23	3.68	3.74	0.042	55	90	30				0.5	5			1	4		276	186	90		
4			REF DATA			27405	8.65	0.99	4.75	2.91	0.039	44	75	21			2	1	4				4		274	199	75		
5	1	2434X3 JJ7	Repair medial collateral ligament, elbow, with local tissue	8.65	25th %	27405		1.30	3.68	3.67	0.041	58	90	30				0.5	5			1	4		279	189	90		
6			REF DATA			27405	8.65	0.99	4.75	2.91	0.039	44	75	21			2	1	4				4		274	199	75		
7																													
8	2	299X1 JJ30	Arthroscopy, metacarpalpalangeal joint, diagnostic, includes synovial biopsy	5.42	med	29840		1.12	3.03	1.27	0.021	50	60	20				0.5	4			1	3		216	156	60		
9			REF DATA			29840	5.54	0.78	1.69	3.06	0.068	35	45	18					3				3		143	98	45		
10	2	299X2 JJ31	Arthroscopy, metacarpalpalangeal joint, with debridement	6.13	med	29846		1.12	3.03	1.98	0.026	50	75	20				0.5	4			1	3		231	156	75		
11			REF DATA			29846	6.75	0.87	1.74	4.14	0.057	39	72	20					3				3		176	104	72		
12	2	299X3 JJ32	Arthroscopy, metacarpalpalangeal joint; with reduction of displaced ulnar collateral ligament (eg, Stener lesion)	6.70	med	29846		1.12	3.03	2.55	0.028	50	90	20				0.5	4			1	3		246	156	90		
13			REF DATA			29846	6.75	0.87	1.74	4.14	0.057	39	72	20					3				3		176	104	72		
14																													
15	3	6482X1 JJ33	Sympathectomy; radial artery	8.75	< 25th%	64820		1.19	4.53	3.03	0.051	53	60	30				1	1	4			1	3		266	206	60	
16			REF DATA			64820	10.37	1.23	4.27	4.87	0.054	55	90	70				1	4			1	1	2	303	213	90		
17	3	6482X2 JJ34	Sympathectomy; ulnar artery	8.75	< 25th%	64820		1.19	4.53	3.03	0.051	53	60	30				1	1	4			1	3		266	206	60	
18			REF DATA			64820	10.37	1.23	4.27	4.87	0.054	55	90	70				1	4			1	1	2	303	213	90		
19	3	6482X3 JJ35	Sympathectomy; superficial palmar arch	10.37	med & 25th%	64820		1.19	4.53	4.65	0.052	53	90	30				1	1	4			1	3		296	206	90	
20			REF DATA			64820	10.37	1.23	4.27	4.87	0.054	55	90	70				1	4			1	1	2	303	213	90		
21																													
22	4	2565X1 JJ19	Percutaneous skeletal fixation of ulnar styloid fracture	5.36	med	26608		1.12	3.03	1.21	0.040	50	30	20				0.5	4			1	3		186	156	30		
23			REF DATA			26608	5.36	No data available.																		-	-	-	
24	4	2565X3 JJ20	Open treatment of ulnar styloid fracture	7.60	med	26665		1.12	3.14	3.34	0.056	50	60	25				0.5	4			1	3		221	161	60		
25			REF DATA			26665	7.60	0.78	3.53	3.29	0.047	35	70	19				0.5	1	3.5			3.5		222	152	70		
26	4	2567X1 JJ21	Percutaneous skeletal fixation of distal radioulnar dislocation	6.00	med	26706		1.12	3.14	1.74	0.039	50	45	25				0.5	4			1	3		206	161	45		
27			REF DATA			26706	5.12	0.78	1.99	2.35	0.053	35	44	12									4		151	107	44		
28																													
29	5	2502X1 JJ11	Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment; without debridement of nonviable muscle and/or nerve	9.50	med	25020		1.34	7.08	1.07	0.015	60	70	30				2	1	1	5			1	4		358	288	70
30			REF DATA			25020	5.92	1.01	3.00	1.92	0.035	45	54	19				hosp?	1	3			3		199	145	54		
31	5	2502X2 JJ12	Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment; with debridement of nonviable muscle and/or nerve	16.54	med	25023		1.34	7.72	7.47	0.057	60	130	30				2	2	1	5			1	4		437	307	130
32			REF DATA			25023	12.96	1.16	7.36	4.43	0.044	52	100	28				5.5	1	4.5			4.5		388	288	100		

1	Upper Extremity Summary (Revised April 26, 2001)																	HV	HV	HV	HV		OV	OV	OV	OV	OV	Survey Times		
2	Fam	CPT	Desc	Rec RVW		Ref	ref rvw	Pre RVW	Post RVW	Intra RVW	IWP/UT	PRE	INTR	Im-SD	33	32	31	38	OV #	15	14	13	12	11	Tot min	P/P min	Int min			
33																														
34	6	2539X1 JJ14	Osteoplasty, carpal bone, shortening	10.40	med	28302		1.12	3.25	6.03	0.067	50	90	30				0.5	4				1	3		256	166	90		
35			REF DATA			28302	9.55	1.08	3.81	4.66	0.082	48	57	22				0.5	1	4				4		233	176	57		
36	6	2543X1 JJ15	Insertion of vascular pedicle into carpal bone (eg, Hani procedure)	9.25	25th%	15740		1.12	3.14	4.99	0.050	50	100	25				0.5	4				1	3		261	161	100		
37			REF DATA			15740	10.25	1.21	5.56	3.48	0.029	54	118	32				1	1	4.5				4.5		363	245	118		
38																														
39	7	2433X1 JJ4	Tenolysis, triceps	7.45	med	24305		1.12	3.25	3.08	0.051	50	60	30				0.5	4				1	3		226	166	60		
40			REF DATA			24305	7.45	1.10	2.64	3.71	0.059	49	63	22				0.5	3.5					3.5		205	142	63		
41	7	2500X1 JJ10	Incision, flexor tendon sheath, wrist (eg, flexor carpi radialis)	3.38	25th%	25000		0.67	2.60	0.11	0.004	30	30	20				0.5	3				1	2		151	121	30		
42			REF DATA			25000	3.38	0.65	1.89	0.84	0.028	29	33	17					3.5					3.5		132	99	33		
43	7	2527X1 JJ13	Repair, tendon sheath, extensor, forearm and/or wrist, with free graft (includes obtaining graft) (eg, for extensor carpi ulnaris subluxation)	8.50	med	25274		0.78	3.03	4.69	0.067	35	70	20				0.5	4				1	3		211	141	70		
44			REF DATA			25274	8.75	0.94	2.90	4.91	0.053	42	93	24				0.5	4					4		237	144	93		
45	7	2908X1 JJ29	Application, cast, finger (eg, contracture)	0.62	25th%	29131		0.45	0.22	-0.05	-0.004	20	13	10					0							43	30	13		
46			REF DATA			29131	0.55	0.16	0.11	0.28	0.016	7	18	5					0							30	12	18		
47																														
48	8	2449X1 JJ9	Manipulation, elbow, under anesthesia	3.75	med	23700		1.01	3.78	-1.04	-0.052	45	20	25				0.5	6					6		198	178	20		
49			REF DATA			23700	2.52	0.25	0.72	1.55	0.082	11	25	13					1					1		64	39	25		
50						27275	2.27	0.63	1.34	0.30	0.019	28	16	12				0.5	1					1		89	73	16		
51	8	2549X1 JJ18	Manipulation, wrist, under anesthesia	3.75	med	23700		1.03	3.67	-0.95	-0.047	46	20	20				0.5	6					6		194	174	20		
52			REF DATA			23700	2.52	0.25	0.72	1.55	0.082	11	25	13					1					1		64	39	25		
53	8	2659X1 JJ25	Manipulation, finger joint, under anesthesia, each joint	2.50	med	26600		0.56	3.56	-1.62	-0.108	25	15	15				0.5	6					6		163	148	15		
54			REF DATA			26600	1.96	0.20	1.47	0.29	0.016	9	18	8					3					3		80	62	18		
55																														
56	9	2543X2 JJ16	Repair of nonunion of carpal bone (excluding carpal scaphoid (navicular)) (includes obtaining graft and necessary fixation), each bone (For vascularized bone graft, use 2095X1)	10.44	med & 25th%	25440		1.30	3.25	5.89	0.059	58	100	30				0.5	4				1	3		274	174	100		
57			REF DATA			25440	10.44	1.16	3.86	5.42	0.060	52	90	24				0.5	1	4				4		272	182	90		

April 3, 2001

James E. Hoehn, M.D.
Chairman
AMA/Specialty Society RVS Update Committee (RUC)
515 North State Street
Chicago Illinois 60610

Subject: Codes with Editorial Revisions
CPT codes 26510, 26587, 26590, 26685, 26843, 26844

Dear Jim:

In reviewing the upper extremity surgery section of the CPT manual, the ASSH made recommendations for editorial changes to several existing codes to make certain that the language was current and unambiguous. At the February 2001 CPT meeting, HCFA representatives indicated that some of these revisions may not be editorial, and they recommended that a RUC survey be conducted. The ASSH disagrees with HCFA and offers the following discussion to the RUC for each of the codes as rationale to maintain the current RVW for these codes and to accept these changes as editorial.

JJ22 090 ▲26510 Cross intrinsic transfer, each tendon
CPT 26510 was surveyed during the Harvard study. Only intra-service time was surveyed and only three orthopaedic surgeons provided information for the intra-time. The Harvard study report indicates that this code did not have a statistically significant response. The "vignette" for the survey of this code was "cross intrinsic transfer/thumb tendon transfer." The AMA CPT "short" descriptor for this code is "thumb tendon transfer." The orthopaedic and plastic hand surgeons who use this code for reporting purposes believe that both the Harvard study and the CPT nomenclature never represented more than one tendon. As you know, this code is typically used to describe the transfer of one intrinsic tendon from one finger to the adjacent finger to limit ulnar drift.

J24 090 ▲26590 Repair macrodactylia, each digit
CPT 26590 has always referred to repair of one digit. The Harvard vignette was "repair macrodactylia/repair finger deformity," but the code was initially carrier priced. This code was reviewed by ASRM/ASSH members and a recommendation was submitted to the RUC in 1994. The vignette used

the intra-service description, and discussion at the RUC indicated the value for this code is based on one digit.

~~26585~~ ——— ~~Repair bifid digit~~

(26585 has been deleted. To report, use 26587)

JJ23 090 ▲26587 Reconstruction of polydactylous ~~supernumerary~~ digit, soft tissue and bone

In 1992 and 1993, HCFA asked the RUC to recommend work-RVUs for carrier priced codes. The ASSH and ASRM surveyed many replantation and reconstruction codes. Our 1992 historical files indicate that both 26585 and 26587 were both surveyed, but the HCFA, RUC, and Society paper trail is not clear as to why only a recommendation for CPT 26585 proceeded to the RUC and why 26587 remained carrier priced. That aside, in the final analysis, microsurgical reconstructive hand surgeons who perform this operation have proposed that 26585 should be deleted since it is the same as 26587. Further, the term *supernumerary* is more correctly indicated as *polydactylous*. The CPT Editorial Panel accepted both of these changes based on this rationale. With respect to valuing 26587, which until now has been carrier priced, we recommend crosswalking the value from 26585. A review of the vignette and service description from the RUC summary for 26587 supports our recommendation that both codes represent the same operation and that crosswalking is appropriate.

JJ26 090 ▲26685 Open treatment of carpometacarpal dislocation, other than thumb (~~Bennett fracture~~) ; single, with or without internal or external fixation, each joint,

We do not understand why the editorial nature of this change was questioned. The nomenclature was revised to be consistent with CPT standards and "single" was changed to "each joint" and Bennett fracture was deleted because that fracture is specifically for a thumb only.

JJ27 090 ▲26843 Arthrodesis, carpometacarpal joint, digits , other than thumb, each ;

JJ28 090 26844 with autograft (includes obtaining graft)

April 3, 2001

The "arthrodesis" procedure refers to the CMC "joint" and not to a digit (ie, an arthrodesis is performed on a joint, not a digit). It was poor grammar to indicate "digits" as plural when the arthrodesis was for one joint. For those surgeons who perform this operation, this code logically would never have been thought to include the work of arthrodesis of more than one CMC joint. We also note that the Harvard vignette for this code was "Arthrodesis of carpometacarpal digits, not thumb/fusion of hand joint". Admittedly, this too was poor language - but clearly included only one joint and one arthrodesis procedure. We also note that the AMA CPT short descriptor is "fusion of hand joint" (ie, not plural). The addition of the word "each" was to clearly and unambiguously describe the procedure for those persons without a clear understanding of medical terminology (eg, personnel with no medical background working in an insurance claims department).

The ASSH appreciates the RUC's consideration of our comments regarding these codes with editorial changes. We recommend that the RUC accept our rationale that: 1) the nomenclature changes for these codes are editorial; and 2) that the value for deleted code 26585 be crosswalked to 26587.

Sincerely,

Daniel J. Nagle, MD
Chair, ASSH CPT/RUC Committee

C: Sherry Smith
Blair Filler, MD
Ray Janevicius, MD
Keith Brandt, MD
Melanie Clawson

24343

CPT Code: 2434X1 (JJ5)

Global: 090

Recommended RVW 8.65

CPT Descriptor: Repair lateral collateral ligament, elbow, with local tissue

Survey Vignette (Typical Patient)

A 25-year-old woman develops elbow instability after a fall on the ice. An acute open repair of the lateral collateral ligament is performed.

CLINICAL DESCRIPTION OF SERVICE:**Preoperative work:**

- Imaging studies are carefully reviewed including X-rays, CT scans, and MRIs.
- Pre-operative laboratory tests are reviewed.
- Consultation is completed with the referring physician and other healthcare professionals
- The family and patient are apprised of the proposed surgery.
- The risks and complications associated with the surgery are discussed with the patient and family.
- Informed consent is obtained.
- The surgeon goes to the operating room and verifies that all appropriate equipment is available
- The patient is brought to the operating room and placed on the operating table in the supine position.
- The patient's bony prominences are padded.
- Thermal regulation drapes are applied
- The position of the extremities and head are checked and adjusted.
- The patient's involved arm is prepped and draped.
- A sterile tourniquet is applied to the proximal arm.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- The patient's arm is brought across the chest.

INTRA-SERVICE WORK: The joint capsule is exposed through Kocher's interval reflecting the anconeus posteriorly. The ulnar attachment of the lateral ulnar collateral ligament is palpated. The triceps and anconeus are reflected from the posterior margin of the lateral column. The common extensor tendon is elevated to expose the anterior capsule. The common extensor is carefully reflected from the epicondyle. Care is taken to preserve the capsule and lateral ulnar collateral ligament. A transverse incision is made in the anterior capsule of the radiohumeral joint. A similar incision is made posteriorly behind the lateral complex. Sutures were placed in the lateral ligament complex, including both the radial collateral ligament and the lateral ulnar collateral ligament. The sutures are then brought out through drill holes that are placed in the anatomic origin of the ligament at the mid-portion of the lateral epicondyle. Any capsular redundancy is eliminated by plicating the anterior and posterior capsules. Instability of the elbow is tested. The wound is irrigated. The fascia is repaired. The skin is then closed in layers.

Postoperative work: in hospital

- Application of dressing and splint.
- Monitoring patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative imaging studies are reviewed
- Postoperative laboratory studies are reviewed
- Preparation of discharge records

Postoperative work: in office

- Post-discharge office visits for this procedure for 90 days
- Assessment of circulation, sensation and motor function of the operated extremity
- Removal of splint
- Assessment of surgical wound
- Redress wound
- Order physical / occupational therapy
- Supervision of rehabilitation
- Ordering and reviewing radiographs.
- Antibiotic and pain medication management.
- Removal of sutures
- Evaluation laboratory reports
- Communication with other health care professionals
- Communication with patient and family regarding progress.

SURVEY DATA

Presenter(s): Daniel J. Nagle, MD, FACS

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

CPT: 2434X1

Sample Size: 100 **Resp n:** 45 **Resp %:** 45%

Sample Type: random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	7.48	8.65	8.65	9.43	15.80
Pre-Service			55		
Intra-Service	45	75	90	110	150

Post-Service	<u>Total Min</u>	<u>CPT code / # of visits</u>
<i>Day of Surgery:</i>		
Immediate	30	
Other	18	99236 X 0.5 (same day surgery)
<i>After Day of Surgery:</i>		
Critical Care	0	99236
Other Hospital	0	
Dischg Day Mgmt	0	
Office Visits	83	99213x1 99212x4

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
27405	Repair, primary, torn ligament and/or capsule, knee; collateral	8.65	090

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

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT
	2434X1	27405 (Hvd)
Pre-service time	55	45
Intra-service time	90	75
Same Day Immediate Post-service time	30	21
Same Day Other Post-service time	0	38
Post Total critical care time (not same day)	0	
Post Total other hospital visit time (not same day)	0	
Discharge management time	18	36
Total office visit time	83	60

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	3.64	3.64
Intra-service	3.82	3.76
Post-service	3.77	3.60

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.51	3.24
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.44	3.24
Urgency of medical decision making	3.56	3.48

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.13	3.80
Physical effort required	3.69	3.68

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.87	3.72
Outcome depends on the skill and judgment of physician	4.15	3.84
Estimated risk of malpractice suit with poor outcome	3.72	3.60

ADDITIONAL RATIONALE

The total work for 2434X1 *Repair lateral collateral ligament, elbow, with local tissue* is equivalent to that of 27405 *Repair, primary, torn ligament and/or capsule, knee; collateral*. We recommend the survey median RVW of 8.65.

Additional survey question and results:

"Where is this service performed (check all that apply)?"

Hospital

Outpatient Hospital / Surgi-Center

Office

FREQUENCY INFORMATION

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

24999 Unlisted procedure, humerus or elbow (Medicare frequency = 167)

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

Specialty: hand/orthopaedic surgery Commonly ~~————~~ Sometimes Rarely

3. 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: hand/orthopaedic surgery Frequency: 300

4. 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: hand/orthopaedic surgery Frequency: 9 (3% or less of national frequency)

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to surgeons/practices that specialize in surgery of the hand/upper extremity.

CPT Code: 2434X2 (JJ6)

Global: 090

Interim Recommended RVW: 14.00

Descriptor: Reconstruction lateral collateral ligament, elbow, with tendon graft (includes harvesting of graft).

Survey Vignette (Typical Patient)

A 40-year-old male has a post-traumatic lateral instability of the elbow requiring lateral collateral ligament reconstruction with a palmaris longus tendon graft.

CLINICAL DESCRIPTION OF SERVICE:

Preoperative work:

- Imaging studies are carefully reviewed including X-rays, CT scans, and MRIs.
- Pre-operative laboratory tests are reviewed.
- Consultation is completed with the referring physician and other healthcare professionals
- The family and patient are apprised of the proposed surgery.
- The risks and complications associated with the surgery are discussed with the patient and family.
- Informed consent is obtained.
- The surgeon goes to the operating room and verifies that all appropriate equipment is available
- The patient is brought to the operating room and placed on the operating table in the supine position.
- The patient's bony prominences are padded.
- Thermal regulation drapes are applied
- The position of the extremities and head are checked and adjusted.
- The patient's involved arm is prepped and draped.
- A sterile tourniquet is applied to the proximal arm.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- The patient's arm is brought across the chest.

INTRA-SERVICE WORK: The joint capsule is exposed through Kocher's interval reflecting the anconeus posteriorly. The ulnar attachment of the lateral ulnar collateral ligament is palpated. The triceps and anconeus are reflected from the posterior margin of the lateral column. The common extensor tendon is elevated to expose the anterior capsule. The common extensor is carefully reflected from the epicondyle. Care is taken to preserve the capsule and lateral ulnar collateral ligament. A transverse incision is made in the anterior capsule of the radiohumeral joint. A similar incision is made posteriorly behind the lateral collateral complex. An incision is made at the wrist and the palmaris longus tendon is harvested using a tendon stripper. Care is taken to protect the median nerve during this maneuver. The tendon donor site incision is closed using a subcuticular suture. The insertion site of the lateral ulnar collateral ligament on the tubercle of the supinator crest is identified. A 3-4 mm hole is made in the ulna with a burr just posterior to this point. Another hole is made proximally near the annular ligament. A tunnel is created between these two holes with a curved awl. A suture is passed through the holes and tied to itself. The suture loop is then pulled proximally using a snap until the isometric point on the epicondyle is identified. The elbow is taken through a full range of motion to determine the exact position of the isometric point. The cortex is burred superficially at the isometric point. The correct position of the isometric point is once again verified. The burr-hole is then deepened and placed slightly proximal and slightly posterior to the exact isometric point. An exit hole is created with a burr just posterior to the supracondylar ridge. A tunnel is created between the isometric hole and the proximal hole. A second hole is made anterior to the posterior hole. This too is connected to the point of isometry using an awl. The tendon graft is then passed through the tunnel in the ulna. Its two ends of the tendon graft are sutured to themselves. The two ends are then pulled through the anterior tunnel and tension is maintained on the graft. The elbow is held in full pronation and 40 degrees of flexion. The graft is then passed through the posterior hole and through the tunnel to the point of isometry again. The end of the graft is then sewn to itself at the ulna. The capsule is closed such that the tendon will not rub directly on the lateral margin of the capitellum. The three limbs of the collateral ligament reconstruction that pass between the capitellum and ulna are sewn together using PDS suture. The fascia is closed and the skin is closed in layers.

Postoperative work: in hospital

- Application of dressing and splint.
- Monitoring patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative imaging studies are reviewed
- Postoperative laboratory studies are reviewed
- Preparation of discharge records

Postoperative work: in office

- Post-discharge office visits for this procedure for 90 days
- Assessment of circulation, sensation and motor function of the operated extremity
- Removal of splint
- Assessment of surgical wound
- Redress wound
- Order physical / occupational therapy
- Supervision of rehabilitation
- Ordering and reviewing radiographs.
- Antibiotic and pain medication management.
- Removal of sutures
- Evaluation laboratory reports
- Communication with other health care professionals
- Communication with patient and family regarding progress.

SURVEY DATA Not available.

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
2434X3	Repair medial collateral ligament, elbow, with local tissue	8.65*	090
20924	Tendon graft, from a distance (eg, palmaris, toe extensor, plantaris)	6.48	090
27405	Repair, primary, torn ligament and/or capsule, knee; collateral	8.65	090
27428	Ligamentous reconstruction (augmentation), knee; intra-articular (open)	14.00	090
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation reconstruction	13.90	090
29889	Arthroscopically aided posterior cruciate ligament repair/augmentation reconstruction	15.13	090

*recommended

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

TIME ESTIMATES (MEDIAN)	Ref CPT	Ref CPT	Ref CPT	Ref CPT	Ref CPT	Ref CPT
	2434X3 Svy	20924 Hvd	27405 Hvd	27428 RUC	29888 Hvd	29889 RUC
Work - RVUs	8.65*	6.48	8.65	14.00	13.90	15.13
Pre-service time	58	44	45	60	41	90
Intra-service time	90	34	75	120	127	150
Same Day Immediate Post-service time	30	20	21	30	22	30
Same Day Other Post-service time	0	0	0	0	0	0
Post Total critical care time (not same day)	0	0	0	0	0	0
Post Total other hospital visit time (not same day)	0	10	38	0	28	0
Discharge management time	18	36	36	36	36	36
Total office visit time	114	45	60	115	60	122

*recommended

INTENSITY/COMPLEXITY MEASURES (mean) Not Available

RATIONALE FOR INTERIM VALUE:

The work associated with the reconstruction of the elbow ulnar (2434X2) or elbow radial (2434X4) collateral ligament is similar to the work associated with the reconstruction of the anterior cruciate ligament of the knee (27428). The knee and elbow ligament reconstructions have the following elements in common:

- Indicated for major joint instability
- Harvesting of a tendon graft
- Precise positioning and creation of periarticular bone tunnels
- Passage of tendon graft through bone tunnels
- Precise tensioning of the graft
- Close monitoring postoperative therapy
- Reconstruction of RCL (2434X4) and reconstruction of ACL both require an arthrotomy. Reconstruction of MCL (2434X2) is extra-articular, but an arthrotomy is routinely performed to assess the joint.
- Major neurovascular structures are at risk for both the knee and elbow reconstructions. The popliteal structures are at risk with the knee reconstruction, while the radial and ulnar nerves are at risk in the elbow reconstruction.

Survey data for 2434X1 and 2434X3 indicate that a RVW of 8.65 is appropriate for these primary repairs. This value is the same as that assigned to the primary repair of a knee collateral ligament (27405). As demonstrated above, the increase in complexity inherent in the reconstruction of the collateral ligament of the elbow and knee is similar. We therefore recommend that 2434X2 and 2434X4 be given an interim RVW of 14.00 which is equal to the current RVW for 27428.

Additional survey question and results:

"Where is this service performed (check all that apply)?"

Hospital X Outpatient Hospital / Surgi-Center X Office

FREQUENCY INFORMATION

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

24999 Unlisted procedure, humerus or elbow (Medicare frequency = 167)

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

Specialty: hand/orthopaedic surgery ~~Commonly~~ ~~Sometimes~~ Rarely

3. 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: hand/orthopaedic surgery Frequency: 200

4. 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: hand/orthopaedic surgery Frequency: 6 (3% or less of national frequency)

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to a few medical centers.

CPT Code: 2434X4 (JJ8)

Global: 090

Interim Recommended RVW 14 00

CPT Descriptor: Reconstruction medial collateral ligament, elbow, with tendon graft (includes harvesting of graft)

Survey Vignette (Typical Patient)

A baseball pitcher develops elbow medial collateral ligament laxity requiring reconstruction with a tendon graft.

CLINICAL DESCRIPTION OF SERVICE:

Preoperative work:

- Imaging studies are carefully reviewed including X-rays, CT scans, and MRIs.
- Pre-operative laboratory tests are reviewed.
- Consultation is completed with the referring physician and other healthcare professionals
- The family and patient are apprised of the proposed surgery.
- The risks and complications associated with the surgery are discussed with the patient and family.
- Informed consent is obtained.
- The surgeon goes to the operating room and verifies that all appropriate equipment is available
- The patient is brought to the operating room and placed on the operating table in the supine position.
- The patient's bony prominences are padded.
- Thermal regulation drapes are applied
- The position of the extremities and head are checked and adjusted.
- The patient's involved arm is prepped and draped.
- A sterile tourniquet is applied to the proximal arm.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- The patient's arm is brought across the chest.

INTRA-SERVICE WORK: A 10 cm incision is centered over the medial epicondyle. Care is taken to protect the medial antebrachial cutaneous nerve. The ulnar nerve is identified and protected. A longitudinal split is made in the fascia and the underlying flexor pronator aponeurosis. The muscle mass is retracted out of the field and the anterior portion of the ulnar collateral ligament is exposed. Convergent drill holes are made in the ulna at the level of the tubercle at the medial aspect of the coronoid process. The holes are separated by approximately 1cm. The humeral attachment of the reconstructed collateral ligament is then repaired. The isometric point of attachment of the ulnar collateral ligament on the humerus is identified and marked. A point is made 10 mm proximal to this on the medial column. Another hole is made 10 mm proximal to the second hole. These holes are deepened and then a gouge is used to create a tunnel from each hole oriented towards each of the two proximal holes, oriented towards the isometric point. The palmaris longus is then harvested through a transverse incision at the wrist using a tendon stripper. Care is taken to not injure the median nerve. The wound at this level is closed using a subcuticular stitch. The tendon graft is then passed through the bone tunnels in a figure "8" fashion. A suture is placed through one of the free ends of the tendon graft to facilitate this process. With the elbow held at 45 degrees of flexion and neutral varus-valgus position, the graft is pulled taught and sutured to itself. The graft is also sutured to the fascia near the intermuscular septum and the remnants of the ulnar collateral ligament. The elbow is taken through a full range of motion and gentle stressed. The flexor pronator muscle group is reattached to the medial epicondyle. The wound is closed in layers.

Postoperative work: in hospital

- Application of dressing and splint.
- Monitoring patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative imaging studies are reviewed
- Postoperative laboratory studies are reviewed

- Preparation of discharge records

Postoperative work: in office

- Post-discharge office visits for this procedure for 90 days
- Assessment of circulation, sensation and motor function of the operated extremity
- Removal of splint
- Assessment of surgical wound
- Redress wound
- Order physical / occupational therapy
- Supervision of rehabilitation
- Ordering and reviewing radiographs.
- Antibiotic and pain medication management.
- Removal of sutures
- Evaluation laboratory reports
- Communication with other health care professionals
- Communication with patient and family regarding progress.

SURVEY DATA Not available.

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
2434X3	Repair medial collateral ligament, elbow, with local tissue	8.65*	090
20924	Tendon graft, from a distance (eg, palmaris, toe extensor, plantaris)	6.48	090
27405	Repair, primary, torn ligament and/or capsule, knee; collateral	8.65	090
27428	Ligamentous reconstruction (augmentation), knee; intra-articular (open)	14.00	090
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation reconstruction	13.90	090
29889	Arthroscopically aided posterior cruciate ligament repair/augmentation reconstruction	15.13	090

*recommended

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

TIME ESTIMATES (MEDIAN)	Ref CPT	Ref CPT	Ref CPT	Ref CPT	Ref CPT	Ref CPT
	2434X3 Svy	20924 Hvd	27405 Hvd	27428 RUC	29888 Hvd	29889 RUC
Work - RVUs	8.65*	6.48	8.65	14.00	13.90	15.13
Pre-service time	58	44	45	60	41	90
Intra-service time	90	34	75	120	127	150
Same Day Immediate Post-service time	30	20	21	30	22	30
Same Day Other Post-service time	0	0	0	0	0	0
Post Total critical care time (not same day)	0	0	0	0	0	0
Post Total other hospital visit time (not same day)	0	10	38	0	28	0
Discharge management time	18	36	36	36	36	36
Total office visit time	114	45	60	115	60	122

*recommended

INTENSITY/COMPLEXITY MEASURES (mean) Not Available

RATIONALE FOR INTERIM VALUE:

The work associated with the reconstruction of the elbow ulnar (2434X2) or elbow radial (2434X4) collateral ligament is similar to the work associated with the reconstruction of the anterior cruciate ligament of the knee

(27428) The knee and elbow ligament reconstructions have the following elements in common:

- Indicated for major joint instability
- Harvesting of a tendon graft
- Precise positioning and creation of periarticular bone tunnels
- Passage of tendon graft through bone tunnels
- Precise tensioning of the graft
- Close monitoring postoperative therapy
- Reconstruction of RCL (2434X4) and reconstruction of ACL both require an arthrotomy. Reconstruction of MCL (2434X2) is extra-articular, but an arthrotomy is routinely performed to assess the joint.
- Major neurovascular structures are at risk for both the knee and elbow reconstructions. The popliteal structures are at risk with the knee reconstruction, while the radial and ulnar nerves are at risk in the elbow reconstruction.

Our survey data for 2434X1 and 2434X3 indicate that a RVW of 8.65 is appropriate for these primary repairs. This value is the same as that assigned to the primary repair of a knee collateral ligament (27405). As demonstrated above, the increase in complexity inherent in the reconstruction of the collateral ligament of the elbow and knee is similar. We therefore recommend that 2434X2 and 2434X4 be given an interim RVW of 14.00 which is equal to the current RVW for 27428.

Additional survey question and results:

"Where is this service performed (check all that apply)?"

Hospital Outpatient Hospital / Surgi-Center Office

FREQUENCY INFORMATION

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

24999 Unlisted procedure, humerus or elbow (Medicare frequency = 167)

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

Specialty: hand/orthopaedic surgery Commonly ~~_____~~ Sometimes Rarely

3. 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: hand/orthopaedic surgery Frequency: 300

4. 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: hand/orthopaedic surgery Frequency: 9 (3% or less of national frequency)

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to a few medical centers.

CPT Code: 2434X3 (JJ7)

Global: 090

Recommended RVW: 8.65

CPT Descriptor: Repair medial collateral ligament, elbow, with local tissue

Survey Vignette (Typical Patient)

A 40-year-old male develops medial elbow instability after a ski accident. Surgical repair of the medial collateral ligament is performed using local tissues.

CLINICAL DESCRIPTION OF SERVICE:

Preoperative work:

- Imaging studies are carefully reviewed including X-rays, CT scans, and MRIs.
- Pre-operative laboratory tests are reviewed.
- Consultation is completed with the referring physician and other healthcare professionals
- The family and patient are apprised of the proposed surgery.
- The risks and complications associated with the surgery are discussed with the patient and family.
- Informed consent is obtained.
- The surgeon goes to the operating room and verifies that all appropriate equipment is available
- The patient is brought to the operating room and placed on the operating table in the supine position.
- The patient's bony prominences are padded.
- Thermal regulation drapes are applied
- The position of the extremities and head are checked and adjusted.
- The patient's involved arm is prepped and draped.
- A sterile tourniquet is applied to the proximal arm.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.

INTRA-SERVICE WORK: A 10 cm incision is centered over the medial epicondyle. Care is taken to protect the medial antebrachial cutaneous nerve. The ulnar nerve is identified and protected. A longitudinal split is made in the fascia and the underlying flexor pronator aponeurosis. The muscle mass is retracted out of the field and the anterior portion of the ulnar collateral ligament is exposed. An incision is made along the medial aspect of the elbow taking care to protect the ulnar nerve. The elbow joint is examined. The elbow is flexed to 20 or 30 degrees and a valgus stress applied. The avulsed ligament is identified. Any fibrous material and scar is debrided. A Bunnell type stitch is past up through the collateral ligament. Drill holes are made in the medial epicondyle. The suture is then brought up through the holes in the medial epicondyle and secured. Prior to the attachment of the ligament to the medial epicondyle, the recipient site of the repaired ligament is roughened. The stability of the repair is verified. The wound is thoroughly irrigated and then closed in layers.

Postoperative work: in hospital

- Application of dressing and splint.
- Monitoring patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative imaging studies are reviewed
- Postoperative laboratory studies are reviewed
- Preparation of discharge records

Postoperative work: in office

- Post-discharge office visits for this procedure for 90 days
- Assessment of circulation, sensation and motor function of the operated extremity
- Removal of splint
- Assessment of surgical wound

- Redress wound
- Order physical / occupational therapy
- Supervision of rehabilitation
- Ordering and reviewing radiographs.
- Antibiotic and pain medication management.
- Removal of sutures
- Evaluation laboratory reports
- Communication with other health care professionals
- Communication with patient and family regarding progress.

SURVEY DATA**Presenter(s):** Daniel J. Nagle, MD, FACS**Specialty(s):** American Society for Surgery of the Hand
American Academy of Orthopaedic Surgeons
American Shoulder and Elbow Surgeons**CPT:** 2434X3**Sample Size:** 100 **Resp n:** 47 **Resp %:** 47%**Sample Type:** random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	8.50	8.65	9.00	10.00	16.00
Pre-Service			58		
Intra-Service	45	90	90	120	180

Post-Service	<u>Total Min</u>	<u>CPT code / # of visits</u>
<i>Day of Surgery:</i>		
Immediate	30	
Other	18	99236 X 0.5 (same day surgery)
<i>After Day of Surgery:</i>		
Critical Care	0	
Other Hospital	0	
Dischg Day Mgmt	0	
Office Visits	83	99213x1 99212x4

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
27405	Repair, primary, torn ligament and/or capsule, knee; collateral	8.65	090

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

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT
	2434X3	27405 (Hvd)
Pre-service time	58	45
Intra-service time	90	75
Same Day Immediate Post-service time	30	21
Same Day Other Post-service time	0	38
Post Total critical care time (not same day)	0	
Post Total other hospital visit time (not same day)	0	
Discharge management time	18	36
Total office visit time	83	60

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	3.90	3.73
Intra-service	4.14	3.82
Post-service	3.88	3.64

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.93	3.59
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.79	3.68
Urgency of medical decision making	3.40	3.64

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.29	3.95
Physical effort required	3.86	3.86

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.00	3.82
Outcome depends on the skill and judgment of physician	4.19	3.86
Estimated risk of malpractice suit with poor outcome	3.79	3.59

ADDITIONAL RATIONALE

Total work for 2434X3 *Repair medial collateral ligament, elbow, with local tissue* is equivalent to 27405 *Repair, primary, torn ligament and/or capsule, knee; collateral*. We recommend the survey 25th percentile RVW of 8.65 for 2434X3 instead of the survey median to correctly set these codes relative to each other..

Additional survey question and results:

"Where is this service performed (check all that apply)?"

Hospital

Outpatient Hospital / Surgi-Center

Office

FREQUENCY INFORMATION

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

24999 Unlisted procedure, humerus or elbow (Medicare frequency = 167)

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

Specialty: hand/orthopaedic surgery Commonly ~~————~~ Sometimes Rarely

3. 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: hand/orthopaedic surgery Frequency: 200

4. 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: hand/orthopaedic surgery Frequency: 8 (4% or less of national frequency)

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to surgeons/practices that specialize in surgery of the hand/upper extremity.

CPT Code: 299X1 (JJ30)

Global: 090

Recommended RVW: 5.42

Descriptor: Arthroscopy, metacarpophalangeal joint, diagnostic, includes synovial biopsy
(Do not report 299X1 with 299X2, 299X3)

Survey Vignette (Typical Patient)

A 43-year-old male presents for assessment of post-traumatic pain of his third metacarpophalangeal joint. A diagnostic arthroscopy is performed to delineate treatment options.

CLINICAL DESCRIPTION OF SERVICE:

Preoperative work:

- Imaging studies are carefully reviewed including X-rays, CT scans, and MRIs.
- Pre-operative laboratory tests are reviewed.
- Consultation is completed with the referring physician and other healthcare professionals
- The family and patient are apprised of the proposed surgery.
- The risks and complications associated with the surgery are discussed with the family.
- Informed consent is obtained.
- The surgeon goes to the operating room and verifies that all appropriate equipment is available
- The patient is brought to the operating room and placed on the operating table in the supine position.
- The patient's bony prominences are padded.
- Thermal regulation drapes are applied
- The position of the extremities and head are checked and adjusted.
- The patient's involved arm is prepped and draped.
- A sterile tourniquet is applied to the proximal arm.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.

INTRA-SERVICE WORK: A 20-gauge needle is introduced into the metacarpophalangeal joint and the joint is inflated with lactated ringer's solution. A dorsal-radial portal is established after making a small incision in the skin over the dorsal-radial aspect of the metacarpophalangeal joint. Blunt dissection is carried down to capsule. The cannula system is then put into the joint and the scope is introduced. A separate ulnar portal is established. A probe is introduced through the ulnar portal to palpate the joint. A synovial biopsy is harvested using the small joint biopsy punch. Because of the small size of the joint, the manipulation of the scope is carried out in a very delicate fashion. The scope itself is 1.9 mm in diameter and must be handled delicately as well. Once the pathology has been diagnosed, the scope and instruments are removed. The skin is approximated using a nylon suture.

Postoperative work: in hospital

- Application of dressing and splint.
- Monitoring patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative imaging studies are reviewed
- Postoperative laboratory studies are reviewed
- Preparation of discharge records

Postoperative work: in office

- Post-discharge office visits for this procedure for 90 days
- Assessment of circulation, sensation and motor function of the operated extremity
- Removal of splint
- Assessment of surgical wound
- Redress wound

- Order physical / occupational therapy
- Supervision of rehabilitation
- Ordering and reviewing radiographs.
- Antibiotic and pain medication management.
- Removal of sutures
- Evaluation laboratory reports
- Communication with other health care professionals
- Communication with patient and family regarding progress.

SURVEY DATA**Presenter(s):** Daniel J. Nagle, MD, FACS**Specialty(s):** American Society for Surgery of the Hand
American Academy of Orthopaedic Surgeons
Arthroscopy Association of North America**CPT:** 299X1**Sample Size:** 45 **Resp n:** 19 **Resp %:** 42%**Sample Type:** Panel – surgeons who have taken an arthroscopy course

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	3.35	5.00	5.42	5.54	7.60
Pre-Service			50		
Intra-Service	20	40	60	65	90

Post-Service	<u>Total Min</u>	<u>CPT code / # of visits</u>
<i>Day of Surgery:</i>		
Immediate	20	
Other	18	99238 x 0.5 (same day surgery)
<i>After Day of Surgery:</i>		
Critical Care	0	
Other Hospital	0	
Dischg Day Mgmt	0	
Office Visits	68	99213x1 99212x3

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
29840	Arthroscopy, wrist, diagnostic, with or without synovial biopsy (separate procedure)	5.54	090

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

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT
	299X1	29840 (Hvd)
Pre-service time	50	35
Intra-service time	60	45
Same Day Immediate Post-service time	20	18
Same Day Other Post-service time	0	
Post Total critical care time (not same day)	0	
Post Total other hospital visit time (not same day)	0	
Discharge management time	18	
Total office visit time	68	45

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	2.98	3.13
Intra-service	3.72	3.57
Post-service	2.75	2.87

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	2.98	3.23
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.73
Urgency of medical decision making	2.73	2.80

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.65	3.34
Physical effort required	2.88	3.27

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	2.89	2.93
Outcome depends on the skill and judgment of physician	3.55	3.67
Estimated risk of malpractice suit with poor outcome	2.57	2.87

ADDITIONAL RATIONALE

299X1 *Arthroscopy, metacarpophalangeal joint, diagnostic, includes synovial biopsy* and 29840 *Arthroscopy, wrist, diagnostic, with or without synovial biopsy* represent similar procedures. Although 299X1 requires the creation of two portals as compared to four portals for 29840, the insertion of a small arthroscope and instruments into the MCP joint is more difficult given the small size of the MCP joint. Furthermore, because of the small size of the MCP joint, there is an increased risk of iatrogenic joint surface damage. We recommend the survey median RVW of 5.42 for 299X1. This value reasonably reflects the slightly lower total work for 299X1 compared with 29840.

Additional survey question and results:

"Where is this service performed (check all that apply)?"

Hospital Outpatient Hospital / Surgi-Center Office

FREQUENCY INFORMATION

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

29909 Unlisted procedure, arthroscopy (Medicare frequency = 780)

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

Specialty: hand/orthopaedic surgery ~~Commonly~~ ~~Sometimes~~ Rarely

3. 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: hand/orthopaedic surgery Frequency: 50
[New technology (smaller arthroscopes) recent training]

4. 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: hand/orthopaedic surgery Frequency: 6 (13% or less of national frequency)

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to a few medical centers.

CPT Code: 299X2 (JJ31)

Global: 090

Recommended RVW: 6 13

Descriptor: Arthroscopy, metacarpophalangeal joint,surgical; with debridement

Survey Vignette (Typical Patient)

A 43-year-old male presents status post injury to metacarpophalangeal joint with decreased motion, pain, and swelling. An arthroscopic debridement of the joint is performed.

CLINICAL DESCRIPTION OF SERVICE:

Preoperative work:

- Imaging studies are carefully reviewed including X-rays, CT scans, and MRIs.
- Pre-operative laboratory tests are reviewed.
- Consultation is completed with the referring physician and other healthcare professionals
- The family and patient are apprised of the proposed surgery.
- The risks and complications associated with the surgery are discussed with the family.
- Informed consent is obtained.
- The surgeon goes to the operating room and verifies that all appropriate equipment is available
- The patient is brought to the operating room and placed on the operating table in the supine position.
- The patient's bony prominences are padded.
- Thermal regulation drapes are applied
- The position of the extremities and head are checked and adjusted.
- The patient's involved arm is prepped and draped.
- A sterile tourniquet is applied to the proximal arm.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.

INTRA-SERVICE WORK: A 20-gauge needle is introduced into the metacarpophalangeal joint and the joint is inflated with lactated ringer's solution. A dorsal-radial portal is established after making a small incision in the skin over the dorsal-radial aspect of the metacarpophalangeal joint. Blunt dissection is carried down to capsule. The cannula system is then put into the joint and the scope is then introduced. A separate ulnar portal is established. A probe is introduced into the metacarpophalangeal joint through the ulnar portal. A chondral flap and synovitis are palpated. The small joint 2.0-mm full radius cutter is brought into the joint and the chondral flap and synovitis are excised. A laser or radiofrequency device may also be used. Great care must be taken during this procedure as the joint is very small and tight and the risk for injury to the cartilage is always present. Once the procedure is completed, the probes and scope are removed. The skin is sutured.

Postoperative work: in hospital

- Application of dressing and splint.
- Monitoring patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative imaging studies are reviewed
- Postoperative laboratory studies are reviewed
- Preparation of discharge records

Postoperative work: in office

- Post-discharge office visits for this procedure for 90 days
- Assessment of circulation, sensation and motor function of the operated extremity
- Removal of splint
- Assessment of surgical wound
- Redress wound

- Order physical / occupational therapy
- Supervision of rehabilitation
- Ordering and reviewing radiographs.
- Antibiotic and pain medication management.
- Removal of sutures
- Evaluation laboratory reports
- Communication with other health care professionals
- Communication with patient and family regarding progress.

SURVEY DATA

Presenter(s): Daniel J. Nagle, MD, FACS

Specialty(s): American Society for Surgery of the Hand
 American Academy of Orthopaedic Surgeons
 Arthroscopy Association of North America

CPT: 299X2

Sample Size: 45 **Resp n:** 19 **Resp %:** 42%

Sample Type: Panel – surgeons who have taken an arthroscopy course

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	4.05	5.03	6.13	6.75	8.00
Pre-Service			50		
Intra-Service	20	60	75	80	90

Post-Service	<u>Total Min</u>	<u>CPT code / # of visits</u>
<i>Day of Surgery:</i>		
Immediate	20	
Other	18	99238 x 0.5 (same day surgery)
<i>After Day of Surgery:</i>		
Critical Care	0	
Other Hospital	0	
Dischg Day Mgmt	0	
Office Visits	68	99213x1 99212x3

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
29846	Arthroscopy, wrist, surgical; excision and/or repair of triangular fibrocartilage and/or joint debridement	6.75	090

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

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT
	299X2	29846 (Hvd)
Pre-service time	50	39
Intra-service time	75	72
Same Day Immediate Post-service time	20	20
Same Day Other Post-service time	0	
Post Total critical care time (not same day)	0	
Post Total other hospital visit time (not same day)	0	
Discharge management time	18	
Total office visit time	68	45

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	2.88	3.30
Intra-service	3.59	3.80
Post-service	2.71	2.80

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.00	3.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	3.70
Urgency of medical decision making	2.71	2.70

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.00	3.72
Physical effort required	3.06	3.10

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.00	3.00
Outcome depends on the skill and judgment of physician	3.53	3.70
Estimated risk of malpractice suit with poor outcome	2.65	2.90

ADDITIONAL RATIONALE

299X2 Arthroscopy, metacarpophalangeal joint, surgical; with debridement and 29846 Arthroscopy, wrist, surgical; excision and/or repair of triangular fibrocartilage and/or joint debridement are comparable procedures. Although 299X2 requires the creation of two portals as compared to four for 29846, the insertion of a small arthroscope and instruments into the MCP joint is more difficult given the small size of the MCP joint. Furthermore, because of the small size of the MCP joint, there is an increased risk of iatrogenic joint surface damage. The work needed to debride the radio-carpal or ulno-carpal joint is greater than that needed to debride the smaller MCP joint. Additionally, the intra-operative work to debride an MCP joint is greater than the intra-operative needed to perform a diagnostic wrist arthroscopy and biopsy as described in 29840. We therefore recommend the survey median RVW of 6.13 for 299X2. This value correctly estimates the relatively lower total work for 299X2 compared with 29846 and the relatively higher work compared with 29840.

Additional survey question and results:

"Where is this service performed (check all that apply)?"

Hospital Outpatient Hospital / Surgi-Center Office

FREQUENCY INFORMATION

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

29909 Unlisted procedure, arthroscopy (Medicare frequency = 780)

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

Specialty: hand/orthopaedic surgery Commonly Sometimes Rarely

3. 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: hand/orthopaedic surgery Frequency: 50
[New technology (smaller arthroscopes) recent training]

4. 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: hand/orthopaedic surgery Frequency: 6 (13% or less of national frequency)

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to a few medical centers.

CPT Code: 299X3 (JJ32)

Global: 090

Recommended RVW: 6 70

Descriptor: Arthroscopy, metacarpophalangeal joint, surgical; with reduction of displaced ulnar collateral ligament (eg, Stener lesion)

Survey Vignette (Typical Patient)

A 25-year-old male is treated for an injury to the first metacarpophalangeal joint ulnar collateral ligament with an arthroscopically aided reduction of the displaced ulnar collateral ligament (Stener lesion).

CLINICAL DESCRIPTION OF SERVICE:

Preoperative work:

- Imaging studies are carefully reviewed including X-rays, CT scans, and MRIs.
- Pre-operative laboratory tests are reviewed.
- Consultation is completed with the referring physician and other healthcare professionals
- The family and patient are apprised of the proposed surgery.
- The risks and complications associated with the surgery are discussed with the family.
- Informed consent is obtained.
- The surgeon goes to the operating room and verifies that all appropriate equipment is available
- The patient is brought to the operating room and placed on the operating table in the supine position.
- The patient's bony prominences are padded.
- Thermal regulation drapes are applied
- The position of the extremities and head are checked and adjusted.
- The patient's involved arm is prepped and draped.
- A sterile tourniquet is applied to the proximal arm.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.

INTRA-SERVICE WORK: A 20-gauge needle is introduced into the metacarpophalangeal joint and the joint is inflated with lactated ringer's solution. A dorsal-radial portal is established after making a small incision in the skin over the dorsal-radial aspect of the metacarpophalangeal joint. Blunt dissection is carried down to capsule. The cannula system is then put into the joint and the scope is then introduced. A separate dorsal ulnar portal is established. With the scope in the radial portal, 2.0 full radius cutter is brought into the joint through the ulnar portal to clear any fibrinous debris or synovitis. Once this is completed, the visualization of the ulnar aspect of the joint is completed. The ulnar collateral ligament stump is identified. The probe is introduced through the dorsal-ulnar portal, and the ulnar collateral ligament is teased back in its anatomic position. The scope and probe are removed. The wounds are sutured.

Postoperative work: in hospital

- Application of dressing and splint.
- Monitoring patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative imaging studies are reviewed
- Postoperative laboratory studies are reviewed
- Preparation of discharge records

Postoperative work: in office

- Post-discharge office visits for this procedure for 90 days
- Assessment of circulation, sensation and motor function of the operated extremity
- Removal of splint
- Assessment of surgical wound

- Redress wound
- Order physical / occupational therapy
- Supervision of rehabilitation
- Ordering and reviewing radiographs.
- Antibiotic and pain medication management.
- Removal of sutures
- Evaluation laboratory reports
- Communication with other health care professionals
- Communication with patient and family regarding progress.

SURVEY DATA**Presenter(s):** Daniel J. Nagle, MD, FACS**Specialty(s):** American Society for Surgery of the Hand
American Academy of Orthopaedic Surgeons
Arthroscopy Association of North America**CPT:** 299X3**Sample Size:** 45 **Resp n:** 19 **Resp %:** 42%**Sample Type:** Panel – surgeons who have taken an arthroscopy course

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	4.70	5.63	6.70	6.75	8.00
Pre-Service			50		
Intra-Service	20	70	90	95	100

Post-Service	<u>Total Min</u>	<u>CPT code / # of visits</u>
<i>Day of Surgery:</i>		
Immediate	20	
Other	18	99238 x 0.5 (same day surgery)
<i>After Day of Surgery:</i>		
Critical Care	0	
Other Hospital	0	
Dischg Day Mgmt	0	
Office Visits	68	99213x1 99212x3

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
29846	Arthroscopy, wrist, surgical; excision and/or repair of triangular fibrocartilage and/or joint debridement	6.75	090

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

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT
	299X3	29846 (Hvd)
Pre-service time	50	39
Intra-service time	90	72
Same Day Immediate Post-service time	20	20
Same Day Other Post-service time	0	
Post Total critical care time (not same day)	0	
Post Total other hospital visit time (not same day)	0	
Discharge management time	18	45
Total office visit time	68	

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	3.36	3.46
Intra-service	3.85	3.75
Post-service	2.85	2.92

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.42	3.64
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.55	3.61
Urgency of medical decision making	2.82	2.86

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.00	3.76
Physical effort required	3.62	3.43

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.18	3.07
Outcome depends on the skill and judgment of physician	3.71	3.81
Estimated risk of malpractice suit with poor outcome	2.86	3.00

ADDITIONAL RATIONALE

Total work for 299X3 *Arthroscopy, metacarpophalangeal joint, surgical; with reduction of displaced ulnar collateral ligament (eg, Stener lesion)* is only slightly less than the work for 29846 *Arthroscopy, wrist, surgical; excision and/or repair of triangular fibrocartilage and/or joint debridement*. Although 299X3 requires the creation of two portals as compared to four for 29846, the insertion of a small arthroscope and instruments into the MCP joint is more difficult given the small size of the MCP joint. Furthermore, because of the small size of the MCP joint, there is an increased risk of iatrogenic joint surface damage. The work of 299X3 involves the debridement of the ulnar aspect of the thumb MCP joint followed by the identification and reduction of the displaced ulnar collateral ligament. This work is slightly less complex than the work of 29846 which involves debridement of radio-carpal joint, ulno-carpal joint or triangular fibrocartilage. Additionally, the work to debride the MCP joint requires more intra-operative work than 29840 *Arthroscopy, wrist, diagnostic, with or without synovial biopsy*. We recommend the survey median RVW of 6.70 for 299X3. This value correctly estimates the slightly lower total work for 299X3 compared with 29846 and the higher work when compared with 29840.

Additional survey question and results:

"Where is this service performed (check all that apply)?"

Hospital Outpatient Hospital / Surgi-Center Office

FREQUENCY INFORMATION

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

29909 Unlisted procedure, arthroscopy (Medicare frequency = 780)

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

Specialty: hand/orthopaedic surgery Commonly Sometimes Rarely

3. 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: hand/orthopaedic surgery Frequency: 30
[New technology (smaller arthroscopes) recent training]

4. 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: hand/orthopaedic surgery Frequency: 2 (4% or less of national frequency)

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to a few medical centers.

CPT Code: 6482X1 (JJ33)

Global: 090

Recommended RVW: 8.75

CPT Descriptor: Sympathectomy; radial artery
(Do not report 69990 in addition to code 6482X1)

Survey Vignette (Typical Patient)

A 40-year-old female with Raynaud's disease is treated with a radial artery sympathectomy.

CLINICAL DESCRIPTION OF SERVICE:

Preoperative work:

- Imaging studies are carefully reviewed including X-rays, CT scans, and MRIs.
- Pre-operative laboratory tests are reviewed.
- Consultation is completed with the referring physician and other healthcare professionals
- The family and patient are apprised of the proposed surgery.
- The risks and complications associated with the surgery are discussed with the family.
- Informed consent is obtained.
- The surgeon goes to the operating room and verifies that all appropriate equipment is available
- The patient is brought to the operating room and placed on the operating table in the supine position
- The patient's bony prominences are padded.
- Thermal regulation drapes are applied
- The position of the extremities and head are checked and adjusted.
- The patient's involved arm is prepped and draped.
- A sterile tourniquet is applied to the proximal arm.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.

INTRA-SERVICE WORK: An incision is made over the radial artery. Careful dissection is carried out using loupe magnification. Care is taken to protect the branches of the superficial branches of the radial nerve. The radial artery is exposed. The operating microscope is then brought into position. The adventitia of the radial artery is meticulously removed, taking care not to injure the deeper structures of the radial artery. This dissection is carried out over a distance of approximately 4 to 6 cm. The dissection is carried out into the region of the snuff box. The superficial branch of the radial nerve must be respected in this area as do the adjacent extensor tendons. The tourniquet is released. Hemostasis is achieved. The wound is then closed in layers.

Postoperative work: in hospital

- Application of dressing and splint.
- Monitoring patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative imaging studies are reviewed
- Postoperative laboratory studies are reviewed
- Preparation of discharge records

Postoperative work: in office

- Post-discharge office visits for this procedure for 90 days
- Assessment of circulation, sensation and motor function of the operated extremity
- Removal of splint
- Assessment of surgical wound
- Redress wound
- Order physical / occupational therapy
- Supervision of rehabilitation

- Ordering and reviewing radiographs.
- Antibiotic and pain medication management.
- Removal of sutures
- Evaluation laboratory reports
- Communication with other health care professionals
- Communication with patient and family regarding progress.

SURVEY DATA

Presenter(s): Daniel J. Nagle, MD, FACS
Keith Brandt, MD

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

CPT: 6482X1

Sample Size: 110 **Resp n:** 42 **Resp %:** 38%

Sample Type: random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	8.00	9.50	10.25	10.37	16.00
Pre-Service			50		
Intra-Service	30	60	60	90	240

Post-Service Total Min CPT code / # of visits

Day of Surgery:

Immediate 30

Other 19 99231 ← should this be deleted?

After Day of Surgery:

Critical Care 0

Other Hospital 0

Dischg Day Mgmt 36 99238 LOS=1 *?

Office Visits 68 99213x1 99212x3

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
64820	Sympathectomy, digital arteries, with magnification, each digit	10.37	090

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

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT
	6482X1	64820 (RUC'94)
Pre-service time	50	55
Intra-service time	60	90
Same Day Immediate Post-service time	30	70
Same Day Other Post-service time	19	
Post Total critical care time (not same day)	0	
Post Total other hospital visit time (not same day)	0	
Discharge management time	36	
Total office visit time	68	52

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	3.72	3.81
Intra-service	4.00	4.16
Post-service	3.28	3.31

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.89	3.94
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.78	3.72
Urgency of medical decision making	3.19	3.22

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.11	4.28
Physical effort required	3.11	3.25

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.03	4.09
Outcome depends on the skill and judgment of physician	4.06	4.06
Estimated risk of malpractice suit with poor outcome	3.44	3.47

ADDITIONAL RATIONALE

There is 30 minutes less intraoperative time for 6482X1 compared with 64820. 6482X1 *Sympathectomy; radial artery* involves one artery, while 64820 *Sympathectomy, digital arteries, with magnification, each digit* involves two arteries in each digit. However, 6482X1 has more risk associated because damage to the radial artery may result in loss of several fingers. Pre-service and post-service work are essentially the same for both procedures. Because the only difference is less intraoperative time (albeit slightly more intraoperative and postoperative intensity for 6482X1), both the survey median and the survey 25th percentile may be too high relative to 64820. We are recommending an RVW of 8.75. This value was calculated by taking the estimated IWPUT (see table below) of 0.054 for 64820 times 30 minutes (=1.62 RVWs) and subtracting this from the current value of 64820 (10.37-1.62=8.75).

Building Block Analyses

64820

RVW**10.37**

Pre-op		Time	Intensity	(=time x intensity)
	Pre-op	55	0.0224	1.23
minus Pre-op RVW sum				1.23
Post-op		Time	Intensity	(=time x intensity)
	Immediate post	70	0.0224	1.57
	Subsequent visits:	Visit n	E/M RVW	(=n x E/M RVW)
	99238	1.0	1.28	1.28
	99213	1.0	0.65	0.65
	99212	1.0	0.43	0.43
	99211	2.0	0.17	<u>0.34</u>
minus Post-op RVW sum				4.27
equals Intra-op RVW		Time	IWPUT	
		90	0.054	4.87

Additional survey question and results:

"Where is this service performed (check all that apply)?"

Hospital Outpatient Hospital / Surgi-Center Office **FREQUENCY INFORMATION**

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

20999 Unlisted procedure, musculoskeletal system, general (Medicare frequency = 708)

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

Specialty: hand/orthopaedic surgery Commonly Sometimes Rarely
 Specialty: plastic surgery Commonly Sometimes Rarely

3. 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: hand/orthopaedic/plastic surgery Frequency: 150*
 *Unable to estimate exact split

4. 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: hand/orthopaedic/plastic surgery Frequency: 34* (23% of national frequency)
 *Unable to estimate exact split

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to surgeons/practices that specialize in surgery of the hand/upper extremity.

CPT Code: 6482X2 (JJ34)

Global: 090

Recommended RVW: 8.75

CPT Descriptor: Sympathectomy; ulnar artery
(Do not report 69990 in addition to code 6482X2)

Survey Vignette (Typical Patient)

A 40-year-old female with Raynaud's disease is treated with a ulnar artery sympathectomy.

CLINICAL DESCRIPTION OF SERVICE:

Preoperative work:

- Imaging studies are carefully reviewed including X-rays, CT scans, and MRIs.
- Pre-operative laboratory tests are reviewed.
- Consultation is completed with the referring physician and other healthcare professionals
- The family and patient are apprised of the proposed surgery.
- The risks and complications associated with the surgery are discussed with the family.
- Informed consent is obtained.
- The surgeon goes to the operating room and verifies that all appropriate equipment is available
- The patient is brought to the operating room and placed on the operating table in the supine position.
- The patient's bony prominences are padded.
- Thermal regulation drapes are applied
- The position of the extremities and head are checked and adjusted.
- The patient's involved arm is prepped and draped.
- A sterile tourniquet is applied to the proximal arm.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.

INTRA-SERVICE WORK: An incision is made over the ulnar artery extending into Guyon's canal. The incision is made so as not to cross the wrist flexion crease at a right angle. Careful dissection is carried out using loupe magnification. The ulnar nerve is carefully protected. The operating microscope is then brought into position. The adventitia of the ulnar artery is removed using microsurgical technique. This dissection extends from approximately 3 cm proximal to the wrist flexion crease to the superficial palmar arch. Once the sympathectomy is completed, the tourniquet is released and hemostasis is achieved. The wounds are irrigated and the skin is approximated in layers in the forearm and with interrupted sutures in the hand.

Postoperative work: in hospital

- Application of dressing and splint.
- Monitoring patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative imaging studies are reviewed
- Postoperative laboratory studies are reviewed
- Preparation of discharge records

Postoperative work: in office

- Post-discharge office visits for this procedure for 90 days
- Assessment of circulation, sensation and motor function of the operated extremity
- Removal of splint
- Assessment of surgical wound
- Redress wound
- Order physical / occupational therapy
- Supervision of rehabilitation

- Ordering and reviewing radiographs.
- Antibiotic and pain medication management.
- Removal of sutures
- Evaluation laboratory reports
- Communication with other health care professionals
- Communication with patient and family regarding progress.

SURVEY DATA

Presenter(s): Daniel J. Nagle, MD, FACS
Keith Brandt, MD

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

CPT: 6482X2

Sample Size: 110 **Resp n:** 42 **Resp %:** 38%

Sample Type: random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	8.00	9.50	10.25	10.37	16.00
Pre-Service			50		
Intra-Service	30	60	60	90	240

Post-Service	<u>Total Min</u>	<u>CPT code / # of visits</u>
<i>Day of Surgery:</i>		
Immediate	30	
Other	19	99231
<i>After Day of Surgery:</i>		
Critical Care	0	
Other Hospital	0	
Dischg Day Mgmt	36	99238 LOS=1
Office Visits	68	99213x1 99212x3

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
64820	Sympathectomy, digital arteries, with magnification, each digit	10.37	090

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

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT
	6482X2	64820 (RUC'94)
Pre-service time	50	55
Intra-service time	60	90
Same Day Immediate Post-service time	30	70
Same Day Other Post-service time	19	
Post Total critical care time (not same day)	0	
Post Total other hospital visit time (not same day)	0	
Discharge management time	36	
Total office visit time	68	52

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	3.70	3.79
Intra-service	3.95	4.15
Post-service	3.24	3.24

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.84	3.88
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.76	3.71
Urgency of medical decision making	3.18	3.21

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.11	4.29
Physical effort required	3.08	3.24

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.03	4.12
Outcome depends on the skill and judgment of physician	4.05	4.09
Estimated risk of malpractice suit with poor outcome	3.45	3.50

ADDITIONAL RATIONALE

There is 30 minutes less intraoperative time for 6482X2 compared with 64820. 6482X2 *Sympathectomy; ulnar artery* involves one artery, while 64820 *Sympathectomy, digital arteries, with magnification, each digit* involves two arteries in each digit. However, 6482X2 has more risk associated because damage to the ulnar artery may result in loss of several fingers. Pre-service and post-service work are essentially the same for both procedures. Because the only difference is less intraoperative time (albeit slightly more intraoperative and postoperative intensity for 6482X2), both the survey median and the survey 25th percentile may be too high relative to 64820. We are recommending an RVW of 8.75. This value was calculated by taking the estimated IWPOT (see table below) of 0.054 for 64820 times 30 minutes (=1.62 RVWs) and subtracting this from the current value of 64820 (10.37-1.62=8.75).

Building Block Analyses
64820

RVW
10.37

Pre-op		Time	Intensity	(=time x intensity)
	Pre-op	55	0.0224	1.23
minus Pre-op RVW sum				
				1.23
Post-op		Time	Intensity	(=time x intensity)
	Immediate post	70	0.0224	1.57
	Subsequent visits:	Visit n	E/M RVW	(=n x E/M RVW)
	99238	1.0	1.28	1.28
	99213	1.0	0.65	0.65
	99212	1.0	0.43	0.43
	99211	2.0	0.17	<u>0.34</u>
minus Post-op RVW sum				
				4.27
equals Intra-op RVW		Time	IWPUT	
		90	0.054	4.87

Additional survey question and results:

"Where is this service performed (check all that apply)?"

Hospital Outpatient Hospital / Surgi-Center Office

FREQUENCY INFORMATION

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

20999 Unlisted procedure, musculoskeletal system, general (Medicare frequency = 708)

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

Specialty: hand/orthopaedic surgery Commonly Sometimes Rarely
 Specialty: plastic surgery Commonly Sometimes Rarely

3. 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: hand/orthopaedic/plastic surgery Frequency: 150*
 *Unable to estimate exact split

4. 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: hand/orthopaedic/plastic surgery Frequency: 34* (23% of national frequency)
 *Unable to estimate exact split

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to surgeons/practices that specialize in surgery of the hand/upper extremity.

CPT Code: 6482X3 (JJ35)

Global: 090

Recommended RVW 10 37

CPT Descriptor: Sympathectomy; superficial palmar arch
(Do not report 69990 in addition to code 6482X3)

Survey Vignette (Typical Patient)

A 40-year-old female with Raynaud's disease is treated with a superficial palmar arch sympathectomy.

CLINICAL DESCRIPTION OF SERVICE:

Preoperative work:

- Imaging studies are carefully reviewed including X-rays, CT scans, and MRIs.
- Pre-operative laboratory tests are reviewed.
- Consultation is completed with the referring physician and other healthcare professionals
- The family and patient are apprised of the proposed surgery.
- The risks and complications associated with the surgery are discussed with the family.
- Informed consent is obtained.
- The surgeon goes to the operating room and verifies that all appropriate equipment is available
- The patient is brought to the operating room and placed on the operating table in the supine position.
- The patient's bony prominences are padded.
- Thermal regulation drapes are applied
- The position of the extremities and head are checked and adjusted.
- The patient's involved arm is prepped and draped.
- A sterile tourniquet is applied to the proximal arm.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.

INTRA-SERVICE WORK: An incision is made over the superficial palmar arch in the palm. Careful dissection is carried out using loupe magnification. The palmar fascia is incised. The digital neurovascular bundles are identified, as well as the superficial palmar arch. Great care is taken to protect these underlying structures. The operating microscope is brought into position. Microsurgical technique is then used to remove the adventitia from the superficial palmar arch. Once this is completed the tourniquet is released and hemostasis achieved. The wound is irrigated, and the wound is sutured.

Postoperative work: in hospital

- Application of dressing and splint.
- Monitoring patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative imaging studies are reviewed
- Postoperative laboratory studies are reviewed
- Preparation of discharge records

Postoperative work: in office

- Post-discharge office visits for this procedure for 90 days
- Assessment of circulation, sensation and motor function of the operated extremity
- Removal of splint
- Assessment of surgical wound
- Redress wound
- Order physical / occupational therapy
- Supervision of rehabilitation
- Ordering and reviewing radiographs.

- Antibiotic and pain medication management.
- Removal of sutures
- Evaluation laboratory reports
- Communication with other health care professionals
- Communication with patient and family regarding progress.

SURVEY DATA

Presenter(s): Daniel J. Nagle, MD, FACS
Keith Brandt, MD

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

CPT: 6482X3

Sample Size: 110 **Resp n:** 42 **Resp %:** 38%

Sample Type: random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	9.00	10.37	10.37	11.50	15.00
Pre-Service			50		
Intra-Service	30	60	90	120	240

Post-Service	<u>Total Min</u>	<u>CPT code / # of visits</u>
<i>Day of Surgery:</i>		
Immediate	30	
Other	19	99231
<i>After Day of Surgery:</i>		
Critical Care	0	
Other Hospital	0	
Dischg Day Mgmt	36	99238 LOS=1
Office Visits	68	99213x1 99212x3

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
64820	Sympathectomy, digital arteries, with magnification, each digit	10.37	090

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

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT
	6482X3	64820 (RUC'94)
Pre-service time	50	55
Intra-service time	90	90
Same Day Immediate Post-service time	30	70
Same Day Other Post-service time	19	
Post Total critical care time (not same day)	0	
Post Total other hospital visit time (not same day)	0	
Discharge management time	36	
Total office visit time	68	52

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	3.89	3.82
Intra-service	4.22	4.18
Post-service	3.32	3.21

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.06	3.91
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.78	3.76
Urgency of medical decision making	3.33	3.18

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.39	4.41
Physical effort required	3.31	3.18

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.27	4.12
Outcome depends on the skill and judgment of physician	4.16	4.09
Estimated risk of malpractice suit with poor outcome	3.59	3.50

ADDITIONAL RATIONALE

The intra-operative work for 6482X3 is equivalent to 64820. Intraoperatively, 6482X3 *Sympathectomy; superficial palmar arch* involves the exposure of the superficial palmar arch as it traverses the palm. The operative approach exposes the arch, the adjacent common and proper digital nerves and arteries and the underlying flexor tendons. 64820 *Sympathectomy, digital arteries, with magnification, each digit* involves the exposure of the two digital neurovascular bundles and the two tendons of the involved finger. Pre-service and post-service work are essentially the same for both procedures. We recommend the survey median RVW of 10.37 for 6482X3 to appropriately set these codes relative to each other.

Additional survey question and results:*"Where is this service performed (check all that apply)?"*Hospital Outpatient Hospital / Surgi-Center Office **FREQUENCY INFORMATION**

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

20999 Unlisted procedure, musculoskeletal system, general (Medicare frequency = 708)

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

Specialty: hand/orthopaedic surgery	Commonly <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Rarely <input checked="" type="checkbox"/>
Specialty: plastic surgery	Commonly <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Rarely <input checked="" type="checkbox"/>

3. 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: hand/orthopaedic/plastic surgery Frequency: 150

*Unable to estimate exact split

4. 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: hand/orthopaedic/plastic surgery Frequency: 34 (23% of national frequency)

*Unable to estimate exact split

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to surgeons/practices that specialize in surgery of the hand/upper extremity.

CPT Code: 2565X1 (JJ19)

Global: 090

Recommended RVW. 5 36

Descriptor: Percutaneous skeletal fixation of ulnar styloid fracture

Survey Vignette (Typical Patient)

A 60-year-old female is treated for an ulnar styloid fracture with percutaneous skeletal fixation.

CLINICAL DESCRIPTION OF SERVICE:

Preoperative work:

- Imaging studies are carefully reviewed including X-rays, CT scans, and MRIs.
- Pre-operative laboratory tests are reviewed.
- Consultation is completed with the referring physician and other healthcare professionals
- The family and patient are apprised of the proposed surgery.
- The risks and complications associated with the surgery are discussed with the family.
- Informed consent is obtained.
- The surgeon goes to the operating room and verifies that all appropriate equipment is available
- The patient is brought to the operating room and placed on the operating table in the supine position.
- The patient's bony prominences are padded.
- The position of the extremities and head are checked and adjusted.
- The patient's involved arm is prepped and draped.
- A sterile tourniquet is applied to the proximal arm.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.

INTRA-SERVICE WORK: The ulnar styloid fracture is identified using fluoroscopy. The ulnar styloid is manipulated back into position either with manual manipulation or with the help of a Kirschner wire that is placed in the ulnar styloid but not across the fracture. Once the alignment of the fracture fragments is satisfactory, the Kirschner wire is driven across the ulnar styloid into the distal ulna. Care must be taken to avoid injury to the adjacent neurovascular and tendinous structures. The adequacy of the reduction and the length of the wire are verified using fluoroscopy. The Kirschner wire is cut and a pin cap applied.

Postoperative work: in hospital

- Application of dressing and splint.
- Monitoring patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative imaging studies are reviewed
- Postoperative laboratory studies are reviewed
- Preparation of discharge records

Postoperative work: in office

- Post-discharge office visits for this procedure for 90 days
- Assessment of circulation, sensation and motor function of the operated extremity
- Removal of splint
- Assessment of surgical wound
- Redress wound
- Order physical / occupational therapy
- Supervision of rehabilitation
- Ordering and reviewing radiographs.
- Antibiotic and pain medication management.
- Evaluation laboratory reports

- Communication with other health care professionals
- Communication with patient and family regarding progress.

SURVEY DATA

Presenter(s): Daniel J. Nagle, MD, FACS
Keith Brandt, MD

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

CPT: 2565X1

Sample Size: 110 **Resp n:** 48 **Resp %:** 44%

Sample Type: random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	4.20	5.23	5.36	5.63	8.00
Pre-Service			50		
Intra-Service	20	28	30	45	90

Post-Service	<u>Total Min</u>	<u>CPT code / # of visits</u>
<i>Day of Surgery:</i>		
Immediate	20	
Other	18	99238 x 0.5 (same day surgery)
<i>After Day of Surgery:</i>		
Critical Care	0	
Other Hospital	0	
Dischg Day Mgmt	0	
Office Visits	68	99213x1 99212x3

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
26608	Percutaneous skeletal fixation of metacarpal fracture, each bone	5.36	090

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

TIME ESTIMATES (MEDIAN)	Svy CPT 2565X1	Ref CPT 26608
Pre-service time	50	no Hvd or RUC data avail
Intra-service time	30	
Same Day Immediate Post-service time	20	
Same Day Other Post-service time	0	
Post Total critical care time (not same day)	0	
Post Total other hospital visit time (not same day)	0	
Discharge management time	18	
Total office visit time	68	

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	2.70	2.58
Intra-service	2.88	2.79
Post-service	2.56	2.52

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	2.63	2.64
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.47	2.39
Urgency of medical decision making	2.67	2.67

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.23	3.09
Physical effort required	2.58	2.52

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	2.84	2.73
Outcome depends on the skill and judgment of physician	3.09	2.94
Estimated risk of malpractice suit with poor outcome	2.65	2.70

ADDITIONAL RATIONALE

The total work of 2565X1 *Percutaneous skeletal fixation of ulnar styloid fracture* is essentially equivalent to 26608 *Percutaneous skeletal fixation of metacarpal fracture, each bone*. Although there is no time and visit data for 26608, the survey respondents chose this code almost exclusively as the reference code, and the intensity/complexity measures validate the work equivalency. Another reference code 26706 *Percutaneous skeletal fixation of metacarpophalangeal dislocation, single, with manipulation* was only chosen by four surgeons, but can also be compared to 2565X1. Pre-service and post-service work for 2565X1 and 26706 should be equivalent, however, the Harvard data (which was predicted) reflects a lower pre and post work and higher intra work. This disparity may be the result of the difficulty in defining the start and finish of intra-work for percutaneous procedures such that some of the pre and post work has been included in the intra-work. The fact the total time for 2565X1 (186 minutes) is 35 minutes greater than the total time for 26706 (151 minutes) supports our recommendation that 2565X1 be valued slightly higher than 26706 (5.36 v 5.12). We recommend the survey median RVW of 5.36 for 2565X1, which is equal to 26608 and slightly more than 26706 to account for the similarities and differences in work as discussed above.

Additional survey question and results:

"Where is this service performed (check all that apply)?"

Hospital X

Outpatient Hospital / Surgi-Center X

Office

FREQUENCY INFORMATION

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

25999 Unlisted procedure, forearm or wrist (Medicare freq. = 324)

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

Specialty: hand/orthopaedic surgery	Commonly <u> </u>	Sometimes <u> </u>	Rarely <u> </u>
Specialty: plastic surgery	Commonly <u> </u>	Sometimes <u> </u>	Rarely <u> </u>

3. 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: hand/orthopaedic/plastic surgery* Frequency: 200

*Unable to estimate exact split, but a higher percentage is expected for hand/orthopaedic surgery compared with plastic surgery

4. 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: hand/orthopaedic/plastic surgery* Frequency: 20 (10% or less of national frequency)

*Unable to estimate exact split, but a higher percentage is expected for hand/orthopaedic surgery compared with plastic surgery

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to surgeons/practices that specialize in surgery of the hand/upper extremity.

CPT Code: 2565X3 (JJ20)

Global: 090

Recommended RVW: 7.60

Descriptor: Open treatment of ulnar styloid fracture

Survey Vignette (Typical Patient)

A 60-year-old female is treated for an ulnar styloid fracture with an open reduction and internal fixation.

CLINICAL DESCRIPTION OF SERVICE:

Preoperative work:

- Imaging studies are carefully reviewed including X-rays, CT scans, and MRIs.
- Pre-operative laboratory tests are reviewed.
- Consultation is completed with the referring physician and other healthcare professionals
- The family and patient are apprised of the proposed surgery.
- The risks and complications associated with the surgery are discussed with the family.
- Informed consent is obtained.
- The surgeon goes to the operating room and verifies that all appropriate equipment is available
- The patient is brought to the operating room and placed on the operating table in the supine position.
- The patient's bony prominences are padded.
- Thermal regulation drapes are applied
- The position of the extremities and head are checked and adjusted.
- The patient's involved arm is prepped and draped.
- A sterile tourniquet is applied to the proximal arm.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.

INTRA-SERVICE WORK: An incision is made over the ulnar styloid. Careful dissection is carried out using loupe magnification. Care is taken to protect the underlying neurovascular and tendinous structures. The periosteum overlying the fracture is identified. The periosteum is elevated. The fracture is cleared of any fibrinous material and clot. The fracture is then reduced and held in position while definitive fixation is achieved using pins, screws, or wire. The fracture reduction is verified both directly and with x-rays. The periosteum is repaired if possible. The overlying fascia is closed. The skin is closed in layers.

Postoperative work: in hospital

- Application of dressing and splint.
- Monitoring patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative imaging studies are reviewed
- Postoperative laboratory studies are reviewed
- Preparation of discharge records

Postoperative work: in office

- Post-discharge office visits for this procedure for 90 days
- Assessment of circulation, sensation and motor function of the operated extremity
- Removal of splint
- Assessment of surgical wound
- Redress wound
- Order physical / occupational therapy
- Supervision of rehabilitation
- Ordering and reviewing radiographs.
- Antibiotic and pain medication management.

- Removal of sutures
- Evaluation laboratory reports
- Communication with other health care professionals
- Communication with patient and family regarding progress.

SURVEY DATA

Presenter(s): Daniel J. Nagle, MD, FACS
Keith Brandt, MD

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

CPT: 2565X3

Sample Size: 110 **Resp n:** 52 **Resp %:** 47%

Sample Type: random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	4.90	7.00	7.60	7.60	10.00
Pre-Service			50		
Intra-Service	20	45	60	60	120

Post-Service	<u>Total Min</u>	<u>CPT code / # of visits</u>
<i>Day of Surgery:</i>		
Immediate	25	
Other	18	99238 x 0.5 (same day surgery)
<i>After Day of Surgery:</i>		
Critical Care	0	
Other Hospital	0	
Dischg Day Mgmt	0	
Office Visits	68	99213x1 99212x3

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
26665	Open treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), with or without internal or external fixation	7.60	090

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

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT
	2565X3	26665 (Hvd)
Pre-service time	50	35
Intra-service time	60	70
Same Day Immediate Post-service time	25	19
Same Day Other Post-service time	0	0
Post Total critical care time (not same day)	0	0
Post Total other hospital visit time (not same day)	0	10
Discharge management time	18	36
Total office visit time	68	52

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	2.89	2.91
Intra-service	3.28	3.31
Post-service	2.67	2.66

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	2.89	2.84
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.60	2.59
Urgency of medical decision making	2.81	2.88

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.74	3.68
Physical effort required	2.89	2.97

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.19	3.28
Outcome depends on the skill and judgment of physician	3.38	3.44
Estimated risk of malpractice suit with poor outcome	2.74	2.94

ADDITIONAL RATIONALE

The total work for 2565X3 *Open treatment of ulnar styloid fracture* is equivalent to 26665 *Open treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), with or without internal or external fixation*. Both procedures require an arthrotomy and mobilization of adjacent tendons and nerves. Both require the manipulation of small fracture fragments. A failure to repair the ulnar styloid fracture can lead to instability and arthrosis of the distal radio-ulnar joint while the failure to repair a Bennett fracture will lead to instability and arthrosis of the first CMC joint. The postoperative immobilization of a Bennett fracture includes a forearm based splint/cast while the postoperative immobilization of an ulnar styloid fracture requires a long arm splint/cast. We recommend the survey median RVW of 7.60 for 2565X3. This value is the same as 26665 and greater than 2565X1 *Percutaneous skeletal fixation of ulnar styloid fracture*.

Additional survey question and results:*"Where is this service performed (check all that apply)?"*Hospital Outpatient Hospital / Surgi-Center Office **FREQUENCY INFORMATION****1. How was this service previously reported (if unlisted code, please ensure that the medicare frequency for this unlisted code is reviewed)?**

25999 Unlisted procedure, forearm or wrist (Medicare freq. = 324)

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

Specialty: hand/orthopaedic surgery	Commonly	<u>Sometimes</u>	Rarely
Specialty: plastic surgery	Commonly	<u>Sometimes</u>	<u>Rarely</u>

3. 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: hand/orthopaedic/plastic surgery* Frequency: 400

*Unable to estimate exact split, but a higher percentage is expected for hand/orthopaedic surgery compared with plastic surgery

4. 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: hand/orthopaedic/plastic surgery* Frequency: 20 (5% or less of national frequency)

*Unable to estimate exact split, but a higher percentage is expected for hand/orthopaedic surgery compared with plastic surgery

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to surgeons/practices that specialize in surgery of the hand/upper extremity.

CPT Code: 2567X1 (JJ21)

Global: 090

Recommended RVW: 6.00

CPT Descriptor: Percutaneous skeletal fixation of distal radioulnar dislocation

Survey Vignette (Typical Patient)

A 55-year-old female is treated for a distal radio-ulnar dislocation with manipulation and percutaneous fixation.

CLINICAL DESCRIPTION OF SERVICE:

Preoperative work:

- Imaging studies are carefully reviewed including X-rays, CT scans, and MRIs.
- Pre-operative laboratory tests are reviewed.
- Consultation is completed with the referring physician and other healthcare professionals
- The family and patient are apprised of the proposed surgery.
- The risks and complications associated with the surgery are discussed with the family.
- Informed consent is obtained.
- The surgeon goes to the operating room and verifies that all appropriate equipment is available
- The patient is brought to the operating room and placed on the operating table in the supine position.
- The patient's bony prominences are padded.
- Thermal regulation drapes are applied
- The position of the extremities and head are checked and adjusted.
- The patient's involved arm is prepped and draped.
- A sterile tourniquet is applied to the proximal arm.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.

INTRA-SERVICE WORK: The distal radioulnar joint dislocation is manipulated under fluoroscopic control. Once the reduction is achieved, the reduction is held with the arm in either supination or pronation depending upon the type of dislocation. Pins are then driven across the distal radioulnar joint taking care to avoid injury to the overlying neurovascular and tendinous structures. The adequacy of the reduction and the position of the pins are verified using fluoroscopy or standard x-rays. The pins are cut and capped or placed beneath the skin.

Postoperative work: in hospital

- Application of dressing and splint.
- Monitoring patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative imaging studies are reviewed
- Postoperative laboratory studies are reviewed
- Preparation of discharge records

Postoperative work: in office

- Post-discharge office visits for this procedure for 90 days
- Assessment of circulation, sensation and motor function of the operated extremity
- Removal of splint
- Assessment of surgical wound
- Redress wound
- Order physical / occupational therapy
- Supervision of rehabilitation
- Ordering and reviewing radiographs.
- Antibiotic and pain medication management.
- Evaluation laboratory reports

- Communication with other health care professionals
- Communication with patient and family regarding progress.

SURVEY DATA

Presenter(s): Daniel J. Nagle, MD, FACS
keith Brandt, MD

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

CPT: 2567X1

Sample Size: 110 **Resp n:** 47 **Resp %:** 43%

Sample Type: random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	5.00	5.40	6.00	6.50	10.00
Pre-Service			50		
Intra-Service	20	35	45	45	90

Post-Service	<u>Total Min</u>	<u>CPT code / # of visits</u>
<i>Day of Surgery:</i>		
Immediate	25	
Other	18	99238 x 0.5 (same day surgery)
<i>After Day of Surgery:</i>		
Critical Care	0	
Other Hospital	0	
Dischg Day Mgmt	0	
Office Visits	68	99213x1 99212x3

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
26706	Percutaneous skeletal fixation of metacarpophalangeal dislocation, single, with manipulation	5.12	090

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

TIME ESTIMATES (MEDIAN)	Svy CPT 2567X1	Ref CPT 26706 (Hvd)
Pre-service time	50	35
Intra-service time	45	44
Same Day Immediate Post-service time	25	12
Same Day Other Post-service time	0	
Post Total critical care time (not same day)	0	
Post Total other hospital visit time (not same day)	0	
Discharge management time	18	
Total office visit time	68	60

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	3.24	2.85
Intra-service	3.45	2.95
Post-service	3.12	2.85

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.27	2.76
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.85	2.48
Urgency of medical decision making	3.12	3.05

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.43	2.95
Physical effort required	2.59	2.35

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.64	3.05
Outcome depends on the skill and judgment of physician	3.20	2.95
Estimated risk of malpractice suit with poor outcome	3.05	2.90

ADDITIONAL RATIONALE

2567X1 *Percutaneous skeletal fixation of distal radioulnar dislocation* is slightly more work than 26706 *Percutaneous skeletal fixation of metacarpophalangeal dislocation, single, with manipulation*. Pre-operative evaluation for 2567X1 is more extensive than for 26706, as a distal radio-ulnar joint dislocation can be associated with injuries to the radius and/or ulna, the interosseous membrane, and the elbow joint. The percutaneous fixation of an MCP joint dislocation and a distal radio-ulnar joint dislocation are similar in that both place tendinous structures at risk. However, 2567X1 places the ulnar neurovascular bundle and its branches at risk, while 26706 is carried out through planes that are relatively free of significant neurovascular structures. The postoperative immobilization for 2567X1 includes a long arm splint/cast, while the postoperative immobilization for 26706 includes a hand based splint/cast. We recommend the survey median RVW of 6.00 for 2567X1. This value is greater than 26706 and accounts for the differences discussed above.

Additional survey question and results:*"Where is this service performed (check all that apply)?"*Hospital Outpatient Hospital / Surgi-Center Office **FREQUENCY INFORMATION**

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

25999 Unlisted procedure, forearm or wrist (Medicare freq. = 324)

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

Specialty: hand/orthopaedic surgery	Commonly <input type="checkbox"/>	Sometimes <input checked="" type="checkbox"/>	Rarely <input type="checkbox"/>
Specialty: plastic surgery	Commonly <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Rarely <input checked="" type="checkbox"/>

3. 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: hand/orthopaedic/plastic surgery* Frequency: 200

*Unable to estimate exact split, but a higher percentage is expected for hand/orthopaedic surgery compared with plastic surgery

4. 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: hand/orthopaedic/plastic surgery* Frequency: 10 (5% or less of national frequency)

*Unable to estimate exact split, but a higher percentage is expected for hand/orthopaedic surgery compared with plastic surgery

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to surgeons/practices that specialize in surgery of the hand/upper extremity.

CPT Code: 2502X1 (JJ11)

Global: 090

Recommended RVW: 9 50

Descriptor: Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment; without debridement of nonviable muscle and/or nerve

Survey Vignette (Typical Patient)

A 7-year-old boy presents with a displaced supracondylar fracture. Compartment pressures are increased both dorsally and volarly. A decompression fasciotomy is performed of the flexor and extensor compartments.

CLINICAL DESCRIPTION OF SERVICE:

Preoperative work:

- Imaging studies are carefully reviewed.
- Pre-operative laboratory tests are reviewed.
- Consultation is completed with the referring physician and other healthcare professionals
- The family and patient are apprised of the proposed surgery.
- The risks and complications associated with the surgery are discussed with the patient and family.
- Informed consent is obtained.
- The surgeon goes to the operating room and verifies that all appropriate equipment is available
- The patient is brought to the operating room and placed on the operating table in the supine position.
- The patient's bony prominences are padded.
- Thermal regulation drapes are applied
- The position of the extremities and head are checked and adjusted.
- The patient's involved arm is prepped and draped.
- A sterile tourniquet is applied to the proximal arm.

INTER-SERVICE WORK: A curvilinear incision is made extending from the antecubital fossa across the volar aspect of the forearm and extending into the hand. Dissection is carried out carefully to avoid any injury to the underlying neurovascular structures. The fascia of the volar surface of the forearm is released. The transverse carpal ligament is also released, as is Guyon's canal. Care is taken to protect the ulnar neurovascular bundles as well as the median nerve. The distal flap is closed to cover the median nerve after the fasciotomy has been completed. The rest of the wounds are left open. The arm is then rotated to expose its dorsal surface. A longitudinal incision is made. The incision is carried down to the fascia, again taking care to protect any underlying neurovascular structures. The fascia of the dorsal compartment is incised to decompress the extensor compartments. All wounds are left open.

Postoperative work: in hospital

- Application of dressing and splint.
- Monitoring patient stabilization in the recovery room and during the hospitalization.
- Consultation with the family and patient regarding the surgery and postoperative regimen immediately after surgery and during the hospital stay.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative imaging studies are reviewed
- Postoperative laboratory studies are reviewed
- The circulation, sensation and motor function of the operated extremity are assessed at regular intervals during hospitalization.
- Drains are removed
- Operative dressing is changed.
- Laboratory tests are ordered
- Laboratory test results are reviewed
- Preparation of hospital discharge documents including orders and prescriptions.
- Coordination of followup appointments with

- Review of postoperative instructions with patient and family

Postoperative work: in office

- Post-discharge office visits for this procedure for 90 days
- Assessment of circulation, sensation and motor function of the operated extremity
- Removal of splint
- Assessment of surgical wound
- Redress wound
- Order physical / occupational therapy
- Supervision of rehabilitation
- Ordering and reviewing radiographs.
- Antibiotic and pain medication management.
- Removal of sutures
- Evaluation laboratory reports
- Communication with other health care professionals
- Communication with patient and family regarding progress.

Note: Secondary procedures to close the wounds are not included in the work described by 2502X1.

SURVEY DATA

Presenter(s): Daniel J. Nagle, MD, FACS
Keith Brandt, MD

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

CPT: 2502X1

Sample Size: 110 **Resp n:** 40 **Resp %:** 36%

Sample Type: random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	8.00	8.95	9.50	11.00	12.96
Pre-Service			60		
Intra-Service	45	60	70	80	120

Post-Service	<u>Total Min</u>	<u>CPT code / # of visits</u>	
<i>Day of Surgery:</i>			
Immediate	30		
Other	19	99231	
<i>After Day of Surgery:</i>			
Critical Care	0		
Other Hospital	60	99232x2	LOS = 3
Dischg Day Mgmt	36	99238	
Office Visits	83	99213x1 99212x4	

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
25020	Decompression fasciotomy, forearm and/or wrist, flexor OR extensor compartment; without debridement of nonviable muscle and/or nerve	5.92	090

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

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT
	2502X1	25020 (Hvd)
Pre-service time	60	45
Intra-service time	70	54
Same Day Immediate Post-service time	30	19
Same Day Other Post-service time	19	0
Post Total critical care time (not same day)	0	0
Post Total other hospital visit time (not same day)	60	0
Discharge management time	36	36
Total office visit time	83	45

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	4.24	3.85
Intra-service	3.76	3.42
Post-service	3.74	3.38

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.76	3.69
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.84	3.62
Urgency of medical decision making	4.82	4.65

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.80	3.54
Physical effort required	3.18	3.08

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.64	4.46
Outcome depends on the skill and judgment of physician	4.36	4.38
Estimated risk of malpractice suit with poor outcome	4.58	4.62

ADDITIONAL RATIONALE

2502X1 *Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment; without debridement of nonviable muscle and/or nerve* requires more pre-service, intra-service, and post-service time and is intraoperatively and postoperatively more intense than 25020 (flexor OR extensor). Currently, it is possible to report 25999 (*unlisted*) or 25020-22 with 25020-51 for cases requiring decompression of both compartments, but this does not permit accurate tracking because 25020-51 may be secondary to another procedure. Also, using multiple procedure reporting does not account for the increased complexity of this patient (compared with a patient requiring 25020). We recommend the survey median RVW of 9.50 for 2502X1. This value reasonably captures the increased work and intensity involved in the typical patient requiring decompression of two compartments compared with 25020.

We also would like to indicate that we disagree with the Harvard postoperative hospital time data for 25020. These patients will typically require a hospital stay of at least two days to permit the surgeon to monitor the wound and neurovascular status of the patient. We note that Harvard surveyed orthopaedic surgeons (which did not include hand surgeons) for intraoperative time only and that pre-operative and post-operative data was predicted. We do not know the anchor code used to predict the pre- and post-times, but believe it was incorrect because the data does not correctly reflect the hospital work required for these patients. Additionally, we note that using the survey median RVW and a building block comparison *still* results in an intra-RVW of 1.07 and an input of 0.015, which significantly understates the work involved in 70 minutes of surgery.

Additional survey question and results:

"Where is this service performed (check all that apply)?"

Hospital X Outpatient Hospital / Surgi-Center Office

FREQUENCY INFORMATION

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

25999 Unlisted procedure, forearm or wrist (Medicare freq. = 324)
 25020-22 + 25020-51 Decompression fasciotomy, forearm and/or wrist, flexor OR extensor compartment; without debridement of nonviable muscle and/or nerve (Medicare frequency for 25020-22 = 0 25020-51 = 127)

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

Specialty: hand/orthopaedic surgery	Commonly <u> </u>	Sometimes <u> </u>	Rarely <u> </u>
Specialty: plastic surgery	Commonly <u> </u>	Sometimes <u> </u>	Rarely <u> </u>

3. 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: hand/orthopaedic/plastic surgery* Frequency: 200

*Unable to estimate exact split, but a higher percentage is expected for hand/orthopaedic surgery compared with plastic surgery

4. 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: hand/orthopaedic/plastic surgery* Frequency: 20 (10% of national frequency)

*Unable to estimate exact split, but a higher percentage is expected for hand/orthopaedic surgery compared with plastic surgery

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to a few medical centers.

CPT Code: 2502X2 (JJ12)

Global: 090

Recommended RVW 18 48

RUC Recommended RVW 16 54

Descriptor: Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment; with debridement of nonviable muscle and/or nerve

Survey Vignette (Typical Patient)

A 7-year-old boy presents with a displaced supracondylar fracture. Compartment pressures are increased both dorsally and volarly. A decompression fasciotomy is performed of the flexor and extensor compartments and all non-viable muscle and nerve tissue is debrided.

CLINICAL DESCRIPTION OF SERVICE:

Preoperative work:

- Imaging studies are carefully reviewed.
- Pre-operative laboratory tests are reviewed.
- Consultation is completed with the referring physician and other healthcare professionals
- The family and patient are apprised of the proposed surgery.
- The risks and complications associated with the surgery are discussed with the patient and family.
- Informed consent is obtained.
- The surgeon goes to the operating room and verifies that all appropriate equipment is available
- The patient is brought to the operating room and placed on the operating table in the supine position.
- The patient's bony prominences are padded.
- Thermal regulation drapes are applied
- The position of the extremities and head are checked and adjusted.
- The patient's involved arm is prepped and draped.
- A sterile tourniquet is applied to the proximal arm.

INTER-SERVICE WORK: A curvilinear zig-zag incision is made extending from the antecubital fossa across the volar aspect of the forearm and extending into the hand. Dissection is carried out carefully to avoid any injury to the underlying neurovascular structures. The fascia of the volar surface of the forearm is released. The transverse carpal ligament is also released as is Guyon's canal. Care is taken to protect the ulnar neurovascular bundles as well as the median nerve. Any nonviable muscle or other tissues are excised down to viable tissue. The distal flap is closed to cover the median nerve after the fasciotomy has been completed. The rest of the wounds are left open. The arm is then rotated so as to expose its dorsal surface. A longitudinal incision is made. The incision is carried down to the fascia, again taking care to protect any underlying neurovascular structures. The fascia of the dorsal compartment is incised to decompress the extensor compartments. Any nonviable muscle or other tissues are excised down to viable tissue. All wounds are left open.

Postoperative work: in hospital; in operating & recovery rooms

- Application of dressing and splint.
- Monitoring patient stabilization in the recovery room and during the hospitalization.
- Consultation with the family and patient regarding the surgery and postoperative regimen immediately after surgery and during the hospital stay.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative imaging studies are reviewed
- Postoperative laboratory studies are reviewed
- The circulation, sensation and motor function of the operated extremity are assessed at regular intervals during hospitalization.
- Drains are removed
- Operative dressing is changed.
- Laboratory tests are ordered
- Laboratory test results are reviewed

- Preparation of hospital discharge documents including orders and prescriptions.
- Coordination of followup appointments with
- Review of postoperative instructions with patient and family

Postoperative work: in office

- Post-discharge office visits for this procedure for 90 days
- Assessment of circulation, sensation and motor function of the operated extremity
- Removal of splint
- Assessment of surgical wound
- Redress wound
- Order physical / occupational therapy
- Supervision of rehabilitation
- Ordering and reviewing radiographs.
- Antibiotic and pain medication management.
- Removal of sutures
- Evaluation laboratory reports
- Communication with other health care professionals
- Communication with patient and family regarding progress.

Note: Secondary procedures to close the wounds are not included in the work described by 2502X1.

SURVEY DATA

Presenter(s): Daniel J. Nagle, MD, FACS
Keith Brandt, MD

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

CPT: 2502X2

Sample Size: 110 **Resp n:** 37 **Resp %:** 34%

Sample Type: random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	13.15	15.00	18.48	20.00	26.00
Pre-Service			60		
Intra-Service	75	90	125	150	180

Post-Service	<u>Total Min</u>	<u>CPT code / # of visits</u>	
<i>Day of Surgery:</i>			
Immediate	30		
Other	19	99231	
<i>After Day of Surgery:</i>			
Critical Care	0		
Other Hospital	79	99232x2 99231x1	LOS = 5
Dischg Day Mgmt	36	99238	
Office Visits	83	99213x1 99212x4	

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
25023	Decompression fasciotomy, forearm and/or wrist, flexor OR extensor compartment; with debridement of nonviable muscle and/or nerve	12.96	090

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

TIME ESTIMATES (MEDIAN)	Svy CPT 2502X2	Ref CPT 25023 (Hvd)
Pre-service time	60	52
Intra-service time	125	100
Same Day Immediate Post-service time	30	28
Same Day Other Post-service time	19	104
Post Total critical care time (not same day)	0	
Post Total other hospital visit time (not same day)	79	
Discharge management time	36	36
Total office visit time	83	68

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	4.37	4.21
Intra-service	4.37	4.14
Post-service	4.37	3.93

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.88	3.78
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.84	3.66
Urgency of medical decision making	4.91	4.88

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.32	4.13
Physical effort required	3.50	3.31

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.88	4.78
Outcome depends on the skill and judgment of physician	4.53	4.50
Estimated risk of malpractice suit with poor outcome	4.66	4.56

ADDITIONAL RATIONALE

2502X2 Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment; with debridement of nonviable muscle and/or nerve requires more pre-service, intra-service, and post-service time and is intraoperatively and postoperatively more intense than 25023 (flexor OR extensor). Currently, it is possible to report 25999 or 25023-22 with 25023-51 for cases requiring decompression of both compartments, but this does not permit accurate tracking because 25023-51 may actually be secondary to another procedure (therefore 25023 would simply reflect that 25023 was associated with another procedure and not the decompression of a second compartment). Also, using multiple procedure reporting does not account for the increased complexity of this patient (compared with a patient requiring 25023). We recommend the survey median RVW of 18.48 for 2502X2. This value reasonably captures the increased work and intensity involved in the typical patient requiring decompression of two compartments and debridement compared with 25023.

Additional survey question and results:*"Where is this service performed (check all that apply)?"*Hospital Outpatient Hospital / Surgi-Center Office **FREQUENCY INFORMATION****1. How was this service previously reported (if unlisted code, please ensure that the medicare frequency for this unlisted code is reviewed)?**

25999 Unlisted procedure, forearm or wrist (Medicare freq. = 324)
 25023-22 + 25023-51 Decompression fasciotomy, forearm and/or wrist, flexor OR extensor compartment;
 without debridement of nonviable muscle and/or nerve (Medicare frequency for 25023-22 = 0 25023-51 = 49)

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

Specialty: hand/orthopaedic surgery Commonly Sometimes Rarely
 Specialty: plastic surgery Commonly Sometimes Rarely

3. 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: hand/orthopaedic/plastic surgery* Frequency: 150

*Unable to estimate exact split, but a higher percentage is expected for hand/orthopaedic surgery compared with plastic surgery

4. 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: hand/orthopaedic/plastic surgery* Frequency: 15 (10% of national frequency)

*Unable to estimate exact split, but a higher percentage is expected for hand/orthopaedic surgery compared with plastic surgery

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to a few medical centers.

CPT Code: 2539X1 (JJ14)

Global: 090

Recommended RVW: 10 40

Descriptor: Osteoplasty, carpal bone, shortening

Survey Vignette (Typical Patient)

A 45-year-old male with an ulnar plus variance undergoes a capitate shortening for early Kienböck's disease.

CLINICAL DESCRIPTION OF SERVICE:

Preoperative work:

- Imaging studies are carefully reviewed including X-rays, CT scans, and MRIs.
- Pre-operative laboratory tests are reviewed.
- Consultation is completed with the referring physician and other healthcare professionals
- The family and patient are apprised of the proposed surgery.
- The risks and complications associated with the surgery are discussed with the family.
- Informed consent is obtained.
- The surgeon goes to the operating room and verifies that all appropriate equipment is available
- The patient is brought to the operating room and placed on the operating table in the supine position.
- The patient's bony prominences are padded.
- Thermal regulation drapes are applied
- The position of the extremities and head are checked and adjusted.
- The patient's involved arm is prepped and draped.
- A sterile tourniquet is applied to the proximal arm.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.

INTER-SERVICE WORK: A dorsal incision is made over the capitate. Careful dissection is carried down to the extensor mechanism. Care is taken to protect the neurovascular structures dorsally. The fourth dorsal compartment tendons are retracted out of the field. The dorsal capsule of the wrist is opened. The capitulunate joint is exposed by elevating the radial and ulnar capsular flaps. Two Kirschner wires are driven across the capitate from dorsal to palmar to indicate the level of the osteotomy. A fluoroscopy is used to verify the position of the K-wires. The osteotomy is carried out under fluoroscopic control. An osteotome is then used to shorten the capitate by approximately 2 mm. Care is taken to not injure the adjacent articular surfaces or penetrate the carpal tunnel. The proximal pole of the capitate is then re-approximated to the distal portion of the body of the capitate. Internal fixation using Kirschner wires, staples, or other means are used to fix the capitate fragments. The capsule is repaired. X-rays are taken during the surgery to verify the shortening has been accomplished. The skin is then approximated in layers.

Postoperative work: in hospital

- Application of dressing and splint.
- Monitoring patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative imaging studies are reviewed
- Postoperative laboratory studies are reviewed
- Preparation of discharge records

Postoperative work: in office

- Post-discharge office visits for this procedure for 90 days
- Assessment of circulation, sensation and motor function of the operated extremity
- Removal of splint
- Assessment of surgical wound

- Redress wound
- Order physical / occupational therapy
- Supervision of rehabilitation
- Ordering and reviewing radiographs.
- Antibiotic and pain medication management.
- Removal of sutures
- Evaluation laboratory reports
- Communication with other health care professionals
- Communication with patient and family regarding progress.

SURVEY DATA

Presenter(s): Daniel J. Nagle, MD, FACS
Keith Brandt, MD

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

CPT: 2539X1

Sample Size: 110 **Resp n:** 27 **Resp %:** 25%

Sample Type: random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	7.60	9.36	10.40	10.47	12.50
Pre-Service			50		
Intra-Service	45	70	90	95	120
Post-Service	Total Min	CPT code / # of visits			
<i>Day of Surgery:</i>					
Immediate	20				
Other	18	99238 x 0.5 (same day surgery)			
<i>After Day of Surgery:</i>					
Critical Care	0				
Other Hospital	0				
Dischg Day Mgmt	0				
Office Visits	68	99213x1 99212x3			

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
28302	Osteotomy; talus	9.55	090

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

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT
	2539X1	28302 (Hvd)
Pre-service time	50	48
Intra-service time	90	57
Same Day Immediate Post-service time	30	22
Same Day Other Post-service time	0	8
Post Total critical care time (not same day)	0	
Post Total other hospital visit time (not same day)	0	
Discharge management time	18	36
Total office visit time	68	60

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	3.60	3.19
Intra-service	3.68	3.69
Post-service	3.20	3.25

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.88	3.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.81	3.56
Urgency of medical decision making	2.88	2.88

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.73	3.81
Physical effort required	3.31	3.38

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.62	3.56
Outcome depends on the skill and judgment of physician	4.00	3.88
Estimated risk of malpractice suit with poor outcome	3.19	3.06

ADDITIONAL RATIONALE

2539X1 *Osteoplasty, carpal bone, shortening* is an intra-articular procedure that demands accurate restoration of the capitate articular surface. This precision requires more intraoperative work than 28302 *Osteotomy; talus*, which is extra-articular. Both procedures are carried out near neurovascular and tendinous structures that must be protected. Both procedures require internal fixation and cast immobilization. Both procedures require management and monitoring of postoperative therapy. We recommend the survey median RVW of 10.40 for 2539X1, which is slightly higher than the value for 28302 to account for the additional intraoperative work.

Additional survey question and results:

"Where is this service performed (check all that apply)?"

Hospital X Outpatient Hospital / Surgi-Center X Office

FREQUENCY INFORMATION

for this unlisted code is reviewed)?

25999 Unlisted procedure, forearm or wrist (Medicare freq. = 324)

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

Specialty: hand/orthopaedic surgery	Commonly <u> </u>	Sometimes <u> </u>	Rarely <u> </u>
Specialty: plastic surgery	Commonly <u> </u>	Sometimes <u> </u>	Rarely <u> </u>

3. 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: hand/orthopaedic/plastic surgery* Frequency: 100

*Unable to estimate exact split, but a higher percentage is expected for hand/orthopaedic surgery compared with plastic surgery

4. 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: hand/orthopaedic/plastic surgery* Frequency: 6 (6% or less of national frequency)

*Unable to estimate exact split, but a higher percentage is expected for hand/orthopaedic surgery compared with plastic surgery

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to surgeons/practices that specialize in surgery of the hand/upper extremity.

CPT Code: 2543X1 (JJ15)

Global: 090

Recommended RVW 9.25

Descriptor: Insertion of vascular pedicle into carpal bone (eg, Harii procedure)

Survey Vignette (Typical Patient)

A 25-year-old male presents with Kienböck's disease. The terminal branches of the posterior interosseous artery and vein are implanted in the lunate.

CLINICAL DESCRIPTION OF SERVICE:

Preoperative work:

- Imaging studies are carefully reviewed including X-rays, CT scans, and MRIs.
- Pre-operative laboratory tests are reviewed.
- Consultation is completed with the referring physician and other healthcare professionals
- The family and patient are apprised of the proposed surgery.
- The risks and complications associated with the surgery are discussed with the family.
- Informed consent is obtained.
- The surgeon goes to the operating room and verifies that all appropriate equipment is available
- The patient is brought to the operating room and placed on the operating table in the supine position.
- The patient's bony prominences are padded.
- Thermal regulation drapes are applied
- The position of the extremities and head are checked and adjusted.
- The patient's involved arm is prepped and draped.
- A sterile tourniquet is applied to the proximal arm.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.

INTER-SERVICE WORK: An incision is made over the wrist and distal forearm. The fourth dorsal compartment tendons are retracted out on the field. The terminal branches of the posterior interosseous artery and vein are identified. The vein and artery are ligated distally, transected distal to the ligature and then dissected proximally under loupe magnification. The position of the lunate is verified using intraoperative x-ray. A capsulotomy is made over the dorsal aspect of the lunate. The dorsal aspect of the lunate is identified. A drill hole is made in the dorsal aspect of the lunate. The drill penetrates to the mid substance of the lunate. The posterior interosseous vein and artery are then placed in the cavity in the lunate. They are secured to the overlying periosteum using 9/0 nylon. The capsule is repaired and the skin is then repaired in layers.

Postoperative work: in hospital

- Application of dressing and splint.
- Monitoring patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative imaging studies are reviewed
- Postoperative laboratory studies are reviewed
- Preparation of discharge records

Postoperative work: in office

- Post-discharge office visits for this procedure for 90 days
- Assessment of circulation, sensation and motor function of the operated extremity
- Removal of splint
- Assessment of surgical wound
- Redress wound
- Order physical / occupational therapy

- Supervision of rehabilitation
- Ordering and reviewing radiographs.
- Antibiotic and pain medication management.
- Removal of sutures
- Evaluation laboratory reports
- Communication with other health care professionals
- Communication with patient and family regarding progress.

SURVEY DATA

Presenter(s): Daniel J. Nagle, MD, FACS
Keith Brandt, MD

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

CPT: 2543X1

Sample Size: 75 **Resp n:** 25 **Resp %:** 33%

Sample Type: random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	9.00	9.25	10.25	11.41	13.50
Pre-Service			50		
Intra-Service	45	90	100	120	120
Post-Service	<u>Total Min</u>	<u>CPT code / # of visits</u>			
<i>Day of Surgery:</i>					
Immediate	30				
Other	18	99238 x 0.5 (same day surgery)			
<i>After Day of Surgery:</i>					
Critical Care	0				
Other Hospital	0				
Dischg Day Mgmt	0				
Office Visits	68	99213x1 99212x3			

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
15740	Flap; island pedicle	10.25	090

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

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT
	2543X1	15740 (Hvd)
Pre-service time	50	54
Intra-service time	100	118
Same Day Immediate Post-service time	25	32
Same Day Other Post-service time	0	19
Post Total critical care time (not same day)	0	
Post Total other hospital visit time (not same day)	0	
Discharge management time	18	36
Total office visit time	68	28

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	3.87	3.56
Intra-service	4.17	3.94
Post-service	3.61	3.56

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.26	3.81
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.96	3.50
Urgency of medical decision making	3.13	3.19

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.43	4.13
Physical effort required	3.65	3.38

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.65	3.56
Outcome depends on the skill and judgment of physician	4.04	4.00
Estimated risk of malpractice suit with poor outcome	3.22	3.00

ADDITIONAL RATIONALE

The concensus committee reviewing the data for 2543X1 *Insertion of vascular pedicle into carpal bone (eg, Harii procedure)* believe the survey respondents overestimated the RVW by comparing the work to 15740 *Flap; island pedicle*. We recognize that 15740 is "generic" in that the flap can be quite variable and the survey respondents to this survey were not offered the vignette that resulted in the Harvard data shown above (ie, a patient that plastic surgeons considered as the "typical" patient requiring 15740). We recommend the 25th percentil RVW of 9.25 for 2543X1. This value correctly places the Harii procedure lower than 15740 for total work.

Additional survey question and results:

"Where is this service performed (check all that apply)?"

Hospital X Outpatient Hospital / Surgi-Center X Office

FREQUENCY INFORMATION

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

25999 Unlisted procedure, forearm or wrist (Medicare freq. = 324)

15750 Flap; neurovascular pedicle (Medicare freq. = 265)

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

Specialty: hand/orthopaedic surgery Commonly Sometimes Rarely X

Specialty: plastic surgery Commonly Sometimes Rarely X

3. 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: hand/orthopaedic/plastic surgery* Frequency: 50

*Unable to estimate exact split, but a higher percentage is expected for hand/orthopaedic surgery compared with plastic surgery

4. 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: hand/orthopaedic/plastic surgery* Frequency: 2 (4% or less of national frequency)

*Unable to estimate exact split, but a higher percentage is expected for hand/orthopaedic surgery compared with plastic surgery

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to surgeons/practices that specialize in surgery of the hand/upper extremity at a few medical centers.

CPT Code: 2433X1 (JJ4)

Global: 090

Recommended RVW: 7 45

CPT Descriptor: Tenolysis, triceps

Survey Vignette (Typical Patient)

A 20-year-old football player develops scarring around the triceps from repeated trauma, which limits elbow motion. A tenolysis is performed to release the triceps contracture.

CLINICAL DESCRIPTION OF SERVICE:

Preoperative work:

- Imaging studies are carefully reviewed including X-rays, CT scans, and MRIs.
- Pre-operative laboratory tests are reviewed.
- Consultation is completed with the referring physician and other healthcare professionals
- The family and patient are apprised of the proposed surgery.
- The risks and complications associated with the surgery are discussed with the patient and family
- Informed consent is obtained.
- The surgeon goes to the operating room and verifies that all appropriate equipment is available
- The patient is brought to the operating room and placed on the operating table in the supine position.
- The patient's bony prominences are padded.
- Thermal regulation drapes are applied
- The position of the extremities and head are checked and adjusted.
- The patient's involved arm is prepped and draped.
- A sterile tourniquet is applied to the proximal arm.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- The patient's arm is brought across the chest.

INTRA-SERVICE WORK: A posterior distal arm incision is made centered over the triceps. The ulnar nerve is identified and protected. The interval between the medial triceps and humerus is identified and developed. The lateral aspect of the triceps is identified. The interval between the lateral triceps and the humerus is identified. The radial nerve is identified and protected. Any adhesions between the humerus and triceps are lysed. The adhesions are approached from the lateral and medial aspects of the triceps. The dissection carried distally to the posterior elbow joint. Any adhesions between the triceps and the posterior elbow joint are lysed. The elbow is taken through a full range of motion and further lysis completed as needed. The wound is irrigated and the skin is closed in layers.

Postoperative work: in hospital

- Application of dressing and splint.
- Monitoring patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative imaging studies are reviewed
- Postoperative laboratory studies are reviewed
- Preparation of discharge records

Postoperative work: in office

- Post-discharge office visits for this procedure for 90 days
- Assessment of circulation, sensation and motor function of the operated extremity
- Removal of splint
- Assessment of surgical wound
- Redress wound

- Order physical / occupational therapy
- Supervision of rehabilitation
- Ordering and reviewing radiographs.
- Antibiotic and pain medication management.
- Removal of sutures
- Evaluation laboratory reports
- Communication with other health care professionals
- Communication with patient and family regarding progress.

SURVEY DATA**Presenter(s):** Daniel J. Nagle, MD, FACS**Specialty(s):** American Society for Surgery of the Hand
American Academy of Orthopaedic Surgeons
American Shoulder and Elbow Surgeons**CPT:** 2433X1**Sample Size:** 100 **Resp n:** 45 **Resp %:** 45%**Sample Type:** random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	6.50	7.27	7.45	8.00	13.30
Pre-Service			50		
Intra-Service	30	60	60	90	150

Post-Service	<u>Total Min</u>	<u>CPT code / # of visits</u>
<i>Day of Surgery:</i>		
Immediate	30	
Other	18	99236 X 0.5 (same day surgery)
<i>After Day of Surgery:</i>		
Critical Care	0	
Other Hospital	0	
Dischg Day Mgmt	0	
Office Visits	68	99213x1 99212x3

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
24305	Tendon lengthening, upper arm or elbow, each tendon	7.45	090

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

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT
	2433X1	24305 (Hvd)
Pre-service time	50	49
Intra-service time	60	63
Same Day Immediate Post-service time	30	22
Same Day Other Post-service time	0	0
Post Total critical care time (not same day)	0	0
Post Total other hospital visit time (not same day)	0	0
Discharge management time	18	18
Total office visit time	68	52

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	3.48	3.50
Intra-service	3.38	3.50
Post-service	3.08	3.25

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.08	3.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.97	3.00
Urgency of medical decision making	2.49	2.42

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.59	3.67
Physical effort required	3.38	3.08

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.13	3.17
Outcome depends on the skill and judgment of physician	3.49	3.75
Estimated risk of malpractice suit with poor outcome	3.10	2.92

ADDITIONAL RATIONALE

The total work for 2433X1 *Tenolysis, triceps* is equivalent to 24305 *Tendon lengthening, upper arm or elbow, each tendon*. Both of these procedures require the isolation of a myotendinous unit. Both procedures place important neurovascular structures at risk. Both procedures require the prescription and monitoring of postoperative therapy. 24305 includes the incision and lengthening of a tendon, 2433X1 includes the lysis of adhesion from around the triceps tendon and muscle. We recommend the survey median RVW of 7.45 for 2433X1. This is the same value as 24305 and correctly sets these two codes relative to each other.

Additional survey question and results:

"Where is this service performed (check all that apply)?"

Hospital Outpatient Hospital / Surgi-Center Office **FREQUENCY INFORMATION**

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

24999 Unlisted procedure, humerus or elbow (Medicare frequency = 167)

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

Specialty: hand/orthopaedic surgery Commonly Sometimes Rarely

3. 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: hand/orthopaedic surgery Frequency: 200

4. 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: hand/orthopaedic surgery Frequency: 8 (4% of national frequency)

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to surgeons/practices that specialize in surgery of the hand/upper extremity.

CPT Code: 2500X1 (JJ10)

Global 090

Recommended RVW 3.38

Descriptor: Incision, flexor tendon sheath, wrist (eg, flexor carpi radialis)

Survey Vignette (Typical Patient)

A 50-year-old female has chronic flexor carpi radialis tendonitis requiring decompression.

CLINICAL DESCRIPTION OF SERVICE:

Preoperative work:

- Imaging studies are carefully reviewed including X-rays, CT scans, and MRIs.
- Pre-operative laboratory tests are reviewed.
- Consultation is completed with the referring physician and other healthcare professionals
- The family and patient are apprised of the proposed surgery.
- The risks and complications associated with the surgery are discussed with the patient and family.
- Informed consent is obtained.
- The surgeon goes to the operating room and verifies that all appropriate equipment is available
- The patient is brought to the operating room and placed on the operating table in the supine position.
- The position of the extremities and head are checked and adjusted.
- The patient's involved arm is prepped and draped.
- A sterile tourniquet is applied to the proximal arm.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.

INTER-SERVICE WORK: An incision is made over the flexor carpi radialis extending along the radial aspect of the first metacarpal. Care is taken to not cross the wrist flexion crease at a right angle. The branches of the superficial branch of the radial nerve are carefully identified and protected, as is the palmar branch of the radial artery. The flexor carpi radialis tendon sheath is opened. The tendon is freed of any adhesions and the tenosynovium is excised. The operative site is examined for any occult ganglions or other occult pathology. The wound is irrigated and the skin is then closed in layers.

Postoperative work: in hospital

- Application of dressing and splint.
- Monitoring patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative imaging studies are reviewed
- Postoperative laboratory studies are reviewed
- Preparation of discharge records

Postoperative work: in office

- Post-discharge office visits for this procedure for 90 days
- Assessment of circulation, sensation and motor function of the operated extremity
- Removal of splint
- Assessment of surgical wound
- Redress wound
- Order physical / occupational therapy
- Supervision of rehabilitation
- Ordering and reviewing radiographs.
- Antibiotic and pain medication management.
- Removal of sutures
- Evaluation laboratory reports

- Communication with other health care professionals
- Communication with patient and family regarding progress.

SURVEY DATA

Presenter(s): Daniel J. Nagle, MD, FACS
Keith Brandt, MD

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

CPT: 2500X1

Sample Size: 110 **Resp n:** 40 **Resp %:** 36%

Sample Type: random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	3.00	3.38	3.84	4.50	6.55
Pre-Service			30		
Intra-Service	15	20	30	38	60
Post-Service	<u>Total Min</u>	<u>CPT code / # of visits</u>			
<i>Day of Surgery:</i>					
Immediate	20				
Other	18	99238 X 0.5 (same day surgery)			
<i>After Day of Surgery:</i>					
Critical Care	0				
Other Hospital	0				
Dischg Day Mgmt	0				
Office Visits	53	99213x1 99212x2			

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
25000	Incision, extensor tendon sheath, wrist (eg, deQuervains disease)	3.38	090

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

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT
	2500X1	25000 (Hvd)
Pre-service time	30	29
Intra-service time	30	33
Same Day Immediate Post-service time	20	17
Same Day Other Post-service time	0	0
Post Total critical care time (not same day)	0	0
Post Total other hospital visit time (not same day)	0	0
Discharge management time	18	0
Total office visit time	53	53

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	2.54	2.30
Intra-service	2.63	2.42
Post-service	2.40	2.18

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	2.91	2.30
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.37	2.15
Urgency of medical decision making	1.91	1.91

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	2.77	2.61
Physical effort required	2.14	2.12

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	2.51	2.55
Outcome depends on the skill and judgment of physician	2.91	2.70
Estimated risk of malpractice suit with poor outcome	2.34	2.45

ADDITIONAL RATIONALE

The consensus committee reviewing this data believes that the survey respondents overestimated the RVW for 2500X1 *Incision, flexor tendon sheath, wrist (eg, flexor carpi radialis)* which requires a different approach than 25000 *Incision, extensor tendon sheath, wrist (eg, deQuervains disease)*, but represents the same total work. This code was created to complement the "extensor" code and allow correct coding for the less frequently performed incision of "flexor" tendon sheath. We recommend the survey 25th percentile RVW of 3.38 for 2500X1. This value is the same as 25000.

Additional survey question and results:

"Where is this service performed (check all that apply)?"

Hospital X Outpatient Hospital / Surgi-Center X Office

FREQUENCY INFORMATION

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

25999 Unlisted procedure, forearm or wrist (Medicare freq. = 324)

25295 Tenolysis, flexor or extensor tendon*, forearm and/or wrist, single, each tendon (Medicare freq. = 623)
*tendon sheath is clinically/technically different than tendon

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

Specialty: hand/orthopaedic surgery	Commonly <u> </u>	Sometimes <u> </u>	Rarely <u> </u>
Specialty: plastic surgery	Commonly <u> </u>	Sometimes <u> </u>	Rarely <u> </u>

3. 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: hand/orthopaedic/plastic surgery* Frequency: 300

*Unable to estimate exact split, but a higher percentage is expected for hand/orthopaedic surgery compared with plastic surgery

4. 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: hand/orthopaedic/plastic surgery* Frequency: 69 (23% of national frequency)

*Unable to estimate exact split, but a higher percentage is expected for hand/orthopaedic surgery compared with plastic surgery

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to surgeons/practices that specialize in surgery of the hand/upper extremity.

CPT Code: 2527X1 (JJ13)

Global: 090

Recommended RVW 8 50

Descriptor: Repair, tendon sheath, extensor, forearm and/or wrist, with free graft (includes obtaining graft) (eg, for extensor carpi ulnaris subluxation)

Survey Vignette (Typical Patient)

A 47-year-old female presents with subluxation of extensor carpi ulnaris (ECU) tendon at the wrist. The ECU tendon sheath is reconstructed with a retinacular graft harvest from the fourth dorsal compartment.

CLINICAL DESCRIPTION OF SERVICE:

Preoperative work:

- Imaging studies are carefully reviewed including X-rays, CT scans, and MRIs.
- Pre-operative laboratory tests are reviewed.
- Consultation is completed with the referring physician and other healthcare professionals
- The family and patient are apprised of the proposed surgery.
- The risks and complications associated with the surgery are discussed with the family.
- Informed consent is obtained.
- The surgeon goes to the operating room and verifies that all appropriate equipment is available
- The patient is brought to the operating room and placed on the operating table in the supine position.
- The patient's bony prominences are padded.
- The position of the extremities and head are checked and adjusted.
- The patient's involved arm is prepped and draped.
- A sterile tourniquet is applied to the proximal arm.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.

INTER-SERVICE WORK: A curvilinear incision is made over the dorsal ulnar aspect of the wrist and distal ulna. Careful dissection is carried out taking care to protect the dorsal branch of the ulnar nerve. The sixth dorsal compartment is examined. It is incised along its dorsal aspect. The inner tendon sheath is also identified and opened. Any synovitis is excised. The dorsal retinaculum of the wrist overlying the fourth and fifth compartment is identified. An appropriate sized retinacular graft is outlined. The retinacular graft is then harvested, taking care to leave a distal edge of the fourth and fifth dorsal compartment retinaculum intact. Care is taken to avoid removing the distal portion of the third dorsal compartment retinaculum. The graft is then transferred to the sixth dorsal compartment. Three suture anchors are placed along the dorsal aspect of the sixth dorsal compartment. Three suture anchors are placed along the palmar aspect of the sixth dorsal compartment. The retinacular graft is then snugly sewn into position using the suture anchors thus creating a new sixth dorsal compartment. The native sixth dorsal compartment is also reefed to further stabilize the construct. The wound is irrigated and closed in layers.

Postoperative work: in hospital

- Application of dressing and splint.
- Monitoring patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative imaging studies are reviewed
- Postoperative laboratory studies are reviewed
- Preparation of discharge records

Postoperative work: in office

- Post-discharge office visits for this procedure for 90 days
- Assessment of circulation, sensation and motor function of the operated extremity
- Removal of splint
- Assessment of surgical wound
- Redress wound
- Order physical / occupational therapy
- Supervision of rehabilitation
- Ordering and reviewing radiographs.
- Antibiotic and pain medication management.
- Removal of sutures
- Evaluation laboratory reports
- Communication with other health care professionals
- Communication with patient and family regarding progress.

SURVEY DATA

Presenter(s): Daniel J. Nagle, MD, FACS
Keith Brandt, MD

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

CPT: 2527X1

Sample Size: 110 **Resp n:** 35 **Resp %:** 32%

Sample Type: random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	6.00	7.53	8.50	8.75	10.00
Pre-Service			40		
Intra-Service	30	60	70	75	120

Post-Service	<u>Total Min</u>	<u>CPT code / # of visits</u>
<i>Day of Surgery:</i>		
Immediate	23	
Other	18	99238 x 0.5 (same day surgery)
<i>After Day of Surgery:</i>		
Critical Care	0	
Other Hospital	0	
Dischg Day Mgmt	0	
Office Visits	68	99213x1 99212x3

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
25274	Repair, tendon or muscle, extensor, secondary, with tendon graft (includes obtaining graft), forearm and/or wrist, each tendon or muscle	8.75	090

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

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT
	2527X1	25274 (Hvd)
Pre-service time	40	42
Intra-service time	70	93
Same Day Immediate Post-service time	23	24
Same Day Other Post-service time	0	0
Post Total critical care time (not same day)	0	0
Post Total other hospital visit time (not same day)	0	0
Discharge management time	18	18
Total office visit time	68	60

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	3.03	3.12
Intra-service	3.27	3.36
Post-service	3.03	3.24

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.06	2.81
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.55	2.63
Urgency of medical decision making	2.10	2.17

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.45	3.52
Physical effort required	2.65	2.74

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	2.84	2.93
Outcome depends on the skill and judgment of physician	3.39	3.48
Estimated risk of malpractice suit with poor outcome	2.61	2.63

ADDITIONAL RATIONALE

The work 2527X1 *Repair, tendon sheath, extensor, forearm and/or wrist, with free graft (includes obtaining graft) (eg, for extensor carpi ulnaris subluxation)* is similar to 25274 *Repair, tendon or muscle, extensor, secondary, with tendon graft (includes obtaining graft), forearm and/or wrist, each tendon or muscle*. 2527X1 requires slightly less intraoperative work than 25274 as 25274 usually requires dissection of the injured tendon from scar as well as two tendinous anastomoses. The scaring at the sixth dorsal compartment associated with 2527X1 is usually mild and while the reconstruction of the tendon sheath must be precise, it is a bit less work than two tendinous anastomoses. Postoperative care for both procedures includes some form of immobilization and subsequent prescription and monitoring of therapy. We recommend the survey median RVW of 8.50 for 2527X1. This value is slightly less than 25274.

Additional survey question and results:

"Where is this service performed (check all that apply)?"

Hospital Outpatient Hospital / Surgi-Center Office

FREQUENCY INFORMATION

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

25999 Unlisted procedure, forearm or wrist (Medicare freq. = 324)

25274 Repair, tendon* or muscle, extensor, secondary, with tendon graft
(includes obtaining graft), forearm and/or wrist, each tendon or muscle (Medicare freq. = 92)

*tendon sheath is clinically/technically different than tendon

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

Specialty: hand/orthopaedic surgery Commonly ~~_____~~ Sometimes Rarely

Specialty: plastic surgery Commonly ~~_____~~ Sometimes Rarely

3. 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: hand/orthopaedic/plastic surgery* Frequency: 150

*Unable to estimate exact split, but a higher percentage is expected for hand/orthopaedic surgery compared with plastic surgery

4. 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: hand/orthopaedic/plastic surgery* Frequency: 25 (18% of national frequency)

*Unable to estimate exact split, but a higher percentage is expected for hand/orthopaedic surgery compared with plastic surgery

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to surgeons/practices that specialize in surgery of the hand/upper extremity.

CPT Code: 2908X1 (JJ29)

Global: 000

Recommended RVW 0 62

Descriptor: Application, cast; finger (eg, contracture)

Survey Vignette (Typical Patient)

A 25-year-old female is treated for a flexion contracture of the small finger proximal interphalangeal joint with casting.

CLINICAL DESCRIPTION OF SERVICE:

Preoperative work:

- Imaging studies are carefully reviewed including X-rays, CT scans, and MRIs.
- Consultation is completed with the referring physician and other healthcare professionals
- The family and patient are apprised of the proposed procedure.
- The risks and complications associated with the procedure are discussed with the family.

INTRA-SERVICE WORK: The patient's finger is casted. While the casting material is setting, gentle manipulation of the joint is carried out to hold the finger in as much extension as tolerated without comprising the vascular supply to the finger.

Postoperative work:

- Comfort of the patient is assessed.
- The neurovascular status of the finger is assessed.
- The patient is instructed in the care of the casted finger and followup is scheduled.
- Consultation with consultants and other healthcare professionals are completed (both written and verbal).

SURVEY DATA

Presenter(s): Daniel J. Nagle, MD, FACS
Keith Brandt, MD

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

CPT: 2908X1

Sample Size: 110 **Resp n:** 30 **Resp %:** 27%

Sample Type: random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	0.52	0.62	0.75	1.00	2.75
Pre-Service			20		
Intra-Service	10	10	13	15	30
Post-Service			10		

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
29131	Application of finger splint; dynamic	0.55	000
29075	Application, cast; elbow to finger (short arm)	0.77	000

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

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT
	2908X1	29131 (Hvd)
Pre-service time	20	7
Intra-service time	13	18
Post-service time	10	5

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	2.00	1.92
Intra-service	2.29	1.92
Post-service	1.96	1.75

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	2.04	1.79
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.08	1.79
Urgency of medical decision making	1.80	1.64

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	2.52	2.00
Physical effort required	1.92	1.71

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	2.12	1.71
Outcome depends on the skill and judgment of physician	2.40	1.93
Estimated risk of malpractice suit with poor outcome	2.08	1.93

ADDITIONAL RATIONALE

2908X1 *Application, cast; finger (eg, contracture)*, which includes fabrication of the case, is more total work than 29131 *Application of finger splint; dynamic*, as 2908X1 requires the application of casting material directly on the finger skin. This direct cutaneous contact carries more risk of cutaneous and neurovascular compromise than 29131. This increased risk requires more pre and post service patient education and monitoring as reflected in the survey. Additionally, 2908X1 requires less time than 29075. We recommend the survey 25th percentile RVW of 0.62 for 2908X1. This value is correctly placed between 29131 and 29075.

Additional survey question and results:

"Where is this service performed (check all that apply)?"

Hospital Outpatient Hospital / Surgi-Center Office

FREQUENCY INFORMATION

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

29799 Unlisted procedure, casting or strapping (Medicare freq. = 1,459)

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

Specialty: hand/orthopaedic surgery	Commonly	<u>Sometimes</u>	Rarely
Specialty: plastic surgery	Commonly	Sometimes	<u>Rarely</u>

3. 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: hand/orthopaedic/plastic surgery* Frequency: 400

*Unable to estimate exact split, but a higher percentage is expected for hand/orthopaedic surgery compared with plastic surgery

4. 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: hand/orthopaedic/plastic surgery* Frequency: 40 (10% or less of national frequency)

*Unable to estimate exact split, but a higher percentage is expected for hand/orthopaedic surgery compared with plastic surgery

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

May be performed by many physicians across the US, but probably limited to surgeons/practices that specialize in surgery of the hand/upper extremity.

CPT Code: 2449X1 (JJ9)

Global: 090

Recommended RVW: 3.75

CPT Descriptor: Manipulation, elbow, under anesthesia
(For application of external fixation, see 20690 or 20692)

Survey Vignette (Typical Patient)

A 45-year-old male, who suffered trauma to his elbow, develops an elbow contracture requiring manipulation

CLINICAL DESCRIPTION OF SERVICE:

Preoperative work:

- Imaging studies are carefully reviewed including x-rays, CT scans, and MRIs.
- Pre-operative laboratory tests are reviewed.
- Consultation is completed with the referring physician and other healthcare professionals
- The family and patient are apprised of the proposed surgery.
- The risks and complications associated with the surgery are discussed with the patient and family.
- Informed consent is obtained.
- The surgeon goes to the operating room and verifies that all appropriate equipment is available
- The patient is brought to the operating room and placed on the operating table in the supine position.
- The patient's bony prominences are padded.
- The position of the extremities and head are checked and adjusted.
- The patient's involved arm is prepped and draped.
- A sterile tourniquet is applied to the proximal arm.

INTRA-SERVICE WORK: The elbow is gently taken through a full range of motion from the maximum amount of flexion to the maximum amount of extension allowable. Care is taken to avoid applying excessive force. The manipulation of the joint is repeated as needed until the maximum range of motion is achieved.

Postoperative work: in hospital

- Application of splint.
- Monitoring patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative imaging studies are reviewed
- Postoperative laboratory studies are reviewed
- Preparation of discharge records

Postoperative work: in office

- Post-discharge office visits for this procedure for 90 days
 - Assessment of circulation, sensation and motor function of the operated extremity
 - Removal of splint
 - Order physical / occupational therapy
 - Supervision of rehabilitation
 - Ordering and reviewing radiographs.
 - Pain medication management.
 - Evaluation laboratory reports
 - Communication with other health care professionals
 - Communication with patient and family regarding progress.
-

SURVEY DATA**Presenter(s):** Daniel J. Nagle, MD, FACS**Specialty(s):** American Society for Surgery of the Hand
American Academy of Orthopaedic Surgeons
American Shoulder and Elbow Surgeons**CPT:** 2449X1**Sample Size:** 100 **Resp n:** 44 **Resp %:** 44%**Sample Type:** random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	2.00	2.52	3.75	5.00	10.00
Pre-Service			45		
Intra-Service	10	15	20	30	60
Post-Service	<u>Total Min</u>	<u>CPT code / # of visits</u>			

Day of Surgery:

Immediate	25	
Other	18	99238 X 0.5 (same day surgery)

After Day of Surgery:

Critical Care	0	
Other Hospital	0	
Dischg Day Mgmt	0	
Office Visits	90	99212x6

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
23700	Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)	2.52	010

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

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT
	2449X1	23700 (Hvd)
Pre-service time	45	11
Intra-service time	20	25
Same Day Immediate Post-service time	25	13
Same Day Other Post-service time	0	0
Post Total critical care time (not same day)	0	0
Post Total other hospital visit time (not same day)	0	0
Discharge management time	18	0
Total office visit time	90	15

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	3.00	2.96
Intra-service	2.85	2.88
Post-service	3.00	2.35

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.08	3.20
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.08	3.08
Urgency of medical decision making	2.60	2.52

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	2.95	2.96
Physical effort required	3.03	2.96

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.55	3.36
Outcome depends on the skill and judgment of physician	3.35	3.28
Estimated risk of malpractice suit with poor outcome	3.23	3.16

ADDITIONAL RATIONALE

Intra-service work of 2449X1 *Manipulation, elbow, under anesthesia* is similar to 23700 *Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)*. 2449X1 includes more postoperative work because it has been assigned a 90-day global period (compared with 23700, which has a 10-day global). Patients requiring 2449X1 will be seen weekly for the first four weeks and then twice more within the global. We recommend the survey median RVW of 3.75 for 2449X1. This value is higher than 23700 to account for the additional postop work for five additional office visits during the 90-day global.

Additional survey question and results:

"Where is this service performed (check all that apply)?"

Hospital X Outpatient Hospital / Surgi-Center X Office _____

"What percentage of your 2449X1 patients require fixation?"

Internal fixation 0% External fixation 0 to 4%

FREQUENCY INFORMATION

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

24999 Unlisted procedure, humerus or elbow (Medicare frequency = 167)

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

Specialty: hand/orthopaedic surgery Commonly ~~————~~ Sometimes Rarely

3. 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: hand/orthopaedic surgery Frequency: 150

4. 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: hand/orthopaedic surgery Frequency: 27 (18% or less of national frequency)

5. Do many physicians perform this service across the United States?

No.

CPT Code. 2549X1 (JJ18)

Global: 090

Recommended RVW 3 75

CPT Descriptor: Manipulation, wrist, under anesthesia
(For application of external fixation, see 20690 or 20692)

Survey Vignette (Typical Patient)

A 50-year-old female with a wrist joint contracture has the wrist manipulated under anesthesia.

CLINICAL DESCRIPTION OF SERVICE:

Preoperative work:

- Imaging studies are carefully reviewed including X-rays, CT scans, and MRIs.
- Pre-operative laboratory tests are reviewed.
- Consultation is completed with the referring physician and other healthcare professionals
- The family and patient are apprised of the proposed surgery.
- The risks and complications associated with the surgery are discussed with the family.
- Informed consent is obtained.
- The surgeon goes to the operating room and verifies that all appropriate equipment is available
- The patient is brought to the operating room and placed on the operating table in the supine position.
- The position of the extremities and head are checked and adjusted.
- The patient's involved arm is prepped and draped.
- A sterile tourniquet is applied to the proximal arm.

INTRA-SERVICE WORK: The wrist is gently taken through a full range of motion from the maximum amount of flexion to the maximum amount of extension allowable. Care is taken to avoid applying excessive force. The manipulation of the joint is repeated as needed until the maximum range of motion is achieved.

Postoperative work: in hospital

- Application of dressing and splint.
- Monitoring patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative imaging studies are reviewed
- Postoperative laboratory studies are reviewed
- Preparation of discharge records

Postoperative work: in office

- Post-discharge office visits for this procedure for 90 days
 - Assessment of circulation, sensation and motor function of the operated extremity
 - Removal of splint
 - Order physical / occupational therapy
 - Supervision of rehabilitation
 - Ordering and reviewing radiographs.
 - Pain medication management.
 - Evaluation laboratory reports
 - Communication with other health care professionals
 - Communication with patient and family regarding progress.
-

SURVEY DATA

Presenter(s): Daniel J. Nagle, MD, FACS
Keith Brandt, MD

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

CPT: 2549X1

Sample Size: 110 **Resp n:** 44 **Resp %:** 40%

Sample Type: random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	2.00	2.60	3.75	4.52	5.00
Pre-Service			46		
Intra-Service	10	14	20	30	60

Post-Service	<u>Total Min</u>	<u>CPT code / # of visits</u>
<i>Day of Surgery:</i>		
Immediate	20	
Other	18	99238 x 0.5 (same day surgery)
<i>After Day of Surgery:</i>		
Critical Care	0	
Other Hospital	0	
Dischg Day Mgmt	0	
Office Visits	90	99212x6

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
23700	Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)	2.52	010

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

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT
	2549X1	23700 (Hvd)
Pre-service time	46	11
Intra-service time	20	25
Same Day Immediate Post-service time	20	13
Same Day Other Post-service time	0	0
Post Total critical care time (not same day)	0	0
Post Total other hospital visit time (not same day)	0	0
Discharge management time	18	0
Total office visit time	90	15

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	2.75	2.68
Intra-service	2.43	2.52
Post-service	2.70	2.15

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	2.66	2.62
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.56	2.50
Urgency of medical decision making	2.05	2.00

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	2.41	2.48
Physical effort required	2.61	2.85

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	2.51	2.68
Outcome depends on the skill and judgment of physician	2.68	2.74
Estimated risk of malpractice suit with poor outcome	2.37	2.65

ADDITIONAL RATIONALE

Intra-service work of 2549X1 *Manipulation, wrist, under anesthesia* is similar to 23700 *Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)* and previous code 2449X1 (manipulation, elbow). 2549X1 includes more postoperative work because it has been assigned a 90-day global period (compared with 23700, which has a 10-day global). Patients requiring 2549X1 will be seen weekly for the first four weeks and then at 6 weeks and 12 weeks. Total work for 2549X1 and 2449X1 is the same. We recommend the survey median RVW of 3.75 for 2549X1. This value is higher than 23700 to account for the additional postop work for five additional office visits during the 90-day global.

Additional survey question and results:

"Where is this service performed (check all that apply)?"

Hospital X Outpatient Hospital / Surgi-Center X Office

"What percentage of your 2549X1 patients require fixation?"

Internal fixation 0% External fixation 0 to 4%

FREQUENCY INFORMATION

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

25999 Unlisted procedure, forearm or wrist (Medicare freq. = 324)

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

Specialty: hand/orthopaedic surgery Commonly ~~_____~~ Sometimes Rarely
Specialty: plastic surgery Commonly ~~_____~~ Sometimes Rarely

3. 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: hand/orthopaedic/plastic surgery* Frequency: 200

*Unable to estimate exact split, but a higher percentage is expected for hand/orthopaedic surgery compared with plastic surgery

4. 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: hand/orthopaedic/plastic surgery* Frequency: 20 (10% or less of national frequency)

*Unable to estimate exact split, but a higher percentage is expected for hand/orthopaedic surgery compared with plastic surgery

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to a few medical centers.

CPT Code: 2659X1 (JJ25)

Global: 090

Recommended RVW: 2.50

CPT Descriptor: Manipulation, finger joint, under anesthesia, each joint
(For application of external fixation, see 20690 or 20692)

Survey Vignette (Typical Patient)

A 30-year-old female is treated for a post-traumatic flexion contracture of the PIP joint with closed manipulation of the joint.

CLINICAL DESCRIPTION OF SERVICE:

Preoperative work:

- Imaging studies are carefully reviewed including X-rays, CT scans, and MRIs.
- Pre-operative laboratory tests are reviewed.
- Consultation is completed with the referring physician and other healthcare professionals
- The family and patient are apprised of the proposed surgery.
- The risks and complications associated with the surgery are discussed with the family.
- Informed consent is obtained.
- The surgeon goes to the operating room and verifies that all appropriate equipment is available
- The patient is brought to the operating room and placed on the operating table in the supine position.
- The position of the extremities and head are checked and adjusted.
- The patient's involved arm is prepped and draped.
- A tourniquet is applied to the proximal arm.

INTRA-SERVICE WORK: The finger joint is gently taken through a full range of motion from the maximum amount of flexion to the maximum amount of extension allowable. Care is taken to avoid applying excessive force. The manipulation of the joint is repeated as needed until the maximum range of motion is achieved.

Postoperative work: in hospital

- Application of dressing and splint.
- Monitoring patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative imaging studies are reviewed
- Postoperative laboratory studies are reviewed
- Preparation of discharge records

Postoperative work: in office

- Post-discharge office visits for this procedure for 90 days
 - Assessment of circulation, sensation and motor function of the operated extremity
 - Removal of splint
 - Order physical / occupational therapy
 - Supervision of rehabilitation
 - Ordering and reviewing radiographs.
 - Pain medication management.
 - Evaluation laboratory reports
 - Communication with other health care professionals
 - Communication with patient and family regarding progress.
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SURVEY DATA

Presenter(s): Daniel J. Nagle, MD, FACS
Keith Brandt, MD

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

CPT: 2659X1

Sample Size: 110 **Resp n:** 30 **Resp %:** 27%

Sample Type: random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	1.00	2.00	2.50	2.51	4.00
Pre-Service			25		
Intra-Service	10	10	15	15	50

Post-Service	<u>Total Min</u>	<u>CPT code / # of visits</u>
<i>Day of Surgery:</i>		
Immediate	15	
Other	18	99238 x 0.5 (same day surgery)
<i>After Day of Surgery:</i>		
Critical Care	0	
Other Hospital	0	
Dischg Day Mgmt	0	
Office Visits	90	99212x6

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
26600	Closed treatment of metacarpal fracture, single; without manipulation, each bone	1.96	090

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

TIME ESTIMATES (MEDIAN)	Svy CPT 2659X1	Ref CPT 26600 (Hvd)
Pre-service time	25	9
Intra-service time	15	19
Same Day Immediate Post-service time	15	8
Same Day Other Post-service time	0	
Post Total critical care time (not same day)	0	
Post Total other hospital visit time (not same day)	0	
Discharge management time	18	
Total office visit time	90	45

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	2.36	2.00
Intra-service	2.29	1.75
Post-service	2.43	2.00

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	2.52	2.25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.28	1.50
Urgency of medical decision making	2.03	2.25

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	2.59	2.25
Physical effort required	2.17	1.50

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	2.48	2.00
Outcome depends on the skill and judgment of physician	2.66	2.25
Estimated risk of malpractice suit with poor outcome	2.41	2.25

ADDITIONAL RATIONALE

2659X1 *Manipulation, finger joint, under anesthesia, each joint* requires more pre-service time than 26600 *Closed treatment of metacarpal fracture, single; without manipulation, each bone*. 2659X1 will be used most often for post-traumatic contracture while 26600 will be emergent and straightforward. The complications associated with manipulation of a finger joint include fracture, tendon rupture, skin laceration and neurovascular compromise. These complications are not associated with 26600 and therefore the pre-service discussion with the patient is more complex with 2659X1 than with 26600. Additionally, the postop work for 2659X1 will be greater as the surgeon must carefully prescribe and closely monitor intensive postoperative therapy without which the procedure will fail. The treatment of an undisplaced metacarpal fracture requires far less vigilance. These facts are reflected in the survey data. We therefore recommend the survey median RVW of 2.50 for 2659X1. This value is slightly higher than 26600 to account for the additional pre-service and post-service work.

Additional survey question and results:

"Where is this service performed (check all that apply)?"

Hospital X Outpatient Hospital / Surgi-Center X Office

"What percentage of your 2659X1 patients require fixation?"

Internal fixation 0 to 3% External fixation 0 to 7%

FREQUENCY INFORMATION

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

26989 Unlisted procedure, hands or fingers (Medicare freq. = 387)

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

Specialty: hand/orthopaedic surgery Commonly ~~_____~~ Sometimes Rarely
 Specialty: plastic surgery Commonly ~~_____~~ Sometimes Rarely

3. 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: hand/orthopaedic/plastic surgery* Frequency: 200

*Unable to estimate exact split, but a higher percentage is expected for hand/orthopaedic surgery compared with plastic surgery

4. 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: hand/orthopaedic/plastic surgery* Frequency: 20 (10% or less of national frequency)

*Unable to estimate exact split, but a higher percentage is expected for hand/orthopaedic surgery compared with plastic surgery

5. Do many physicians perform this service across the United States?

No.

CPT Code: 2543X2 (JJ16)

Global: 090

Recommended RVW: 10 44

CPT Descriptor: Repair of nonunion of carpal bone (excluding carpal scaphoid (navicular)) (includes obtaining graft and necessary fixation), each bone

Survey Vignette (Typical Patient)

A 30-year-old male presents with a nonunion of a lunate fracture. A repair of the nonunion is performed using a non-vascularized bone graft.

CLINICAL DESCRIPTION OF SERVICE:

Preoperative work:

- Imaging studies are carefully reviewed including X-rays, CT scans, and MRIs.
- Pre-operative laboratory tests are reviewed.
- Consultation is completed with the referring physician and other healthcare professionals
- The family and patient are apprised of the proposed surgery.
- The risks and complications associated with the surgery are discussed with the family.
- Informed consent is obtained.
- The surgeon goes to the operating room and verifies that all appropriate equipment is available
- The patient is brought to the operating room and placed on the operating table in the supine position.
- The patient's bony prominences are padded.
- Thermal regulation drapes are applied
- The position of the extremities and head are checked and adjusted.
- The patient's involved arm is prepped and draped.
- A sterile tourniquet is applied to the proximal arm.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.

INTER-SERVICE WORK: An incision is made over the dorsal aspect of the wrist. Careful dissection is carried out using loupe magnification. The extensor tendons are carefully retracted out of the field. The dorsal wrist capsule is open. The nonunion identified. The nonunion site is cleared of its scar. The debridement is carried back to good cancellus bone. An incision is made over the distal radius and the interval between the first and second dorsal compartments is identified. Care is taken to protect the branches of the superficial branch of the radial nerve. The periosteum is elevated between and the first and second dorsal compartments. A cortical window is created in the radius at this level. The cancellus bone is harvested. The donor site periosteum is then repaired. The bone graft is then packed tightly into the nonunion site. Internal fixation is then placed across the nonunion site. The dorsal capsule is closed and the skin is approximated in layers.

Postoperative work: in hospital

- Application of dressing and splint.
- Monitoring patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative imaging studies are reviewed
- Postoperative laboratory studies are reviewed
- Preparation of discharge records

Postoperative work: in office

- Post-discharge office visits for this procedure for 90 days
- Assessment of circulation, sensation and motor function of the operated extremity
- Removal of splint
- Assessment of surgical wound
- Redress wound
- Order physical / occupational therapy
- Supervision of rehabilitation
- Ordering and reviewing radiographs.
- Antibiotic and pain medication management.
- Removal of sutures
- Evaluation laboratory reports
- Communication with other health care professionals
- Communication with patient and family regarding progress.

SURVEY DATA

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

CPT: 2543X2

Sample Size: 110 **Resp n:** 48 **Resp %:** 44%

Sample Type: random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	9.00	10.44	10.44	10.50	15.00
Pre-Service			58		
Intra-Service	60	90	100	120	180

Post-Service	<u>Total Min</u>	<u>CPT code / # of visits</u>
<i>Day of Surgery:</i>		
Immediate	30	
Other	18	99238 x 0.5 (same day surgery)
<i>After Day of Surgery:</i>		
Critical Care	0	
Other Hospital	0	
Dischg Day Mgmt	0	
Office Visits	68	99213x1 99212x3

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
25440	Repair of nonunion, scaphoid (navicular) bone, with or without radial styloidectomy (includes obtaining graft and necessary fixation)	10.44	090

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

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT
	2543X2	25440 (Hvd)
Pre-service time	58	52
Intra-service time	100	90
Same Day Immediate Post-service time	30	24
Same Day Other Post-service time	0	10
Post Total critical care time (not same day)	0	
Post Total other hospital visit time (not same day)	0	
Discharge management time	18	36
Total office visit time	68	60

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	3.60	3.45
Intra-service	3.81	3.88
Post-service	3.19	3.24

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.65	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.53	3.45
Urgency of medical decision making	2.84	2.86

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.23	4.29
Physical effort required	3.37	3.38

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.70	3.66
Outcome depends on the skill and judgment of physician	3.98	4.02
Estimated risk of malpractice suit with poor outcome	3.23	3.21

ADDITIONAL RATIONALE

Total work for 2543X2 *Repair of nonunion of carpal bone (excluding carpal scaphoid (navicular)) (includes obtaining graft and necessary fixation)*, each bone is equivalent to 25440 *Repair of nonunion, scaphoid (navicular) bone, with or without radial styloidectomy (includes obtaining graft and necessary fixation)*. 2543X2 was created to complement the nonunion repair of the scaphoid and allow correct coding for the less frequently performed nonunion repair of the carpal bone. We recommend the survey median RVW of 10.44 for 2543X2. This value is the same as 25440.

Additional survey question and results:*"Where is this service performed (check all that apply)?"*Hospital Outpatient Hospital / Surgi-Center Office **FREQUENCY INFORMATION**

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

25999 Unlisted procedure, forearm or wrist (Medicare freq. = 324)

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

Specialty: hand/orthopaedic surgery Commonly Sometimes Rarely
 Specialty: plastic surgery Commonly Sometimes Rarely

3. 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: hand/orthopaedic/plastic surgery* Frequency: 150

*Unable to estimate exact split, but a higher percentage is expected for hand/orthopaedic surgery compared with plastic surgery

4. 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: hand/orthopaedic/plastic surgery* Frequency: 6 (4% or less of national frequency)

*Unable to estimate exact split, but a higher percentage is expected for hand/orthopaedic surgery compared with plastic surgery

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to surgeons/practices that specialize in surgery of the hand/upper extremity.

	A	B	C	D	E	F	G	H	I	J	K	L	M
1	Clinical Labor, Medical Supplies, and Procedure Equipment Practice Expense Data						CPT				2433X1	2434X1	2434X2
2							RUC Tracking No.				JJ4	JJ5	JJ6
3							Global				090	090	090
4							99215				0	0	0
5							99214				0	0	0
6							99213				1	1	1
7							99212				3	4	4
8							99211				0	0	0
9	CLINICAL LABOR						Code	staff desc	Price	OUT off	OUT off	OUT off	
10	TOTAL TYPICAL TIME						1130	RN/LPN/MA	\$ 0.317	177	204	204	
11	PRE-service time						1130	RN/LPN/MA	\$ 0.317	60	60	60	
12	SERVICE time						1130	RN/LPN/MA	\$ 0.317	0	0	0	
13	POST-service time						1130	RN/LPN/MA	\$ 0.317	117	144	144	
14	PRE-SERVICE												
15	BEGINS after procedure consult. (In/out)									Min	Min	Min	
16	Complete pre-service diagnostic & referral forms (5/5)						1130	RN/LPN/MA	\$ 0.317	5	5	5	
17	Coord pre-proc services/review test/exam results (10/20)						1130	RN/LPN/MA	\$ 0.317	20	20	20	
18	Schedule space and equipment in facility (0/8)						1130	RN/LPN/MA	\$ 0.317	8	8	8	
19	OV before surgery/procedure - review test/exam results						1130	RN/LPN/MA	\$ 0.317	0	0	0	
20	Provide pre-service education/obtain consent (10/20)						1130	RN/LPN/MA	\$ 0.317	20	20	20	
21	Follow-up phone calls & prescriptions (10/7)						1130	RN/LPN/MA	\$ 0.317	7	7	7	
22	Other Pre-Service Activities (please specify):												
23							1130	RN/LPN/MA	\$ 0.317	0	0	0	
24	ENDS with admission to facility/office												
25	SERVICE PERIOD												
26	Starts with admission to facility/office									Min	Min	Min	
27							1130	RN/LPN/MA	\$ 0.317	0	0	0	
28							1130	RN/LPN/MA	\$ 0.317	0	0	0	
29	Ends with discharge from facility/office												
30	POST-SERVICE												
31	Begins after discharge from facility/office									Min	Min	Min	
32	Postop OV total time (E/M standards)		-211 (16)	-212 (27)	-213 (36)	-214 (53)	-215 (63)	1130	RN/LPN/MA	\$ 0.317	117	144	144
44	Other Activities (please specify):												
45							1130	RN/LPN/MA	\$ 0.317	0	0	0	
46	ENDS after 90 days from day of procedure.												
47	MEDICAL SUPPLIES						Code	Unit Size	Unit Cnt	Price	Out Off QTY	Out Off QTY	Out Off QTY
48													
49	PEAC Minimum visit package (multi-specialty):						PEAC	PKG	1	\$ 1.310	4	5	5
50	exam table paper (7 ft)						11111	foot	1	\$ 0.015			
51	gloves, non-sterile (2 pair)						11302	pair	1	\$ 0.120			
52	patient gown, disposable						11107	item	1	\$ 0.570			
53	pillow case, disposable						11112	item	1	\$ 0.320			
54	thermometer probe cover, disposable						11509	item	1	\$ 0.069			
55	Add'l per visit supplies:												
56	patient education booklet						11115	item	1	\$ 0.920	1	1	1
57	PEAC Postop incision care kit:						PEAC	PKG	1	\$ 15.034	1	1	1
58	betadine						52310	ml	20	\$ 0.140			
59	gauze, sterile 4x4 (10 pack)						31505	pack	2	\$ 2.940			
60	gloves, sterile						14005	pair	1	\$ 0.890			
61	staple remover kit						31702	item	1	\$ 6.830			
62	steri-strip						31513	strip	12	\$ 3.580			
63	swab Alcohol						11302	item	2	\$ 0.034			
64	tape						31514	inch	12	\$ 0.300			
65	tincture benzoin swab						52308	item	1	\$ 0.320			
66	Add'l misc. supplies:												
67											0	0	0
68	PROCEDURE SPECIFIC EQUIPMENT												
69	Exam table						E11001		1	\$ 1,360	1	1	1

	A	B	C	D	E	F	N	O	P	Q	R
1	Clinical Labor, Medical Supplies, and Procedure Equipment Practice Expense Data						2434X3	2434X4	2449X1	2500X1	2502X1
2							JJ7	JJ8	JJ9	JJ10	JJ11
3							090	090	090	090	090
4							0	0	0	0	0
5							0	0	0	0	0
6							1	1	0	1	1
7							4	4	6	2	4
8							0	0	0	0	0
9	CLINICAL LABOR						OUT off	OUT off	OUT off	OUT off	OUT off
10	TOTAL TYPICAL TIME						204	204	222	150	204
11	PRE-service time						60	60	60	60	60
12	SERVICE time						0	0	0	0	0
13	POST-service time						144	144	162	90	144
14	PRE-SERVICE										
15	BEGINS after procedure consult. (In/out)						Min	Min	Min	Min	Min
16	Complete pre-service diagnostic & referral forms (5/5)						5	5	5	5	5
17	Coord pre-proc services/review test/exam results (10/20)						20	20	20	20	20
18	Schedule space and equipment in facility (0/8)						8	8	8	8	8
19	OV before surgery/procedure - review test/exam results						0	0	0	0	0
20	Provide pre-service education/obtain consent (10/20)						20	20	20	20	20
21	Follow-up phone calls & prescriptions (10/7)						7	7	7	7	7
22	Other Pre-Service Activities (please specify):										
23							0	0	0	0	0
24	ENDS with admission to facility/office										
25	SERVICE PERIOD										
26	Starts with admission to facility/office						Min	Min	Min	Min	Min
27							0	0	0	0	0
28							0	0	0	0	0
29	Ends with discharge from facility/office										
30	POST-SERVICE										
31	Begins after discharge from facility/office						Min	Min	Min	Min	Min
32	Postop OV total time (E/M standards)	-211 (16)	-212 (27)	-213 (36)	-214 (53)	-215 (63)	144	144	162	90	144
44	Other Activities (please specify):										
45							0	0	0	0	0
46	ENDS after 90 days from day of procedure.										
47	MEDICAL SUPPLIES						Out Off	Out Off	Out Off	Out Off	Out Off
48							QTY	QTY	QTY	QTY	QTY
49	PEAC Minimum visit package (multi-specialty):						5	5	6	3	5
50	exam table paper (7 ft)										
51	gloves, non-sterile (2 pair)										
52	patient gown, disposable										
53	pillow case, disposable										
54	thermometer probe cover, disposable										
55	Add'l per visit supplies:										
56	patient education booklet						1	1	1	1	1
57	PEAC Postop incision care kit:						1	1	1	1	1
58	betadine										
59	gauze, sterile 4x4 (10 pack)										
60	gloves, sterile										
61	staple remover kit										
62	sten-stnp										
63	swab Alcohol										
64	tape										
65	tincture benzoin swab										
66	Add'l misc. supplies:										
67							0	0	0	0	0
68	PROCEDURE SPECIFIC EQUIPMENT										
69	Exam table						1	1	1	1	1

	A	B	C	D	E	F	S	T	U	V	W	
1	Clinical Labor, Medical Supplies, and Procedure Equipment Practice Expense Data							2502X2	2527X1	2539X1	2543X1	2543X2
2							JJ12	JJ13	JJ14	JJ15	JJ16	
3							090	090	090	090	090	
4							0	0	0	0	0	
5							0	0	0	0	0	
6							1	1	1	1	1	
7							4	3	3	3	3	
8							0	0	0	0	0	
9	CLINICAL LABOR						OUT off	OUT off	OUT off	OUT off	OUT off	
10	TOTAL TYPICAL TIME						204	177	177	177	177	
11	PRE-service time						60	60	60	60	60	
12	SERVICE time						0	0	0	0	0	
13	POST-service time						144	117	117	117	117	
14	PRE-SERVICE											
15	BEGINS after procedure consult. (In/out)						Min	Min	Min	Min	Min	
16	Complete pre-service diagnostic & referral forms (5/5)						5	5	5	5	5	
17	Coord pre-proc services/review test/exam results (10/20)						20	20	20	20	20	
18	Schedule space and equipment in facility (0/8)						8	8	8	8	8	
19	OV before surgery/procedure - review test/exam results						0	0	0	0	0	
20	Provide pre-service education/obtain consent (10/20)						20	20	20	20	20	
21	Follow-up phone calls & prescriptions (10/7)						7	7	7	7	7	
22	Other Pre-Service Activities (please specify):											
23							0	0	0	0	0	
24	ENDS with admission to facility/office											
25	SERVICE PERIOD											
26	Starts with admission to facility/office						Min	Min	Min	Min	Min	
27							0	0	0	0	0	
28							0	0	0	0	0	
29	Ends with discharge from facility/office											
30	POST-SERVICE											
31	Begins after discharge from facility/office						Min	Min	Min	Min	Min	
32	Postop OV total time (E/M standards)		-211 (16)	-212 (27)	-213 (36)	-214 (53)	-215 (63)	144	117	117	117	
44	Other Activities (please specify):											
45							0	0	0	0	0	
46	ENDS after 90 days from day of procedure.											
47	MEDICAL SUPPLIES						Out Off	Out Off	Out Off	Out Off	Out Off	
48							QTY	QTY	QTY	QTY	QTY	
49	PEAC Minimum visit package (multi-specialty):						5	4	4	4	4	
50	exam table paper (7 ft)											
51	gloves, non-sterile (2 pair)											
52	patient gown, disposable											
53	pillow case, disposable											
54	thermometer probe cover, disposable											
55	Add'l per visit supplies:											
56	patient education booklet						1	1	1	1	1	
57	PEAC Postop incision care kit:						1	1	1	1	1	
58	betadine											
59	gauze, sterile 4x4 (10 pack)											
60	gloves, sterile											
61	staple remover kit											
62	steri-sinp											
63	swab Alcohol											
64	tape											
65	tincture benzoin swab											
66	Add'l misc. supplies:											
67							0	0	0	0	0	
68	PROCEDURE SPECIFIC EQUIPMENT											
69	Exam table						1	1	1	1	1	

	A	B	C	D	E	F	X	Y	Z	AA	AB	
1	Clinical Labor, Medical Supplies, and Procedure Equipment Practice Expense Data							2549X1	2565X1	2565X3	2567X1	2659X1
2							JJ18	JJ19	JJ20	JJ21	JJ25	
3							090	090	090	090	090	
4							0	0	0	0	0	
5							0	0	0	0	0	
6							0	1	1	1	0	
7							6	3	3	3	6	
8							0	0	0	0	0	
9	CLINICAL LABOR						OUT off					
10	TOTAL TYPICAL TIME						222	177	177	177	222	
11	PRE-service time						60	60	60	60	60	
12	SERVICE time						0	0	0	0	0	
13	POST-service time						162	117	117	117	162	
14	PRE-SERVICE											
15	BEGINS after procedure consult. (In/out)						Min	Min	Min	Min	Min	
16	Complete pre-service diagnostic & referral forms (5/5)						5	5	5	5	5	
17	Coord pre-proc services/review test/exam results (10/20)						20	20	20	20	20	
18	Schedule space and equipment in facility (0/8)						8	8	8	8	8	
19	OV before surgery/procedure - review test/exam results						0	0	0	0	0	
20	Provide pre-service education/obtain consent (10/20)						20	20	20	20	20	
21	Follow-up phone calls & prescriptions (10/7)						7	7	7	7	7	
22	Other Pre-Service Activities (please specify):											
23							0	0	0	0	0	
24	ENDS with admission to facility/office											
25	SERVICE PERIOD											
26	Starts with admission to facility/office						Min	Min	Min	Min	Min	
27							0	0	0	0	0	
28							0	0	0	0	0	
29	Ends with discharge from facility/office											
30	POST-SERVICE											
31	Begins after discharge from facility/office						Min	Min	Min	Min	Min	
32	Postop OV total time (E/M standards)						162	117	117	117	162	
		-211 (16)	-212 (27)	-213 (36)	-214 (53)	-215 (63)						
44	Other Activities (please specify):											
45							0	0	0	0	0	
46	ENDS after 90 days from day of procedure.											
47	MEDICAL SUPPLIES						Out Off					
48							QTY	QTY	QTY	QTY	QTY	
49	PEAC Minimum visit package (multi-specialty):						6	4	4	4	6	
50	exam table paper (7 ft)											
51	gloves, non-sterile (2 pair)											
52	patient gown, disposable											
53	pillow case, disposable											
54	thermometer probe cover, disposable											
55	Add'l per visit supplies:											
56	patient education booklet						1	1	1	1	1	
57	PEAC Postop incision care kit:						1	1	1	1	1	
58	betadine											
59	gauze, sterile 4x4 (10 pack)											
60	gloves, sterile											
61	staple remover kit											
62	steri-strip											
63	swab Alcohol											
64	tape											
65	tincture benzoin swab											
66	Add'l misc. supplies:											
67							0	0	0	0	0	
68	PROCEDURE SPECIFIC EQUIPMENT											
69	Exam table						1	1	1	1	1	

	A	B	C	D	E	F	AC	AD	AE	AF	AG
1	Clinical Labor, Medical Supplies, and Procedure Equipment Practice Expense Data						299X1	299X2	299X3	6482X1	6482X1
2							JJ30	JJ31	JJ32	JJ33	JJ34
3							090	090	090	090	090
4							0	0	0	0	0
5							0	0	0	0	0
6							1	1	1	1	1
7							3	3	3	3	3
8							0	0	0	0	0
9	CLINICAL LABOR						OUT off	OUT off	OUT off	OUT off	OUT off
10	TOTAL TYPICAL TIME						177	177	177	177	177
11	PRE-service time						60	60	60	60	60
12	SERVICE time						0	0	0	0	0
13	POST-service time						117	117	117	117	117
14	PRE-SERVICE										
15	BEGINS after procedure consult. (In/out)						Min	Min	Min	Min	Min
16	Complete pre-service diagnostic & referral forms (5/5)						5	5	5	5	5
17	Coord pre-proc services/review test/exam results (10/20)						20	20	20	20	20
18	Schedule space and equipment in facility (0/8)						8	8	8	8	8
19	OV before surgery/procedure - review test/exam results						0	0	0	0	0
20	Provide pre-service education/obtain consent (10/20)						20	20	20	20	20
21	Follow-up phone calls & prescriptions (10/7)						7	7	7	7	7
22	Other Pre-Service Activities (please specify):										
23							0	0	0	0	0
24	ENDS with admission to facility/office										
25	SERVICE PERIOD										
26	Starts with admission to facility/office						Min	Min	Min	Min	Min
27							0	0	0	0	0
28							0	0	0	0	0
29	Ends with discharge from facility/office										
30	POST-SERVICE										
31	Begins after discharge from facility/office						Min	Min	Min	Min	Min
32	Postop OV total time (E/M standards)						117	117	117	117	117
33		-211 (16)	-212 (27)	-213 (36)	-214 (53)	-215 (63)					
44	Other Activities (please specify):										
45							0	0	0	0	0
46	ENDS after 90 days from day of procedure.										
47	MEDICAL SUPPLIES						Out Off	Out Off	Out Off	Out Off	Out Off
48							QTY	QTY	QTY	QTY	QTY
49	PEAC Minimum visit package (multi-specialty):						4	4	4	4	4
50	exam table paper (7 ft)										
51	gloves, non-sterile (2 pair)										
52	patient gown, disposable										
53	pillow case, disposable										
54	thermometer probe cover, disposable										
55	Add'l per visit supplies:										
56	patient education booklet						1	1	1	1	1
57	PEAC Postop incision care kit:						1	1	1	1	1
58	betadine										
59	gauze, sterile 4x4 (10 pack)										
60	gloves, sterile										
61	staple remover kit										
62	steri-strip										
63	swab Alcohol										
64	tape										
65	tincture benzoin swab										
66	Add'l misc. supplies:										
67							0	0	0	0	0
68	PROCEDURE SPECIFIC EQUIPMENT										
69	Exam table						1	1	1	1	1

	A	B	C	D	E	F	AH
1	Clinical Labor, Medical Supplies, and Procedure Equipment Practice Expense Data						6482X1
2							JJ35
3							090
4							0
5							0
6							1
7							3
8							0
9	CLINICAL LABOR						OUT off
10	TOTAL TYPICAL TIME						177
11	PRE-service time						60
12	SERVICE time						0
13	POST-service time						117
14	PRE-SERVICE						
15	BEGINS after procedure consult. (In/out)						Min
16	Complete pre-service diagnostic & referral forms (5/5)						5
17	Coord pre-proc services/review test/exam results (10/20)						20
18	Schedule space and equipment in facility (0/8)						8
19	OV before surgery/procedure - review test/exam results						0
20	Provide pre-service education/obtain consent (10/20)						20
21	Follow-up phone calls & prescriptions (10/7)						7
22	Other Pre-Service Activities (please specify):						
23							0
24	ENDS with admission to facility/office						
25	SERVICE PERIOD						
26	Starts with admission to facility/office						Min
27							0
28							0
29	Ends with discharge from facility/office						
30	POST-SERVICE						
31	Begins after discharge from facility/office						Min
32	Postop OV total time (E/M standards)	-211 (16)	-212 (27)	-213 (36)	-214 (53)	-215 (63)	117
44	Other Activities (please specify):						
45							0
46	ENDS after 90 days from day of procedure.						
47	MEDICAL SUPPLIES						Out Off
48							QTY
49	PEAC Minimum visit package (multi-specialty):						4
50	exam table paper (7 ft)						
51	gloves, non-sterile (2 pair)						
52	patient gown, disposable						
53	pillow case, disposable						
54	thermometer probe cover, disposable						
55	Add'l per visit supplies:						
56	patient education booklet						1
57	PEAC Postop incision care kit:						1
58	betadine						
59	gauze, sterile 4x4 (10 pack)						
60	gloves, sterile						
61	staple remover kit						
62	steri-strip						
63	swab Alcohol						
64	tape						
65	tincture benzoin swab						
66	Add'l misc. supplies:						
67							0
68	PROCEDURE SPECIFIC EQUIPMENT						
69	Exam table						1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	
1													PEAC APPROVED DATA					
2	Clinical Labor, Medical Supplies, and Procedure Equipment Practice Expense Data												2908X1		29075		29131	
3													Application, cast; finger (eg, contracture)		Application, elbow to finger (short arm)		Application of finger splint; dynamic	
4													000	000	000	000		
5													CLINICAL LABOR	Code	staff desc	Price	IN Off	OUT off
6	TOTAL TIME	1130	RN/LPN/MA	\$ 0.317	65	25	65	25	36	6								
7	PRE/POST service time	1130	RN/LPN/MA	\$ 0.317	25	25	25	25	6	6								
8	SERVICE time	1130	RN/LPN/MA	\$ 0.317	40	0	40	0	30	0								
9	PRE-SERVICE				0	0	0	0	0	0								
10	BEGINS after procedure consult.																	
11	ENDS with admission to facility/office																	
12	SERVICE PERIOD				40	0	40	0	30	0								
13	Starts with admission to facility/office																	
14	Review charts	1130	RN/LPN/MA	\$ 0.317	2		2		2									
15	Greet patient and provide gowning	1130	RN/LPN/MA	\$ 0.317														
16	obtain vital signs	1130	RN/LPN/MA	\$ 0.317														
17	provide pre-service edutation/obtain consent	1130	RN/LPN/MA	\$ 0.317	3		3		3									
18	prepare room, equipment, supplies	1130	RN/LPN/MA	\$ 0.317	5		5		0									
19	prepare and position patient/monitor patient	1130	RN/LPN/MA	\$ 0.317														
20	sedate/apply anesthesia	1130	RN/LPN/MA	\$ 0.317	2		2		2									
21	Intra service	1130	RN/LPN/MA	\$ 0.317														
22	Assist physician in performing procedure	1130	RN/LPN/MA	\$ 0.317	15		15		15									
23	Monitor pt Following service	1130	RN/LPN/MA	\$ 0.317	5		5		0									
24	clean room equipment by physician staff	1130	RN/LPN/MA	\$ 0.317	3		3		3									
25	complete diagnostic forms, lab & x-ray orders	1130	RN/LPN/MA	\$ 0.317														
26	review/read x-ray, lab and path reports	1130	RN/LPN/MA	\$ 0.317														
27	check dressings & wound/home care instructions / coordinate office visits/ prescriptions	1130	RN/LPN/MA	\$ 0.317	5		5		5									
28	Ends with discharge from facility/office																	
29	POST-SERVICE				25	25	25	25	6	6								
30	Begins after discharge from facility/office																	
31	Conduct phone calls/call in prescptions	1130	RN/LPN/MA	\$ 0.317	6	6	6	6	6	6								
32	Other activity (please specify)																	
33	CAST REMOVAL:																	
34	Review charts	1130	RN/LPN/MA	\$ 0.317	1	1	1	1	0	0								
35	provide pre-service edutation/obtain consent	1130	RN/LPN/MA	\$ 0.317	2	2	2	2	0	0								
36	prepare room, equipment, supplies	1130	RN/LPN/MA	\$ 0.317	3	3	3	3	0	0								
37	Assist physician in performing procedure	1130	RN/LPN/MA	\$ 0.317	7	7	7	7	0	0								
38	clean room equipment by physician staff	1130	RN/LPN/MA	\$ 0.317	3	3	3	3	0	0								
39	conduct phone calls/call in prescptions/labs/x-rays	1130	RN/LPN/MA	\$ 0.317	3	3	3	3	0	0								
40	Other activity (please specify)																	
41	MEDICAL SUPPLIES	Code	Unit Size	Unit Crst	Price	IN Off	OUT off	IN Off	OUT off	IN Off	OUT off							
42						QTY	QTY	QTY	QTY	QTY	QTY							
43	Chux	11102	item	1	\$ 0.050	2	1	2	1	0	1							
44	Drape Sheet	11106	item	1	\$ 0.260	2	1	2	1	0	1							
45	gloves, non-sterile	11302	pair	1	\$ 0.120	5	1	5	1	0	1							
46	stockingnet	32001	yard	1	\$ 0.580	0		0.87		0								
47	cast padding 4"	32012	item	1	\$ 1.740	0		2		0								
48	PROCEDURE SPECIFIC EQUIPMENT																	
49	Cast cart (time-minutes)	?				15	7	22	7	0	0							
50	Cast saw (time-minutes)	E3022				7	7	7	7	0	0							
51	Cast vacuum (time-minutes)	?				7	7	7	7	0	0							

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

April 2001

Closed Treatment of Metacarpal Fracture

Code 26607 *Closed treatment of metacarpal fracture, with manipulation, with ~~internal or external~~ fixation, each bone* was revised to eliminate the inconsistency with describing a closed treatment that also includes internal fixation. Due to the editorial change it was noted that there may be a rank order anomaly in the family of codes since the percutaneous codes had work relative values greater than the open procedures. The RUC agreed with the specialty society recommendation to consider the change to 26607 editorial with the understanding that the specialty will bring the entire family of codes (26600, 26605, 26607, 26608, 26610, and 26615) back to CPT and the RUC to eliminate any rank order anomalies.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲26607	QQ1	Closed treatment of metacarpal fracture, with manipulation, with internal or external fixation, each bone	090	5.36 (no change)
26608	QQ2	Percutaneous skeletal fixation of metacarpal fracture, each bone	090	5.36 (no change)

April 20, 2001

James E. Hoehn, M.D.
Chairman
AMA/Specialty Society RVS Update Committee (RUC)
515 North State Street
Chicago Illinois 60610

Subject: Closed Treatment of Metacarpal Fracture - RUC Meeting Tab 26

Dear Jim:

The ASSH has reviewed historical information for CPT codes 26607 and 26608. As you know, the AAOS submitted an editorial change to CPT for 26607 to remove the reference to "internal fixation," since this code is for the closed treatment of a metacarpal fracture. As we understand it, HCFA representatives at the CPT meeting pointed out that the current RVWs for 26607 (closed treatment of MC fx) and 26608 (percutaneous treatment of MC fx) are valued slightly higher than for 26615 (open treatment of MC fx), and they (HCFA) requested that 26607 and 26608 be surveyed.

The ASSH did not survey these codes because we believe that 26607 and 26608 cannot be isolated for survey, independent of other codes in the metacarpal fracture treatment family (26600-26615) and time did not permit us to consider developing vignettes to survey the entire family. Further, and more importantly, we believe that the work of 26607 and 26608 is closely related to 26615, but the inclusion of the phrase "with or without internal or external fixation" in 26615 makes surveying this code difficult. We understand that the CPT Panel is looking at the "with and without" and "and/or" issue (ie, all inclusive codes). We ask that HCFA retain the current values for codes 26600-26615 until this issue can be addressed through the CPT process.

In addition, we would like to present some historical information to explain how 26607 and 26608 came to be valued slightly higher than 26615. There have been several changes to CPT nomenclature and MFS RVWs from 1992 through the current CPT revision process. On Table 1, you will note that in 1992, code 26607 had an RVW that was just "slightly" less than 26615 (5.40 vs 5.44). In 1993, code 26610 was deleted, and in this same year, new code 26608 was created and valued through the Abt study recommendations to the RUC. The RUC rationale indicates that 26608 was valued using 26607 as a reference (Per RUC database: "Specialty recommendation accepted as qualified. Key reference service is 26607.").

In 1993, the RVWs for 26607 and 26608 were slightly less than 26615 (5.25 vs 5.31). However, in 2001, the relative value for these three codes reversed, and currently, 26607 and 26608 are slightly higher than 26615. This switch can be attributed to the RVW adjustments made to global procedures in 1998 to account for increases in E/M RVWs.

Table 2 presents the Harvard Study data for codes 26600-26615. You will note that 26607 had less intra-time and different hospital and office visit time than code 26615. The end result of the Harvard analysis of these differences resulted in 26607 being valued only slightly less than 26615 in the first MFS in 1992 (Col. C).

It is important to note two interesting data points on Table 2: 1) Pre- and post-times were surveyed for 26615 and were "predicted" for 26607 (see Col. Q); and 26607 required less same day immediate time (Col. M) but more additional other hospital time (Col. O) than 26615. These oddities in these data may be the basis for the reversal of "relativity" between these codes.

Table 3 further explains how the conversion of visit time into EM code levels (per Dunn/HCFA) resulted in 26607 and 26608 getting a slightly higher EM global adjustment than 26615. In Column I, you will note that 26607 (and 26608 through crosswalk) correctly included outpatient discharge (ie, 99238 x 0.5). This information was not included in 26615, although this would be also be an outpatient procedure.

Because we do not know if 26607 and 26608 should be less or if 26615 should be more than their current values, we again request that the current values for codes 26600-26615 be retained until the issue of "all inclusive" codes is addressed through the CPT process.

I will be happy to answer any questions or discuss this further at the RUC meeting.

Sincerely,

Daniel J. Nagle, MD

Table 1: CPT Nomenclature Changes and MFS RVW Changes for Codes 26600-26615 from 1992 to Present

A	B	C	D	E	F	G
CPT	1992 Descriptor	1992 RVW	1993-2001 Descriptor	1993 RVW	2001 RVW	2002 Proposed Descriptor
26600	Treatment of closed metacarpal fracture, single; without manipulation, each bone	1.90	Closed treatment of metacarpal fracture, single; without manipulation, each bone	1.85	1.95	no change
26605	Treatment of closed metacarpal fracture, single; with manipulation, each bone	2.82	Closed treatment of metacarpal fracture, single; with manipulation, each bone	2.74	2.85	no change
26607	Treatment of closed metacarpal fracture, single; with manipulation, with skeletal fixation, each bone	5.40	Closed treatment of metacarpal fracture, with manipulation, with internal or external fixation, each bone	5.25	5.36	Closed treatment of metacarpal fracture, with manipulation, with internal or external fixation, each bone
26608	n/a	n/a	Percutaneous skeletal fixation of metacarpal fracture, each bone	5.25	5.36	no change
26610	Treatment of open metacarpal fracture, single, with uncomplicated soft tissue closure, each bone	4.22	(26610 has been deleted. To report, see 26605, 26607, 26608)	n/a	n/a	no change
26615	Open treatment of closed or open metacarpal fracture, single, with or without internal or external skeletal fixation each bone	5.46	Open treatment of metacarpal fracture, single, with or without internal or external fixation, each bone	5.31	5.33	no change

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Table 2: Harvard Study Work and Time Data for CPT Codes 26600-26615

A CPT	B DESCRIPTOR	C 1992 MFS RVW	D 1993 MFS RVW	E*	F*	G*	H*	I*	J*	K*	L*	M*	N*	O*	P*	Q*				
																Surveyed?? 1=yes; 0=no				
																Pre	Post	SD	ICU	OV
26600	Closed treatment of metacarpal fracture, single; without manipulation, each bone	1.90	1.85	82	42%	115	58%	9	0	0	19	8	0	0	26	1	1	1	1	1
26605	Closed treatment of metacarpal fracture, single; with manipulation, each bone	2.82	2.74	111	43%	150	57%	15	0	0	27	9	0	0	32	1	1	1	1	1
26607	Closed treatment of metacarpal fracture, with manipulation, with internal or external fixation, each bone	5.40	5.25	212	51%	203	49%	18	15	0	46	11	0	5	33	0	0	0	0	0
26608	Percutaneous skeletal fixation of metacarpal fracture, each bone (NEW 1993)	n/a	5.25																	
26610	Treatment of open metacarpal fracture, single, with uncomplicated soft tissue closure, each bone (DELETED 1993)	4.22	n/a	190	53%	168	47%	17	0	0	46	16	0	0	32	0	0	0	0	0
26615	Open treatment of metacarpal fracture, single, with or without internal or external fixation, each bone	5.46	5.31	259	57%	195	43%	19	15	0	56	16	0	0	31	1	1	1	1	1

*Copyright 1992 March 1992; William C. Hsiao, Peter Braun, Daniel Dunn, Edmund Becker, Nancy L. Kelly, Douwe B. Yntema ; The preliminary data contained is part of a federal study performed for the Health Care Financing Administration.

Table 3: Hospital and Office Visit Data* Used for E/M Global Adjustment for CPT Codes 26600-26615

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
CPT	1997 RVW	1998 RVW	RVW diff	HV Source	99231	99232	99233	99238	ICU32	ICU33	OV Source	99211	99212	99213	99214	99215
26600	1.81	1.96	0.15	harv	0.0	0.0	0.0	0.0	0.0	0.0	harv	0.0	3.0	0.0	0.0	0.0
26605	2.67	2.85	0.18	harv	0.0	0.0	0.0	0.0	0.0	0.0	harv	0.0	3.5	0.0	0.0	0.0
26607	5.12	5.36	0.24	harv	0.0	0.0	0.0	0.5	0.0	0.0	harv	0.0	2.5	0.0	0.0	0.0
26608	5.12	5.36	0.24	Abt	.	.	.	.	.	.	Abt	.	.	.	.	.
26610	del															
26615	5.18	5.33	0.15	harv	0.0	0.0	0.0	0.0	0.0	0.0	harv	0.0	3.0	0.0	0.0	0.0

*Received from HCFA July 21, 1997.

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2001

Hallux Valgus Repair

The RUC reviewed code 28299 *Correction, hallux valgus (bunion), with or without sesamoidectomy, by other methods (eg, double osteotomy)* during the five-year review and recommended an increase from 8.88 work RVUs to 9.18 work RVUs. The RUC did not fully agree with the specialty society survey data at the time of the five-year review due to a concern that the CPT code descriptor should be changed to be consistent with the vignette, which described a double osteotomy. The RUC recommended that this issue be referred to CPT.

The CPT Editorial Panel reviewed this code and made revisions as suggested by the RUC. The specialty societies then presented their original work relative value and survey data during the April, 2001 RUC meeting.

The RUC concluded that the work relative value for code 28299 should reflect the work of 28296 *Hallux valgus (bunion) correction, with or without sesamoidectomy; with metatarsal osteotomy (eg, Mitchell, Chevron, or concentric type procedures)* (work RVU = 9.18) plus an increment for the second osteotomy. The RUC developed its recommendation by calculating the work of the second osteotomy as follows:

28310 <i>Osteotomy for shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)</i>	5.43
Less pre- and post-time:	
99238 <i>Discharge Day Management</i>	1.28
99212 <i>Level 2 E/M Office Visit (3 x .45)</i>	<u>1.35</u>
	<u>2.63</u>
Intra-Service Work	2.80
½ of Intra-Service Work (Incision already made)	1.40
28299 (9.18) + 1.40 = 10.58	

The RUC recommends a work relative value of 10.58 for CPT code 28299.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
28299		Correction, hallux valgus (bunion), with or without seamoidectomy by other methods (eg, double osteotomy)	090	10.58



American Academy of
Orthopaedic Surgeons

AAOS American Association of
Orthopaedic Surgeons

6300 North River Road Rosemont, IL 60018-4262
Phone 847/823-7186, 800/346-2267 Fax 847/823-8125 Fax-on-Demand 800/999-2939 Internet www.aaos.org

March 22, 2001

To: RUC members

From: Tye Ouzounian

RUC Advisor: American Orthopaedic Foot and Ankle Society

PEAC Member: American Association of Orthopaedic Surgeons

RE: 28299

2001 CPT Code Descriptor: Correction, hallux valgus (bunion), with or without sesamoidectomy; by other methods (eg, double osteotomy)

2002 revised CPT Code Descriptor: Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy

Dear RUC Members:

We are requesting further refinement of the revised physician work value for CPT code 28299. This code has already been presented for the RUC 5-year review. Based upon the recommendations from our RUC workgroup, further refinement has been recommended for this code, and we are requesting completion of that refinement process.

Our data, presented in conjunction with the American Podiatric Medical Association (APMA), was addressed during the 5-year review workgroup in 2000, and an increase was approved by the RUC during the next meeting. We initially requested an increase in the physician RVU from its current value of 8.88 to a revised survey value of 11.85. It was our understanding from that discussion that the RUC workgroup was uncomfortable allowing the full increase that we had proposed due to the fact that the CPT language was vague, and could be applied to a variety of procedures. The workgroup did allow a partial increase in physician RVU to 9.18, and recommended that the code be referred to CPT for clarification of the code description. It was our understanding that once the code description was clarified, we would be allowed to again request reconsideration of our initially proposed physician RVU.

We have subsequently, in conjunction with the APMA, revised the CPT code description, and the CPT Editorial Panel has accepted this. With this clarification of the CPT code description, we are requesting reconsideration for our initially proposed physician RVU, as the workgroup recommended.

Thank you for allowing us to present our initial data for reconsideration before the entire RUC.

Sincerely,

Tye J Ouzounian, M.D.
RUC Advisor: American Orthopaedic Foot and Ankle Society

Attachments:

Initial presentation materials
CPT code description revision materials



AMERICAN PODIATRIC MEDICAL ASSOCIATION, INC.

March 30, 2001

James G. Hoehn, MD
Chairman
RVS Update Committee
American Medical Association
515 North State Street
Chicago, IL 60610

RE: CPT code 28299

Dear Dr. Hoehn:

The American Podiatric Medical Association (APMA) requests that the RVS Update Committee (RUC) reconsider the physician work relative value units (RVWs) that were recently revised as part of the RUC 5-year review.

The APMA, in cooperation with the American Academy of Orthopaedic Surgeons (AAOS), completed a survey for CPT code 28299 (*Correction, hallux valgus (bunion), with or without sesamoidectomy; by other methods (eg, double osteotomy)*) which demonstrated a RVW of 11.85. However, the workgroup concluded that the existing code descriptor was vague and could be applied to a variety of procedures and, therefore, approved a partial increase in RVWs from 8.88 to 9.18. The workgroup referred CPT code 28299 to the CPT Editorial Panel for revision and APMA again worked cooperatively with AAOS in obtaining this revision. It was our understanding that once that revision was complete, APMA and AAOS could request reconsideration of the initially proposed RVW.

The CPT Editorial Panel approved the following revised code descriptor at its February meeting: (*Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy*). We believe that this code descriptor satisfactorily describes the procedure performed and we request that the RUC reconsider our original RVW recommendation of 11.85 at the April meeting. If there is additional information we can provide, please let us know.

Sincerely,

R.D. Sowell, DPM
President

Marc D. Lenet, DPM
RUC Advisor

enclosures: Initial presentation materials & CPT code description revision materials

CPT Code	Description	2000 Work	RUC Rec RVU	Public Comment to HCFA	RUC Rationale	Key
27828	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal or external fixation; of both tibia and fibula	16.23	16.23	The work of 27828 is equivalent to the work of 27827 (Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal or external fixation; of tibia only (RVW = 14.06)) plus that of 27792 (Open treatment of distal fibular fracture (lateral malleolus), with or without internal or external fixation (RVW = 7.66)). Furthermore, this code was never surveyed in the original Harvard study. Code 27828 was reviewed in the first five-year review, and the AAOS recommended a new RVW of 18.00. This recommendation was rejected by the RUC based upon an increase given during a 1992 refinement. That refinement was not based upon survey data. The AAOS believes the 1995 RVW to be correct, with the addition of approximately 1.00 RVW to account for the increase for E/M services in the post-operative period.	The survey results for code 27828 did not justify a recommendation for an increase in the work RVU. Therefore, as no compelling evidence was provided, the RUC recommends that the current 2000 work RVU of 16.23 be maintained.	2
28299	Correction, hallux valgus (bunion), with or without sesamoidectomy; by other methods (eg, double osteotomy)	8.88	9.18	Hallux valgus surgery continues to evolve with the development of combined osseous and soft tissue procedures. In current practice, code 28299 typically represents a combined osteotomy of the first metatarsal (28296 Correction, hallux valgus (bunion), with or without sesamoidectomy; with metatarsal osteotomy (eg, Mitchell, Chevron, or concentric type procedures) (RVU = 9.18)) and an osteotomy of the proximal phalanx (28310 Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure) (RVU = 5.43)). Applying the multiple procedure rule, the appropriate RVU for 28299 would be the full value of 28296 plus half the value of 28310.	The RUC acknowledged that in the descriptor of this code, the terminology "double osteotomy" did not describe the typical patient when this code was surveyed in the original Harvard study, and therefore the value for code 28299 did not include the work of a "double osteotomy". The workgroup compared this code to the reference service code 28296 (Correction, hallux valgus (bunion), with or without sesamoidectomy; with metatarsal osteotomy (eg, Mitchell, Chevron, or concentric type procedure) (9.18 RVW)). The RUC agreed that even though there was more intraoperative work (time and intensity) for the second osteotomy, a value equal to 28296 of 9.18 would be appropriate with the understanding that the code be sent to CPT to create language that would define the code as a double osteotomy as opposed to "by other methods."	4

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

Key (1= Adopt the recommended increase in RVUs; 2 = Maintain the current RVU; 3 = Adopt the recommended decrease in RVUs; 4 = Suggest a new RVU; 5 = Refer the code to CPT; 6 = No consensus)

Thursday, October 26, 2000

Survey CPT Code: 28299

Global: 090

Current RVW: 8.88

Recommended RVW: ~~11.85~~

RUC Recommended RVW: 10.58

CPT Code Descriptor: Correction, hallux valgus (bunion), with or without sesamoidectomy; by other methods (eg, double osteotomy)

Typical Patient (Vignette): A 44-year old female has a complex hallux valgus deformity that has not responded to conservative treatment. The deformity is surgically corrected with a double osteotomy of the metatarsal and proximal phalanx.

CLINICAL DESCRIPTION OF SERVICE:

PREOPERATIVE WORK:

Preoperative work begins after the decision to operate is made, from the day before surgery until the time of the procedure, when the skin incision is actually made. This includes obtaining and reviewing pre-procedural imaging, pathology, and laboratory studies; with special attention to x-ray review, examination of ipsi- and contralateral lower extremities; consulting with referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or patient's family) to explain operative risks and benefits and to obtain informed consent. Preoperative work also includes ensuring that the surgical instruments and supplies that are necessary are present and available in the operative suite; supervising the organizing fluoroscopic equipment; positioning the patient on the operating table, application of a thigh tourniquet, supervising prepping and draping of the patient; preoperative scrubbing, marking the patient for the planned incision, exsanguination of the extremity and inflation of the tourniquet.

INTRAOPERATIVE WORK:

In order to perform a hallux valgus correction with double osteotomy, two operative procedures must be performed. First a chevron osteotomy of the distal first metatarsal with correction of the hallux valgus, followed by an osteotomy of the proximal phalanx to correct additional angular deformity. A long medial incision is made, centered over the hallux medial eminence extending from the proximal interphalangeal joint to the mid metatarsal shaft. The interval between the dorsal and plantar nerves is developed down to the joint capsule of the metatarsal phalangeal joint. The joint capsule is incised and the joint is inspected for evidence of arthritic changes. Under direct visualization, the joint is distracted and the lateral joint capsule is incised by reaching across the joint and cutting the capsule.

This allows correction of the capsular deformity. By subperiosteal dissection, the distal aspect of the metatarsal is exposed, including the medial eminence. Using a power saw; the medial eminence is then removed. A chevron shaped osteotomy (V-shaped) is then performed across the metatarsal neck.

After completion of the cut, the distal fragment is displaced laterally and impacted into the proximal fragment. Once the desired amount of correction is obtained, internal fixation hardware is inserted to maintain the bone position.

At this point, attention is then directed towards the proximal phalanx and the angular deformity that is present. The proximal phalanx is exposed by subperiosteal dissection. Using a power saw, a displacement osteotomy is then performed near the base of the proximal phalanx. The osteotomy is then displaced and internal fixation hardware is inserted to maintain the bone position. After completion of both osteotomies, fluoroscopy is utilized to verify the correction and hardware placement.

The tourniquet is deflated, and hemostasis is obtained. The wound is washed. Closure is performed in layers, with special attention being paid to the capsular closure to prevent recurrence, or overcorrection of the deformity.

POSTOPERATIVE WORK:

Postoperative work begins after skin closure in the operating room and includes cleaning of the extremity, application of the postoperative dressing and application of a splint or cast. Postoperative work also includes monitoring patient stabilization in the recovery room; writing of postoperative physician orders and medical records; dictation of an operative report; communication with the family and other health care professionals; and all hospital visits and services performed by the surgeon, including monitoring neurovascular status; care and removal of drain; and antibiotic and pain medication and physical therapy management. Discharge day management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records.

Additionally, all post-discharge office visits for this procedure for 90 days after the day the operation are considered part of the postoperative work for this procedure; including removal of sutures; evaluation of periodic imaging to assess bony fusion and laboratory reports; office visits for evaluation of the patient, and assessment of their return to active function; phone calls to the patient, family, physical therapist, and other health care professionals; and pain medication and physical therapy and activity adjustments. Postoperative office care in this procedure is greater than most procedures. During the first six weeks, the patient is seen to retape the forefoot and help control the correction in order to avoid recurrent deformity, or overcorrection. During the next six weeks, the patient is seen to monitor their progressive range of motion and return to full activity.

SURVEY DATA

Presenter(s): Laura Tosi, MD

Specialty(s): American Association of Orthopaedic Surgeons
American Orthopaedic Foot and Ankle Society
American Podiatric Medical Association

Sample Size: 126 **Response Rate:** 42 (33%)

Type of Sample: random (mail)

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	10.00	11.15	11.85	12.18	24.00
Pre-Service			75		
Intra-Service	60	86	90	105	180
Post-Service:	<u>Total Time</u>	<u>CPT code / # of visits</u>			
Immed. Post-Service	30				
Critical Care	0				
Other Hospital	0				
Discharge Day Mgmt	<u>36 18</u>	99238x1			
Office Visits	84	99213x3 99212x1			

KEY REFERENCE SERVICE(S):

<u>'00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
9.18	090	28296	Hallux valgus (bunion) correction, with or without sesamoidectomy; with metatarsal osteotomy (eg, Mitchell, Chevron, or concentric type procedures)
5.43	090	28310	Osteotomy for shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)

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

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

<i>TIME ESTIMATES (MEDIAN)</i>	Survey CPT 28299 (n=42)	Ref CPT 28296 (n=35)
Pre-service time	75	70
Intra-service time	90	60
Immediate Post-service time	30	30
Total critical care time	0	0
Total other hospital visit time	0	0
Discharge management time	36	30
Total office visit time	84	107

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	3.40	3.00
Intra-service	3.98	3.24
Post-service	3.18	2.97

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.79	3.26
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.29	3.14
Urgency of medical decision making	2.26	2.29

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.22	3.65
Physical effort required	3.54	3.24

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.71	3.06
Outcome depends on the skill and judgment of physician	4.17	3.63
Estimated risk of malpractice suit with poor outcome	3.69	3.49

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. **Your rationale should also describe how the work of performing the service has changed over the past five years**

Although the survey descriptor cites "double osteotomy" as an example of "other method," this was not the "typical patient" until recently and the value for this "other method" code was most likely not based on double osteotomy. In fact, the Harvard study did not include the phrase (eg, double osteotomy) in its survey. When this code was originally valued, it is most likely that the orthopaedic surgeons responding may not have known what "other methods" might be employed.

Current practice for hallux valgus surgery continues to evolve with the development of combined osseous and soft tissue procedures. In current practice, 28299 has changed so that typically a double osteotomy is performed (first metatarsal and proximal phalanx). The survey median RVW is recommended and can be justified using two reference comparisons.

28299 requires more intraoperative work (both time and intensity) than 28296 for a second osteotomy. The additional 30 minutes compared with 99291 would equal 2.00 rvu's. This added to the RVW for 28296 equals 11.18 rvu's [9.18 + 2.00 = 11.18].

Using the multiple procedure rule, 50 percent of the RVW for 28310 is 2.71 which represents the work value for one osteotomy. Adding this increment to the current value for 28299 to account for the "typical" double osteotomy in current practice equals 11.59 rvu's [8.88 + 2.71 = 11.59].

FREQUENCY INFORMATION

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

Sometimes

For your specialty, estimate the number of times this service might be provided nationally in a one-year period?

National frequency unavailable; not able to estimate.

For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period?

1998 Medicare frequency from HCFA utilization file :

[Does not include frequency for mods -80 (assistant), -55 (post-op only), -56 (pre-op only)].

1,233 podiatry
 235 orthopaedic surgery
 6 ASC
 4 clinic or group practice (not gppp)
 3 general surgery
 2 anesthesiology
 1 internal medicine
 1 plastic & reconstructive surgery

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

Five-Year Review Specific Questions:

Please indicate the number of survey respondents responding to each of the following questions:

- a. **Has the work of performing this service changed in the past 5 years?**
16 Yes
26 No
- b. **This service represents new technology that has become more familiar (i.e., less work).**
4 I agree
12 I do not agree
- c. **Patients requiring this service are now:**
9 more complex (more work)
0 less complex (less work)
7 no change
- d. **The usual site-of-service has changed:**
0 from outpatient to inpatient
11 from inpatient to outpatient
5 no change

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

April 2001

Arthroscopic Shoulder Procedures

29806 II1

Code 29806 *Arthroscopy, shoulder, surgical, capsulorrhaphy* was created to allow physicians to code for shoulder stabilizations arthroscopically where previously this surgery was always an open procedure. In current practice, the pre-service and post-service "work" (time and intensity) for 29806 (laparoscopic capsulorrhaphy) and the reference code 23455 *Capsulorrhaphy, anterior; with labral repair (eg, Bankart procedure)* (work RVU = 14.37) are essentially equivalent. Since the intra-service time for both procedures is similar, and the RUC concluded that the intensity between the two services was also similar, although the specialty society contended that there is greater intensity and complexity for 29806. Given that the 25th percentile value of 14.37 equaled the value of the reference code, the RUC determined that this new code was equivalent in work to the reference code, which describes the open procedure. **The RUC recommends a work relative value of 14.37 for CPT code 29806.**

29807 II2

Code 29807 *Arthroscopy, shoulder, surgical, repair of slap lesion* is similar to the previous code 298006 but involves less work. Code 29807 was also compared to the reference code 23455 *Capsulorrhaphy, anterior; with labral repair (eg, Bankart procedure)* (work RVU = 14.37). Code 29807 requires less intra-operative time than 29806 because; 1) X3 generally requires the insertion of fewer soft tissue stabilization devices, 2) the tissue being stabilized does not need to be "shifted", and 3) the access to the area in question is less occupied by neurovascular structures. Due to the less maneuvering involved, 29807 should have a value slightly less than 29806. The RUC accepted the 25th percentile value of 13.90 as this value was slightly below the recommended value for 29806 and correctly placed the codes in proper rank order. **The RUC recommends a work relative value of 13.90 for CPT code 29807.**

Practice Expense

Codes 29806 and 29807 are only performed in a facility setting, therefore, there are no proposed direct practice expense inputs for the office setting. The RUC recommends that the standard developed for the 090-day major surgical procedures be applied for this code.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
23415		<i>Coracoacromial ligament release, with or without acromioplasty</i> <u>(For arthroscopic procedure, use 29826)</u>	090	9.97 (No change)
23450		<i>Capsulorrhaphy, anterior; Putti-Platt procedure or Magnuson type operation</i> <u>(To report thermal capsulorrhaphy, use 29999)</u>	090	13.40 (No change)
23455		<i>with labral repair (eg, Bankart procedure)</i> <u>(For arthroscopic procedure, use 2980X1)</u>	090	14.37 (No change)
23460		<i>Capsulorrhaphy, anterior, any type; with bone block</i>	090	15.37 (No change)
23462		<i>with coracoid process transfer</i> <u>(To report thermal capsulorrhaphy, use 23929)</u>	090	15.30 (No change)
29804		<i>Arthroscopy, temporomandibular joint, surgical</i> <u>(For open procedure, use 21010)</u>	090	8.14 (No change)

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●298005 29805		Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure) (For open procedure, see 23100-23101, 23065-23066)	090	5.89 (See deleted code 29815)
●29806	II1	Arthroscopy, shoulder, surgical; capsulorrhaphy (For open procedure, use 23450-23466) (To report thermal capsulorrhaphy, use 29999)	090	14.37
●298007	II2	repair of slap lesion	090	13.90
29815		Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure) (29815 has been deleted. To report, use 29805)	090	N/A
▲29819		Arthroscopy, shoulder, surgical; with removal of loose body or foreign body (For open procedure, see 23107, 23040-23044)	090	7.62 (No change)
29820		<i>synovectomy, partial</i> (For open procedure, see 23105)	090	7.07 (No change)
29821		<i>synovectomy, complete</i> (For open procedure, see 23105)	090	7.72 (No change)

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
29822		<i>debridement, limited</i> (For open procedure, see specific open shoulder procedure performed)	090	7.43 (No change)
29823		<i>debridement, extensive</i> (For open procedure, see specific open shoulder procedure performed)	090	8.17 (No change)
•29824	II	distal claviclectomy including distal articular surface (Mumford Procedure) (For open procedure, use 23120)	090	8.25 (adopted at February RUC Meeting)
29825		<i>with lysis and resection of adhesions, with or without manipulation</i> (For open procedure, see specific open shoulder procedure performed)	090	7.62 (No change)
29826		<i>decompression of subacromial space with partial acromioplasty, with or without coracoacromial release</i> (For open procedure, use 23415 or 23130)	090	8.99 (No change)

CPT Code: 2980X2 (II1)

Global: 090

Recommended RVW 15.00
RUC Recommendation 14.37

CPT Descriptor: Arthroscopy, shoulder, surgical; capsulorrhaphy
(For open procedure, use 23450-23466)
(To report thermal capsulorrhaphy, use 29999)

Survey Vignette (Typical Patient)

A 17-year-old high school wrestler falls on the wrestling mat, forcing his arm into abduction and external rotation. The dislocation is reduced at matside, and follow-up x-rays rule out an associated fracture. He is treated conservatively with a sling, ice, and antiinflammatory medication. A gentle program of forward flexion is begun but abduction and external rotation are restricted. After four weeks, the restrictions are lifted and an aggressive rotator cuff and shoulder girdle strengthening program is begun. After returning to wrestling, there are several episodes where his shoulder attempts to redislocate, and a recurrent dislocation takes place during a subsequent match that cannot be reduced matside. After reviewing non-surgical and surgical options with his orthopaedist, the patient elects to undergo an arthroscopic capsulorrhaphy.

CLINICAL DESCRIPTION OF SERVICE:

Pre-service work:

Review pre-operative work-up, including: pre-procedural imaging and laboratory studies, with special attention to reviewing the MRI. Consult with the referring physician and other health care professionals, as necessary. Answer patient and family questions. Obtain informed consent if not already obtained. Review the surgical procedure, length and type of anesthesia, post-op, and expected outcome(s) with patient and family. Change into scrub clothes. Mark the operative site. Review planned procedure and positioning and draping of patient, positioning of monitors and laparoscopic/video equipment. Position the patient supinely and apply a shoulder boom to support the arm and allow the appropriate amount and angle of traction. Roll the patient into the lateral decubitus position and place pads to protect areas from pressure. Ensure that the necessary surgical instruments and supplies are present and available in the operative suite. Scrub and gown. The arthroscopic equipment is positioned to allow an unobstructed view of the monitor. The arm is examined for stability, and then prepped and draped

Intra-service work – Skin to skin:

After induction of general anesthesia, a posterior arthroscopy portal is created. Once the bloody effusion is irrigated, an inspection is performed of the intra-articular structures including the entire articular surface, the biceps tendon, the subscapularis, the superior and middle glenohumeral ligaments, the anterior and posterior inferior glenohumeral ligaments, the labrum, the inferior pouch, the bare area, evaluation for a Hill Sachs lesion, the infraspinatus and the supraspinatus tendons and associated recesses. The anterior inferior glenohumeral ligament (AIGHL) has been avulsed from the anterior glenoid. The labrum has been avulsed with the ligament and will need to be incorporated in the repair. The articular surface is intact and no evidence of a Hill-Sachs lesion is identified. An anterior portal is created with an inside-out or outside-in technique. A plastic canula with a rubber dam is placed anteriorly to allow access, but not allow extravasations. The original anterior portal is created in a high position to allow a second anterior portal to be made above the subscapularis tendon. The adhesions of the AIGHL are released from the glenoid. All attachments of the ligament to the subscapularis must be released to allow shifting of the ligament back to its original or to a slightly advanced position. The anterior glenoid neck is then burred to a bleeding surface without injuring the articular surface. Once the neck is abraded a drill is inserted into the lower large bore anterior canula. This lower position will allow a more perpendicular approach to the glenoid rim. The drill hole is made for placement of a bone anchor. The bone anchor has one or two sutures, which are carefully and painstakingly passed through the AIGHL in such a fashion to advance/shift the ligament when the knots are tied. This sequence of steps; drill guide placement, creation of the drill hole, placement of the bone anchor, passing the sutures and tying the sutures is repeated for one or two more bone anchors. When these tasks are completed and the AIGHL is tightly held against the glenoid, the stabilization is complete. The arthroscope is then removed from the glenohumeral joint and placed in the subacromial space to rule-out concomitant pathology in this location. The portal incisions are sutured

Post-service work:

Postoperative work begins after the skin closure in the operating room and includes application of sterile

dressings and a shoulder immobilizer. Postoperative work also includes monitoring patient stabilization in the recovery room, with special attentions to monitoring of neurovascular status and function of the arm; communication with the family and other health care professionals (including written and oral reports and orders). Discharge plans include instructions for continuing care, ordering of postoperative pain medication and antibiotics, physiotherapy and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures; periodic assessment and adjustment of the splint; direct patient physiotherapy instruction by the surgeon; ordering and assessing adjunctive physiotherapy progress; and pain medication adjustments.

SURVEY DATA

Presenter(s): David Martin, MD
William Beach, MD

Specialty(s): American Association of Orthopaedic Surgeons
Arthroscopy Association of North America
American Shoulder and Elbow Surgeons

CPT: 2980X2

Sample Size: 200 **Resp n:** 57 **Resp %:** 29%

Sample Type: random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RWW	10.00	14.37	15.00	17.00	21.56
Pre-Service			55		
Intra-Service	40	75	100	120	180
Post-Service	<u>Total Min</u>	<u>CPT code / # of visits</u>			
<i>Day of Surgery:</i>					
Immediate	30				
Other	18	99238 x 0.5 (same day surgery)			
<i>After Day of Surgery:</i>					
Critical Care	0				
Other Hospital	0				
Dischg Day Mgmt	0				
Office Visits	91	99213x2 99212x3			

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
23455	Capsulorrhaphy, anterior; with labral repair (eg, Bankart procedure)	14.37	090

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

	Svy CPT	Ref CPT
	2980X2	23455 (Hvd)
TIME ESTIMATES (MEDIAN)		
Pre-service time	55	55
Intra-service time	100	104
Same Day Immediate Post-service time	30	26
Same Day Other Post-service time	0	0
Post Total critical care time (not same day)	0	0
Post Total other hospital visit time (not same day)	0	19
Discharge management time	18	36
Total office visit time	91	60

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	3.65	3.55
Intra-service	4.46	3.96
Post-service	3.35	3.27

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.46	3.31
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.24	3.13
Urgency of medical decision making	2.76	2.73

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.67	3.96
Physical effort required	3.93	3.79

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.70	3.52
Outcome depends on the skill and judgment of physician	4.70	4.04
Estimated risk of malpractice suit with poor outcome	3.35	3.23

ADDITIONAL RATIONALE

In current practice, the pre-service and post-service "work" (time and intensity) for 2980X2 (laparoscopic capsulorrhaphy) and 23455 (open capsulorrhaphy) are essentially equivalent. Although the intra-service "time" for both procedures is similar, there is greater intensity and complexity for 2980X2 that justifies an RVW that is higher than 23455. The complexity arises from the technical difficulty of placing the fixation devices and the intricate work required in stabilizing the tissue to the bone. The intensity of the procedure is magnified by the time constraints caused by the inevitable fluid extravasation into the soft tissue. The time, as previously noted, is equivalent but the technical skill and intra-service complexity are significantly greater. The outcome is entirely dependent on the technical ability of the surgeon to accurately and completely execute each step of the surgical procedure. We recommend the survey median RVW of 15.00 for 2980X2 and note that the survey total times and the mean intensity/complexity measures above support this recommendation.

Additional survey question and results:

"Where is this service performed (check all that apply)?"

Hospital

Outpatient Hospital / Surgi-Center

Office

FREQUENCY INFORMATION

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

29909 Unlisted procedure, arthroscopy

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

Specialty: Orthopaedic Surgery Commonly

3. 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: Orthopaedic Surgery Frequency: 40,000

4. 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: Orthopaedic Surgery Frequency: 400

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Performed by many physicians across the US.

CPT Code: 2980X3 (II2)

Global: 090

Recommended RWV 14.37
RUC Recommendations 13.90

CPT Descriptor: Arthroscopy, shoulder, repair of slap lesion

Survey Vignette (Typical Patient)

A 35-year-old construction worker grabs a support to prevent a fall, but feels a pulling, tearing sensation in the shoulder. Emergency room x-rays show no sign of fracture. Despite a program of anti-inflammatory medication, thermal modalities, and gentle physical therapy, after three weeks, he is still unable to elevate his arm past shoulder level, especially with the palm facing the ceiling. MRI identifies a superior labrum anterior/posterior (SLAP) tear. An arthroscopic SLAP lesion repair is scheduled.

CLINICAL DESCRIPTION OF SERVICE:

Pre-service work:

Review pre-operative work-up, including: pre-procedural imaging and laboratory studies, with special attention to reviewing the MRI. Consult with the referring physician and other health care professionals, as necessary. Answer patient and family questions. Obtain informed consent if not already obtained. Review the surgical procedure, length and type of anesthesia, post-op, and expected outcome(s) with patient and family. Change into scrub clothes. Mark the operative site. Review planned procedure and positioning and draping of patient, positioning of monitors and laparoscopic/video equipment. Position the patient supinely and apply a shoulder boom to support the arm and allow the appropriate amount and angle of traction. Roll the patient into the lateral decubitus position and place pads to protect areas from pressure. Ensure that the necessary surgical instruments and supplies are present and available in the operative suite. Scrub and gown. The arthroscopic equipment is positioned to allow an unobstructed view of the monitor. The arm is examined for stability and then prepped and draped.

Intra-service work – Skin to skin:

A posterior portal is made for insertion of the arthroscope. The intra-articular structures are evaluated. An anterior portal is then made and a probe is inserted. The probe is used to palpate these structures. Care and patience must be taken to closely evaluate every inter-articular structure to determine the often present, co-morbid condition. Once assured of the isolated pathology, the superior labrum is thoroughly investigated. The biceps/labral complex has been avulsed from the superior glenoid. A shaver is introduced to debride and abrade the superior glenoid, down to bone to provide a bleeding bed. The undersurface of the biceps/labral complex is also debrided. A second anterior portal is made through the rotator cuff interval after needle localization. A large bore canula with a rubber damn is placed into this portal to allow access but prevent extravasation. A drill is placed through this portal and a drill hole is created on the extra-articular surface of the superior glenoid. Great care is taken to prevent angling the drill toward the articular surface. Once the hole is made, a bone anchor is placed into the hole. The bone anchor has at one or two sutures attached (two or four suture ends respectively). Each of these sutures is passed through the biceps/labral complex. Once on the non-articular side of the complex the sutures are tied arthroscopically. The arthroscopic knots must be accurately tied and tightly to hold the complex against the bleeding surface of the superior glenoid. After tying the sutures are cut and any loose edges are debrided. The arthroscope is then removed from the glenohumeral joint and placed in the subacromial space. The rotator cuff, acromion, coracoacromial ligament and the undersurface of the acromion are closely inspected. Pathology found in this area may also require specific treatment. All arthroscopic instrumentation is removed and the portal incisions are sutured.

Post-service work:

Postoperative work begins after the skin closure in the operating room and includes application of sterile dressings and a shoulder immobilizer. Postoperative work also includes monitoring patient stabilization in the recovery room, with special attentions to monitoring of neurovascular status and function of the arm; communication with the family and other health care professionals (including written and oral reports and orders). Discharge plans include instructions for continuing care, ordering of postoperative pain medication and antibiotics, physiotherapy and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of sutures; periodic assessment and adjustment of the splint; direct patient physiotherapy instruction by the surgeon; ordering and assessing adjunctive physiotherapy progress; and pain medication adjustments.

SURVEY DATA

Presenter(s): David Martin, MD
William Beach, MD

Specialty(s): American Association of Orthopaedic Surgeons
Arthroscopy Association of North America
American Shoulder and Elbow Surgeons

CPT: 2980X3

Sample Size: 200 **Resp n:** 55 **Resp %:** 28%

Sample Type: random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	8.25	13.90	14.37	15.00	21.00
Pre-Service			55		
Intra-Service	30	60	90	98	180

Post-Service	<u>Total Min</u>	<u>CPT code / # of visits</u>
<i>Day of Surgery:</i>		
Immediate	30	
Other	18	99238 x 0.5 (same day surgery)
<i>After Day of Surgery:</i>		
Critical Care	0	
Other Hospital	0	
Dischg Day Mgmt	0	
Office Visits	91	99213x2 99212x3

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
23455	Capsulorrhaphy, anterior; with labral repair (eg, Bankart procedure)	14.37	090

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

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT
	2980X3	23455 (Hvd)
Pre-service time	55	55
Intra-service time	90	104
Same Day Immediate Post-service time	30	26
Same Day Other Post-service time	0	0
Post Total critical care time (not same day)	0	0
Post Total other hospital visit time (not same day)	0	19
Discharge management time	18	36
Total office visit time	91	60

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	3.81	3.41
Intra-service	4.23	3.93
Post-service	3.29	3.24

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.08	3.31
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.60	3.17
Urgency of medical decision making	2.81	2.81

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.50	3.90
Physical effort required	3.75	3.81

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.46	3.57
Outcome depends on the skill and judgment of physician	4.40	4.02
Estimated risk of malpractice suit with poor outcome	3.23	3.29

ADDITIONAL RATIONALE

2980X3 (Arthroscopy, shoulder, repair of slap lesion) compares well with 23455 and new code 2980X2. All three codes require similar pre-service and post-service work. 2980X3 requires less intra-operative time than 2980X2 because; 1) X3 generally requires the insertion of fewer soft tissue stabilization devices, 2) the tissue being stabilized does not need to be "shifted", and 3) the access to the area in question is less occupied by neurovascular structures. Therefore, 2980X3 should have a value slightly less than 2980X2. In comparison to 23455, 2980X3 requires slightly less intra-operative time, but involves more complexity and intensity for the approach. The complexity arises from the technical difficulty of placing the fixation devices and the intricate work required in stabilizing the tissue to the bone. The intensity of the procedure is magnified by the time constraints caused by the inevitable fluid extravasation into the soft tissue. The time, as previously noted, is equivalent but the technical skill and intra-service complexity are significantly greater. The outcome is entirely dependent on the technical ability of the surgeon to accurately and completely execute each step of the surgical procedure. It is our opinion that the "total work" for 2980X3 and 23455 is the same. We recommend the survey median RVW of 14.37 for 2980X3, which is slightly less than 2980X2 and is the same as 23455.

Additional survey question and results:

"Where is this service performed (check all that apply)?"

Hospital Outpatient Hospital / Surgi-Center Office

FREQUENCY INFORMATION

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

29909 Unlisted procedure, arthroscopy

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

Specialty: Orthopaedic Surgery Sometimes

3. 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: Orthopaedic Surgery Frequency: 10,000

4. 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: Orthopaedic Surgery Frequency: 100

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Performed by many physicians across the US.

CPT Code: 2980X2
Specialty Society: AAOS, AANA, ASES

**AMA/Specialty Society Update Process
RUC Summary of Recommendation
Out-Of-Office Direct Inputs [In-Office Not Applicable]**

CPT Code: 2980X2 (II1) Global: 090 CPT Descriptor: Arthroscopy, shoulder, surgical; capsulorrhaphy

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

The American Association of Orthopaedic Surgeons' clinical staff times and procedure specific medical supplies and equipment were developed by the AAOS RUC Advisory Panel, with representatives from the various orthopaedic subspecialty societies. The membership of the advisory panel represents a combination of rural, suburban, and urban practices, solo, single and multi-specialty groups, as well as medical school faculty.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities

We believe the pre-service clinical labor activities are consistent with the basic preoperative package that has been developed by the PEAC for the 90 day global codes.

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities

We have applied the previously accepted E/M clinical staff times.

**AMA/Specialty Society Update Process
RUC Summary of Recommendation
Out-Of-Office Direct Inputs [In-Office Not Applicable]**

CPT Code: 2980X3 (II2) Global: 090 CPT Descriptor: Arthroscopy, shoulder, surgical; repair of slap lesion

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

The American Association of Orthopaedic Surgeons' clinical staff times and procedure specific medical supplies and equipment were developed by the AAOS RUC Advisory Panel, with representatives from the various orthopaedic subspecialty societies. The membership of the advisory panel represents a combination of rural, suburban, and urban practices, solo, single and multi-specialty groups, as well as medical school faculty.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities

We believe the pre-service clinical labor activities are consistent with the basic preoperative package that has been developed by the PEAC for the 90 day global codes.

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities

We have applied the previously accepted E/M clinical staff times.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
1	Clinical Labor, Medical Supplies, and Procedure Equipment Practice Expense Data						CPT				2980X2	2980X2	2980X3	2980X3
2							Global				090	090	090	090
3							Number/Level of Post OV:				N/A	99212X3 99213X2	N/A	99212X3 99213X2
4	CLINICAL LABOR						Code	staff desc	Price	IN Off	OUT off	IN Off	OUT off	
5	TOTAL TYPICAL TIME						1130	RN/LPN/MA	\$ 0.317	0	213	0	213	
6	PRE-service time						1130	RN/LPN/MA	\$ 0.317	0	60	0	60	
7	SERVICE time						1130	RN/LPN/MA	\$ 0.317	0	0	0	0	
8	POST-service time						1130	RN/LPN/MA	\$ 0.317	0	153	0	153	
9	PRE-SERVICE													
10	BEGINS after procedure consult. (In/out)									Min	Min	Min	Min	
11	Complete pre-service diagnostic & referral forms (5/5)						1130	RN/LPN/MA	\$ 0.317	0	5	0	5	
12	Coord pre-proc services/review test/exam results (10/20)						1130	RN/LPN/MA	\$ 0.317	0	20	0	20	
13	Schedule space and equipment in facility (0/8)						1130	RN/LPN/MA	\$ 0.317	0	8	0	8	
14	OV before surgery/procedure - review test/exam results (0/0)						1130	RN/LPN/MA	\$ 0.317	0	0	0	0	
15	Provide pre-service education/obtain consent (10/20)						1130	RN/LPN/MA	\$ 0.317	0	20	0	20	
16	Follow-up phone calls & prescriptions (10/7)						1130	RN/LPN/MA	\$ 0.317	0	7	0	7	
17	Other Pre-Service Activities (please specify):													
18							1130	RN/LPN/MA	\$ 0.317	0	0	0	0	
19	ENDS with admission to facility/office													
20	SERVICE PERIOD													
21	Starts with admission to facility/office									Min	Min	Min	Min	
22							1130	RN/LPN/MA	\$ 0.317	0	0	0	0	
23							1130	RN/LPN/MA	\$ 0.317	0	0	0	0	
24	Ends with discharge from facility/office													
25	POST-SERVICE													
26	Begins after discharge from facility/office									Min	Min	Min	Min	
27	Postop OV total time (E/M standards)		-211 (16)	-212 (27)	-213 (36)	-214 (53)	-215 (63)	1130	RN/LPN/MA	\$ 0.317	0	153	0	153
39	Other Activities (please specify):													
40							1130	RN/LPN/MA	\$ 0.317	0	0	0	0	
41	ENDS after 90 days from day of procedure.													
42	MEDICAL SUPPLIES						Code	Unit Size	Unit Cnt	Price	Out Off QTY	Out Off QTY	Out Off QTY	Out Off QTY
43														
44	PEAC Minimum visit package (multi-specialty):						PEAC	PKG	1	\$ 1,310	0	5	0	5
45	exam table paper (7 ft)						11111	foot	1	\$ 0.015				
46	gloves, non-sterile (2 pair)						11302	pair	1	\$ 0.120				
47	patient gown, disposable						11107	item	1	\$ 0.570				
48	pillow case, disposable						11112	item	1	\$ 0.320				
49	thermometer probe cover, disposable						11509	item	1	\$ 0.069				
50	Add'l visit supplies:													
51	patient education booklet						11115	item	1	\$ 0.920	0	1	0	1
52	PEAC Postop incision care kit:						PEAC	PKG	1	\$ 15.034	0	1	0	1
53	betadine						52310	ml	20	\$ 0.140				
54	gauze, sterile 4x4 (10 pack)						31505	pack	2	\$ 2.940				
55	gloves, sterile						14005	pair	1	\$ 0.890				
56	staple remover kit						31702	item	1	\$ 8.630				
57	steri-stmp						31513	stmp	12	\$ 3.580				
58	swab Alcohol						11302	item	2	\$ 0.034				
59	tape						31514	inch	12	\$ 0.300				
60	tincture benzoin swab						52308	item	1	\$ 0.320				
61	Add'l supplies:													
62										0	0	0	0	
63	PROCEDURE SPECIFIC EQUIPMENT													
64	Exam table						E11001	1		\$ 1,360	0	1	0	1

Medical Supplies: 4 Multi-specialty Minimum Supply Package for Visits; post-operative incision kit

Medical Equipment: Exam Table

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommenda- tion
29819		<i>Arthroscopy, shoulder, surgical; with removal of loose body or foreign body</i> <i>(For open procedure, see 23107, 23040-23044)</i>	090	7.62 (no change)
●29824	I1	distal claviclectomy including distal articular surface (Mumford procedure) <i>(For open procedure, use 23120)</i>	090	8.25
23120		<i>Claviclectomy; partial</i> <i>(For arthroscopic procedure, use 29824)</i>	090	7.11 (no change)

CPT Code: 2982X

Global: 090

Recommended RVW: 8.25

CPT Descriptor: Arthroscopy, shoulder, surgical; distal claviclectomy including distal articular surface (Mumford procedure)

Survey Vignette (Typical Patient)

A 35-year-old weightlifter presents with pain located over the acromioclavicular joint region of his right shoulder. On physical examination there is tenderness located at the acromioclavicular joint. A cross arm adduction stress test is positive. The pain is reproduced by abduction of the shoulder to 180 degrees. X-rays show osteolysis of the distal clavicle. The patient is treated with rest and nonsteroidal anti-inflammatory medications. His symptoms persist with weight lifting. A local injection of anesthetic and a steroid into his right acromioclavicular joint yields immediate relief of his pain. The cross arm adduction stress test and abduction to 180 degrees are painless. The patient's pain is temporarily relieved but recurs again with resumption of weight lifting. A bone scan is positive at the acromioclavicular joint. The patient undergoes arthroscopic resection of the distal 1cm of the clavicle.

CLINICAL DESCRIPTION OF SERVICE

Pre-service work – Day before surgery:

- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up, including: History and physical examination; review laboratory results (CBC, electrolytes, renal function); review appropriate x-ray, MRI, CT scans
- 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
- Obtain informed consent if not already obtained
- Review length and type of anesthesia with anesthesiologist
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Monitor/assist application of longitudinal skin traction to upper extremity
- Scrub and gown

Intra-service work – Skin to skin:

- Arthroscope is inserted posteriorly
- Anterior working portal established in the interval between the biceps tendon and the subscapularis, and the intra-articular contents of the shoulder are inspected and palpated
- Articular surface of the rotator cuff is closely inspected
- Arthroscope removed from the glenohumeral joint and placed into the subacromial bursa via the same posterior portal
- Anterior subacromial portal also established just lateral to the coracoacromial ligament, and an anterior cannula is placed through this portal into the subacromial space
- Subacromial space inspected for signs of impingement, such as abrasion of the periosteum on the undersurface of the acromion or tearing of the bursal surface of the rotator cuff; assuming neither of these is found, the surgeon proceeds with distal claviclectomy
- The periosteum on the undersurface of the acromion is removed; this requires defining the anterior and medial edges of the acromion and the margins of the acromioclavicular joint

- Remove joint capsule from the inferior aspect of the acromioclavicular joint
- In order to gain a good view of the AC joint it is often necessary to remove some of the anterior and medial acromion adjacent to the AC joint; also must remove soft tissue attachments, joint capsule, and periosteum circumferentially around the distal end of the clavicle to define the margins
- Removal of soft tissue requires use of a motorized soft tissue resector and an electrothermal soft tissue ablation device to provide hemostasis (eg, Arthrocare Wand)
- Following adequate exposure of the distal end of the clavicle, a motorized burr is introduced through the anterior portal and approximately 8-10 mm of the distal end of the clavicle is removed circumferentially
- Intraoperative x-ray may be obtained to ensure distal clavicle has been adequately resected
- Subacromial space and the area of the resected AC joint are injected with mixture of Marcaine and morphine
- Portal sites closed with one or two stitches

Post-op same day work through discharge:

- Sterile dressings are applied to the incisions
- Traction removed
- Sling applied to upper extremity
- Sign OR forms, indicating pre and post-op diagnoses, operation performed
- Write orders for post-op labs, chest x-ray, medications, diet, and patient activity
- Write brief operative note for patient's chart documenting in the daily progress notes pre-and postoperative diagnoses, operation performed, findings, blood loss, intraoperative IV fluids administered, complications, specimens sent to pathology, and condition of patient at the end of the procedure
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Dictate post-op report
- Discuss procedure outcome with referring physician
- Coordinate care with other physicians
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Revisit patient to assess progress, pulmonary, cardiac, renal function and assess status of dressings
- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient / family questions
- Answer nursing/other staff questions

Post-op office work – After discharge from hospital through 90 day global period

- Examine and talk with patient
- Check wounds and patient progress
- Write orders for and coordinate care with physical therapy
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians
- Write orders for medications
- Review post-discharge labs/films
- Discuss progress with patient/family
- Remove sutures/drains
- Dictate patient progress notes for medical chart

SURVEY DATA

Presenter(s): Laura Tosi, MD
Thomas Degenhardt, MD

Specialty(s): Arthroscopy Association of North America
American Academy of Orthopaedic Surgeons

Sample Size: 200 **Response Rate:** 43 (22%)

Type of Sample: Random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	7.11	7.76	8.25	9.25	12.50
Pre-Service			48		
Intra-Service	30	45	60	68	90
Post-Service	<u>Total Time</u>	<u>CPT code / # of visits</u>			
Day of Surgery:					
Immediate	20				
Other	18	99238 (x0.5)			
After Day of Surgery:					
Critical Care	n/a	n/a			
Other Hospital	n/a	n/a			
Discharge Day Mgmt	n/a	n/a			
Office Visits	76	99213x2 99212x2			

KEY REFERENCE SERVICE(S):

CPT	Descriptor	glob	2001 RVW
23120	Claviclectomy; partial	090	7.11
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with or without coracoacromial release	090	8.99
29881	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving)	090	7.76

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)	Svy CPT	Ref CPT
	2982X	23120
Count	43	28
Pre-service time	50	55
Intra-service time	60	45
Same Day Immediate Post-service time	20	20
Same Day Other Post-service time (*critical care)	18	18
Post Total critical care time (not same day)	0	0
Post Total other hospital visit time (not same day)	0	0
Discharge management time (not same day)	0	0
Total office visit time	76	76

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	2.84	2.81
Intra-service	3.81	3.05
Post-service	2.81	2.90

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.10	3.04
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.88	2.76
Urgency of medical decision making	2.37	2.28

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.29	2.80
Physical effort required	3.49	2.68

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.10	2.76
Outcome depends on the skill and judgment of physician	4.10	3.20
Estimated risk of malpractice suit with poor outcome	2.93	2.88

ADDITIONAL RATIONALE

CPT 2982X can be compared to current procedures in several ways.

Pre work and patient positioning is greater with 2982X than 23120. Intra work, including physician technical skill, is much greater with 2982X than 23120.

2982X is very similar in pre and post work to 29826, but is somewhat less intra work. CPT 29826 is a shoulder arthroscopic procedure that involves excision of bone (anterior acromion), release and excision of the coracoacromial ligament and excision of the subacromial bursa. CPT 2982X involves excision of bone (the distal clavicle) while preserving as much ligament stability of the acromio-clavicular joint as possible.

Using the multiple procedure rule, 2982X is essentially two procedures: the work of a diagnostic shoulder arthroscopy and the work of a partial claviclectomy. As such, an estimated work value should be similar to 23120 plus 50% of 29815 [$10.05 = 7.11 + (5.89 \times 0.5)$].

Based on this discussion and the survey data presented above, the survey median of 8.25 rvu's is recommended for 2982X.

FREQUENCY INFORMATION

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

Specialty: orthopaedic surgery ~~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.

Data not available.

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: orthopaedic surgery 1999 Medicare Frequency of 29909 (unlisted arthroscopy): 711

Only a small percentage of 29909 represent 2982X as this procedure is primarily performed on non-Medicare patients.

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

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

April 2001

Implantation/Removal of Ventricular Assist Device

Two codes were created and three existing codes were editorially revised to differentiate insertion and removal of extracorporeal and intracorporeal ventricular assist devices. The specialty society initially was prepared to present its recommendation for new CPT codes 33979 *Insertion of ventricular assist device; implantable intracorporeal, single ventricle* and 33980 *Removal of ventricular assist device; implantable intracorporeal, single ventricle*, however, upon further review of the survey responses the specialty society concluded that the survey respondents did not accurately assess the time required for these procedures due to a comparison with the reference code that had a 90 day global period. Additionally, within the next several months data from an NIH study of 20 institutions using this new technology will become available. The specialty society requested to bring these codes back to the RUC when the supporting institutional data from the NIH study are available. In the interim, the specialty society requested that the codes be carrier priced for 2002. The RUC agreed with the specialty society request that the codes be carrier priced for a year. **The RUC recommends that codes 33979 and 33980 be carrier priced for 2002.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲33975	KK1	Insertion Implantation of ventricular assist device; <u>extracorporeal, single ventricle support</u>	XXX	21.00 (No change)
▲33976	KK2	<u>extracorporeal, biventricular support</u>	XXX	23.00 (No change)
▲33977	KK3	Removal of ventricular assist device; <u>extracorporeal,</u> single ventricle support	090	19.29 (No change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲33978	KK4	<u>extracorporeal</u> biventricular	090	21.73 (No change)
●33979	KK5	Insertion of ventricular assist device; implantable intracorporeal, single ventricle	XXX	Carrier Priced
●33980	KK6	Removal of ventricular assist device; implantable intracorporeal, single ventricle	090	Carrier Priced

Dr. Hoehn,

The Society of Thoracic Surgeons would like to request that the summary form data for the Ventricular Assist Devices (339x1, 339x3) be withdrawn for the following reasons:

- It is obvious from the survey data that our respondents did not understand the survey methodology. Due to the fact that the survey did not request time data on the reference service code, we feel that the physicians responding to the survey did not accurately account for the differences in the XXX global for the 339x1 and the 90-day global period for the reference service code (33863 – ascending aortic graft with aortic root replacement). We feel that the physicians looked at the two codes and felt that the 339x1 was a more difficult procedure than the 33863 reference code, but did not make the adjustment for the differences in the pre- and post service time periods. We have data from the institution with the nations largest experience that indicates that the survey data from the time component is flawed for a number of reasons.
- This procedure is performed by a very small number of physicians. However, within the next several months, we expect unmasking of blinded data from an NIH study of 20 institutions on this new technology. The investigators associated with the REMATCH study have worked closely with the HCFA in order to define cost and cost effectiveness of the procedures including physician work components.
- In combination with the misunderstandings on the survey, the short turn around time on the surveys due to a delay in finalizing the code descriptions also affected the survey results.

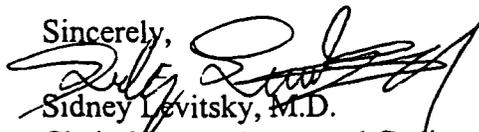
Recommendation:

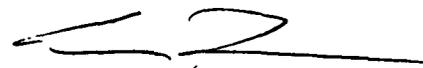
At this time, the STS would like to recommend that these codes remain in CPT for 2002 and request that HCFA recommend that the codes be carrier priced for the first year.

Further Action:

The STS will bring the codes back before the RUC when the supporting institutional data from the NIH sponsored study are available.

Sincerely,


Sidney Levitsky, M.D.
Chair, Nomenclature and Coding Committee
STS/AATS RUC Advisor


Eric Rose, M.D.
Chairman of Surgery, Columbia
University Health Sciences

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

April 2001

Vascular Procedures

35647 (LL1) / 35646 (LL2)

Work Relative Value:

In October 2000, the RUC recommended that code 35646 *Bypass graft, with other than vein; aortofemoral or bifemoral* (work RVU = 25.81) be referred to CPT to split the code before it could be evaluated as an undervalued code as part of the Five-Year Review of the RBRVS. The CPT Editorial Panel then split the code into 35647 *Bypass graft, other than vein; aortofemoral* and 35646 *Bypass graft, other than vein; aortobifemoral*. The specialty surveyed 34 vascular surgeons to obtain a median work RVU of 29.00 for 35647 and 31.00 for 35646. The specialty, however, recommended the 25th percentile for 35647 of 28.00 to retain the appropriate relativity with revised code 35646, as this new code is the same procedure except that only femoral artery dissection and anastomosis is performed, while two femoral anastomoses are performed in revised 35646. The pre- and post-operative care for each procedure is similar. However, 35646 requires an additional 40 minutes intra-service time for the additional anastomosis. The RUC agreed that the current value of 25.81 for the existing 35646 was undervalued and increases to 28.00 and 31.00 were warranted to retain relativity with other vascular procedures increased in this five-year review. The RUC also noted that the frequency of this service has declined by 25% from 1995 to 1999, which supports the specialty's argument that the patient population receiving this service is sicker and more complex as more patients are now being treated with percutaneous angioplasty. **The RUC recommends 28.00 for code 35647 and 31.00 for 35646.**

Direct Practice Expense Inputs:

These services are only provided in a facility setting. The RUC recommends the standard practice expense inputs for major surgical procedures with a 090 day global period for codes 35647 and 35646. These inputs are attached to this recommendation.

35685 (LL3)/ 35686 (LL4)

Work Relative Value:

The CPT Editorial Panel created two new add-on codes, as follows: 35685 *Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit (List separately in addition to code for primary procedure)* and 35686 *Creation of distal arteriovenous fistula during lower extremity bypass surgery (non-hemodialysis) (List separately in addition to code for primary procedure)* to describe rare procedures (<1,000 per year) to improve the poor long term patency rates of long or disadvantaged lower extremity bypass grafts constructed with synthetic conduit. The RUC reviewed these new codes in relation to reference 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)* (work RVU = 6.45) and considering data collected from 34 vascular surgeons. The survey respondents indicated that these new add-on codes require 45 minutes and 35 minutes of physician time, respectively. Reference service code 35500 has previous RUC survey time of 60 minutes. Based on the difference in physician time, the RUC agreed that the 25th percentile of the survey work relative value was reasonable for both of these new codes. **The RUC recommends a work relative value of 4.05 for 35685 and 3.35 for 35686.**

Direct Practice Expense Inputs:

There is no direct expense inputs as both of these services are add-on codes performed in the facility only.

36819 (LL5) / 36820 (LL6)

The CPT Editorial Panel revised code 36819 *Arteriovenous anastomosis, open; by basilic vein transposition* (work RVU = 14.00) to differentiate between upper arm and forearm vein transposition. A survey of 31 vascular surgeons indicated that there is no difference in physician work between revised code 36819 and 36820. **The RUC recommends a work relative value of 14.00 for both codes 36819 and 36820.**

Direct Practice Expense Inputs:

These services are only provided in a facility setting. The RUC recommends the standard practice expense inputs for major surgical procedures with a 090 day global period for these codes. These inputs are attached to this recommendation.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
35601		<i>Bypass graft, with other than vein; carotid</i>	090	17.50 (No change)
● 35647	LL1	aortofemoral	090	28.00
▲ 35646	LL2	aortofemoral or bifemoral aortobifemoral	090	31.00
<p>Arteries and Veins Bypass Grafts <u>Adjuvant Techniques</u></p> <p><u>Adjuvant (additional) technique(s) may be required at the time a bypass graft is created to improve patency of that lower extremity autogenous or synthetic bypass graft (eg, femoral-popliteal, femoral-tibial, or popliteal-tibial arteries). Code 35685 should be reported in addition to the primary synthetic bypass graft procedure, when an interposition of venous tissue (vein patch or cuff) is placed at the anastomosis between the synthetic bypass conduit and the involved artery (includes harvest).</u></p> <p><u>Code 35686 should be reported in addition to the primary bypass graft procedure, when autogenous vein is used to create a fistula between the tibial or peroneal artery and vein at or beyond the distal bypass anastomosis site of the involved artery.</u></p> <p><u>(For composite graft(s), see 35681-35683)</u></p>				
●+ 35685	LL3	Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit (List separately in addition to code for primary procedure) (Use 35685 in conjunction with codes 35656, 35666, or 35671)	ZZZ	4.05
●+ 35686	LL4	Creation of distal arteriovenous fistula during lower extremity bypass surgery (non-hemodialysis) (List separately in addition to code for primary procedure) (Use 35686 in conjunction with codes 35556, 35566, 35571, 35583, 35585, 35587, 35623, 35656, 35666, 35671)	ZZZ	3.35

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲36819	LL5	Arteriovenous anastomosis, open; by <u>upper arm</u> basilic vein transposition	090	14.00 (No change)
●36820	LL6	by forearm vein transposition	090	14.00

CPT Code: 3564X (LL1)

Global: 090

Recommended RVW: 28.00

CPT Descriptor: Bypass graft, with other than vein; aortofemoral

Survey Vignette (Typical Patient)

A 75-year old patient with coronary artery disease and emphysema presents with ischemic rest pain in both legs and dry gangrene of one toe. He has undergone a left above-knee amputation in the past. Physical examination reveals the absence of femoral pulses, a very ischemic right lower extremity, and a well-healed left above-knee amputation. An arteriogram identifies occlusion of the distal aorta and both common iliac arteries. Angioplasty is not an option because the arterial disease is too far advanced. Placement of an aortofemoral bypass (**NOTE: Aortofemoral NOT Aortobifemoral**) graft is recommended and performed. Pre-service work includes review of all preoperative studies, review of risk/benefit analysis with patient and family, final discussion with anesthesia and nursing, plus dress, scrub, prepare equipment, position patient, prep and drape. 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 may begin the day prior to surgery. Pre-Service Work begins after the decision to operate 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, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Abdominal laparotomy
- Routine abdominal exploration
- Incise retroperitoneum
- Dissect soft tissue to expose aorta, from renal artery origins to aortic bifurcation
- Carefully dissect soft tissue from around proximal aorta
- Carefully dissect soft tissue around right proximal common iliac artery
- Elevate retroperitoneum over the iliac artery
- Incise groin
- Dissect soft tissue to expose the common femoral artery
- Carefully dissect distal common femoral and proximal superficial and profunda femoral artery
- Create tunnel between the femoral region and the abdominal cavity
- Administer intravenous anticoagulant (e.g. heparin) and wait for circulation
- Apply vascular clamps proximal and distal to aorta
- With bifurcated synthetic graft perform anastomosis between aorta and proximal end of graft
- Remove vascular clamps

- Suture-ligate back-bleeding branches
- Pass graft limbs through the tunnel between abdomen and groin
- Ascertain no kinks or twists
- Place vascular clamps at femoral bifurcation
- Perform arteriotomy
- Modify graft to appropriate length
- Anastomose prosthetic graft to femoral artery
- Remove vascular clamps
- Check anastomosis for hemostasis
- Apply additional vascular sutures as required
- Confirm adequate perfusion to lower extremity
- Check abdominal cavity again for hemostasis
- Irrigate abdomen with saline and replace viscera
- Reapproximate retroperitoneum
- Close laparotomy
- Close skin at abdominal incision
- Irrigate groin incision with saline
- Inspect for hemostasis
- Apply additional vascular sutures as required
- Close groin incision in multiple layers
- Reverse anticoagulant (e.g. protamine)
- Irrigate subcutaneous tissue
- Close skin at groin incision
- Final doppler check of extremity

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient upon arrival
- Write post-op orders and notes
- Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, graft patency, nutrition, renal function, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

PLEASE NOTE: This procedure was identified by vascular surgeons during the 5-year as an undervalued service, but we were unable to survey for it because the single CPT code (35646) included two different operations, aortobifemoral bypass *and* aortofemoral bypass. We included the service on our original 5-year submission to HCFA, and we explained that the code would first be sent to the CPT Editorial Panel to revise and clarify the definition. The Panel divided the original CPT code into two separate codes. The newly revised 35646 is defined exclusively as aortobifemoral bypass, and this new code 3564X is defined as aortofemoral bypass graft. Thus, these two codes were surveyed using the additional questions added to the RUC survey for the 5-year review.

SURVEY DATA

Presenter(s): Gary R. Seabrook, MD

Specialty(s): The Society for Vascular Surgery & American Association for Vascular Surgery

CPT: 3564X

Sample Size: 114

Response: n= 33

Rate: 29%

Sample Type: random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	26.00	28.00	29.00	30.76	36.91
Pre-Service			100		
Intra-Service	120	130	170	210	250
Post-Service	Total Min	CPT code / # of visits			
<i>Day of Surgery:</i>					
Immediate	30				
Other	30	99232			
<i>After Day of Surgery:</i>					
Critical Care	0				
Other Hospital	117	99232x2	99231x3		
Dischg Day Mgmt	36	99238			
Office Visits	53	99213x1	99212x2		
Total Time	536				

KEY REFERENCE SERVICE:

CPT	Descriptor	2001 RVW	Glob
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)	30.76	090

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE:

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT
	3564X	35102 (RUC '95)
Pre-service time	100	108
Intra-service time	170	240
Same Day Immediate Post-service time	30	60
Same Day Other Post-service time	30	
Post Total critical care time (not same day)	0	201
Post Total other hospital visit time (not same day)	87	
Discharge management time	36	36
Total office visit time	53	46
Total Time for Entire Service	536	691

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	4.06	4.11
Intra-service	4.25	4.50
Post-service	3.84	4.00

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.79
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.15	4.11
Urgency of medical decision making	3.61	3.68

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.55	4.42
Physical effort required	4.27	4.32

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.58	4.63
Outcome depends on the skill and judgment of physician	4.58	4.58
Estimated risk of malpractice suit with poor outcome	4.09	4.16

ADDITIONAL RATIONALE**Building Block Method to Calculate RVW for CPT 3564X Aortofemoral Bypass Graft**

			<u>RVW</u>
Pre-op Work	Time	Intensity	(=time x intensity)
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	40	0.0081	0.32
Pre-op RVW sum			1.67
Intra-op RVW	Time	IWPUT*	
	170	0.094	15.98
Post-op Work	Time	Intensity	(=time x intensity)
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVW	(=n x E/M RVW)
99232	3.0	1.06	3.18
99231	3.0	0.64	1.92
99238	1.0	1.28	1.28
99213	1.0	0.65	0.65
99212	2.0	0.43	0.86
Post-op RVW sum			8.56
Total RVW by Building Block Method			26.21

* Please note the IWPUT applied to this service is the value obtained for 35646 as part of our 5-Year Review
 We surveyed 180 vascular surgery operations exclusively for intra-op intensity
 The survey was completed by 44 surgeons, and the data used extensively in our 5-year submission
 The median IWPUT for this service was 0.094. 25th percentile was 0.090, 75th percentile was 0.097
 The description and full set of results are listed on pages 479-491 of our 5-year submission

ADDITIONAL RATIONALE

Comparison to Most Commonly Cited Reference Service

Several respondents chose CPT 35102 as their reference service, and the median survey RVW for the service under consideration (29.00) is 1.76 RVUs less than 35102 (2001 RVW 30.76). The intensity and complexity values are nearly identical between the two services. There is some disparity, however, between these two codes in total time and the distribution of time within pre, intra, and post. The reference service has more total time (691 vs. 536 minutes) and more intra-service time (240 vs. 170 minutes) than the service we are valuing. In contrast the respondents estimated that there is more office visit time in the survey code as compared to the reference code (53 vs. 46 minutes). So with equal intensity and fewer total minutes, how do we justify this RVW?

- **This is the first time that the RUC Summary Document lists time derived from the RUC database.** This represents a major change since past Summary Recommendations contained the time estimates for the commonly chosen reference service *and* the survey service provided by the respondents. The RUC had difficulty understanding the relationship between survey respondent estimates of reference service times and database times, and therefore the decision was made at the February 2001 RUC to exclude the former. In addition, the RUC decided *not* to include reference service times on the survey document reference tables, so in completing the surveys based on the reference table *the respondents are anchoring their responses to work, not time.* We think this is a reasonable approach, but it should come as no surprise when some discrepancies appear in the time column.
- **The total physician minutes in the RUC database are not directly comparable to minutes determined on the current surveys.** In 1995 the RUC surveys asked for number of post-op visits and time, but visit level was not surveyed, and the instruction tables indicated face-to-face time. In current surveys we ask for number and level of visits, plus total time (rather than face-to-face time). Subsequent adjustments in post-op times have been made in the RUC database to align visits and total time. For example, the total time for 35102 on our 1995 Summary Recommendation was *598 minutes, not the 691 as currently found in the RUC database.* It is therefore difficult to draw direct relationships from a comparison of RUC database minutes to new survey minutes, and **we believe that the work RVW estimates carry more power than comparison of "fuzzy" times.** There is not enough statistical strength in the time comparison to significantly alter the survey respondents' work estimate.

Comparison to More Common Sister Service 35646

- 3564X is exactly the same operation as 35646 except that only one femoral artery dissection and anastomosis is performed in 3564X while two femoral anastomoses are performed in 35646. 3564X was estimated to have 40 minutes less intra-service time than 35646, and the pre and post-op care is nearly identical. If we subtract an estimate of the work for the second femoral artery dissection/anastomosis from 35646 then we should reach a valid RVW for 3564X. Taking [40 min x IWP/UT 0.094 = 3.76 rvus] from the 35646 median survey value of 31.00, the resultant RVW estimate for 3564X would be 27.24.

CONCLUSION

- **We recommend the 25th percentile survey RVW of 28.00 based on the following data:**
 - Median Survey of 29.00
 - Building Block Method of 26.21
 - Comparison to 35646 results in 27.24

FREQUENCY INFORMATION

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

CPT 35646 was used previously for both aortobifemoral bypass and aortofemoral bypass. Most of these operations were equivalent to the newly revised 35646 while a minority of these constitute what will now be 3564X.

2. 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

3. 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: Vascular Surgery; **Frequency:** Only data available is Medicare. Patients undergoing this procedure are over 50 years of age, and most are in the Medicare population. It is impossible to be more specific. See next question for Medicare frequency. With regard to what percentage of prior 35646 are aortobifemoral bypasses vs. aortofemoral bypasses, no actual data exist. Having said that, we estimate 95% are aortobifems, based on clinical experience. That means only 5% will represent this service, 3564X.

4. 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: Vascular Surgery; **Frequency:** CPT 35646 was performed 6,018 according to the 1999 RUC database, and that code is now split into revised 35646 and new code 3564X. Assuming 95% of the total are aortobifemoral bypass grafts (35646) and 5% are aortofemoral bypass grafts (3564X), then 3564X will be performed $6,018 \times 0.05 = 301$ / yr.

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Performed by **some** physicians across the US.
Limited to a few medical centers.

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

Yes – Patient cohort has changed for the worse, see below
No

This service represents new technology that has become more familiar (i.e., less work).
I agree
I do not agree

Patients requiring this service are now:

More complex (more work) (n=8) A large percentage of patients who would have undergone this procedure 5 years ago are now treated with percutaneous angioplasty. Currently the only patients who require open aortofemoral bypass are those with arteries too far gone for angioplasty. As you can imagine, these folks have a much greater burden of atherosclerotic disease involving the aorta, iliac, and femoral arteries. This makes the operation much more difficult. Since atherosclerosis is a systemic disorder, they also have more advanced coronary artery disease and cerebrovascular disease. That means they are more likely to have a multitude of postoperative complications.

Less complex (less work)
No change

The usual site-of-service has changed:

From outpatient to inpatient
From inpatient to outpatient
No change

**AMA/Specialty Society Update Process
RUC Summary of Recommendation
090 Day Global Periods
Out-Of-Office Direct Inputs**

Sample Size: 114 Response Rate: (%): 29 Global Period: 90

Tracking Number: LL1 Reference Code 1 35102 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:

Our practice expense recommendations are based on Practice Expense Advisory Committee recommendations from the Pre and Post Service Time Workgroup, the E/M Workgroup, and from RUC approved supply packages. These summary data have been examined by the AAVS Government Relations Committee, which is comprised of seven vascular surgeons representing private practice and academia, urban and rural settings, and a wide geographic base (California, Wisconsin, Michigan, New York, New Hampshire, Maryland, and Washington, D.C.)

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Pre-Service clinical activities for this out of office service follows the recommendations of the PEAC Pre and Post Service Workgroup reported at the February 2001 PEAC Meeting (Tab 8). The staff mix of RN/LPN/MA is used.

Intra-Service Clinical Labor Activities:

According to HCFA there are no Intra-service practice expense direct inputs for this out of office service.

Post-Service Clinical Labor Activities:

Post-Service clinical activities for this out of office service follows the recommendations of the PEAC E/M Workgroup adopted at the April 2001 PEAC Meeting and provided in "Instructions for Specialty Societies Reviewing CPEP Data". The staff mix of RN/LPN/MA is used.

HCFA's Staff Type Code***	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	Cost Estimate and Source (if applicable)
1130	RN/LPN/MA	60				3	90	

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

**Excluding Time of Office Visits

*** From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	3 Multi-spec Min Supply Pack for visits			
11107	Patient gown, disposable	3 items		
11111	Exam table paper 7 ft	21 feet		
11112	Pillow Case, disposable	3 items		
1302	Gloves (non-sterile)	6 pairs		
11509	Temp probe cover	3 items		
	Adjusted Post-Op Incision Care kit			
14005	Gloves (sterile)	1 pair		
31101	Alcohol swabs	2 items		
31113	Steri-strips	3 packages		
31514	Paper tape (6 inches)	5 increments		
31702	Staple remover kit	1 unit		
52301	Betadine (10 ml)	2 units		
31505	Gauze, sterile 4x4	3 packages		
52308	Tincture of Benzoin swab	1 package		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
E11001	Exam table	1 item			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

**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 5 RN, LPN, MA, Other _____

Coordinate pre-surgery services 20 RN, LPN, MA, Other _____

Schedule space and equipment in facility 8 RN, LPN, MA, Other _____

Office visit before surgery/procedure
Review test and exam results _____ RN, LPN, MA, Other _____

Provide pre-service education/obtain consent 20 RN, LPN, MA, Other _____

Follow-up phone calls & prescriptions 7 RN, LPN, MA, Other _____

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 _____

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 _____ RN, LPN, MA, Other _____

Other Activity (please specify) _____
 _____ RN, LPN, MA, Other _____

End: Patient discharge from hospital

st-Service Period

start: Patient discharge from hospital

Conduct phone calls/call in prescriptions _____ 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

**All
Standard
PEAC
Times
99213 X 36
99212 X 27
99212 X 27**

_____ RN, LPN, MA, Other _____

List total number of office visits

A _____
 B 3

Total office visit time (A * B)

 90

Conduct phone calls between office visits _____ RN, LPN, MA, Other _____

Other Activity (please specify)

_____ RN, LPN, MA, Other _____

End: With last office visit before end of global period

CPT Code: 35646 (LL2)

Global: 090

Recommended RVW: 31.00

CPT Descriptor: Bypass graft, with other than vein; ~~aortofemoral or bifemoral~~ aortobifemoral

Survey Vignette (Typical Patient)

A 75-year old patient with coronary artery disease and emphysema presents with ischemic rest pain in both legs and dry gangrene of one toe. Physical examination reveals the absence of femoral pulses and very ischemic lower extremities. An arteriogram identifies occlusion of the distal aorta and both common iliac arteries. Placement of an aorto-bifemoral bypass graft is recommended because the disease has advanced beyond the point where angioplasty is an option. Pre-service work includes review of all preoperative studies, review of risk/benefit analysis with patient and family, final discussion with anesthesia and nursing, plus dress, scrub, prepare equipment, position patient, prep and drape. 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 may begin the day prior to surgery. Pre-Service Work begins after the decision to operate 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, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape.

Description of Intra-Service Work:

Every patient requires individualized assessment and surgical approach, and every surgeon has his or her own "best" method to accomplish an operation. Realizing that, a typical case may include the following steps:

- Abdominal laparotomy
- Routine abdominal exploration
- Incise retroperitoneum
- Dissect soft tissue to expose aorta, from renal artery origins to aortic bifurcation
- Carefully dissect soft tissue from around proximal aorta
- Carefully dissect soft tissue around proximal common iliac arteries
- Elevate retroperitoneum over iliac arteries
- Incise groins bilaterally
- Dissect soft tissue to expose femoral arteries
- Carefully dissect distal common femoral and proximal superficial and profunda femoral arteries
- Create tunnel between the femoral regions and the abdominal cavity
- Administer intravenous anticoagulant (e.g. heparin) and wait for circulation
- Apply vascular clamps proximal and distal to aorta
- With bifurcated synthetic graft perform anastomosis between aorta and proximal end of graft
- Remove vascular clamps
- Suture-ligate back-bleeding branches

- Pass graft limbs through each tunnel between abdomen and groin
- Ascertain no kinks or twists
- Place vascular clamps at femoral bifurcation
- Perform arteriotomy
- Modify graft to appropriate length
- Anastomose prosthetic graft to femoral artery
- Remove vascular clamps
- Check anastomosis for hemostasis
- Apply additional vascular sutures as required
- Perform femoral artery anastomosis on opposite side in identical fashion
- Confirm adequate perfusion for both lower extremities
- Check abdominal cavity again for hemostasis
- Irrigate abdomen with saline and replace viscera
- Reapproximate retroperitoneum
- Close laparotomy
- Close skin at abdominal incision
- Irrigate groin incisions with saline
- Inspect for hemostasis
- Apply additional vascular sutures as required
- Close groin incisions in multiple layers
- Reverse anticoagulant (IV protamine)
- Irrigate subcutaneous tissue
- Close skin at groin incisions
- Final Doppler signal check of extremities

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital and outpatient care for 90 days. A typical case includes:

- Apply sterile dressings
- Help transfer patient from OR table to gurney
- Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)
- Stabilize patient upon arrival
- Write post-op orders and notes
- Dictate operative note
- Communicate with PACU/ICU nurses and referring physicians
- Discuss case with family
- Discuss case with patient following emergence from anesthesia
- Multiple post-operative checks on day of surgery
- Daily attention to wounds, graft patency, nutrition, renal function, other patient needs
- Daily orders and progress notes
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.
- Dictate discharge summary
- Outpatient visits as required for 90 days

PLEASE NOTE: This procedure was identified by vascular surgeons during the 5-year as an undervalued service, but we were unable to survey for it because the single CPT code (35646) included two different operations, aortobifemoral bypass *and* aortofemoral bypass. We included the service on our original submission to HCFA, and we explained that the code would first be sent to the CPT Editorial Panel to revise and clarify the definition. The Panel divided the original CPT code into two separate codes. The newly revised 35646 is defined exclusively as aortobifemoral bypass, and the brand new code 3564X is defined as aortofemoral bypass graft. Thus, these two codes were surveyed using the additional questions added to the RUC survey for the 5-year review.

SURVEY DATA

Presenter: Gary R. Seabrook, MD
Specialty: The Society for Vascular Surgery/American Association for Vascular Surgery

CPT: 35646 Aortobifemoral Bypass Graft

Sample Size: 114 **Response:** N=34 **Rate:** 30%

Sample Type: Random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	28.00	30.00	31.00	32.78	36.91
Pre-Service			100		
Intra-Service	120	180	210	260	300
Post-Service	<u>Total Min</u>	<u>CPT code / # of visits</u>			
<i>Day of Surgery:</i>					
Immediate	30				
Other	41	99233			
<i>After Day of Surgery:</i>					
Critical Care	0				
Other Hospital	117	99232x2	99231x3		
Dischg Day Mgmt	36	99238			
Office Visits	68	99214x1	99212x2		
Total Time	602				

KEY REFERENCE SERVICE:

CPT	Descriptor	2001 RVW	Glob
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)	30.76	090

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

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT
	35646	35102 (RUC95)
Pre-service time	100	108
Intra-service time	210	240
Same Day Immediate Post-service time	30	60
Same Day Other Post-service time	41	
Post Total critical care time (not same day)	0	201
Post Total other hospital visit time (not same day)	117	
Discharge management time	36	36
Total office visit time	68	46
Total Time for entire service	602	691

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	4.32	4.33
Intra-service	4.53	4.55
Post-service	4.12	4.09

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.21	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.24	4.27
Urgency of medical decision making	3.79	3.73

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.62	4.58
Physical effort required	4.50	4.55

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.71	4.67
Outcome depends on the skill and judgment of physician	4.71	4.67
Estimated risk of malpractice suit with poor outcome	4.29	4.18

ADDITIONAL RATIONALE**Building Block Method to Calculate RVW for CPT 35646 Aortobifemoral Bypass Graft**

			<u>RVW</u>
Pre-op Work	Time	Intensity	(=time x intensity)
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	40	0.0081	0.32
Pre-op RVW sum			<u>1.67</u>
Intra-op RVW	Time	IWPUT*	
	210	0.094	19.74
Post-op Work	Time	Intensity	(=time x intensity)
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVW	(=n x E/M RVW)
	99233	1.0	1.51
	99232	2.0	1.06
	99231	3.0	0.64
	99238	1.0	1.28
	99214	1.0	1.08
	99212	2.0	0.86
Post-op RVW sum			9.44
Total RVW by Building Block Method			30.85

* Please note the IWPUT applied to this service is the value obtained as part of our 5-Year Review
 We surveyed 180 vascular surgery operations exclusively for intra-op intensity
 The survey was completed by 44 surgeons, and the data used extensively in our 5-year submission
 The median IWPUT for this service was 0.094. 25th percentile was 0.090, 75th percentile was 0.097
 The description and full set of results are listed on pages 479-491 of our 5-year submission

ADDITIONAL RATIONALE**Building Block Method to Calculate RVW for CPT 35646 Aortobifemoral Bypass Graft
Recalculated after incorporation of actual skin-to-skin time from VS database**

			<u>RVW</u>
Pre-op Work	Time	Intensity	(= <i>time x intensity</i>)
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	40	0.0081	<u>0.32</u>
Pre-op RVW sum			1.67
Intra-op RVW	Time**	IWPOT*	
	222	0.094	20.87
Post-op Work	Time	Intensity	(= <i>time x intensity</i>)
Immediate post	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVW	(= <i>n x E/M RVW</i>)
99233	1.0	1.51	1.51
99232	2.0	1.06	2.12
99231	3.0	0.64	1.92
99238	1.0	1.28	1.28
99214	1.0	1.08	1.08
99212	2.0	0.43	0.86
Post-op RVW sum			9.44
Total RVW by Building Block Method			31.98

* Please note the IWPOT applied to this service is the value obtained as part of our 5-Year Review
We surveyed 180 vascular surgery operations exclusively for intra-op intensity
The survey was completed by 44 surgeons, and the data used extensively in our 5-year submission
The median IWPOT for this service was 0.094. 25th percentile was 0.090, 75th percentile was 0.097
The description and full set of results are listed on pages 479-491 of our 5-year submission

** Skin-to-skin time taken from Vascular Surgery database of 3500 total operations.
Value of 222 minutes for 35646 represents mean of 29 operations
Performed by a mix of private and academic surgeons in 3 states (OH, CA, NH)

ADDITIONAL RATIONALE

Comparison to Most Commonly Cited Reference Service

Several respondents chose CPT 35102 as their reference service, and the median survey RVW for the service under consideration (31.00) is essentially equal to that of 35102 (2001 RVW 30.76). The intensity and complexity values are nearly identical between the two services. There is some disparity, however, between these two codes in total time and the distribution of time within pre, intra, and post. The reference service has more total time (691 vs. 602 minutes) and more intra-service time (240 vs. 210 minutes) than the service we are valuing. In contrast the respondents estimated that there is more office visit time in the survey code as compared to the reference code (68 vs. 46 minutes). So with equal intensity and fewer total minutes, how do we justify an equal RVW?

- **This is the first time that the RUC Summary Document lists time derived from the RUC database.** This represents a major change since past Summary Documents contained the time estimates for the commonly chosen reference service *and* the survey service provided by the respondents. The RUC had difficulty understanding the relationship between survey respondent estimates of reference service times and database times, and therefore the decision was made at the February 2001 RUC to exclude the former. In addition, the RUC decided *not* to include reference service times on the survey document reference tables, so in completing the surveys based on the reference table *the respondents are anchoring their responses to work, not time.* We think this is a reasonable approach, but it should come as no surprise when some discrepancies appear in the time column.
- **The total physician minutes in the RUC database are not linearly comparable to minutes determined on the current surveys.** In 1995 the RUC survey asked for number of post-op visits and time, but the visit level was not surveyed, and the instruction tables indicated face-to-face time. In current surveys we ask for number and level of visits, plus total time (rather than face-to-face time). Subsequent adjustments in post-op times have been made in the RUC database to align visits and total time. For example, the total time for 35102 on our 1995 Summary Recommendation was *598 minutes, not the 691 as currently found in the RUC database.* It is therefore difficult to draw direct relationships from a comparison of RUC database minutes to new survey minutes, and **we believe that the work RVW estimates carry more power than comparison of "fuzzy" times.** There is not enough statistical strength in the time data to significantly alter the survey respondents' work estimate.

CONCLUSION

We recommend an RVW of 31.00 based on the following data:

- Median Survey value of 31.00
- Building Block using median survey times of 30.85
- Building Block using actual OR log times of 31.98

FREQUENCY INFORMATION

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

CPT 35646 was used to report both aortobifemoral bypass and aortofemoral bypass.

2. 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

3. 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: Vascular Surgery; **Frequency:** Only data available is Medicare. Patients undergoing this procedure are over 50 years of age, and most are likely to be >65 years, therefore Medicare beneficiaries. It is impossible to be more specific. See next question for Medicare frequency. With regard to what percentage of prior 35646 are aortobifemoral bypasses vs. aortofemoral bypasses, no actual data exist. Based on clinical experience we estimate 95% are aortobifemoral bypass grafts (35646) while 5% are aortofemoral bypass grafts (3564X).

4. 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: Vascular Surgery; **Frequency:** 6,018 in 1999 RUC database, reflecting 1997 frequencies(?) Assuming 95% are aortobifemoral bypass grafts, then 35646 will be performed $6,018 \times 0.95 = 5717$ / yr.

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Performed by many physicians across the US.
Limited to a few medical centers.

Five-Year Review Specific Questions:

Please indicate the number of respondents responding to each of the following questions: (first number is survey count; second number is consensus committee count)

Has the work of performing this service changed in the past 5 years?

Yes – Patient cohort has changed for the worse, see below
No

This service represents new technology that has become more familiar (i.e., less work).

I agree
I do not agree

Patients requiring this service are now:

More complex (more work) (n=11) A large percentage of patients who would have undergone this procedure 5 years ago are now treated with percutaneous angioplasty. Currently the only patients who require open aortofemoral bypass are those with arteries too far gone for angioplasty. As you can imagine, these folks have a much greater burden of atherosclerotic disease involving the aorta, iliac, and femoral arteries. This makes the operation much more difficult. Since atherosclerosis is a systemic disorder, they also have more advanced coronary artery disease and cerebrovascular disease. That means they are more likely to have a multitude of postoperative complications.

Less complex (less work)

No change

The usual site-of-service has changed:

From outpatient to inpatient

From inpatient to outpatient

No change

**AMA/Specialty Society Update Process
RUC Summary of Recommendation
090 Day Global Periods
Out-Of-Office Direct Inputs**

Sample Size: 114 Response Rate: (%): 30 Global Period: 90

Tracking Number: LL2 Reference Code 1 35102 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:

Our practice expense recommendations are based on Practice Expense Advisory Committee recommendations from the Pre and Post Service Time Workgroup, the E/M Workgroup, and from RUC approved supply packages. These summary data have been examined by the AAVS Government Relations Committee, which is comprised of seven vascular surgeons representing private practice and academia, urban and rural settings, and a wide geographic base (California, Wisconsin, Michigan, New York, New Hampshire, Maryland, and Washington, D.C.)

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Pre-Service clinical activities for this out of office service follows the recommendations of the PEAC Pre and Post Service Workgroup reported at the February 2001 PEAC Meeting (Tab 8). The staff mix of RN/LPN/MA is used.

Intra-Service Clinical Labor Activities:

According to HCFA there are no Intra-service practice expense direct inputs for this out of office service.

Post-Service Clinical Labor Activities:

Post-Service clinical activities for this out of office service follows the recommendations of the PEAC E/M Workgroup adopted at the April 2001 PEAC Meeting and provided in "Instructions for Specialty Societies Reviewing CPEP Data". The staff mix of RN/LPN/MA is used.

HCFA's Staff Type Code***	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	Cost Estimate and Source (if applicable)
1130	RN/LPN/MA	60				3	107	

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

**Excluding Time of Office Visits

*** From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	3 Multi-spec Min Supply Pack for visits			
11107	Patient gown, disposable	3 items		
11111	Exam table paper 7 ft	21 feet		
11112	Pillow Case, disposable	3 items		
302	Gloves (non-sterile)	6 pairs		
11509	Temp probe cover	3 items		
	Adjusted Post-Op Incision Care kit			
14005	Gloves (sterile)	1 pair		
31101	Alcohol swabs	2 items		
31113	Steri-strips	4 packages		
31514	Paper tape (6 inches)	6 increments		
31702	Staple remover kit	1 unit		
52301	Betadine (10 ml)	2 units		
31505	Gauze, sterile 4x4	3 packages		
52308	Tincture of Benzoin swab	1 package		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
E11001	Exam table	1 item			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

**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 5 RN, LPN, MA, Other _____

Coordinate pre-surgery services 20 RN, LPN, MA, Other _____

Schedule space and equipment in facility 8 RN, LPN, MA, Other _____

Office visit before surgery/procedure
 Review test and exam results _____ RN, LPN, MA, Other _____

Provide pre-service education/obtain consent 20 RN, LPN, MA, Other _____

Follow-up phone calls & prescriptions 7 RN, LPN, MA, Other _____

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 _____



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 _____ 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 _____ 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 _____ RN, LPN, MA, Other _____

**All
 Standard
 PEAC
 Times
 99214 X 53
 99212 X 27
 99212 X 27**

List total number of office visits

A _____
 B 3

Total office visit time (A * B)

 107

Conduct phone calls between office visits _____ RN, LPN, MA, Other _____

Other Activity (please specify) _____ RN, LPN, MA, Other _____

End: With last office visit before end of global period

CPT Code: 3568X1 (LL3)

Global: ZZZ

Recommended RVW: ~~5.35~~
RUC Rec. RVW: 4.05

CPT Descriptor: Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit (List separately in addition to code for primary procedure)
(Use 356X1 in conjunction with codes 35656, 35666, or 35671)

Survey Vignette (Typical Patient):

Typical Patient/Service: 75-year old with gangrenous toe requires a femoral-distal anterior tibial artery. The patient has no autogenous vein. Synthetic conduit is used for the bypass graft. A vein patch or cuff is added to the distal anastomosis.

Note: Physician work undergoing assessment in this survey is only the additional intraoperative work involved in harvest and placement of the vein patch or cuff.

Pre-Service Work: None. All pre-service work is included in the primary code.

Post-Service Work: None. All post-service work is included in the primary code.

CLINICAL DESCRIPTION OF SERVICE

Description of Total Add-on Work:

- Isolate 2 cm more tibial artery than required if no patch/cuff
- Skin incision at distant site to harvest vein patch/cuff
- Find and isolate 6-8 cm vein
- Ligate vein branches
- Ligate inflow and outflow ends of donor vein
- Resect donor vein
- Open harvested vein in longitudinal fashion
- Perform modified distal anastomosis of bypass graft using harvested vein as patch or cuff
- Suture with 7-0 Polypropylene using loupe magnification
- Irrigate vein donor site
- Achieve hemostasis at vein donor site
- Close subcutaneous tissue and skin at vein donor site

SURVEY DATA**Presenter:** Gary R. Seabrook, MD**Specialty(s):** The Society for Vascular Surgery / American Association for Vascular Surgery**CPT: 3568X1 Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit (List separately in addition to code for primary procedure)**

	Response:				
Sample Size: 139	N= 34		Rate: 24%		
Sample Type: random					
	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	2.60	4.05	6.00	7.00	8.50
Intra-Service	20	35	45	50	65

KEY REFERENCE SERVICE:

CPT	Descriptor	2001 RVW	Glob
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)	6.45	ZZZ

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

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT
	3568X1	35500 (RUC '98)
Intra-service time	45	60

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Intra-service	3.68	3.33
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MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.22	3.09
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.88	2.73
Urgency of medical decision making	3.09	2.64

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.00	3.27
Physical effort required	3.72	3.18

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.79	3.36
Outcome depends on the skill and judgment of physician	4.21	3.55
Estimated risk of malpractice suit with poor outcome	3.21	3.09

ADDITIONAL RATIONALE

Survey respondents chose CPT 35500 most often as the best reference service (11/34). CPT 35500 is also a ZZZ service, making a direct comparison of intraservice time and intensity relatively straightforward. The median time for 3568X1 is 45 minutes, while the RUC database time for 35500 is 60 minutes. Survey respondents estimated intra-service intensity of 3568X1 as 3.68 compared to 3.33 for 35500. Thus, the ratio of time, R_t , is 45/60, and the ratio of intensity, R_i , is 3.68/3.33. The RVW of 3568X1 may be derived from the RVW of 35500 by the following relationship:

$$RVW_{3568X1} = RVW_{35500} \times R_t \times R_i = 6.45 \times 45/60 \times 3.68/3.33 = 5.35$$

Conclusion: Based on a time and intensity relationship to the most commonly chosen reference service we recommend an RVW of 5.35 for new service 3568X1. This value lies between the 25th percentile and the survey median value.

FREQUENCY INFORMATION

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

37799 Unlisted vascular surgery procedure

2. 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

3. 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: Vascular Surgery Frequency: This is a newly devised means to improve the poor long term patency rates of long lower extremity bypass grafts constructed with synthetic conduit. On a clinical basis this procedure will be used most often in conjunction with CPT 35666 and 35671, and these two procedures have RUC99 database frequencies of 3,040 and 500 respectively. We estimate that this procedure will be used at most 1/3 of the time, suggesting that the service may be used 1,000/yr. These estimates are based on RUC99 data that reflects Medicare frequency in 1997 or 1998. There are no data available for non-Medicare patients, but the majority of patients will be Medicare beneficiaries.

4. 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: Vascular Surgery Frequency: New service. Estimate 1,000 / year based on information in previous question.

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Performed by many physicians across the US.
Limited to a few medical centers.

CPT Code: 3568X2 (LL4)

Global: ZZZ

Recommended RVW: 4.64
RUC Rec. RVW: 3.35

CPT Descriptor: Creation of distal arteriovenous fistula during lower extremity bypass surgery (non-hemodialysis) (List separately in addition to code for primary procedure)
(Use 356X2 in conjunction with codes 35556, 35566, 35571, 35583, 35585, 35587, 35623, 35656, 35666, 35671)

Survey Vignette (Typical Patient):

Typical Patient/Service: 75-year old with gangrenous toe requires a femoral-distal anterior tibial artery. The patient has no autogenous vein. Synthetic conduit is used for the bypass graft. A distal arteriovenous fistula is created.

Note: Physician work undergoing assessment in this survey is only the additional intraoperative work involved in creation of the arteriovenous fistula.

Pre-Service Work: None. All pre-service work is included in the primary code.

Post-Service Work: None. All post-service work is included in the primary code.

CLINICAL DESCRIPTION OF SERVICE

Description of Total Add-on Work:

- Dissect extra 3-5 cm of tibial artery
- Dissect 3-5 cm tibial vein
- Ligate vein branches
- Ligate inflow outflow end of donor vein
- Occlude venous backbleeding with temporary micro clip
- Perform longitudinal incision in vein
- Perform modified distal bypass anastomosis to include vein
- Suture with 7-0 Polypropylene using loupe magnification
- Remove microclip
- Irrigate vein donor site
- Achieve hemostasis in area of vein

SURVEY DATA**Presenter(s):** Gary R. Seabrook, MD**Specialty(s):** The Society for Vascular Surgery / American Association for Vascular Surgery**CPT: 3568X2 Creation of distal arteriovenous fistula during lower extremity bypass surgery (non-hemodialysis) (List separately in addition to code for primary procedure)****Sample Size:** 139**Response:** N=31**Rate:** 22%**Sample Type:** random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	2.50	3.35	4.50	6.23	9.00
Intra-Service	20	30	35	44	60

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
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)	6.45	ZZZ

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE:

TIME ESTIMATES (MEDIAN)	Svy CPT 3568X2	Ref CPT 35500 (RUC '98)
Intra-service time	35	60

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Intra-service	3.58	2.90
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MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.19	3.27
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.87	2.91
Urgency of medical decision making	3.00	2.64

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.29	3.36
Physical effort required	3.68	3.55

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.71	3.09
Outcome depends on the skill and judgment of physician	4.23	3.55
Estimated risk of malpractice suit with poor outcome	3.13	2.82

ADDITIONAL RATIONALE

Survey respondents (11/31) chose CPT 35500 most often as the best reference service. CPT 35500 is also a ZZZ service, making a direct comparison of intraservice time and intensity relatively straightforward. The median time for 3568X2 is 35 minutes, while the RUC database time for 35500 is 60 minutes. Survey respondents estimated intra-service intensity of 3568X2 as 3.58 compared to 2.90 for 35500. Thus, the ratio of time, R_t , is 35/60, and the ratio of intensity, R_i , is 3.58/2.90. The RVW of 3568X2 may be derived from the RVW of 35500 by the following relationship:

$$RVW_{3568X2} = RVW_{35500} \times R_t \times R_i = 6.45 \times 35/60 \times 3.58/2.90 = 4.64$$

Conclusion: Based on a time and intensity relationship to the most commonly chosen reference service we recommend an RVW of 4.64 for new service 3568X2. This value lies essentially at the survey median value of 4.50.

FREQUENCY INFORMATION

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

36821 Arteriovenous Anastomosis, open; direct, any site (eg Cimino type)(separate procedure)

2. 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

3. 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: Vascular Surgery Frequency: This is a method to improve the long term patency rates of disadvantaged lower extremity bypass grafts constructed with synthetic or autogenous conduit. The current frequency of mother-code 36821 is 15,977 according to RUC99 database. The huge majority of these are performed for hemodialysis access. We estimate that <5% are performed to assist patency of distal bypass grafts. Thus, we estimate the annual frequency of this code to be $0.05 \times 16,000 = 800$.

4. 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: Vascular Surgery Frequency: Since all dialysis patients are Medicare beneficiaries, we estimate $n=800$ as per pervious question.

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Performed by many physicians across the US.

Limited to a few medical centers.

CPT Code: 3682X (LL6)

Global: 090

Recommended RVW: 14.00

CPT Descriptor: Arteriovenous anastomosis, open; by forearm vein transposition

Survey Vignette (Typical Patient)

A 38-year-old diabetic female requires hemodialysis for chronic renal failure due to diabetic nephropathy. She has no superficial veins of adequate size to perform a traditional arteriovenous Cimino-type fistula at the wrist nor does she have visible antecubital veins. A 3mm vein is identified in the medial aspect of the forearm by duplex ultrasound, but this vein is not close enough to the radial artery to perform a direct arteriovenous anastomosis. Placement of a synthetic dialysis graft is not the best clinical choice for this young woman. Transposition of the forearm vein is recommended to provide a fully autogenous dialysis access. Pre-service work includes review of all preoperative studies, review of risk/benefit analysis with patient and family, final discussion with anesthesia and nursing, plus prepare equipment, position patient, prep and drape the patient, scrub, gown and wait. Creation of an arteriovenous fistula by forearm vein transposition is performed. Post-service work includes postoperative care starting after skin closure plus all related subsequent in-hospital outpatient care for 90 days.

CLINICAL DESCRIPTION OF SERVICE:

Description of Pre-Service Work:

Pre-service work may begin the day prior to surgery. Pre-Service work begins after the decision to operate 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, ensure all necessary equipment is present, position the patient, scrub, gown, prep, drape, and wait.

Description of Intra-Service Work:

- Incise skin over forearm vein
- Extend incision from wrist to elbow
- Carefully dissect subcutaneous tissue until vein located
- Ligate and divide all vein branches
- Continue to carefully dissect until whole forearm vein is free
- Make small skin incision over radial artery
- Dissect soft tissue and radial veins from artery
- Create subcutaneous tunnel from radial artery to elbow
- Administer intravenous anticoagulant (e.g. heparin) and wait for circulation
- Ligate and divide forearm vein
- Clamp forearm vein and pull through tunnel
- Apply vascular clamp to radial artery temporarily
- Perform longitudinal arteriotomy
- Fashion forearm vein to artery using a cobra-head-shape
- Suture anastomosis with fine (e.g. 7-0 polypropylene) suture
- Flush anastomosis with proximal and distal bleeding
- Evaluate pulse with Doppler

- Irrigate wound with saline
- Achieve hemostasis
- Close subcutaneous tissue
- Close skin at both incisions
- Evaluate distal and proximal pulses with Doppler
- Check hand for adequate perfusion

Description of Post-Service Work:

Post-service work begins after skin closure and includes application of dressings, supervising transport to the recovery area, writing postoperative orders, and communicating with family and referring physicians. The operative note is dictated. The patient is checked in the recovery area for hemodynamic stability, homeostasis at the surgical site, and patency of the new dialysis access. Close attention is paid to assuring adequate blood flow to the hand beyond the new access. Postoperative in-hospital work also includes pain management and wound care. Discharge management includes the surgeon's final examination of the patient, instructions for outpatient wound care and pain management, and arrangement for follow-up visits. All post-discharge office visits for 90 days are included in post-service work. This includes wound checks, removal of sutures, arrangement for subsequent graft surveillance studies, and whatever other related diagnostic or therapeutic maneuvers may be necessary.

SURVEY DATA

Presenter: Gary R. Seabrook, MD

Specialty: The Society for Vascular Surgery / American Association for Vascular Surgery

CPT: 3682X Arteriovenous Anastomosis, open, by forearm vein transposition

Sample Size: 99 **Response:** N=31 **Rate:** 31%

Sample Type: random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RWW	12.00	14.00	14.00	15.00	20.00
Pre-Service			81		
Intra-Service	60	90	90	120	180

Post-Service	<u>Total Min</u>	<u>CPT code / # of visits</u>
<i>Day of Surgery:</i>		
Immediate	23	
Other	19	99231 (23 to 36 hour overnight admit)
<i>After Day of Surgery:</i>		
Critical Care	0	
Other Hospital	0	
Dischg Day Mgmt	36	99238 (23 to 36 hour overnight admit)
Office Visits	38	99213x1 99212x1

KEY REFERENCE SERVICE:

CPT	Descriptor	2001 RVW	Glob
36819	Arteriovenous anastomosis, open; by basilic vein transposition	14.00	090

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

TIME ESTIMATES (MEDIAN)	Svy CPT	Ref CPT
	3682X	36819 (RUC '99)
Pre-service time	81	25
Intra-service time	90	120
Same Day Immediate Post-service time	23	15
Same Day Other Post-service time	19	19
Post Total critical care time (not same day)	0	0
Post Total other hospital visit time (not same day)	19	19
Discharge management time	36	36
Total office visit time	38	38

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	3.37	3.27
Intra-service	3.63	3.59
Post-service	2.89	2.82

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.36	3.23
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.25	3.05
Urgency of medical decision making	2.75	2.73

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.89	3.86
Physical effort required	3.21	3.14

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.04	3.00
Outcome depends on the skill and judgment of physician	3.93	3.86
Estimated risk of malpractice suit with poor outcome	2.79	2.77

ADDITIONAL RATIONALE:**Comparison to Most Commonly Cited Reference Service**

Twenty-five out of 31 respondents used 36819 (Basilic Vein Transposition for Hemodialysis) as the reference service, and 17 of those 25 recommended an RVW of 14.00, equal to that of 36819. Of the remaining 8 individuals who chose 36819 as a reference, 4 recommended 1-2 RVUs less than 36819, and 4 recommended 1-4 RVUs greater than 36819. It is clear that most individuals completing this survey felt the RVW should be exactly the same as that of 36819.

ADDITIONAL RATIONALE:**Building Block Method RVW for CPT 3682X Forearm Vein Transposition for Hemodialysis**

			<u>RVW</u>
Pre-op Work	Time	Intensity	(= <i>time x intensity</i>)
Day prior evaluation	28	0.0224	0.63
Same day evaluation	23	0.0224	0.52
Scrub, prep	30	0.0081	<u>0.24</u>
Pre-op RVW sum			1.39
Intra-op RVW	Time	IWPUT*	
	90	0.081	7.29
Post-op Work	Time	Intensity	(= <i>time x intensity</i>)
Immediate post	23	0.0224	0.52
Subsequent visits:	Visit n	E/M RVW	(= <i>n x E/M RVW</i>)
99232	0.0	1.06	0.00
99231	1.0	0.64	0.64
99238	1.0	1.28	1.28
99213	1.0	0.65	0.65
99212	1.0	0.43	0.43
Post-op RVW sum			3.52
Total RVW by Building Block Method			12.19

* Please note the IWPUT of 0.081 used in this calculation was obtained by the following steps:

Start with IWPUT=0.080 for common reference service 36819 Basilic Vein Transposition for Hemodialysis

This value (0.080) is based on Summary Recommendation presented to RUC in April 2000 for 36819

Multiply by ratio of intraservice intensities from Intensity data $3.63/3.59 = 1.011$

IWPUT for current service = $0.080 \times 1.011 = 0.081$

CONCLUSION

The survey data for this service is tighter than any survey we have ever performed. 81% of survey respondents chose the reference service 36819, and 68% of those said the RVW should be 14.00. The remainder were evenly split. The lowest survey RVW is 12. The 25th percentile and the median survey value are both 14.00. The building block analysis justifies a slightly lower value of 12.19 based on an intraservice time 30 minutes less than the reference but an intraservice intensity slightly higher. Pre-service time is greater than the reference service. **We believe the median survey RVW of 14.00 is justified by the remarkably tight data curve.**

FREQUENCY INFORMATION

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

Unlisted vascular surgery code 37799

2. 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

3. 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: Vascular Surgery Frequency: unknown, new procedure, estimate < 1,000

4. 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: Vascular Surgery Frequency: Unknown, new procedure, since all dialysis patients are Medicare patients, estimate is same, <1,000

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Performed by many physicians across the US.
Limited to a few medical centers.

**AMA/Specialty Society Update Process
RUC Summary of Recommendation
090 Day Global Periods
Out-Of-Office Direct Inputs**

Sample Size: 99 Response Rate: (%): 31% Global Period: 90

Tracking Number: LL6 Reference Code 1 36819 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:

Our practice expense recommendations are based on Practice Expense Advisory Committee recommendations from the Pre and Post Service Time Workgroup, the E/M Workgroup, and from RUC approved supply packages. These summary data have been examined by the AAVS Government Relations Committee, which is comprised of seven vascular surgeons representing private practice and academia, urban and rural settings, and a wide geographic base (California, Wisconsin, Michigan, New York, New Hampshire, Maryland, and Washington, D.C.)

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Pre-Service clinical activities for this out of office service follows the recommendations of the PEAC Pre and Post Service Workgroup reported at the February 2001 PEAC Meeting (Tab 8). The staff mix of RN/LPN/MA is used.

Intra-Service Clinical Labor Activities:

According to HCFA there are no Intra-service practice expense direct inputs for this out of office service.

Post-Service Clinical Labor Activities:

Post-Service clinical activities for this out of office service follows the recommendations of the PEAC E/M Workgroup adopted at the April 2001 PEAC Meeting and provided in "Instructions for Specialty Societies Reviewing CPEP Data". The staff mix of RN/LPN/MA is used.

HCFA's Staff Type Code***	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	Cost Estimate and Source (if applicable)
1130	RN/LPN/MA	60				2	63	

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

**Excluding Time of Office Visits

*** From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	2x Multi-spec Min Supply Pack for visits			
11107	Patient gown, disposable	2 items		
11111	Exam table paper 7 ft	14 feet		
11112	Pillow Case, disposable	2 items		
302	Gloves (non-sterile)	4 pairs		
1509	Temp probe cover	2 items		
	Basic Post-Op Incision Care kit			
14005	Gloves (sterile)	1 pair		
31101	Alcohol swabs	2 items		
31113	Steri-strips	2 packages		
31514	Paper tape (6 inches)	2 increments		
31702	Staple remover kit	1 unit		
52301	Betadine (10 ml)	2 units		
31505	Gauze, sterile 4x4	2 packages		
52308	Tincture of Benzoin swab	1 package		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
E11001	Exam table	1 item			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

**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	_ 5 _	RN, LPN, MA, Other _____
Coordinate pre-surgery services	_ 20 _	RN, LPN, MA, Other _____
Schedule space and equipment in facility	_ 8 _	RN, LPN, MA, Other _____
Office visit before surgery/procedure Review test and exam results	_____	RN, LPN, MA, Other _____
Provide pre-service education/obtain consent	_ 20 _	RN, LPN, MA, Other _____
Follow-up phone calls & prescriptions	_ 7 _	RN, LPN, MA, Other _____
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 _____
<i>Intra-service</i>		
Assist physician in performing surgery/procedure	_____	RN, LPN, MA, Other _____

ist-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 _____ RN, LPN, MA, Other _____

Other Activity (please specify) _____
 _____ RN, LPN, MA, Other _____

End: Patient discharge from hospital

ist-Service Period

Start: Patient discharge from hospital

Conduct phone calls/call in prescriptions _____ 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

**All
 Standard
 PEAC
 Times
 99213 X 36
 99212 X 27**

RN, LPN, MA, Other _____

List total number of office visits

A _____
 B 2

Total office visit time (A * B)

 63

Conduct phone calls between office visits _____ 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 2001
Ultrasound Guided Intravascular Thrombin Injection**

A new CPT code 36002 *Injection procedure (eg, thrombin) for percutaneous treatment of extremity pseudoaneurysm* has been created to describe a new service that has become widely used over the past two to three years.

The RUC reviewed survey data from 34 interventional radiologists and concluded that a submitted work relative value recommendation of 2.87 was too high. The RUC reviewed other injection codes, 47500 *Injection procedure for percutaneous transhepatic cholangiography* (work relative value = 1.96) and 50390 *Aspiration and/or injection of renal cyst or pelvis by needle, percutaneous* (work relative value = 1.96), and determined that the work of 36002 is similar to these injection codes. The physician time from the Harvard study for 50390 (38 minutes intra-time and 83 minutes total) is very similar to the time for 36002 (30 minutes intra-time and 80 minutes total). The RUC also noted that the 25th percentile of the survey work relative value is 2.00, which is comparable to the 1.96 work RVU for these other injection codes. **The RUC recommends a work relative value of 1.96 for CPT code 36002.**

Practice Expense

The RUC recommended reductions in the estimated clinical staff time for this service. Modifications were also made to the medical supplies. The specific direct practice expense inputs for both the in-office and out-of-office are attached.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●36002	R1	Injection procedure (e.g., thrombin) for percutaneous treatment of extremity pseudoaneurysm (For imaging guidance, see codes 76003, 76360, 76393 or 76942) (For ultrasound guided compression repair of pseudoaneurysms, see code 76936) (Do not report 36002 for vascular sealant of an arteriotomy site)	000	1.96

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: **36XXX** Tracking Number: **R1** Global Period: **000** Recommended RVW: **~~2.87~~
1.96 (RUC)**
CPT Descriptor: **Injection procedure (e.g., thrombin) for percutaneous treatment of extremity
pseudoaneurysm**

(For imaging guidance, see codes 76003, 76360, 76393, or 76942)
(For ultrasound guided compression repair of pseudoaneurysms, see code 76936.)
(Do not report 36XXX for vascular sealant of an arteriotomy site)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 68-year old male s/p cardiac catheterization develops an expanding painful hematoma not controlled by compression, with groin tenderness, and a femoral bruit. A duplex scan examination is performed (reported separately), which demonstrates a pseudoaneurysm arising from the common femoral artery. The patient is referred for percutaneous therapy of this injury.

Description of Pre-Service Work:

- Review of any prior studies.
- Physician examines patient and pseudoaneurysm site including extremity pulse.
- Pre-service education is provided and consent obtained.

Description of Intra-Service Work:

- The physician supervises patient positioning and site prep.
- Using sterile technique and local anesthesia, the physician advances an angio catheter, needle, micro-puncture catheter, or other introducer into the pseudoaneurysm with the aid of imaging guidance (reported separately as 76003, 76360, 76393, or 76936). A syringe containing thrombin solution is attached to introducer. Small amounts of the thrombin mixture are injected into the pseudoaneurysm, under imaging guidance (reported separately as 76003, 76360, 76393, or 76936) until total thrombosis of the pseudoaneurysm is demonstrated. The needle or catheter is withdrawn and the native artery, vein, and the thrombosed pseudoaneurysm are examined and recorded. Patency of the native artery and vein are confirmed.

Description of Post-Service Work:

- Post-pseudoaneurysm occlusion vital signs are monitored.
 - Procedure report is dictated and reviewed.
 - Referring physician is apprised of procedure outcome.
-

SURVEY DATA:

Presenter(s): Robert L. Vogelzang, MD
James Borgstede, MD

Specialty(s): Society of Cardiovascular & Interventional Radiology
American College of Radiology

SURVEY DATA:

Sample Size: 175 Response Rate: (%): 19.4% (n=34) Median RVW: 2.87

Type of Sample (Circle One): random, **PANEL**, convenience.

Explanation of sample size: **The panel of survey recipients included both SCVIR and ACR committee Members.**

ESTIMATED WORK RVU FOR NEW CPT CODE 36XXX

25th Percentile RVW: 2.0 75th Percentile RVW: 4.73 Low: 1.3 High: 18.14

Median Pre-Service Time: 35 minutes Median Intra-Service Time: 30 minutes

25th Percentile Intra-Svc Time: 25 minutes 75th Percentile Intra-Svc Time: 45 minutes

Low: 10 minutes High: 60 minutes

Median Post Service Time: 15 minutes

KEY REFERENCE SERVICE:

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
Reference Service 1	48102	Biopsy of pancreas , percutaneous needle	4.68

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)

	<u>CPT Code</u>	<u>Reference Service 1 CPT</u>
	36XXX	48102
Day Preceding Procedure Pre-Service Time (Minutes)	10	30
Day of Procedure Pre-Service Time (Minutes)	20	30
Intra-Service Time (Minutes)	30	45
Post Service Time (Minutes)	15	15

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	2.49	2.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.66	3.33
Urgency of medical decision making	3.46	2.17

Technical Skill/Physical Effort (Mean)

Technical skill required	3.66	3.0
Physical effort required	2.66	3.17

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.03	3.17
Outcome depends on the skill and judgement of physician	3.94	3.33
Estimated risk of malpractice suit with poor outcome	3.94	2.83

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****36XXX****48102****Time Segments (Mean)**

Pre-Service intensity/complexity

2.71**3.17**

Intra-Service intensity/complexity

3.83**3.17**

Post-Service intensity/complexity

2.74**2.33****ADDITIONAL RATIONALE**

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

The process used consisted of a survey of physicians (panel sample) who typically perform this service. Final recommendation and work values were reviewed by physicians representing SCVIR and ACR. These physicians reviewed all components of work for the newly proposed CPT Code, 36XXX, as well as the information provided for the reference procedure. The recommended RVW (2.87) is the median RVW of the pooled respondents (n=34) from SCVIR and ACR surveys. In addition, the injection of thrombin for the percutaneous treatment of pseudoaneurysm carriers with it the risk of thrombin entering the native vasculature, which could lead to arterial occlusion and severe ischemia of the extremity with possible need for emergent percutaneous or surgical intervention.

FREQUENCY INFORMATION

How was this service previously reported? 36299 or 37204-52

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

Specialty **Interventional Radiologists** 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.

Unable to quantify. (See estimate of services for Medicare patients below.)

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.

Medicare claims data from 1998 suggests that approximately 11,000 pseudoaneurysms were treated. Of these 11,000 a substantial percentage would be appropriately treated by percutaneous injection.

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

**AMA/Specialty Society Update Process
RUC Summary of Recommendation
000 Day Global Period
In Office Direct Inputs**

Sample Size: CONSENSUS Response Rate: (%): n/a Global Period: 0-day

Tracking Number: **R1** Reference Code 1 **50390** Reference Code 2 **47000**

Geographic Practice Setting %: Rural **19%** Suburban **35%** Urban **46%**

Type of Practice %: **0%** Solo Practice
50% Single Specialty Group
4% Multispecialty Group
46% 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:

SCVIR's Economics Committee that serves as the Society's Practice Expense Committee developed the direct input recommendation. The Economics Committee's 26 members exhibit the geographic and practice type distribution as detailed above. The process used to reach these practice expense recommendations was largely a consensus panel. SCVIR received 10 practice expense surveys (six for In-Office Setting) as part of its survey on physician work. Data from these surveys, though limited, provided a starting point for practice expense input recommendation. These preliminary recommendations were reviewed by both SCVIR and ACR incorporating any revisions along the way. Final recommendation and practice expense values were reviewed by physicians representing SCVIR and ACR.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- ~~Complete pre-service diagnostic and referral forms~~
- ~~Coordinate pre-surgery services and scheduling~~
- ~~Obtain necessary medical records~~
- ~~Provides education and obtains consent~~
- ~~Greets patient and provides gown~~
- ~~Obtain vital signs~~
- Follow-up phone calls & prescriptions

Intra-Service Clinical Labor Activities:

- Prepares room
- Assists physician
- Monitors patient post-procedural
- Cleans room
- Provides post-care instruction
- Checks wound
- Escort Patient to Recovery Room

HCFA's Staff Type Code*	Clinical Labor - Description	Pre-Service Time - Minutes	Service Period (Day of service) Minutes	Cost Estimate and Source (if applicable)
1033	RN/LPN/MA	20-5	56 33	
1040	Vascular Tech		60 41	

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies - Description	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
11107	Gown	1	Item	
14005	Sterile Gloves	4	Pair	
11306	Masks	3	Item	
11509	Sterile Probe Cover	1	Item	
14002	Sterile drape	1	Item	
91407	Syringe 10 ml	3	Item	
91408	Syringe 1 ml	1	Item	
53067	Sterile saline 10cc	2	MI	
Not listed	Thrombin 10,000 u	4	MI	11.73
51502	Lidocaine 25 ml	1	ml	
11111	Exam table paper	7	feet	
31505	Sterile gauze 4x4	5	Item	
11112	Pillow case	1	Item	
31127	Alcohol pad	2	item	
52305	Betadine swab, 3 pack	1	Item	

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

HCFA Equipment Code*	Medical Equipment - Description	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
E11001	Exam table	1	15		

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	10 minutes 0	RN, LPN, MA, Other _____
Coordinate pre-surgery services	5 minutes 0	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	5 minutes	RN/LPN/MA , 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	5 minutes 2 minutes	RN/LPN/MA , LPN, MA, Other _____
Greet patient and provide gowning	3 minutes	RN/LPN/MA , LPN, MA, Other _____
Obtain vital signs	3 minutes	RN/LPN/MA , LPN, MA, Other _____
Provide pre-service education/obtain consent	5 minutes	RN/LPN/MA , LPN, MA, Other _____
Prepare room, equipment, supplies	15 minutes 5 minutes	RN, LPN, MA, Other VASC. TECH _____
Prepare and position patient/ monitor patient/ set up IV	10 minutes 3 minutes	RN/LPN/MA , LPN, MA, Other _____
Sedate/apply anesthesia	5 minutes	RN/LPN/MA , LPN, MA, Other _____
<i>Intra-service</i>		_____
Assist physician in performing procedure	30 minutes	RN, LPN, MA, Other VASC. TECH _____

Specialty Society('s)_

Monitor pt. following service/check tubes, monitors, drains	20 minutes 6 minutes	RN/LPN/MA , LPN, MA, Other
Clean room/equipment by physician staff	5 minutes 3 minutes	RN, LPN, MA, Other VASC. TECH
Complete diagnostic forms, lab & X-ray requisitions	10 minutes 3 minutes	RN, LPN, MA, Other VASC. TECH
Review/read X-ray, lab, and pathology reports		RN, LPN, MA, Other _____
Check dressings & wound/ home care instructions/coordinate office visits/prescriptions	5 minutes 3 minutes	RN/LPN/MA , LPN, MA, Other
Other Clinical Activity (please specify)		_____
Escort Patient to Recovery Room		
_____	3 minutes	RN/LPN/MA , LPN, MA, Other
<i>End: Patient leaves office</i>		_____

**AMA/Specialty Society Update Process
RUC Summary of Recommendation
000 Day Global Period
Out-Of-Office Direct Inputs**

Sample Size: **consensus** Response Rate: (%): **n/a** Global Period: **0-day**

Tracking Number: **R1** Reference Code 1 **50390** Reference Code 2 **47000**

Geographic Practice Setting %: Rural **19%** Suburban **35%** Urban **46%**

Type of Practice %:
 0% Solo Practice
 50% Single Specialty Group
 4% Multispecialty Group
 46% 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:

SCVIR's Economics Committee that serves as the Society's Practice Expense Committee developed the direct input recommendation. The Economics Committee's 26 members exhibit the geographic and practice type distribution as detailed above. The process used to reach these practice expense recommendations was largely a consensus panel. SCVIR received 10 practice expense surveys (nine for Out-of-Office Setting) as part of its survey on physician work. Data from these surveys, though limited, provided a starting point for practice expense input recommendation. These preliminary recommendations were reviewed by both SCVIR and ACR incorporating any revisions along the way. Final recommendation and practice expense values were reviewed by physicians representing SCVIR and ACR.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- **Complete pre-service diagnostic and referral forms**
- **Coordinate pre-surgery services and scheduling**
- **Obtain necessary medical records**
- **Provides education and obtains consent**

Intra-Service Clinical Labor Activities:

- ~~**Grooms patient and provides gown**~~
- ~~**Obtain vital signs**~~
- ~~**Review chart**~~
- ~~**Monitors patient post-procedural**~~
- ~~**Cleans room**~~
- ~~**Provides post-care instruction**~~
- ~~**Checks wound**~~

HCFA's Staff Type Code**	Clinical Labor	Pre-Service Time	Service Period	Coordination of Care*	Cost Estimate and Source (if applicable)
1033	RN/LPN/MA	25 20	41-0	20 5	

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

**From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	NONE			

*From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	NONE				

*From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

**TYPE OF SERVICE: Minor Surgical Procedures
 000 Global Period**

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 minutes	RN/LPN/MA , LPN, MA, Other _____
Coordinate pre-surgery services	5 minutes	RN/LPN/MA , LPN, MA, Other _____
Schedule space and equipment in facility	5 minutes	RN/LPN/MA , 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	5 minutes	RN, LPN, MA, Other _____
or Clinical 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	5 minutes 0	RN, LPN, MA, Other _____
Greet patient and provide gowning	3 minutes 0	RN, LPN, MA, Other _____
Obtain vital signs	3 minutes 0	RN, LPN, MA, Other _____
Provide pre-service education/obtain consent	5 minutes 0	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 _____
<i>Intra-service</i>		
Assist physician in performing surgery/procedure	_____	RN, LPN, MA, Other _____

monitor patient following service/check tubes, monitors, drains	20 minutes 0	RN, LPN, MA, Other _____
Clean room/equipment by physician staff	_____	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	5 minutes 0	RN, LPN, MA, Other _____
Coordination of care by staff in office	20 minutes 5 minutes	RN/LPN/MA , LPN, MA, Other _____
Other Clinical Activity (please specify)	_____	_____
_____	_____	RN, LPN, MA, Other _____
End: Patient leaves facility		

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
February 2001

Pediatric Venipuncture

The RUC submitted a recommendation on CPT code 36400 *Venipuncture, under age 3 years; femoral, jugular or sagittal sinus* in the Five-Year Review of the RBRVS to increase the work relative value from 0.18 to 0.38. During the course of the collecting data on this service, the pediatricians noted that this procedure is no longer performed with venipuncture of the sagittal sinus and, therefore, asked CPT to delete this reference. The RUC recommends that this change in nomenclature is editorial and does not change the previous RUC recommendation of 0.38 for this service.

CPT Code	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
36400	T1	Venipuncture, under age 3 years; femoral <u>or</u> jugular or sagittal sinus	XXX	0.38* *This code was reviewed in the Five-Year Review and the RUC recommended an increase to 0.38.

11/20/00

James G. Hoehn, MD
Chair, AMA/Specialty Society RVS Update Committee
Relative Value Systems
American Medical Association
515 North State Street
Chicago, IL 60610

Re: Venipuncture CPT Code 36400

Dear Dr. Hoehn:

During the most recent Five Year Review, the American Academy of Pediatrics (AAP) presented recommendations for CPT code 36400 (*venipuncture, under age 3 years; femoral, jugular or sagittal sinus*). Workgroup Six reviewed the AAP recommendations and accepted a new work RVU of 0.38 (an increase from its current work RVU of 0.18). This value was accepted by the full RUC during its October 2000 meeting.

During the course of conducting surveys for CPT code 36400, the Academy received several comments from respondents regarding the irrelevance of the term 'sagittal sinus' in the descriptor. Respondents filled out the surveys and supplemented their answers with comments ranging from "never use the sagittal sinus" to "this site is never used for a pediatric draw anymore...in fact, I cannot recall when it ever *was* used!" The accuracy of these comments was confirmed by the Academy's National Committee on Coding and Reimbursement. Please note, however, that these comments were not reflected in the Workgroup Six Report.

Based on the comments received during the Five Year Review, the Academy submitted a CPT code proposal to revise the descriptor of 36400 to remove the term 'sagittal sinus' in order to make the descriptor more reflective of actual practice. This proposal was presented during the November 2000 CPT meeting and the CPT Editorial Panel accepted the revision to CPT code 36400.

However, since the Five Year Review respondents' comments were not reflected in the Workgroup Six Report, there was no way for the CPT Editorial Panel to discern that the sagittal sinus site was, in fact, not taken into consideration during the valuation of the code and therefore, establish that removal of the term 'sagittal sinus' was an editorial change.

Therefore, we are asking that the removal of the term 'sagittal sinus' from CPT code 36400 be considered an editorial change and that the Five Year Review recommendation of 0.38 be accepted for the revised descriptor.

If you have any questions, please feel free to contact Linda Walsh (AAP staff) at 800/433-9016 x 7931.

Thank you for your consideration of this matter.

Sincerely,

Joel F. Bradley

Joel F. Bradley, Jr, MD, FAAP
AAP Representative to the RUC

cc: Charlie Schulte, MD, FAAP
Steve Krug, MD, FAAP
Julia Pillsbury, DO, FAAP
Rick Tuck, MD, FAAP

JFB/ljw

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

April 2001

Esophagoplasty for Congenital Defect

During the August 2000 5-Year Review, the work relative values for CPT codes 43310 *Esophagoplasty, (plastic repair or reconstruction), thoracic approach; without repair of tracheoesophageal fistula* and 43312 *Esophagoplasty, (plastic repair or reconstruction), thoracic approach; with repair of tracheoesophageal fistula* were reviewed. The specialty society's survey results for the August 2001 5-Year Review was restricted to pediatric patients, however the RUC noted that this service may also be performed on adults, and therefore recommended no change in the relative values for these codes. The RUC recommended the specialty society to CPT breaking the procedure into two separate CPT codes. One code for adults and one to reflect the same procedure performed on children. As a result, CPT created CPT codes 43313 *Esophagoplasty for congenital defect, (plastic repair or reconstruction), thoracic approach; without repair of congenital tracheoesophageal fistula* and 43314 *Esophagoplasty for congenital defect, (plastic repair or reconstruction), thoracic approach; with repair of congenital tracheoesophageal fistula*.

43310 *Esophagoplasty, (plastic repair or reconstruction), thoracic approach; without repair of tracheoesophageal fistula*

The RUC recommends the current work RVU of 27.47 for CPT code 43310.

43312 *Esophagoplasty, (plastic repair or reconstruction), thoracic approach; with repair of tracheoesophageal fistula*

The RUC recommends the current work RVU of 30.50 for CPT code 43312

43313 *Esophagoplasty for congenital defect, (plastic repair or reconstruction), thoracic approach; without repair of congenital tracheoesophageal fistula*

The RUC based their recommendation on their understanding that, at the August 2000 5-Year Review, the RUC thoroughly reviewed the specialty society's survey results and approved the values recommended by the specialty, directing the specialty society to return to CPT to create codes for the pediatric population. During the August 2000 5-Year Review, the RUC agreed that the values based on the survey would be appropriate for this procedure performed on critically ill neonates. Critically ill neonates, the specialty argued, required a more extensive and intensive post operative care than for the adult population. The RUC agreed that based on the survey results and relative to CPT code 43314, code 43313 has

similar intra-operative time and intensity as well as similar NICU days. Also, CPT code 43313 has similar post-operative visits and time, however to maintain relativity between the two new codes, the RUC recommended a lower work RVU for 43313 than for 43314, as suggested by the specialty. **The RUC recommends a work relative value of 45.28 for CPT code 43313.**

Practice Expense

The RUC modified the practice expense inputs for CPT code 43313 to include the following, full details of the practice expense are attached.

- 30 minutes of pre-service clinical labor time
- 135 minutes of intra-service clinical labor time
- 197 minutes of post-service clinical labor time from 5 follow up office visits
- 5 multi-specialty minimum visit supply packages
- 1 post operative incision care kit
- 1 exam table

43314 Esophagoplasty for congenital defect, (plastic repair or reconstruction), thoracic approach; with repair of congenital tracheoesophageal fistula

The RUC based their recommendation on their understanding that, at the August 2000 5-Year Review, the RUC thoroughly reviewed the specialty society's survey results and approved the values recommended by the specialty, directing the specialty society to return to CPT to create codes for the pediatric population. During the August 2000 5-Year Review, the RUC agreed that the values based on the survey would be appropriate for this procedure performed on critically ill neonates. Thirty-one randomly selected pediatric surgeons responded to the survey by the American Pediatric Surgical Association indicating a median work RVU of 50.27. The RUC recognized that the survey responses were tightly centered around the median and the post operative time and visits reaffirmed the specialty's argument that critically ill neonates required a more extensive and intensive post operative care than for the adults. **The RUC recommends a work relative value of 50.27 for CPT code 43314.**

Practice Expense

The RUC modified the practice expense inputs for CPT code 43314 to include the following, full details of the practice expense are attached.

- 30 minutes of pre-service clinical labor time
- 143 minutes of intra-service clinical labor time
- 197 minutes of post-service clinical labor time from 5 follow up office visits
- 5 multi-specialty minimum visit supply packages
- 1 post operative incision care kit
- 1 exam table

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
43310	MM1	Esophagoplasty, (plastic repair or reconstruction), thoracic approach; without repair of tracheoesophageal fistula	090	2001 RVW = 27.47
43312	MM2	with repair of tracheoesophageal fistula	090	2001 RVW = 30.50
● 43313	MM3	Esophagoplasty for congenital defect, (plastic repair or reconstruction), thoracic approach; without repair of congenital tracheoesophageal fistula	090	45.28
● 43314	MM4	with repair of congenital tracheoesophageal fistula	090	50.27

3
OK

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

(August 2000)

5-yr-rev

Survey CPT Code: 43312

43314

Global: 090

Current RVW: 30.50

~~Recommended RVW: 50.27~~

CPT Descriptor: Esophagoplasty, (plastic repair or reconstruction), thoracic approach; with repair of tracheoesophageal fistula

Family CPT Code: 43305

Global: 090

Current RVW: 17.39

Recommended RVW: 28.66

CPT Descriptor: Esophagoplasty, (plastic repair or reconstruction), cervical approach; with repair of tracheoesophageal fistula

Family CPT Code: 43310

43313

Global: 090

Current RVW: 27.47

~~Recommended RVW: 45.28~~

CPT Descriptor: Esophagoplasty, (plastic repair or reconstruction), thoracic approach; without repair of tracheoesophageal fistula

Typical Patient (Survey Vignette): A 2.0-kg infant has respiratory difficulty, inability to tolerate feedings, and inability to pass a naso-gastric tube. The diagnosis of tracheoesophageal fistula with proximal esophageal atresia is made. After initial stabilization, a thoracotomy with primary repair is performed. Postoperative management includes initial ventilator management, management of drain, feeding and airway management including tracheomalacia, discharge management, and postoperative office management through the 90-day global period.

CLINICAL DESCRIPTION OF SERVICE:

Pre-service work - Day before surgery:

- Write preoperative orders for perioperative medications.
- Review preoperative work-up, with particular attention to systems review for associated malformations, including cardiac, spinal, anorectal, and limb anomalies; consider syndromic involvement.
- Review pre-operative work-up, with particular attention to radiology and cardiology evaluation.
- Confirm position of aorta and distal extent of upper pouch
- Discuss risks, benefits, planned incisions and procedure, and expected post-operative course with family, including call/visit with mother in maternity ward.
- Confirm OR start time –notify patient's family and neonatal nursing.
- Arrange for surgical assistance.

Pre-service work - Day of surgery:

- Check with lab – make certain blood and/or x-match is available, check morning lab results.
- Change into scrub clothes.
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome with family.
- Answer family questions and obtain informed consent.
- Review length and type of anesthesia with anesthesiologist.
- Review planned procedure, positioning and draping of patient with OR nurses.
- Ensure that operating room is warm and intraoperative heating equipment is available and working.
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite.
- Accompany patient with nurses from NICU to operating room.
Monitor patient positioning and draping, and assist with positioning as needed.
Assist with intubation as necessary, watching for patient decompensation with positive pressure ventilation.
- Adjust headlight and surgical telescopic loupes.
- Scrub and gown.

Intra-service work - Skin to skin:

- Place arterial line, percutaneous or by cutdown.
- Position patient for bronchoscopy with preparation to block fistula if needed.
- Perform bronchoscopy with attention to size and configuration of airway, position of fistula, anomalies including multiple fistulae.
- Reposition patient for right thoracotomy with attention to padding and skin protection.
- Make skin incision with extension through thoracic musculofascial layers.
- Retract scapula and confirm level of thoracotomy.
- Perform thoracotomy, sparing the pleura.
- Dissect retropleurally until right lung can be retracted and thoracic structures are identified, including azygous vein, proximal and distal esophagus, trachea, and fistula.
- Ligate azygous vein.
- Isolate fistula, with careful sparing of recurrent nerve.
- Transect fistula at trachea, repairing posterior wall of trachea with interrupted sutures.
- Test security of tracheal closure.
- Mobilize proximal pouch from mediastinal tissue and trachea, looking for proximal fistulae.
- Test gap length using the orogastric tube to place the proximal segment on tension.
- Perform circular esophageal myotomies if necessary to lengthen the proximal segment.
- Trim both the proximal and distal esophageal segments to healthy tissue and place stay sutures to maintain alignment and length.
- Place posterior wall sutures with care to include all layers of the wall.
- Tie posterior wall sutures.
- Guide orogastric tube through open anastomosis into distal esophagus and stomach; have anesthesia secure tube at appropriate position.
- Complete anastomosis by placing and tying anterior sutures.
- Mediastinal tissue is mobilized and brought between the tracheal and esophageal closures.
- Place retropleural drainage tube, keeping tip clear of anastomosis.
- Monitor reinflation and expansion of lung, repairing any rents in pleura and evacuating intrapleural air.
- The pleural cavity is irrigated and checked meticulously for bleeding.
- The ribs are approximated and the thoracic musculofascial layers are closed in layers.
- The skin is closed.

Post-op Same day work through discharge from operating suite to NICU

- Dress wound and chest drainage tube with sterile dressings.
- Transfer patient to transport isolette with appropriate monitoring.
- Sign OR forms, indicating pre and post-op diagnosis and operation performed.
- Accompany patient back to the NICU with anesthesiologists and nurses.
- Transfer patient to neonatal heating bed with appropriate monitoring equipment.
- Write orders for post-op labs, x-rays, initial ventilator settings, monitors, drains, medications, diet, and nursing care.
- Accompany infant back to NICU.
- Write post-operative orders for medications, intravenous fluids, labs, x-rays, and ventilator settings.
- Review operative findings and post-operative orders with NICU nursing staff.
- Discuss operation with parents.
- Discuss operation and outcome with referring obstetrician and pediatrician or neonatologist.
- Assess arterial blood gas (ABG) results and adjust ventilator settings.
- Assess peripheral perfusion and adjust intravenous fluids.
- Monitor urine output and acid/base status.
- Monitor blood sugars.
- Check post-operative chest x-ray for position of all tubes and lung fields.
Re-position tubes as indicated by x-ray.
- ✓ Re-examine infant and check repeat ABG, urine output, perfusion, and post-operative labs including blood sugar.
- Treat any laboratory abnormalities.

- Discuss peri-operative management with cardiologist (if associated cardiac anomaly).
- Chart patient progress note.
- Place chest drainage tube on appropriate suction.
- Write an op note in the patient's record.
- Dictate post-op report.
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company.
- Examine patient for postoperative stability.
- Revisit patient to assess progress, pulmonary, cardiac, renal function and status of abdominal dressings.
- Write and summarize orders for NICU nurse.

Post-op Same day work after transfer to NICU

- Examine patient, check wounds and patient progress.
- Wean ventilator as able.
- Check function of OG tube, fluid and electrolyte status and urine output.
- Review nursing/other staff patient chart notes.
- Answer patient family questions.
- Answer nursing/other staff questions.
- Write orders for following day's labs, x-rays, medications, diet, and nursing care.
- Chart patient progress notes

Post-op Other Hospital work - Beginning on post-op day 1, until discharge day

- Review daily labs and x-rays.
- Check wound, chest tube drainage, and patient progress.
- Extubate patient when appropriate and use supplemental oxygen as needed
- Frequently revisit patient to assess progress, pulmonary, cardiac, renal function and hemodynamic status
- Determine when enteral feedings via the transanastomotic tube can be started.
- Discuss patient progress with family.
- Discuss patient progress with referring physician (verbal and written).
- Review nursing/other staff patient chart notes.
- Answer patient/family questions.
- Answer nursing/other staff questions (verbal and written).
- Answer insurance staff questions.
- Accompany patient to radiology suite to obtain postoperative contrast swallow at POD 5-7.
- Remove orogastric tube if no leak seen; continue orogastric feedings if leak seen for additional week.
- Write daily orders.
- Chart patient progress notes.

Discharge day work –

- Examine and talk with patient's family.
- Carefully explain to patient's family dietary management, activities permitted, bathing, handling of wound or any drains, return appointment to office, etc.
- Check wounds and patient progress.
- Review nursing/other staff patient chart notes.
- Answer patient/family questions.
- Answer nursing/other staff questions.
- Answer insurance staff questions.
- Write orders for post-discharge labs, films, and medications.
- Chart patient discharge notes.
- Arrange home nursing.
Discuss oxygen therapy and apnea monitoring and write orders for same.
- Assure CPR training.

Post-op Office work - After discharge from hospital

- Examine patient, check wounds and patient progress.
- Write orders for medications.
- Evaluate need for oxygen therapy and continue apnea monitoring.
- Review post-discharge labs and x-rays.
- Discuss progress with patient/family
- Answer patient's family questions.
- Answer insurance staff questions.
- Discuss patient progress with referring physician (verbal and written).
- Arrange follow-up barium swallow.
- Review barium swallow(s).
- Determine need for dilatation.
- Adjust feeding regimen.
- Monitor anti-reflux therapy.
- Evaluate tracheomalacia.
- Dictate patient progress notes for medical chart.

SURVEY DATA

Presenter(s): Eugene Wiener, MD

Specialty(s): American Pediatric Surgical Association

Sample Size: 54 **Response Rate:** 31 (57%)

Type of Sample: Random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	32.97	45.00	50.27	59.00	86.50
Pre-Service			128		
Intra-Service	90	128	178	180	230

Post-Service:	<u>Total Time</u>	<u>CPT code / # of visits</u>
Immed. Post-Service	45	180 90
Critical Care	1080	99296x2 99297x8 + 70
Other Hospital	139	99233x1 99232x2 99231x2
Discharge Day Mgmt	57 40	99239
Office Visits	130	99214x1 99213x4

KEY REFERENCE SERVICE(S):

<u>00 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
16.58	90	43324	Esophagogastric fundoplasty (eg, Nissen, Belsey IV, Hill procedures)
21.74	90	47760	Anastomosis, of extrahepatic biliary ducts and gastrointestinal tract

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

<i>TIME ESTIMATES (MEDIAN)</i>	Survey CPT 43312 (n=31)	Ref CPT 43324 (n=5)	Ref CPT 47760 (n=5)
Pre-service time	128	73	85
Intra-service time	178	90	180
Immediate Post-service time	45	30	30
Total critical care time	1080	0	0
Total other hospital visit time	139	120	136
Discharge management time	40	30	30
Total office visit time	130	46	61

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	4.25	3.00	3.40
Intra-service	4.82	3.00	4.20
Post-service	4.25	2.80	3.40

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.06	2.80	3.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.94	2.80	3.60
Urgency of medical decision making	4.39	3.20	3.60

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.81	3.40	4.20
Physical effort required	3.97	2.80	3.60

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.68	3.00	3.80
Outcome depends on the skill and judgment of physician	4.81	3.00	4.00
Estimated risk of malpractice suit with poor outcome	3.97	2.80	3.40

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

A RUC survey was performed (see Attachment VI-3. A consensus panel (see Attachment I) reviewed the survey and made final recommendation. The consensus panel noted the following: With increased prenatal diagnosis these infants are more frequently born at specialized centers. An increased number of surviving preterm infants present for surgery.

CPT 43312 intraop work compares to 43324, and 47760 although the time is greater than 43324 and the intensity by all measures is greater. However, the postop work for 43312 is significantly greater in both time and intensity. Neonates requiring this procedure are typically in the hospital 16 days (survey 25th pctl LOS was 12 days and 75th pctl LOS was 19 days), with 10 days of that in NICU. Daily care is significant – as described in the service description. We note that the survey median RVW of 50.27 does not fully compensate for even the post-op work of this code. We also note that the neonatal codes were not valued when this code was last reviewed and the post service work for them alone exceed the recommended RVWs. We would like *consideration* given to changing the global period from 90 days to 0 days to deal with the unique post service work. **We recommend an RVW of 50.27.**

Building block comparison:

50.27 Recommended RVW

58.34 Subtract postop HV & OV RVWs

(8.07) Negative balance RVWs for pre-op and intra-op work

FAMILY CODE RECOMMENDATIONS (43305 AND 43310)

A mini-survey of time, visits, and relative intraop intensity was conducted for two additional codes. The recommendations for these codes is based on a comparison of this data.

43305: Relative to CPT 43312 (as the anchor code), CPT 43305 data for intraop time (120) and NICU (6) and other HV (4) and OV (3) are all lower. Intraop intensity for 43305 is also less than 43312. We recommend an RVW of 28.66 for 43305. This RVW maintains the previous relativity between 43305 and 43312. **We recommend an RVW of 28.66 for 43305.**[old RVW ratio (17.39/30.50) = new RVW ratio (28.66/50.27)]

43310: Relative to CPT 43312 (as the anchor code), CPT 43310 has similar intraop time (160) and intensity as well as similar NICU days (8). It has the same number of HV (6) and OV (5). Esophageal myotomies (see service descriptor) are typically performed for 43310. **We recommend an RVW of 45.28 for 43310.** This RVW maintains the previous relativity between 43310 and 43312. [old RVW ratio (27.47/30.50) = new RVW ratio (45.28/50.27)]

FREQUENCY INFORMATION

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

Specialty: Pediatric Surgery 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: Pediatric Surgery Frequency: 300

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: Pediatric Surgery

Frequency: 0 all codes

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. Has the work of performing this service changed in the past 5 years?

2 Yes

18 No

b. This service represents new technology that has become more familiar (i.e., less work).

0 I agree

2 I do not agree

c. Patients requiring this service are now:

1 more complex (more work)

0 less complex (less work)

1 no change

d. The usual site-of-service has changed:

0 from outpatient to inpatient

0 from inpatient to outpatient

2 no change

	A	B	C	D	E	F	G	H	I	J	K	L	M	N				
1	Clinical Labor, Medical Supplies, and Procedure Equipment Practice Expense Data										CPT				4331X1	4331X1	43312X2	43312X2
2											Global				090	090	090	090
3											Number/Level of Post OV:				N/A	99214x1 99213x4	N/A	99214x1 99213x4
4	CLINICAL LABOR						Code	staff desc	Price		IN Off	OUT off	IN Off	OUT off				
5	TOTAL TYPICAL TIME						1130	RN/LPN/MA	\$ 0.317		0	362	0	370				
6	PRE-service time						1130	RN/LPN/MA	\$ 0.317		0	30	0	30				
7	SERVICE time						1130	RN/LPN/MA	\$ 0.317		0	135	0	143				
8	POST-service time						1130	RN/LPN/MA	\$ 0.317		0	197	0	197				
9	PRE-SERVICE																	
10	BEGINS after procedure consult. (in/out)										Min	Min	Min	Min				
11	Complete pre-service diagnostic & referral forms (5/5)						1130	RN/LPN/MA	\$ 0.317		0	0	0	0				
12	Coord pre-proc services/review test/exam results (10/20)						1130	RN/LPN/MA	\$ 0.317		0	10	0	10				
13	Schedule space and equipment in facility (0/8)						1130	RN/LPN/MA	\$ 0.317		0	0	0	0				
14	OV before surgery/procedure - review test/exam results (0/0)						1130	RN/LPN/MA	\$ 0.317		0	0	0	0				
15	Provide pre-service education/obtain consent (10/20)						1130	RN/LPN/MA	\$ 0.317		0	20	0	20				
16	Follow-up phone calls & prescriptions (10/7)						1130	RN/LPN/MA	\$ 0.317		0	0	0	0				
17	Other Pre-Service Activities (please specify):																	
18							1130	RN/LPN/MA	\$ 0.317		0	0	0	0				
19	ENDS with admission to facility/office																	
20	SERVICE PERIOD																	
21	Starts with admission to facility/office										Min	Min	Min	Min				
22	phone calls with family and insurance carriers @7.5 min						1130	RN/LPN/MA	\$ 0.317		0	105	0	97.5				
23	pre discharge counselling and coordination (@15 min)						1130	RN/LPN/MA	\$ 0.317		0	30	0	45				
24	Ends with discharge from facility/office																	
25	POST-SERVICE																	
26	Begins after discharge from facility/office										Min	Min	Min	Min				
27	Postop OV total time (E/M standards)						1130	RN/LPN/MA	\$ 0.317		0	197	0	197				
28																		
29	Other Activities (please specify):																	
30							1130	RN/LPN/MA	\$ 0.317		0	0	0	0				
31	ENDS after 90 days from day of procedure.																	
32	MEDICAL SUPPLIES						Code	Unit Size	Unit Cnt	Price	Out Off	Out Off	Out Off	Out Off				
33											QTY	QTY	QTY	QTY				
34	PEAC Minimum visit package (multi-specialty):						PEAC	PKG	1	\$ 1.310	0	5	0	5				
35	exam table paper (7 ft)						11111	foot	1	\$ 0.015								
36	gloves, non-sterile (2 pair)						11302	pair	1	\$ 0.120								
37	patient gown, disposable						11107	item	1	\$ 0.570								
38	pillow case, disposable						11112	item	1	\$ 0.320								
39	thermometer probe cover, disposable						11509	item	1	\$ 0.069								
40	Add'l visit supplies:																	
41	patient education booklet						11115	item	1	\$ 0.920	0	1	0	1				
42	PEAC Postop incision care kit:						PEAC	PKG	1	\$ 15.034	0	1	0	1				
43	betadine						52310	ml	20	\$ 0.140								
44	gauze, sterile 4x4 (10 pack)						31505	pack	2	\$ 2.940								
45	gloves, sterile						14005	pair	1	\$ 0.890								
46	staple remover kit						31702	item	1	\$ 6.830								
47	steri-strip						31513	strip	12	\$ 3.580								
48	swab Alcohol						11302	item	2	\$ 0.034								
49	tape						31514	inch	12	\$ 0.300								
50	tincture benzoin swab						52308	item	1	\$ 0.320								
51	Add'l supplies:																	
52											0	0	0	0				
53	PROCEDURE SPECIFIC EQUIPMENT																	
54	Exam table						E11001	1	\$ 1,360		0	1	0	1				

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

April 2001

Repair Small Intestine Atresia

Three new CPT codes were created to describe treatment for congenital small intestine atresias. The surgical techniques for correcting this anomaly are unique to congenital small intestine atresias. Thirty to forty percent of the patients treated by this service are premature newborns. These procedures are extremely rare (less than 250 per year).

44126 Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; without tapering

The RUC reviewed the specialty society's survey results from 44 practicing pediatric surgeons. The specialty recommended the 75th percentile of their survey results since the typical patient's are full term and premature infants requiring more extensive post-operative care. Typically, these infants require a length of stay of 21 days after surgery. The RUC agreed that the pediatric surgeon is performing all the post-operative care described by the survey. It is also common for a neonatologist to provide care during this time period. These are extremely rare cases and it is reasonable to assume that more than one physician would be responsible for caring for these newborns. The RUC noted that even if the two critical care visits were converted to level three hospital visits, a computed IWPOT of 0.07 (as described on page 5 of the summary form) justifies the specialty recommendation of 35.50. **The RUC recommends a relative work value of 35.50 for CPT code 44126.**

Practice Expense

The RUC reduced the pre-service clinical labor time from the standard 60 minutes for 090 day global period codes, to 30 minutes based on the understanding that the typical patient would be in the hospital already. The RUC recommended direct practice expense inputs for code 44126 are attached.

44127 Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; with tapering

The RUC reviewed the specialty society's survey results from 44 practicing pediatric surgeons. The specialty recommended the 75th percentile of their survey results since the typical patient's are full term and premature infants requiring more extensive post-operative care. Typically, these infants require a length of stay of 26 days after surgery. The RUC agreed that the pediatric surgeon is performing all the post-operative care

described by the survey. It is also common for a neonatologist to provide care during this time period. These are extremely rare cases and it is reasonable to assume that more than one physician would be responsible for caring for these newborns. The RUC noted that even if the two critical care visits were converted to level three hospital visits, a computed IWPOT of 0.07 (as described on page 5 of the summary form) justifies the specialty recommendation of 41.00. **The RUC recommends a relative work value of 41.00 for CPT code 44127.**

Practice Expense

The RUC reduced the pre-service clinical labor time from the standard 60 minutes for 090 day global period codes, to 30 minutes based on the understanding that the typical patient would be in the hospital already. The RUC recommended direct practice expense inputs for code 44126 are attached.

44128 – E3 Enterectomy, resection of small intestine for congenital atresia; single resection and anastomosis of proximal segment of intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure) (Use 44128 in conjunction with 44126, 44127)

The RUC agreed that the time associated with this code was correct after reviewing three other codes; 22614 *Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)* (work RVU = 6.44), 35600 *Harvest of upper extremity artery, one segment, for coronary artery bypass procedure* (work RVU = 4.95), and 38746 *Thoracic lymphadenectomy, regional, including mediastinal and peritracheal nodes (List separately in addition to code for primary procedure)* (work RVU = 4.39)

Each of these codes have 40 minutes of RUC surveyed physician intra-service time, ZZZ global period, and have similar work intensity as the new code 44128. In addition, the RUC reviewed the reference code 44121 *Enterectomy, resection of small intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure)* (work RVU = 4.45), and believed CPT code 44128 would be more appropriately valued below the specialty society's recommended value and equivalent to its reference code. **The RUC recommends a relative work value of 4.45 for CPT code 44128.**

Practice Expense

The RUC recommended no practice expense inputs for this ZZZ day global code, 44128.

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
• 44126	E1	Enterectomy, resection of small intestine for congenital atresia; single resection and anastomosis of proximal segment of intestine; without tapering	090	N/A	35.50
• 44127	E2	with tapering	090	N/A	41.00
• 44128	E3	each additional resection and anastomosis (List separately in addition to primary procedure) (Use 44128 in conjunction with 44126, 44127)	ZZZ	N/A	4.45

CPT Code: 4412X1 (E1)

Global: 090

Recommended RVW: 35.50

CPT Descriptor: Enterectomy, resection of small intestine for congenital atresia; single resection and anastomosis, without tapering of proximal segment of intestine

Survey Vignette (Typical Patient)

A 1500 gram 32 week gestation male infant is born to a 16 year-old unmarried mother with polyhydramnios. After vomiting green material, abdominal X-rays show a large distended upper small intestinal bowel loop with no distal gas. A colon contrast study refluxed contrast into the terminal ileum; there was a micro colon. At laparotomy, there is a jejunal atresia approximately 15 cm from the ligament of Treitz. In order to insure that there are no other atresias, the bowel is examined and injected with sterile saline until the contrast from the distal colon study is encountered. There are no other atresias. The bulbous distal portion of the proximal jejunum is resected and an end-to-back intestinal anastomosis is then performed using fine interrupted sutures with magnification. The abdominal wall and skin is closed in layers. All subsequent postoperative NICU and hospital visits and services performed by the surgeon, such as daily neonatal care, volume resuscitation and fluid management, ventilatory management, medications, TPN management, enteral feeding management, pain management, wound care, as well as ordering and reviewing postoperative X-rays and laboratory studies and communication with nurses, family and physicians and documentation are included. Discharge day management includes final examination of the patient, instructions for follow-up including coordination with primary care physicians and home care agencies, and dictation of a detailed hospital summary and letter to the patient's pediatrician. This also may include home TPN arrangements and management, if needed. All post-discharge office visits and TPN and feeding management, review of laboratory studies, phone calls with the parent and PCP and visiting nurse agencies for the 90-day global period are also included.

CLINICAL DESCRIPTION OF SERVICE:

Pre- service work – day before surgery:

- Write preoperative orders for perioperative medications
- Review preoperative workup, with particular attention to radiographic studies
- Check function of NG tube and state of perioperative hydration
- Review planned incisions and procedure
- Confirm OR start time - notify family

Pre- service work – day of surgery:

- Change into scrub clothes
- Make certain blood and/or crossmatch is available
- Review the surgical procedure, postop recovery, and expected outcomes with family
- Answer family's questions and obtain informed consent, arrange where to meet postoperatively
- Review anesthesia with anesthesiologist including possible caudal or local anesthesia
- Review planned procedure, positioning and draping of patient
- Verify that all necessary surgical instruments and supplies are available in the operative suite
- Ensure adequate thermoregulation control
- Monitor patient positioning and assist with positioning and draping as needed
- Scrub and gown

Intra- service work – skin to skin

- Skin incision is made, usually transverse supraumbilical
- Abdominal wall musculature divided with cautery
- Examine intestine to assess level of atresia
- Explore abdomen to check for other distal atresias or anomalies
- Determine continuity of the distal segment
- Choose site of resection of atretic segment if there is adequate length of gut
- Ligate and divide appropriate mesenteric vessels
- Control bowel lumen with noncrushing bowel clamps
- Perform end to back anastomosis with interrupted suture
- Close mesenteric defect being careful to avoid damaging the blood supply
- Close fascia and skin

Postop same-day work through discharge from recovery

- Apply dressing
- Write an OP note in the patient's record
- Sign OR forms, including pre- and postoperative diagnosis, operations performed
- Write orders for postop mechanical ventilation, blood gases, intravenous fluid including NG replacement, labs, x-ray films, perioperative antibiotics, sedation, and analgesia.
- Review neonatal ICU care including ventilator settings and medications with staff
- Discuss procedure outcome with family
- Dictate postop report
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company

Postop same day work after discharge from recovery

- Examine patient, check incision, adequacy of mechanical ventilation, cardiovascular status, adequacy of intravenous fluid management, and patients progress
- Check function of nasogastric tube, monitor output for replacement
- Review adequacy of postop pain control
- Review nursing/other staff patient chart note
- Answer nursing/other staff questions
- Answer family questions
- Write orders for following day's lab, films, medications, IV fluids including TPN
- Chart patient progress note

Postop other hospital work – beginning on postop day 1, until discharge day

- Examine patient and talk with family
- Wean from ventilator and extubate when minute ventilation adequate
- Check incision and patient's pain control
- Determine when NG tube can be discontinued and feeding can be started
- Order daily TPN until able to tolerate enteral feedings.
- Transition from TPN to oral gastric tube feedings
- Transition from oral gastric tube feeding to PO feeding
- Remove central line catheter when adequately tolerating PO feedings
- Transition from radiant warmer to incubator to open crib
- Discuss patient progress with primary care physician (verbal/written)
- Review nursing/other staff patient's chart note
- Review lab and film results
- Answer family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for postop ventilator settings including weaning parameters, blood gases, lab, films, medications, and diet
- Chart patient progress notes

Discharge day work

- Examine patient and talk with family
- Explain to family handling of incision, bathing, diet, return appointment to office etc.
- Check incision and patient's progress
- Discuss patient progress with primary care physician (verbal/written)
- Review nursing/other staff patient's chart note
- Answer family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for discharge medications, and diet
- Chart patient discharge note
- Dictate discharge summary

Postop office work-after discharge from hospital

- Examine patient and talk with family
- Check incision, patient's progress, and growth
- Answer family questions
- Answer insurance staff questions
- Discuss patient progress with primary care physician (verbal/written)
- Write orders for medications
- Dictate patient progress note for medical record

SURVEY DATA

Presenter(s): Eugene S. Wiener, MD, FACS
 Samuel Smith, MD, FACS

Specialty(s): American Pediatric Surgical Association

CPT: 4412X1

Sample Size: 44 **Resp n:** 31 **Resp %:** 71%

Sample Type: random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	16.00	21.00	25.00	35.50	72.10
Pre-Service			90		
Intra-Service	60	90	120	120	200

Post-Service Total Min CPT code / # of visits

Day of Surgery:

Immediate	30	
Other	60	99291*

After Day of Surgery:

Critical Care	60	99291*x1			
Other Hospital	493	99233x3	99232x6	99231x10	LOS = 21
Dischg Day Mgmt	36	99238			
Office Visits	99	99214x1	99213x2	99212x1	

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
44120	Enterectomy, resection of small intestine; single resection and anastomosis	14.50*	090

*This code was reviewed during the second five year review and the RUC approved an increase to 17.00 rvu's.

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

	Svy CPT 4412X1	Ref CPT 44120 (RUC '00)
TIME ESTIMATES (MEDIAN)		
Pre-service time	90	60
Intra-service time	120	90
Same Day Immediate Post-service time	30	30
Same Day Other Post-service time	60*	30
Post Total critical care time (not same day)	60*	0
Post Total other hospital visit time (not same day)	493	87
Discharge management time	36	36
Total office visit time	99	46
TOTAL Time	988	379

*critical care

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	3.97	3.15
Intra-service	4.14	3.30
Post-service	4.21	2.95

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.86	3.20
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.62	3.20
Urgency of medical decision making	4.03	3.65

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.34	3.15
Physical effort required	3.66	3.20

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.03	3.20
Outcome depends on the skill and judgment of physician	4.31	3.25
Estimated risk of malpractice suit with poor outcome	3.62	3.35

ADDITIONAL RATIONALE

CPT 4412X1 is performed on newborn patients, of which 30-40% are premature newborns. The existing code 44120 for resection of small intestine does not reflect the anatomic conditions found by the surgeon in treating atresia of the small intestine and does not reflect the pre-service, intra-service, and post-service work effort, and the prolonged postoperative care under a 90-day global necessary to treat these patients. Because these patients are newborn, additional pre-service work is required. At surgery, considerations must be given to preventing future "short bowel syndrome." The resection must consider the massive size differences between the proximal atretic segment and the distal unused atretic segments. Postoperative care is prolonged in the NICU and involves respirators, TPN, and complicated initiation of diets. In comparison to the reference code, new code 4412X1 requires 30% more intraoperative time and almost four times more hospital time, including critical care management. The intensity/complexity measures above support this. However, we believe that the survey median does not adequately consider the extensive postoperative care required for these critically ill neonates/infants.

In addition to comparing service "time," the consensus panel looked at the service "work" components under two different BBM assumptions (see below). The first BBM analysis, using the surveyed postop visit pattern, resulted in a negative balance for the operation. A second BBM analysis, which changed the critical care visits to non-critical care visits, still resulted in a negative balance for the operation.

Based on this discussion, **we are recommending the survey 75th percentile RVW of 35.50.** Using the surveyed postop visit pattern (which correctly includes critical care), the 75th percentile RVW of 35.50 results in a negative intraoperative RVW and IWPUT. When we changed all critical care visits to non-critical care level and used an RVW of 35.50, the resulting intraoperative RVW is only 8.41 with an IWPUT of 0.070.

Reference code 44120 has appreciably less stress, intensity, and requires less technical skill than 4412X1. The RUC approved value of 17.00 for 44120 results in an IWPUT of 0.093. This procedure was surveyed during the recent five year review as having a five day length of stay and two postop office visits. The intra-operative time was surveyed at 30 minutes less than 4412X1. Additionally, we note that our survey indicated that pediatric surgeons are typically responsible for a majority of the critical care management of these patients at least on the day of surgery and on the first postoperative day. CPT 44120 does not include critical care management.

Building Block Analyses	4412x1	4412x1
A. Survey Median and 75th pctl RVW	25.00	35.50

Pre-op	Time	Intensity	(=time x int)	(=time x int)
Day prior evaluation	45	0.0224	1.01	1.01
Same day evaluation	45	0.0224	1.01	1.01
B. Pre-op RVW sum			2.02	2.02
Post-op	Time	Intensity	(=time x int)	(=time x int)
Immediate post	30	0.0224	0.67	0.67
Subsequent visits:	Visit n	E/M RVW	(=n x E/M RVW)	(=n x E/M RVW)
99291	2	4.00	8.00	8.00
99292	0	2.00	0.00	0.00
99233	3	1.51	4.53	4.53
99232	6	1.06	6.36	6.36
99231	10	0.64	6.40	6.40
99238	1	1.28	1.28	1.28
99239	0	1.75	0.00	0.00
99215	0	1.73	0.00	0.00
99214	1	1.08	1.08	1.08
99213	2	0.65	1.30	1.30
99212	1	0.43	0.43	0.43
99211	0	0.17	0.00	0.00
C. Post-op RVW sum			29.38	29.38
A - B - C = Intra-op RVW	Time	IWPUT	RVW	IWPUT
	120	-0.059	-7.07	0.029

ALTERNATE BBM - NO CRITICAL CARE

A. Survey Median and 75th pctl RVW

25.00

35.50

Pre-op	Time	Intensity	(=time x int)	(=time x int)
Day prior evaluation	45	0.0224	1.01	1.01
Same day evaluation	45	0.0224	1.01	1.01
B. Pre-op RVW sum			2.02	2.02
Post-op	Time	Intensity	(=time x int)	(=time x int)
Immediate post	30	0.0224	0.67	0.67
Subsequent visits:	Visit n	E/M RVW	(=n x E/M RVW)	(=n x E/M RVW)
99291	0	4.00	0.00	0.00
99292	0	2.00	0.00	0.00
99233	5	1.51	7.55	7.55
99232	6	1.06	6.36	6.36
99231	10	0.64	6.40	6.40
99238	1	1.28	1.28	1.28
99239	0	1.75	0.00	0.00
99215	0	1.73	0.00	0.00
99214	1	1.08	1.08	1.08
99213	2	0.65	1.30	1.30
99212	1	0.43	0.43	0.43
99211	0	0.17	0.00	0.00
C. Post-op RVW sum			24.40	24.40
A - B - C = Intra-op RVW	Time	IWPUT	RVW	IWPUT
	120	-0.017	-2.09	0.070

Additional survey question and results:

"As necessary, for the typical patient described on the first page of this survey, do you – as the surgeon – perform daily neonatal care such as:"

<u>YES</u>	<u>NO</u>	
94%	6%	Volume resuscitation and fluid management
42%	58%	Cardiac and/or ventilator management
65%	35%	Continuous or frequent vital sign monitoring
100%	0%	Ordering and reviewing postoperative X-rays and laboratory studies
97%	3%	Lab and blood gas interpretations
94%	6%	Medication management (eg, antibiotics, pain management)
81%	19%	TPN / Enteral feeding management
100%	0%	Wound care

FREQUENCY INFORMATION

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

44799 Unlisted procedure, intestine (Medicare frequency = 1,055)

44120-22 Enterectomy, resection of small intestine; single resection and anastomosis (Medicare freq = 792)

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

Specialty: pediatric surgery Rarely

3. 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: pediatric surgery Frequency: 250

4. 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: pediatric surgery Frequency: 0

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to centers with pediatric surgeons

CPT Code: 4412X2 (E2)

Global: 090

Recommended RVW: 41.00

CPT Descriptor: Enterectomy, resection of small intestine for congenital atresia; single resection and anastomosis, with tapering of proximal segment of intestine

Survey Vignette (Typical Patient)

A 1500 gram 32 week gestation male infant is born to a 16 year-old unmarried mother with polyhydramnios. After vomiting green material, abdominal X-rays show a large distended upper small intestinal bowel loop with no distal gas. A colon contrast study refluxed contrast into the terminal ileum; there was a micro colon. At laparotomy, there is a jejunal atresia approximately 15 cm from the ligament of Treitz. In order to insure that there are no other atresias, the bowel is examined and injected with sterile saline until the contrast from the distal colon study is encountered. There are no other atresias. The ligament of Treitz is taken down and after the most bulbous distal portion of the proximal jejunum is resected, the remaining proximal jejunum is tapered with a 12 cm suture line prior to performing the anastomosis. An end-to-back intestinal anastomosis is then performed using fine interrupted sutures with magnification. The abdominal wall and skin is closed in layers. All subsequent postoperative NICU and hospital visits and services performed by the surgeon such as daily neonatal care, volume resuscitation and fluid management, ventilatory management, medications, TPN management, enteral feeding management, pain management, wound care, as well as ordering and reviewing postoperative x-rays and laboratory studies and communication with nurses, family and physicians and documentation are included. Discharge day management includes final examination of the patient, instructions for follow-up including coordination with primary care physicians and home care agencies, and dictation of a detailed hospital summary and letter to the patient's pediatrician. This also may include home TPN arrangements and management, if needed. All post-discharge office visits and TPN and feeding management, review of laboratory studies, phone calls with the parent and PCP and visiting nurse agencies for the 90-day global period are also included.

CLINICAL DESCRIPTION OF SERVICE:

Pre- service work -- day before surgery:

- Write preoperative orders for perioperative workup, with particular attention to radiographic studies
- Check function of NG tube and state of perioperative hydration
- Review planned incisions and procedure
- Confirm OR start time - notify family

Pre- service work -- day of surgery:

- Change into scrub clothes
- Make certain blood and/or crossmatch is available
- Review the surgical procedure, postop recovery, and expected outcomes with family
- Answer family's questions and obtain informed consent, arrange where to meet postoperatively
- Review anesthesia with anesthesiologist including possible caudal or local anesthesia
- Review planned procedure, positioning and draping of patient
- Verify that all necessary surgical instruments and supplies are available in the operative suite
- Ensure adequate thermoregulation control
- Monitor patient positioning and assist with positioning and draping as needed
- Scrub and gown

Intra- service work -- skin to skin

- Skin incision is made, usually transverse supraumbilical
- Abdominal wall musculature divided with cautery
- Examine intestine to assess level of atresia
- Explore abdomen to check for other distal atresias or anomalies
- Determine continuity of the distal segment
- Choose site for tapering or plicating the proximal dilated atretic segment
- Taper or plicate dilated atretic segment using stapler or suture being careful to avoid narrowing the lumen of the intestine excessively
- Ligate and divide appropriate mesenteric vessels
- Control bowel lumen with noncrushing bowel clamps
- Perform end to back anastomosis with interrupted suture
- Close mesenteric defect being careful to avoid damaging the blood supply
- Close fascia and skin

Postop same-day work through discharge from recovery

- Apply dressing
- Write an OP note in the patient's record
- Sign OR forms, including pre- and postoperative diagnosis, operations performed
- Write orders for postop mechanical ventilation, blood gases, intravenous fluid including NG replacement, labs, x-ray films, perioperative antibiotics, sedation, and analgesia.
- Review neonatal ICU care including ventilator settings and medications with staff
- Discuss procedure outcome with family
- Dictate postop report
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company

Postop same day work after discharge from recovery

- Examine patient, check incision, adequacy of mechanical ventilation, cardiovascular status, adequacy of intravenous fluid management, and patients progress
- Check function of nasogastric tube, monitor output for replacement
- Review adequacy of postop pain control
- Review nursing/other staff patient chart note
- Answer nursing/other staff questions
- Answer family questions
- Write orders for following day's lab, films, medications, IV fluids including TPN
- Chart patient progress note

Postop other hospital work – beginning on postop day 1, until discharge day

- Examine patient and talk with family
- Wean from ventilator and extubate when minute ventilation adequate
- Check incision and patient's pain control
- Determine when NG tube can be discontinued and feeding can be started
- Order daily TPN with appropriate laboratory monitoring until able to tolerate enteral feedings.
- Transition from TPN to oral gastric tube feedings
- Transition from oral gastric tube feeding to PO feeding
- Remove central line catheter when adequately tolerating PO feedings
- Transition from radiant warmer to incubator to open crib
- Discuss patient progress with primary care physician (verbal/written)
- Review nursing/other staff patient's chart note
- Review lab and film results
- Answer family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for postop ventilator settings including weaning parameters, blood gases, lab, films, medications, and diet
- Chart patient progress notes

Discharge day work

- Examine patient and talk with family
- Explain to family handling of incision, bathing, diet, return appointment to office etc.
- Check incision and patient's progress
- Discuss patient progress with primary care physician (verbal/written)
- Review nursing/other staff patient's chart note
- Answer family questions
- Answer nursing/other staff questions
- Answer insurance staff questions
- Write orders for discharge medications, and diet
- Chart patient discharge note
- Dictate discharge summary

Postop office work-after discharge from hospital

- Examine patient and talk with family

- Check incision, patient's progress, and growth
- Answer family questions
- Answer insurance staff questions
- Discuss patient progress with primary care physician (verbal/written)
- Write orders for medications
- Dictate patient progress note for medical record

SURVEY DATA

Presenter(s): Eugene S. Wiener, MD, FACS
Samuel Smith, MD, FACS

Specialty(s): American Pediatric Surgical Association

CPT: 4412X2

Sample Size: 44 **Resp n:** 31 **Resp %:** 71%

Sample Type: random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RWV	18.00	23.50	30.00	41.00	77.40
Pre-Service			90		
Intra-Service	80	120	150	180	240

Post-Service **Total Min** **CPT code / # of visits**

Day of Surgery:

Immediate 30

Other 60 99291*

After Day of Surgery:

Critical Care	90	99291*x1+99292*x1 (on PO day 1)	
Other Hospital	621	99233x4 99232x7 99231x13	LOS = 26
Dischg Day Mgmt	45	99239	
Office Visits	99	99214x1 99213x2 99212x1	

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
44120	Enterectomy, resection of small intestine; single resection and anastomosis	14.50*	090

*This code was reviewed during the second five year review and the RUC approved an increase to 17.00 rvu's.

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

	Svy CPT 4412X2	Ref CPT 44120 (RUC '00)
TIME ESTIMATES (MEDIAN)		
Pre-service time	90	60
Intra-service time	150	90
Same Day Immediate Post-service time	30	30
Same Day Other Post-service time	60*	30
Post Total critical care time (not same day)	90*	0
Post Total other hospital visit time (not same day)	621	87
Discharge management time	45	36
Total office visit time	99	46
TOTAL Time	1,185	379

*critical care

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	3.89	3.06
Intra-service	4.43	3.38
Post-service	4.32	3.13

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.93	3.13
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.62	3.13
Urgency of medical decision making	4.07	3.63

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.52	3.19
Physical effort required	3.83	3.31

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.21	3.19
Outcome depends on the skill and judgment of physician	4.38	3.19
Estimated risk of malpractice suit with poor outcome	3.72	3.38

ADDITIONAL RATIONALE

CPT 4412X2 is performed on newborn patients, of which 30-40% are premature newborns. The existing code 44120 for resection of small intestine does not reflect the anatomic conditions found by the surgeon in treating atresia of the small intestine and does not reflect the pre-service, intra-service, and post-service work effort, and the prolonged postoperative care under a 90-day global necessary to treat these patients. Because these patients are newborn, additional pre-service work is required. At surgery, considerations must be given to preventing future "short bowel syndrome." The resection must consider the massive size differences between the proximal atretic segment and the distal unused atretic segments. Postoperative care is prolonged in the NICU and involves respirators, TPN, and complicated initiation of diets. In comparison to the reference code 44120, new code 4412X2 requires 60% more intraoperative time and five times more hospital time, including critical care management. The intensity/complexity measures above validate this. However, we believe that the survey median does not adequately consider the extensive postoperative care required for these critically ill neonates/infants.

In addition to comparing service "time," we looked at the service "work" components under two different BBM assumptions (see below). The first BBM analysis, using the surveyed postop visit pattern, resulted in a negative balance for the operation. A second BBM analysis, which changed all of the critical care visits to non-critical care visits, still resulted in a negative balance for the operation.

Based on this discussion, **we are recommending the survey 75th percentile RVW of 41.00.** Using the surveyed postop visit pattern (which correctly includes critical care), the 75th percentile RVW of 41.00 results in an RVW of 1.97 and IWPUT of 0.013. When we change all critical care visits to non-critical care levels and use an RVW of 41.00, the resulting intraoperative RVW is 8.95 with an IWPUT of 0.060, which is less than ICU care. Additionally, we note that our survey indicated that pediatric surgeons are typically responsible for a majority of the critical care management of these patients.

Reference code 44120 has appreciably less stress, intensity, and requires less technical skill than 4412X2. The RUC approved value of 17.00 for 44120 results in an IWPUT of 0.093. This procedure was surveyed during the recent five year review as having a five day length of stay and two postop office visits. The intra-operative time was surveyed at 60 minutes less than 4412X2. Additionally, we note that our survey indicated that pediatric surgeons are typically responsible for a majority of the critical care management of these patients at least on the day of surgery and on the first postoperative day. CPT 44120 does not include critical care management.

Building Block Analyses				4412x2	4412x2
A. Survey Median and 75th pctl RVW				30.00	41.00
Pre-op	Time	Intensity	(=time x int)		(=time x int)
Day prior evaluation	45	0.0224	1.01		1.01
Same day evaluation	45	0.0224	1.01		1.01
B. Pre-op RVW sum				2.02	2.02
Post-op	Time	Intensity	(=time x int)		(=time x int)
Immediate post	30	0.0224	0.67		0.67
Subsequent visits:	Visit n	E/M RVW	(=n x E/M RVW)		(=n x E/M RVW)
99291	2	4.00	8.00		8.00
99292	1	2.00	2.00		2.00
99233	4	1.51	6.04		6.04
99232	7	1.06	7.42		7.42
99231	13	0.64	8.32		8.32
99238	0	1.28	0.00		0.00
99239	1	1.75	1.75		1.75
99215	0	1.73	0.00		0.00
99214	1	1.08	1.08		1.08
99213	2	0.65	1.30		1.30
99212	1	0.43	0.43		0.43
99211	0	0.17	0.00		0.00
C. Post-op RVW sum				36.34	36.34
A - B - C = Intra-op RVW				Time 150	IWPUT RVW 0.013 1.97
				IWPUT RVW -9.03	IWPUT RVW 1.97

ALTERNATE BBM - NO CRITICAL CARE				30.00	41.00
A. Survey Median and 75th pctl RVW				30.00	41.00
Pre-op	Time	Intensity	(=time x int)		(=time x int)
Day prior evaluation	45	0.0224	1.01		1.01
Same day evaluation	45	0.0224	1.01		1.01
B. Pre-op RVW sum				2.02	2.02
Post-op	Time	Intensity	(=time x int)		(=time x int)
Immediate post	30	0.0224	0.67		0.67
Subsequent visits:	Visit n	E/M RVW	(=n x E/M RVW)		(=n x E/M RVW)
99291	0	4.00	0.00		0.00
99292	0	2.00	0.00		0.00
99233	6	1.51	9.06		9.06
99232	7	1.06	7.42		7.42
99231	13	0.64	8.32		8.32
99238	0	1.28	0.00		0.00
99239	1	1.75	1.75		1.75
99215	0	1.73	0.00		0.00
99214	1	1.08	1.08		1.08
99213	2	0.65	1.30		1.30
99212	1	0.43	0.43		0.43
99211	0	0.17	0.00		0.00
C. Post-op RVW sum				29.36	29.36
A - B - C = Intra-op RVW				Time 150	IWPUT RVW 0.060 8.95
				IWPUT RVW -2.05	IWPUT RVW 8.95

Additional survey question and results:

"As necessary, for the typical patient described on the first page of this survey, do you – as the surgeon – perform daily neonatal care such as:"

<u>YES</u>	<u>NO</u>	
94%	6%	Volume resuscitation and fluid management
42%	58%	Cardiac and/or ventilator management
65%	35%	Continuous or frequent vital sign monitoring
100%	0%	Ordering and reviewing postoperative X-rays and laboratory studies
97%	3%	Lab and blood gas interpretations
94%	6%	Medication management (eg, antibiotics, pain management)
77%	23%	TPN / Enteral feeding management
100%	0%	Wound care

FREQUENCY INFORMATION

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

44799 Unlisted procedure, intestine (Medicare frequency = 1,055)

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

Specialty: pediatric surgery Rarely

3. 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: pediatric surgery Frequency: 100

4. 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: pediatric surgery Frequency: 0

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to centers with pediatric surgeons

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

(April 2001)

CPT Code: 4412X3 (E3)

Global: ZZZ

Recommended RVW: 5.00

RUC Recommended RVW: 4.45

CPT Descriptor: Enterectomy, resection of small intestine for congenital atresia;
each additional resection and anastomosis
(List separately in addition to primary procedure)
(Use 4412X3 in conjunction with 4412X1 or 4412X2)

Survey Vignette (Typical Patient)

At laparotomy, there is a jejunal atresia approximately 15 cm from the ligament of Treitz. There is one other atresia in the ileum. Following management of the proximal atresia, the proximal and distal bowel of the ileal atretic segment are resected and an end-to-back intestinal anastomosis is then performed using fine interrupted sutures with magnification. (Include only the work involved for the additional atresia, not the preservice, postservice, or intraservice work already included in the survey for the primary procedure 4412X1 or 4412X2).

CLINICAL DESCRIPTION OF SERVICE:

Add-on Intra- service work

- Choose additional site of resection of atretic segment if there is adequate length of gut
- Ligate and divide appropriate mesenteric vessels
- Control bowel lumen with noncrushing bowel clamps
- Perform end to back anastomosis with interrupted suture
- Close mesenteric defect being careful to avoid damaging the blood supply

SURVEY DATA

Presenter(s): Eugene S. Wiener, MD, FACS
Samuel Smith, MD, FACS

Specialty(s): American Pediatric Surgical Association

CPT: 4421X3

Sample Size: 44 **Resp n:** 33 **Resp %:** 75%

Sample Type: random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	2.00	5.00	6.65	10.00	25.00
Intra-Service	20	30	40	45	75

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
44121	Enterectomy, resection of small intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure)	4.45	ZZZ

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

	Svy CPT 4412X3	Ref CPT 44121 (RUC '95)
TIME ESTIMATES (MEDIAN)		
Intra-service time	40	60
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Intra-service	4.10	3.00
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3.76	2.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.34	2.83
Urgency of medical decision making	3.72	3.17
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	4.28	3.06
Physical effort required	3.86	3.28
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	4.21	3.11
Outcome depends on the skill and judgment of physician	4.18	3.12
Estimated risk of malpractice suit with poor outcome	3.39	3.33

ADDITIONAL RATIONALE

The technical skill, stress and judgment required for 4421x3 is significantly greater than that for normal sized bowel. The atretic segments distal to a proximal atresia are very small in caliber. The APSA consensus panel agreed with the median survey time, but chose the 25th percentile RVW as the recommended RVW to maintain IWPUP consistency and to maintain relativity with the reference code.

FREQUENCY INFORMATION

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

44799 Unlisted procedure, intestine (Medicare frequency = 1,055)

44121-22 Enterectomy, resection of small intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure) (Medicare frequency = 26)

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

Specialty: pediatric surgery Multiple atresias are rare

3. 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: pediatric surgery Frequency: 50

4. 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: pediatric surgery Frequency: 0

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Limited to centers with pediatric surgeons

CPT: 4412X1, 4412X2, 4412X3
Specialty: APSA

**AMA/Specialty Society Update Process
RUC Summary of Recommendation
Out-Of-Office Direct Inputs [In-Office Not Applicable]**

American Pediatric Surgical Association

CPT Code: 4412X1 (E1)	Global: 090
CPT Descriptor: Enterectomy, resection of small intestine for congenital atresia; single resection and anastomosis, without tapering of proximal segment of intestine	
CPT Code: 4412X2 (E2)	Global: 090
CPT Descriptor: Enterectomy, resection of small intestine for congenital atresia; single resection and anastomosis, with tapering of proximal segment of intestine	
CPT Code: 4412X3 (E3)	Global: ZZZ
CPT Descriptor: Enterectomy, resection of small intestine for congenital atresia; each additional resection and anastomosis	

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
A consensus panel of 14 pediatric surgeons representing all geographic settings and types of practice met via phone conference to considered the clinical staff work and supplies associated with these three new congenital atresia codes.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
The PEAC approved time of 60 minutes is being recommended. These babies are sick prior to surgery and are often born to young mothers. The mother and her family will require considerable time for explanations and counselling of the procedure and the expected extended hospital stay. The other aspects of approved time appear reasonable to the APSA consensus panel for E1 and E2.

Intra-Service Clinical Labor Activities:
These babies are in the hospital for 21 days (E1) and 26 days (E2). Phone discussions with the mother and her parents and the insurance clinical staff to explain the lengthy stay and the baby's

Post-Service Clinical Labor Activities
The PEAC approved typical times medical supplies for EM services and postoperative incision care are recommended.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	
1	Clinical Labor, Medical Supplies, and Procedure Equipment Practice Expense Data						CPT					4412X1	4412X1	4412X2	4412X2	4412X3	4412X3
2							Global					090	090	090	090	ZZZ	ZZZ
3							Number/Level of Post OV:					N/A	99214x1 99213x2 99212x1	N/A	99214x1 99213x2 99212x1	N/A	N/A
4	CLINICAL LABOR						Code	staff desc	Price	IN Off	OUT off	IN Off	OUT off	IN Off	OUT off		
5	TOTAL TYPICAL TIME						1130	RN/LPN/MA	\$ 0.317	0	362	0	399.5	0	0		
6	PRE-service time						1130	RN/LPN/MA	\$ 0.317	0	30	0	30	0	0		
7	SERVICE time						1130	RN/LPN/MA	\$ 0.317	0	180	0	217.5	0	0		
8	POST-service time						1130	RN/LPN/MA	\$ 0.317	0	152	0	152	0	0		
9	PRE-SERVICE									Min	Min	Min	Min	Min	Min		
10	BEGINS after procedure consult. (in/out)																
11	Complete pre-service diagnostic & referral forms (5/5)						1130	RN/LPN/MA	\$ 0.317	0	0	0	0	0	0		
12	Coord pre-proc services/review test/exam results (10/20)						1130	RN/LPN/MA	\$ 0.317	0	10	0	10	0	0		
13	Schedule space and equipment in facility (0/8)						1130	RN/LPN/MA	\$ 0.317	0	0	0	0	0	0		
14	OV before surgery/procedure - review test/exam results						1130	RN/LPN/MA	\$ 0.317	0	0	0	0	0	0		
15	Provide pre-service education/obtain consent (10/20)						1130	RN/LPN/MA	\$ 0.317	0	20	0	20	0	0		
16	Follow-up phone calls & prescriptions (10/7)						1130	RN/LPN/MA	\$ 0.317	0	0	0	0	0	0		
17	Other Pre-Service Activities (please specify):																
18							1130	RN/LPN/MA	\$ 0.317	0	0	0	0	0	0		
19	ENDS with admission to facility/office																
20	SERVICE PERIOD									Min	Min	Min	Min	Min	Min		
21	Starts with admission to facility/office																
22	phone calls with family and insurance carriers (@7.5min)						1130	RN/LPN/MA	\$ 0.317	0	135	0	172.5	0	0		
23	pre discharge counseling and coordination (@15 min)						1130	RN/LPN/MA	\$ 0.317	0	45	0	45	0	0		
24	Ends with discharge from facility/office																
25	POST-SERVICE									Min	Min	Min	Min	Min	Min		
26	Begins after discharge from facility/office																
27	Postop OV total time (E/M standards)						211: (18) 212: (27) 213: (36) 214: (53) 215: (63)	1130	RN/LPN/MA	\$ 0.317	0	152	0	152	0	0	
29	Other Activities (please specify):																
30							1130	RN/LPN/MA	\$ 0.317	0	0	0	0	0	0		
41	ENDS after 90 days from day of procedure:																
42	MEDICAL SUPPLIES						Code	Unit Size	Unit Cnt	Price	Out Off QTY	Out Off QTY	Out Off QTY	Out Off QTY	Out Off QTY	Out Off QTY	
43	PEAC Minimum visit package (multi-specialty):						PEAC	PKG	1	\$ 1.310	0	4	0	4	0	0	
45	exam table paper (7 R)						11111	foot	1	\$ 0.015							
46	gloves, non-sterile (2 pair)						11302	pair	1	\$ 0.120							
47	patient gown, disposable						11107	item	1	\$ 0.570							
48	pillow case, disposable						11112	item	1	\$ 0.320							
49	thermometer probe cover, disposable						11509	item	1	\$ 0.069							
50	Add'l visit supplies:																
51	patient education booklet						11115	item	1	\$ 0.920	0	0	0	0	0	0	
52	PEAC Postop incision care kit:						PEAC	PKG	1	\$ 15.034	0	1	0	1	0	0	
53	betadine						52310	ml	20	\$ 0.140							
54	gauze, sterile 4x4 (10 pack)						31505	pack	2	\$ 2.840							
55	gloves, sterile						14005	pair	1	\$ 0.890							
56	staple remover kit						31702	item	1	\$ 6.830							
57	steri-strip						31513	strip	12	\$ 3.580							
58	swab Alcohol						11302	item	2	\$ 0.034							
59	tape						31514	inch	12	\$ 0.300							
60	tincture benzoin swab						52308	item	1	\$ 0.320							
61	Add'l supplies:																
62											0	0	0	0	0	0	
63	PROCEDURE SPECIFIC EQUIPMENT																
64	Exam table						E11001		1	\$ 1,360	0	1	0	1	0	0	
65	Exam lamp						E30006		1	\$ 1,850	0	1	0	1	0	0	

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
February and April 2001

Laparoscopic Colon Procedures

The CPT Editorial Panel approved three new codes to describe laparoscopic colon procedures. The RUC reviewed codes 44204 *Laparoscopy, surgical; colectomy, partial with anastomosis* and 44205 *Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocecostomy* at the February 2001 RUC meeting. The RUC reviewed code 44203 *Laparoscopy, surgical; each additional small intestine resection and anastomosis (List separately in addition to code for primary procedure)* at the April 2001 RUC meeting.

44203 Laparoscopy, surgical; each additional small intestine resection and anastomosis (list separately in addition to code for primary procedure):

The CPT Editorial Panel created new code 44203 as the current code 44202 *Laparoscopy, surgical; intestinal resection with anastomosis (intra or extracorporeal)* (work RVU = 22.04) only described the work of a single resection and anastomosis. The RUC reviewed survey data from 30 colon and rectal surgeons and compared this code to 44121 *Enterectomy, resection of small intestine; each additional resection and anastomosis (list separately in addition to code for primary procedure)* (work RVU = 4.45). Both add-on procedures describe similar work and require one-hour of intra-service time. **The RUC recommends a work relative value of 4.45 for code 44203.**

Direct Practice Expense Inputs:

This is an add-on code performed in a facility setting. Therefore, there is no direct practice expense inputs attributed to this service.

44204 Laparoscopy, surgical; colectomy, partial with anastomosis:

The RUC reviewed survey data from 38 colon and rectal surgeons that indicated a median survey work relative value of 22.00. The survey time for this procedure (45 minutes pre, 180 minutes intra, 30 minutes immediate post, 4 hospital visits, discharge day management, and 3 office visits) was compared to the existing RUC database time for CPT code 44140 *Colectomy, partial; with*

anastomosis (work RVU = 18.35) (90 minutes pre, 150 minutes intra, 40 minutes immediate post, 6 hospital visits, discharge day management, and 3 office visits). The RUC focused its review on the increased intra-service time required with 44204 (180 vs. 150 minutes) and also considered that the survey respondents indicated that the laparoscopic approach was more intense than 44140. **The RUC recommends a work relative value of 22.00 for code 44204.**

Direct Practice Expense Inputs:

This service is only performed in the facility setting. The RUC utilized the PEAC proposed 90 day standard direct inputs for this service, as described on the attached summary form.

44205 Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocecostomy:

The RUC reviewed survey data from 38 colon and rectal surgeons that indicated a median survey work relative value of 19.50. The survey time for this procedure (47.5 minutes pre, 165 minutes intra, 30 minutes immediate post, 5 hospital visits, discharge day management, and 3 office visits) and compared it to the existing RUC database time 44160 *Colectomy, partial; with removal of terminal ileum and with ileocolostomy* [work RVU = 15.88 (2001 MFS); 18.62 (Five-Year RUC Rec)] (63 minutes pre, 120 minutes intra, 45 minutes immediate post, 6 hospital visits, discharge day management, and 3 office visits). The RUC focused its review on the increased intra-service time required with 44205 (165 vs 120 minutes) and also considered that the survey respondents indicated that the laparoscopic approach was more intense than 44160. **The RUC recommends a work relative value of 19.50 for CPT code 44205.**

Direct Practice Expense Inputs:

This service is only performed in the facility setting. The RUC utilized the PEAC proposed 90 day standard direct inputs for this service, as described on the attached summary form.

The RUC noted that the committee created a rank order anomaly in reviewing the corresponding open procedures 44140 and 44160 during the recent Five-Year Review. These codes were classified into two separate families at the October 2000 Workgroup meetings. The family with code 44160 was increased (RUC recommended work = 18.62), the family with code 44140 (2001 work RVU = 18.35), was not increased as 44140 had previously been reviewed in 1995, in the first five-year review. The RUC agrees that CPT code 44140 should be valued higher than 44160.

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
44120		<i>Enterectomy, resection of small intestine; single resection and anastomosis</i> <u>(Do not report 44120 in addition to 45136)</u>	090	17.00* *The RUC recommended an increase for this code to 17.00 in this Five-Year Review.
44121		<i>each additional resection and anastomosis (List separately in addition to code for primary procedure)</i> <i>(Use 44121 in conjunction with code 44120)</i>	ZZZ	4.45 (no change)
44140		<i>Colectomy, partial; with anastomosis</i> <u>(For laparoscopic procedure, use 44204)</u>	090	18.35* (no change) *The RUC reviewed this code both of the previous Five-Year Reviews and recommended no change. However, the RUC now realizes that this created a rank order anomaly and recommends that it be valued higher than 44160.

44160(e)		Colectomy, <u>partial</u> , with removal of terminal ileum <u>and with ileocolostomy</u> (For laparoscopic procedure, use 44205)	090	18.62* *The RUC recommended an increase for this code to 18.62 in this Five-Year Review.
▲44202 (old code # 56348)	P1	Laparoscopy, surgical; intestinal resection <u>enterectomy, resection of small intestine, single resection and with anastomosis (intra-or-extracorporeal)</u>	090	22.04 (No Change)
●44203	P2	each additional small intestine resection and anastomosis (List separately in addition to code for primary procedure) (Use 44203 in conjunction with code 44202) (For open procedure, see 44120-44121)	ZZZ	4.45 (Approved at the April 2001 RUC meeting)
●44204	P3	colectomy, partial with anastomosis (For open procedure, use 44140)	090	22.00 (Approved at the February 2001 RUC Meeting)
●44205	P4	colectomy, partial, with removal of terminal ileum with ileocecostomy (For open procedure, use 44160)	090	19.50 (Approved at the February 2001 RUC Meeting)

CPT Code: 4420X1 _____ Tracking Number: P2_ Global Period: ZZZ Recommended RVW: 4.45
 CPT Descriptor:

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

23 yr old female with Crohn's disease has two areas of ileal disease. Failing medical treatment, the operation includes laparoscopic assessment of the intestinal tract for active Crohn's disease. The small bowel segment is mobilized through four laparoscopic ports. The mesenteric and intestinal resection is accomplished intra/extracorporeally. The diseased segment is delivered via the suprapubic incision and the bowel is divided proximally and distally. Intestinal continuity is established by performing a suture or stapled end to end anastomosis. The incision and port sites are closed. Postoperative care manages the associated ileus, immunosuppressive medications and wound care. Outpatient followup includes assessment for anastomotic complications.

Description of Pre-Service Work:

N/A

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Presenter(s) Anthony Senagore, MD, MS, MBA

Specialty(s): American Society of Colon & Rectal Surgeons

Sample Size: 30 Response Rate: (%): 85% Median RVW: 4.45

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

25th Percentile RVW: 4.435 75th Percentile RVW: 4.7 Low: 4 High: 4.9

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

25th Percentile Intra-Svc Time: 47.5 75th Percentile Intra-Svc Time: 62.5 Low: 30 High: 90

Median Post-Service Time:

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

KEY REFERENCE SERVICE:

<u>CPT Code</u> 44121	<u>CPT Descriptor</u> 44121 each additional small intestine resection and anastomosis (List separately in addition to code for primary procedure)	<u>RVW</u> 4.45
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RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

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

TIME ESTIMATES (Median)

New/Revis.
CPT Code: _____
Key Reference
CPT Code:
441121

Median Pre-Time	NA	NA
Median Intra-Time	60	60
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	3
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3	3
Urgency of medical decision making	3	3

Technical Skill/Physical Effort (Mean)

Technical skill required	3	3.2
Physical effort required	3	3

Psychological Stress (Mean)

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

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

Pre-Service intensity/complexity	3	3
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Intra-Service intensity/complexity	3	3
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Post-Service intensity/complexity	3	3
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ADDITIONAL RATIONALE

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

The American Society of Colon and Rectal Surgeons convened a consensus panel to analyze the survey instrument data after it was compiled. The data look good with no changes necessary in the values. There did not seem to be any outliers that were a problem. The final recommendation was decided by the consensus panel, made up of the members of the Society's Socio-Economic Committee.

FREQUENCY INFORMATION

How was this service previously reported? Unlisted; open 44121 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty Colorectal Commonly Sometimes Rarely

Specialty General Surgery 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 General Surgery Frequency 85.70%

Specialty Proctology Frequency 3.89%

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.

Medicare data shows the open code had a frequency of 1,949 for Medicare patients only.

Colon and Rectal surgeons are not listed separately from general surgery

Specialty _____ Frequency _____

Specialty _____ Frequency _____

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

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

CPT Code: 4420X2 Tracking Number: P3 Global Period: 90 Recommended RVW: 22.00

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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is a 68-year-old white male with well-controlled essential hypertension and non-insulin dependent diabetes mellitus, (managed by oral hypoglycemic) and 2 prior attacks of sigmoid-diverticulitis requiring hospitalization and a course of intravenous antibiotics. The patient has responded to his medical treatment of 2 weeks of intravenous/oral antibiotics and a low residue diet. He is currently afebrile and has no abdominal pain or abnormalities of bowel function. A CT scan at the last admission demonstrated a pericolic phlegmon without abscess. The patient has undergone a colonoscopy recently to rule out colonic neoplasia. An elective laparoscopic colectomy is recommended to avoid the risks associated with recurrent diverticulitis and associated complications.

Description of Pre-Service Work: The patient is admitted to the hospital the day of surgery, at which time a review of his medical history is performed as well as a physical examination (General appearance, brief neurologic, cardiorespiratory, abdominal, and digital rectal examination) and both are recorded in the medical record. The informed consent is reviewed with the patient and documented in the medical record.

Description of Intra-Service Work: The patient is administered general anesthesia. The initial 10mm trocar is inserted using open technique and pneumoperitoneum is established at 12mm Hg. Right lower quadrant, left lower quadrant, and right upper quadrant trocars are inserted under direct vision. The small bowel is mobilized out of the pelvis after placing the patient in Trendelenburg position. The sigmoid colon is assessed for laparoscopic resectability based on size of phlegmon and related adhesions. A visual inspection of abdominal and pelvic organs is performed. The superior hemorrhoidal vessels are dissected from the right side and elevated to expose the left uterter, which is completely visualized. The vessels are then divided between metal clips just distal to the left colic artery. Dissection is then continued into the presacral space to expose the proximal rectum, which will be the site of division of the bowel distally. The inflammatory adhesions between the sigmoid colon and lateral abdominal and pelvic walls are lysed and the ureter is once again visualized. After the sigmoid colon is completely freed of lateral attachments to the level of the upper rectum, the mesorectum is divided using a combination of monopolar cautery, bipolar cautery, and metal clips. The rectosigmoid junction is divided using an endoscopic linear stapler/cutter. The sigmoid colon is mobilized and exteriorized thru a left lower quadrant 3 cm incision. The descending colon is divided extra-corporeally and the circular anvil is held in place using a polypropylene pursestring suture. The bowel is returned to the abdomen and the incision is closed in layers. The descending colon is mobilized to allow a tension-free anastomosis. The circular stapler is inserted transanally and the trocar brought thru the distal staple line. The anvil is fitted to the instrument, which is then closed and fired forming the anastomosis. An air leak test is performed. The 10mm trocar fascial sites are closed with suture and skin incisions are closed with running subcuticular sutures. Dressings are applied and the patient is transferred to PACU.

Description of Post-Service Work: The patient is transferred to PACU then to a surgical floor. He is evaluated daily for cardiorespiratory function, analgesic status, and bowel function. His diet is advanced and he is discharged on the 4th post-operative day. All appropriate medical records are completed including operative dictation, daily progress notes, discharge summary, and discharge instructions. He is seen in the office at 2 and 6 weeks for wound assessment, post-operative recovery, and dietary instruction. Evaluation and management components are recorded and information forwarded to the primary care physician.

SURVEY DATA:

Presenter(s) Anthony Senagore, MD, MBA, FASCRS, FACS, Martin Luchtefeld, MD, FASCRS, FACS

Specialty(s): American Society of Colon and Rectal Surgeons

Sample Size: 80 Response Rate: (%): 38 Median RVW: 22.00

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

25th Percentile RVW: 20 75th Percentile RVW: 23.5 Low: 18.4 High: 25

Median Pre-Service Time: 45 Median Intra-Service Time: 180

25th Percentile Intra-Svc Time: 180 75th Percentile Intra-Svc Time: 182.5 Low: 150 High: 300

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>30</u>	
Critical Care:	<u>N/A</u>	
Other Hospital Visits:	<u>87</u>	<u>1-99232, 3-99231</u>
Discharge Day Mgmt.:	<u>36</u>	
Office Visits:	<u>61</u>	<u>1-99212, 2-99213,</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
44140	Colectomy, partial; with anastomosis	18.35

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)

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u>	<u>Reference Service 1 CPT</u>
Median Pre-Time	45	50
Median Intra-Time	180	120
Median Immediate Post-service Time	30	30
Median of Aggregate Critical Care Times	N/A	N/A
Median of Aggregate Other Hospital Visit Times	87	125
Median Discharge Day Management Time	36	15
Median of Aggregate Office Visit Times	61	67.5

INTENSITY/COMPLEXITY MEASURES (Mean)**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	5	4
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	5	4
Urgency of medical decision making	5	4

Technical Skill/Physical Effort (Mean)

Technical skill required	5	4
Physical effort required	5	4

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	5	4
Outcome depends on the skill and judgment 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	4
Intra-Service intensity/complexity	5	4
Post-Service intensity/complexity	4	4

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
 The American Society of Colon and Rectal Surgeons convened a consensus panel to analyze the survey instrument data after it was compiled. The data was consistent with the experience of our panel members and no changes were deemed necessary to the values. There did not seem to be outliers data. The final recommendation was decided by the consensus panel made up of member of the Societies Socio-Economic Committee.

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: American Society of Colon & Rectal Surgeons Commonly _____ Sometimes _____ Rarely

Specialty American Society of General Surgeons _____ 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

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
010 or 090 Day Global Periods
Out-Of-Office Direct Inputs**

CPT Long Descriptor:

Sample Size: 80 Response Rate: (%): 38 Global Period: 90

Geographic Practice Setting %: Rural Suburban 17 Urban 83

Type of Practice %: Solo Practice
29 Single Specialty Group
58 Multispecialty Group
17 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:

: American Society of Colon and Rectal Surgeons convened a consensus panel to analyze the survey instrument data after it was compiled. The data look good with no changes necessary in the values. There did not seem to be any outliers that were a problem. The final recommendation was decided by the consensus panel, made up of the members of the Society's Socio-Economic Committee. Utilized PEAC Standard for 90 day major surgical procedures.

Please describe the clinical activities of your staff:

SEE CHART BELOW of activities

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

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

CPT Code: 4420X3 Tracking Number: P4 Global Period: 90 Recommended RVW: 19.50

CPT Descriptor: Laparoscopy, surgical; colectomy, partial with removal of terminal ileum and ileocecostomy

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 27 year-old-male patient has had Crohn's disease of the terminal ileum for six years. He has been treated with multiple medications but continues to have exacerbations of his disease that are severe enough to require time off of work on a regular basis. The decision is made to proceed with surgery to remove the involved segment of terminal ileum.

Description of Pre-Service Work:

A pertinent medical history is obtained. All relevant hospital admissions are reviewed. Past medical history is reviewed to ensure there are no medical contraindications to surgery and general anesthesia. All endoscopies and x-ray evaluations are reviewed, including previous UGI/small bowel follow-through and recent CT scan of abdomen and pelvis. Physical exam is carried out. This includes auscultation of the chest and listening to the heart to help determine suitability for anesthesia. The abdomen and the groin area is inspected and palpated. The perianal region is evaluated for any evidence of perianal Crohn's disease. The medical history and the role of the surgeon in treating Crohn's disease is reviewed with the patient and family members. The potential risks, some of which are life-threatening, are discussed as well as the potential benefits of improved function and a decrease in the need for medication. The additional variable of the laparoscopic approach is also reviewed in detail. The surgery date is determined and the procedure is scheduled. Appropriate lab tests are ordered. The bowel prep is explained to the patient and prescriptions are given for the mechanical prep to be given as well as the oral antibiotics. A boarding slip and additional orders are faxed to the hospital pre-procedural planning area.

Description of Intra-Service Work:

The patient is seen on the day of surgery and the labs and procedure are all reviewed with the patient. The patient is brought to the operating room and given general anesthesia. The patient continues in the supine position and all extremities are checked for proper positioning and padding to minimize the risk of neuropathy. The abdomen is prepped and draped in a sterile fashion. Trocars are placed through the abdominal wall at the umbilicus, right lower quadrant and lower midline. Special care is taken to avoid the epigastric vessels and all intra-abdominal and retroperitoneal structures with the trocars. An additional port may be necessary depending on patient anatomy. After insufflation with CO₂ the laparoscope is inserted and a visual inspection of the abdominal contents is carried out. The terminal ileum and ascending colon are then mobilized by incising the lateral peritoneal attachments. The hepaticocolic ligament must also be divided to allow mobilization of the hepatic flexure. The duodenum and right ureter must be visualized and protected during this mobilization. Once the mobilization is complete, the trocar in the right lower quadrant is removed and the incision enlarged to allow for delivery of the involved terminal ileum and cecum out of the abdominal cavity. The terminal ileum is then divided 5cm proximal to the Crohn's disease with a stapling device. The ascending colon is divided in a similar fashion. The ileocolic vessels and any other mesentery to the involved bowel is then ligated and divided. The resected specimen is then handed off the surgical field. The anastomosis between the ileum and the remaining ascending colon is accomplished by stapling with a GIA stapler to join the two limbs of bowel. Another TA stapler is used to close the remaining enterotomy and colotomy. The defect in the mesentery is closed using an absorbable running stitch and then the bowel placed back within the abdominal cavity. The fascial defect is then closed in two layers and the abdomen insufflated again to irrigate and inspect. All remaining trocars are then removed under direct vision. The skin is closed using a running subcuticular absorbable stitch.

Description of Post-Service Work:

The patient is escorted to the post-anesthesia care area. The operative note is dictated and post-operative orders are written. Rounds are done on a daily basis for four days. Vital signs, medications, intake and output, laboratory values and nursing notes are reviewed daily. The patient is examined with the emphasis on heart, lungs, abdomen and incision. Progress notes are written and any order changes are written also. The patient is discharged once he

is tolerating a diet and oral pain medications. Discharge instructions and prescriptions are reviewed and written out. A discharge summary is dictated. Two weeks after surgery and again at 6 weeks, the patient is seen back in the office. Physical examination of the abdomen and incision is carried out. Any medication changes are reviewed as well as changes in work activity restrictions. A progress note is written and a letter dictated to the referring physician. A discussion occurs regarding chemoprophylaxis using a S-ASA medication following recovery.

SURVEY DATA:

Presenter(s) Anthony Senagore, MD, MBA, FASCRS, FACS, Martin Luchtefeld, MD, FASCRS, FACS

Specialty(s): American Society of Colon and Rectal Surgeons

Sample Size: 80 Response Rate: (%): 38 Median RVW: 19.5

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

25th Percentile RVW: 17.75 75th Percentile RVW: 22 Low: 15.9 High: 23

Median Pre-Service Time: 47.5 Median Intra-Service Time: 165

25th Percentile Intra-Svc Time: 150 75th Percentile Intra-Svc Time: 180 Low: 120 High: 210

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>30</u>	
Critical Care:	<u>N/A</u>	
Other Hospital Visits:	<u>95</u>	<u>(5) of 99231</u>
Discharge Day Mgmt.:	<u>36</u>	<u>1 of 99238</u>
Office Visits:	<u>45</u>	<u>3 of 99212</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
44140	Colectomy, partial; with anastomosis	18.35

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)

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u>	<u>Reference Service 1 CPT</u>
Median Pre-Time	47..5	40
Median Intra-Time	165	120
Median Immediate Post-service Time	30	25
Median of Aggregate Critical Care Times	N/A	
Median of Aggregate Other Hospital Visit Times	95	109
Median Discharge Day Management Time	36	17
Median of Aggregate Office Visit Times	45	55

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
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4	4
Urgency of medical decision making	4	4

Technical Skill/Physical Effort (Mean)

Technical skill required	5	4
Physical effort required	5	4

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	5	4.5
Outcome depends on the skill and judgement of physician	5	5

Estimated risk of malpractice suit with poor outcome	5	4
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<u>INTENSITY/COMPLEXITY MEASURES</u>	<u>CPT Code</u>	<u>Reference Service 1</u>
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Time Segments (Mean)

Pre-Service intensity/complexity	4	4
Intra-Service intensity/complexity	5	4
Post-Service intensity/complexity	4	4

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
 The American Society of Colon and Rectal Surgeons convened a consensus panel to analyze the survey instrument data after it was compiled. The data look good with no changes necessary in the values. There did not seem to be any outliers that were a problem. The final recommendation was decided by the consensus panel, made up of the members of the Society's Socio-Economic Committee.

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

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
010 or 090 Day Global Periods
Out-Of-Office Direct Inputs**

CPT Long Descriptor:

Sample Size: 80 Response Rate: (%): 38 Global Period: 90

Geographic Practice Setting %: Rural Suburban 17 Urban 83

Type of Practice %: Solo Practice
29 Single Specialty Group
58 Multispecialty Group
17 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:

The American Society of Colon and Rectal Surgeons convened a consensus panel to analyze the survey instrument data after it was compiled. The data look good with no changes necessary in the values. There did not seem to be any outliers that were a problem. The final recommendation was decided by the consensus panel, made up of the members of the Society's Socio-Economic Committee.

Utilized PEAC proposed 90 day major surgical procedure standards.

Please describe the clinical activities of your staff:

SEE CHART BELOW

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

February and April 2001

Placement of Anal Seton and Excision of Ileoanal Reservoir

46020 Placement of seton:

Code 46020 was created to describe placement of a seton as a stand-alone procedure, as this service is being more frequently performed as a separate procedure and not in conjunction with other procedures.

The RUC reviewed survey data from 38 colon and rectal surgeons that indicated that this service typically requires 20 minutes of pre-time, 35 minutes intra-time, 20 minutes immediate post-op, 18 minutes (50% of discharge day mgt), and 2 office visits. The survey respondents indicated that this service was similar in time and intensity to 46230 *Excision of external hemorrhoid tags and/or multiple papillaw* (work RVU = 2.57). **The RUC recommends the survey median of 2.90 for code 46020.**

Practice Expense:

The RUC modified the specialty's submitted practice expense inputs for both the office and out-of-office settings for code 46020 to be consistent with the approved practice expense inputs for major surgical procedures. The medical supplies were also modified for the in-office setting. A summary form with the recommended practice expense inputs is attached.

45136 Excision of ileoanal reservoir with ileostomy:

A new CPT code was created to describe the removal of an ileoanal pouch due to problems with function or sepsis. The ileoanal pouch procedure is a relatively new surgery and there is currently no way to report this removal.

The RUC reviewed survey data from 38 colon and rectal surgeons that indicated that this service typically requires 40 minutes or pre-time, 240 minutes intra-time, 30 minutes immediate post-operative time, one critical care visit, 7 hospital visits, discharge day

management, and 4 office visits. The data from the survey derived a survey median of 25.00, however, the specialty society compared this service to code 44626 *Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)* (work RVU = 22.59 (2001 MFS), 25.36 (RUC Five-Year Rec.) and recommends a work relative value of 27.30. 44626 was recently surveyed in the Five-Year Review and requires the following time: 60 minutes pre-time, 150 minutes intra-time, 30 minutes immediate post-time, 7 hospital visits, discharge day management, and 2 office visits. The RUC considered the significantly higher intra-service time for 45136 (240 minutes vs. 150 minutes) and agreed that a work relative value of 27.30 is appropriate. **The RUC recommends a work relative value of 27.30 for code 45136.**

Practice Expense:

The RUC reviewed the direct practice expense inputs for this code and suggests revisions to be consistent with the standards proposed by the PEAC for 90 day major surgical procedures. A summary sheet listing these inputs is attached.

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
●46020	Q1	Placement of seton <u>(Do not report 46020 in addition to 46060,46280, 46600)</u>	010	2.90
●45136	Q2	Excision of ileoanal reservoir with ileostomy <u>(Do not report 45136 in addition to 44310, 44005, 44120)</u>	090	27.30

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 4460X Tracking Number: Global Period: 10 Recommended RVW: 2.90

CPT Descriptor: Placement of a seton

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An adult patient develops a fistula-in-ano following drainage of a perirectal abscess. At the time of surgical treatment of the fistula, the surgeon elects to proceed with placement of a seton instead of fistulotomy or other surgical methods. Clinical circumstances such as complex or high fistulas, presence of inflammatory bowel disease or other mitigating factors can influence such a decision. The placement of the seton can be considered definitive treatment or in some instances can set the stage for a subsequent surgery.

Description of Pre-Service Work:

Description of Intra-Service Work:

With the patient under appropriate anesthesia the perianal region is prepped and draped in a sterile fashion. The internal and external openings of the fistula as well as its relationship to the anal sphincter are determined by a combination of digital rectal exam, anoscopy, and passage of fistula probes. The probe is then used to guide a non-absorbable material such as silk suture or silastic vascular tape through the fistula tract. The seton can then be tied down in place. The examination reveals a long fistula tract with an external opening of 2cm from the anal verge and an internal opening 1 cm proximal to the anorectal ring. The fistula is lateral to the entire length of external anal sphincter. It is determined that primary fistulotomy would sacrifice all of the sphincter mechanism, and there is too much induration for an endoanal flap.

Description of Post-Service Work: Proper documentation occurs with detailed post operative instructions given to the patient. The patient will be required to come back to the office for two postoperative checks.

SURVEY DATA:

Presenter(s) Anthony Senagore, MD, MBA, FASCRS, FACS, Martin Luchtefeld, MD, FASCRS, FACS

Specialty(s): American Society of Colon and Rectal Surgeons

Sample Size: 80 Response Rate: (%): 38 Median RVW: 2.6

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

25th Percentile RVW: 2.6 75th Percentile RVW: 4.5 Low: 2.5 High: 4

Median Pre-Service Time: 20 Median Intra-Service Time: 35

25th Percentile Intra-Svc Time: 30 75th Percentile Intra-Svc Time: 42.5 Low: 20 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:

N/A

Other Hospital Visits:

Discharge Day Mgmt.:

18

½ of 99238

Office Visits:

30

2@ 99212

-

-

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
46230	Excision of external hemorrhoid tags and/or papillae	2.57

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.**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u>	<u>Reference Service 1 CPT</u>
Median Pre-Time	20	20
Median Intra-Time	35	35
Median Immediate Post-service Time	20	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	18	15
Median of Aggregate Office Visit Times	30	35

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
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3	3
Urgency of medical decision making	3	3

Technical Skill/Physical Effort (Mean)

Technical skill required	3	3
Physical effort required	3	3

Psychological Stress (Mean)

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

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	3	3

ADDITIONAL RATIONALE

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

The American Society of Colon and Rectal Surgeons convened a consensus panel to analyze the survey instrument data after it was compiled. The data look good with no changes necessary in the values. There did not seem to be any outliers that were a problem. The final recommendation was decided by the consensus panel made up of the members of the Society's Socio-Economic Committee.

FREQUENCY INFORMATION

How was this service previously reported? New

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

Specialty ASCRS X Commonly Sometimes Rarely

Specialty Gen Surg 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 ASCRS Frequency 5000

Specialty Gen Surg Frequency 1500

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 ASCRS Frequency 500

Specialty Gen Surg Frequency 150

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

Specialty Society('s)American Society of Colon & Rectal Surgeons

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
010 or 090 Day Global Periods
In Office Direct Inputs**

CPT Long Descriptor: 460XX

Placement of an anal seton

Sample Size: 80 Response Rate: (%): 38 Global Period: 10

Geographic Practice Setting %: Rural Suburban 17 Urban 83

Type of Practice %: Solo Practice
29 Single Specialty Group
58 Multispecialty Group
17 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:

The American Society of Colon and Rectal Surgeons convened a consensus panel to analyze the survey instrument data after it was compiled. The data look good with no changes necessary in the values. There did not seem to be any outliers that were a problem. The final recommendation was decided by the consensus panel, made up of the members of the Society's Socio-Economic Committee.

Please describe the clinical activities of your staff:

SEE CHART BELOW

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

Specialty Society('s)American Society of Colon & Rectal Surgeons

Total Staff Time Out of Office:

Visits in Global Period:

HCFA's Staff Type Code***	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	35	88		6	2	54

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

**Excluding Time of Office Visits

*** From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if appropriate)
	Multispecialty Minimum supply Package	3		
11501	Anoscope, disposable	1		\$1.06
	Vessel loop	1		\$2.00
31105	KY jelly	1 PACKET		\$0.13
91402	needle, 18 to 24 guage	1		\$0.12
	30 cc saline			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
E13102	Olympus Halogen Light	1	15	20	\$950.00
	Fistula probe, set of 4	1	10	2	\$560.00
E11001	Exam table	1			\$1,360.00
E55003	Pulse oximeter	1			\$885.00

**TYPE OF SERVICE: Surgical Procedures
010 and 090 Global Periods**

SITE OF SERVICE: In-OFFICE

<u>Clinical Services</u>	<u>Minutes</u>	<u>Staff Type – Circle</u>
Pre-Service Period		
<i>Start: Following visit when decision for surgery or procedure made</i>		
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 Activity (please specify)		
<hr/>		RN, LPN, MA, Other _____
<i>End: When patient enters office for surgery/procedure</i>	35	Standard pre-time
TOTAL		
Service Period		
<i>Start: When patient enters office for surgery/procedure</i>		
<i>Pre-service services</i>		
Review charts	3	<u>RN, LPN, MA</u> , Other _____
Greet patient and provide gowning	3	<u>RN, LPN, MA</u> , Other _____
Obtain vital signs	2	<u>RN, LPN, MA</u> , Other _____
Provide pre-service education/obtain consent	5	<u>RN, LPN, MA</u> , Other _____
Prepare room, equipment, supplies	5	<u>RN, LPN, MA</u> , Other _____
Prepare and position patient/ monitor patient/ set up IV	5	<u>RN, LPN, MA</u> , Other _____
Sedate/apply anesthesia	5	<u>RN, LPN, MA</u> , Other _____
<i>Intra-service</i>		
Assist physician in performing procedure	30 58	<u>RN, LPN, MA</u> , Other _____
TOTAL		

Specialty Society('s) American Society of Colon & Rectal Surgeons

Post-service

Monitor pt. following service/check tubes, monitors, drains 15 RN, LPN, MA, Other

Clean room/equipment 10 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 5 RN, LPN, MA, Other

Other Activity (please specify) _____

RN, LPN, MA, Other _____

TOTAL POST 30

End: Patient leaves office

TOTAL 88

Post-Service Period

Start: Patient leaves office

Conduct phone calls/call in prescriptions 3 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
- A 27 RN, LPN, MA, Other

List total number of office visits B 2

Total office visit time (A * B) 27

Conduct phone calls between office visits 3 RN, LPN, MA, Other

Other Activity (please specify) _____

0 RN, LPN, MA, Other

End: With last office visit before end of global period

Specialty Society(s) American Society of Colon & Rectal Surgeons

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
010 or 090 Day Global Periods
Out-Of-Office Direct Inputs**

CPT Long Descriptor: 460xx
Placement of an anal seton

Sample Size: 80 Response Rate: (%): 38 Global Period: 10

Geographic Practice Setting %: Rural Suburban 17 Urban 83

Type of Practice %: Solo Practice
29 Single Specialty Group
58 Multispecialty Group
17 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:

The American Society of Colon and Rectal Surgeons convened a consensus panel to analyze the survey instrument data after it was compiled. The data look good with no changes necessary in the values. There did not seem to be any outliers that were a problem. The final recommendation was decided by the consensus panel, made up of the members of the Society's Socio-Economic Committee.

Please describe the clinical activities of your staff:

SEE CHART BELOW

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

Total Staff Time Out of Office:

Visits in Global Period:

HCFA's Staff Type Code***	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	Cost Estimate Source (if applicab
	RN/LPN/MA	60			6	2	54	

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

**Excluding Time of Office Visits

*** From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
11501	Anoscope, disposable	1		1.06
	Multi-specialty Minimum supply package	2		
31105	KY Jelly	1 packette		0.13

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
E11001	Exam Table	1			\$1,360.00
E13102	Olympus Halogen light	1			\$950.00

From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

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 5 RN, LPN, MA, Other

Coordinate pre-surgery services 20 RN, LPN, MA, Other

Schedule space and equipment in facility 8 RN, LPN, MA, Other

Office visit before surgery/procedure RN, LPN, MA, Other
 Review test and exam results

Provide pre-service education/obtain consent 20 RN, LPN, MA, Other

Follow-up phone calls & prescriptions 7 RN, LPN, MA, Other

Other Activity (please specify) RN, LPN, MA, Other

End: When patient enters hospital for surgery/procedure
TOTAL 60

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

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 _____ RN, LPN, MA, Other _____

Other Activity (please specify) _____ RN, LPN, MA, Other _____

_____ RN, LPN, MA, Other _____

End: Patient discharge from hospital

Post-Service Period

Start: Patient discharge from hospital

Conduct phone calls/call in prescriptions 3 **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 **A** 27 **RN, LPN, MA, Other** _____

List total number of office visits **B** 2

Total office visit time (A * B) 54

Conduct phone calls between office visits 3 **RN, LPN, MA, Other** _____

Other Activity (please specify) _____ RN, LPN, MA, Other _____

_____ RN, LPN, MA, Other _____

End: With last office visit to the end of global period

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>30</u>	-
Critical Care:	<u>60</u>	<u>99291</u>
Other Hospital Visits:	<u>210</u>	<u>3@ 99232, 2@ 99231, 2@ 99233</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238</u>
Office Visits:	<u>61</u>	<u>1@ 99214, 1@ 99213, 2@ 99212</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
45111	Proctectomy; complete, combined abdominoperineal, with colostomy, partial resection of rectum, transabdominal approach.	16.48

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.**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u>	<u>Reference Service 1 CPT</u>
Median Pre-Time	40	40
Median Intra-Time	240	145
Median Immediate Post-service Time	30	30
Median of Aggregate Critical Care Times	60	
Median of Aggregate Other Hospital Visit Times	210	145
Median Discharge Day Management Time	36	30
Median of Aggregate Office Visit Times	61	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	5	5
--------------------------------------------------------------------------------------------------	---	---

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	5	5
--------------------------------------------------------------------------------------------------------------------------------	---	---

Urgency of medical decision making	5	5
------------------------------------	---	---

Technical Skill/Physical Effort (Mean)

Technical skill required	5	5
--------------------------	---	---

Physical effort required	5	5
--------------------------	---	---

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	5	5
-------------------------------------------------------------------	---	---

Outcome depends on the skill and judgement of physician	5	5
---------------------------------------------------------	---	---

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.

The American Society of Colon and Rectal Surgeons convened a consensus panel to analyze the survey instrument data after it was compiled. The data look good with no changes necessary in the values. There did not seem to be any outliers that were a problem. The final recommendation was decided by the consensus panel, made up of the members of the Society's Socio-Economic Committee.

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

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
010 or 090 Day Global Periods
Out-Of-Office Direct Inputs**

CPT Long Descriptor: 451xx

Excision of an ileoanal reservoir with ileostomy

Sample Size: 80 Response Rate: (%): 38 Global Period: 10

Geographic Practice Setting %: Rural Suburban 17 Urban 83

Type of Practice %: Solo Practice
29 Single Specialty Group
58 Multispecialty Group
17 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:

The American Society of Colon and Rectal Surgeons convened a consensus panel to analyze the survey instrument data after it was compiled. The data look good with no changes necessary in the values. There did not seem to be any outliers that were a problem. The final recommendation was decided by the consensus panel, made up of the members of the Society's Socio-Economic Committee.

STANDARD INPUTS FOR 90 DAY GLOBAL MAJOR SURGICAL PROCEDURE

Please describe the clinical activities of your staff:

SEE CHART BELOW

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

Total Staff Time Out of Office:

Visits in Global Period:

HCFA's Staff Type Code***	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	Cost Estimate Source (if applicable)
	RN/LPN/MA	60				2 x 99212 1 x 99213 1 x 99214	143	

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

**Excluding Time of Office Visits

*** From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	Basic Post-operative Incision Care Kit	1		
	Multi-specialty Minimum Supply Package	4		
31126	Stoma adhesive	4 oz		\$8.89
3601	Bag and wafer, stoma	4		\$4.39

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Exam Table				

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

**AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS**

April 2001

Ablation of Hepatic Tumors

Codes 47370 – 47381 will be reviewed by the RUC at the September 2001 meeting. If HCFA is unable to review recommendations from this meeting in time for the Final Rule, the RUC recommends that these services be carrier priced in 2002. The RUC was unable to evaluate codes 47382, 76362, 76394, and 76490 at this time due to continued confusion over the appropriateness of reporting ultrasound guidance separately from the primary procedure. The CPT Editorial Panel will provide further clarification of this issue. The RUC will review these codes in September 2001.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●47370	F1	Laparoscopy, surgical, ablation of one or more liver tumor(s); radiofrequency (For imaging guidance, use 76490)	090	Carrier Price
●47371	F2	cryosurgical (For imaging guidance, use 76490)	090	Carrier Price
●47380	F3	Ablation, open, of one or more liver tumor(s); radiofrequency (For imaging guidance, use 76490)	090	Carrier Price
●47381	F4	cryosurgical (For imaging guidance, use 76490)	090	Carrier Price
●47382	F5	Ablation, one or more liver tumor(s), percutaneous, radiofrequency (For imaging guidance and monitoring, see codes 76362, 76394, or 96490)	010	No RUC Recommendation at this time – Specialty society information is attached.

● 76362	F6	Computerized axial tomography guidance for, and monitoring of, tissue ablation <u>(For percutaneous radiofrequency ablation, use 47382)</u>	XXX	No RUC Recommendation at this time – Specialty society information is attached.
● 76394	F7	Magnetic resonance guidance for, and monitoring of, tissue ablation <u>(For percutaneous radiofrequency ablation, use 47382)</u>	XXX	No RUC Recommendation at this time – Specialty society information is attached.
● 76490	F8	Ultrasound guidance for, and monitoring, of tissue ablation <u>(Do not report 76490 in addition to 76986)</u> <u>(For ablation, see codes 47370-47382)</u>	XXX	No RUC Recommendation at this time – Specialty society information is attached.

Report of Facilitation Committee #6
Luncheon meeting, Saturday, April 28, 2001

Report Not Approved by RUC – for Information only

Ablation of Liver Tumors (Tab E)

The facilitation committee agreed that the work of 4737X5 *Ablation, one or more liver tumor(s), percutaneous, radiofrequency* should be evaluated as follows:

Pre-Service	30 minutes x .0224	0.66
Intra-Service	180 minutes x .071*	12.78
Same day post	30 minutes x .0224	0.66
½ discharge day management		0.64
Office visit (99212)		0.45
Total work RVU		15.19

The committee agreed that this service was at least as intense as cyrosurgical ablation of the prostate (IWPUT = 0.71) and that the total work of code 55873 (February 2001 RUC recommendation = 19.19) is comparable to (or less than) the total work of the ablation of the liver tumor 4737X5, when the radiologic guidance code (F6, F7, or F8) is added to this code.

The facilitation committee recommends 15.19 for code 4737X5 (F5)

The facilitation committee also reviewed the radiologic guidance codes F6, F7, and F8 and determine that the relative values as presented by the specialty societies (SCVIR, ACR, and ACS) are appropriate. The committee agreed that this radiologic guidance may be performed by a second physician and that the intensity if less than an E/M intensity of 0.31. The committee compared an intensity of 0.026 per minute with the time for each of these services and **determined that the specialty recommendations of 4.00 (F6), 4.25 (F7), and 4.00 (F8) are appropriate.**

The practice expense for F5 has been modified to compare to the standard packages developed by the PEAC and approved by the RUC. There are no direct practice expense inputs for F6-F8.

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

CPT Code: 4737X5 Tracking Number: F5 Global Period: 010 Recommended RVW: 17.5
NO RUC Rec.

CPT Descriptor: **Ablation, percutaneous, one or more liver tumor(s), radiofrequency**
(For imaging guidance and monitoring, see codes 7637X, 7639X, or 7649X)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 73 year old man with colon cancer developed two metastatic lesions to the liver. Lesions were 2 cm x 2 cm and 4 cm by 4 cm. Because the lesions were not surgically resectable due to their location, the patient's oncologist referred him for evaluation for radiofrequency (RF) ablation. The patient was evaluated by the treating physician, and the lesions were determined to be amenable to percutaneous RF ablation.

Description of Pre-Service Work:

In addition to the standard pre-service activities as defined by RUC, Code 4737X5 includes the following pre-service work:

- Obtain and review pertinent imaging studies and lab results
- Discuss procedure with patient and family; answer questions
- Obtain informed consent
- Plan operative approach
- Check equipment, supplies, and instruments
- Supervise patient positioning and placement of ground pads
- Prep and drape upper abdomen into a sterile field

Description of Intra-Service Work:

Physician work associated with imaging guidance should be excluded from your evaluation of code 4737X5, since imaging guidance is separately reportable. The intra-service period includes all "skin-to-skin" work that is a necessary part of the procedure.

- After imaging localization of the lesion (coded separately), local anesthesia is injected and a small incision is made to facilitate RF needle electrode placement
- The RF needle electrode is placed into the lesion
- RF power is applied until satisfactory core heating is achieved
- Overlapping ablations are performed as needed to assure complete tumor necrosis and satisfactory margins
- After satisfactory necrosis, the RF needle is withdrawn to the liver capsule and cauterization is performed to achieve hemostasis along the needle tract

After adequate hemostasis of the first lesion, the additional lesion is treated in turn using the same process

Description of Post-Service Work:

In addition to the standard post-service activities as defined by RUC, Code 4737X5 includes the following pre-service work:

- Discuss results with patient's family
- Observe patient in holding area to assure hemodynamic stability
- Dictate, review, and sign report of the procedure
- Discuss outcome with referring physician
- Follow patient with telephone calls

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
37204	Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve homeostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck	18.14

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

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

TIME ESTIMATES (Median)

	<u>New/Revis.</u>	<u>Key</u>
	<u>CPT Code:</u>	<u>Reference</u>
	4737X5	37204
Median Pre-Time	30 minutes	
Median Intra-Time	180 minutes	
Median Immediate Post-service Time	30 minutes	
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times	15 minutes	
Median Discharge Day Management Time	30 minutes	
Median of Aggregate Office Visit Times	15 minutes	

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.13	3.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.19	3.95
Urgency of medical decision making	3.31	3.48

Technical Skill/Physical Effort (Mean)

Technical skill required	4.56	4.29
Physical effort required	4.31	3.95

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.22	4.29
Outcome depends on the skill and judgement of physician	4.66	4.10
Estimated risk of malpractice suit with poor outcome	3.66	3.67

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

4737X5

37204

Pre-Service intensity/complexity	4.06	3.86
Intra-Service intensity/complexity	4.41	4.33
Post-Service intensity/complexity	3.75	3.52

ADDITIONAL RATIONALE

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

The process used consisted of a survey of physicians (panel sample) who typically perform this service. Final recommendation and work values were reviewed by physicians representing SCVIR and ACR. These physicians reviewed all components of work for the newly proposed CPT code, 4737X5, as well as the information provided for the reference procedure. The recommended RVW (18) is the median RVW of the polled respondents (n=32) from SCVIR and ACR surveys.

FREQUENCY INFORMATION

How was this service previously reported? 49200, 49201, or 49999 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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 **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.

There are approximately 100,000 patients per year who have metastatic disease and/or primary hepatic tumors, who would be candidates for treatment. An estimated 5 to 15 percent of these patients would be candidates for percutaneous radiofrequency ablation (PRA).

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.

Unable to quantify. (See estimate of services for general population, above.)

Do many physicians perform this service across the United States? X Yes ___ No

**AMA/Specialty Society Update Process
RUC Summary of Recommendation
010 or 090 Day Global Periods
In Office Direct Inputs**

Sample Size: **consensus** Response Rate: (%): **n/a** Global Period: **10-day**

Tracking Number: **F5** 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:

The consensus of the ACR and SCVIR is that RFA is not performed in an office setting at this time.

**AMA/Specialty Society Update Process
RUC Summary of Recommendation
010 or 090 Day Global Periods
Out-Of-Office Direct Inputs**

Sample Size: **consensus** Response Rate: (%): **n/a** Global Period: **10-day**

Tracking Number: **F5** 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:

Consensus on direct inputs for 4737X5 was reached via a conference call with representation from ACR's Practice Expense Committee and SCVIR's Economic's Committee. (SCVIR's Economics Committee serves as its RUC/Practice Expense Committee.) Both the ACR's Practice Committee and SCVIR's Economics Committee consist of broad representation of geographic regions and practice types.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Completes pre-service diagnostic and referral forms
- Coordinates pre-surgery services and scheduling
- Obtains necessary medical records
- Provides education and obtains consent

Intra-Service Clinical Labor Activities:

- Coordinates post procedural care

Post-Service Clinical Labor Activities:

- Conducts phone calls and calls in prescriptions
- Coordinates home and outpatient care

HCFA's Staff Type Code***	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	Cost Estimate and Source (if applicable)
	RN/LPN/MA	60 min			7 min	1	27 min	

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

**Excluding Time of Office Visits

*** From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
11107	Patient gown	1	Item	
11111	Exam table paper	7	Foot	
11112	Pillow case	1	Item	
11302	Non-sterile gloves	2	Pair	
11509	Temp probe cover	1	Item	

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
E11001	Exam table	4	20	40	

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

**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	5 minutes	<u>RN, LPN, MA, Other</u> _____
Coordinate pre-surgery services	20 minutes	<u>RN, LPN, MA, Other</u> _____
Schedule space and equipment in facility	8 minutes	<u>RN, LPN, MA, Other</u> _____
Office visit before surgery/procedure Review test and exam results	_____	<u>RN, LPN, MA, Other</u> _____
Provide pre-service education/obtain consent	20 minutes	<u>RN, LPN, MA, Other</u> _____
Follow-up phone calls & prescriptions	7 minutes	<u>RN, LPN, MA, Other</u> _____
Other Activity (please specify) _____	_____	<u>RN, LPN, MA, Other</u> _____

End: When patient enters hospital for surgery/procedure

Service Period

*Start: Patient admitted to hospital for surgery/procedure
Pre-service services*

Review charts		<u>RN, LPN, MA, Other</u> _____
Greet patient and provide gowning	_____	<u>RN, LPN, MA, Other</u> _____
Obtain vital signs	_____	<u>RN, LPN, MA, Other</u> _____
Provide pre-service education/obtain consent	_____	<u>RN, LPN, MA, Other</u> _____
Prepare room, equipment, supplies	_____	<u>RN, LPN, MA, Other</u> _____
Prepare and position patient/ monitor patient/ set up IV	_____	<u>RN, LPN, MA, Other</u> _____
Sedate/apply anesthesia	_____	<u>RN, LPN, MA, Other</u> _____
<i>Intra-service</i>		
Assist physician in performing surgery/procedure	_____	<u>RN, LPN, MA, Other</u> _____

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		<u>RN</u> , LPN, MA, Other _____
Coordination of care by staff in office		<u>RN</u> , 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	7 minutes	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	A <u>27 minutes</u>	RN, LPN, MA, Other _____
List total number of office visits	B <u>1</u>	
Total office visit time (A * B)	<u>27 minutes</u>	
Conduct phone calls between office visits	_____	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 PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 7637X Tracking Number: F6 Global Period: XXX Recommended RVW: 4.0
No RUC Recommendation

CPT Descriptor: **Computerized tomography guidance for, and monitoring of, tissue ablation
(For percutaneous radiofrequency ablation, use 4737X5)**

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 73 year old man with colon cancer developed two metastatic lesions to the liver. Lesions were 2 cm x 2 cm and 4 cm x 4 cm. Because the lesions were not surgically resectable due to their location, the patient's oncologist referred him for evaluation for radiofrequency (RF) ablation. The patient was evaluated by the treating physician, and the lesions were determined to be amenable to percutaneous RF ablation.

Description of Pre-Service Work:

- Review of any previous imaging studies
- Confirmation of patient positioning and imaging setup
- Determine need for intravascular contrast to identify liver masses

Description of Intra-Service Work:

- Preliminary CT images acquired to assess appropriate approach to the tumor(s)
- CT guidance to direct RF needle electrode to tumor(s)
- CT monitoring for needle electrode repositioning within lesion, if and as necessary for multiple ablations to coagulate the lesion
- CT to confirm satisfactory coagulative necrosis of the lesion(s) and comparison to pre-ablation images
- CT of liver for post-ablation bleeding

Description of Post-Service Work:

- Dictate, review and sign CT report

SURVEY DATA:

Presenter(s): **James P. Borgstede, MD, ACR RUC advisor
Bibb Allen, Jr., MD, ACR Alternate RUC advisor
Robert L. Vogelzang, MD, SCVIR RUC advisor**

Specialty(s): **American College of Radiology
Society of Cardiovascular & Interventional Radiology**

Sample Size: **108** Response Rate: (%): **22% (n=24)** Median RVW: **4**

Type of Sample (Circle One): random, **panel**, convenience.

Explanation of sample size: **The panel of survey recipients included both SCVIR and ACR members.**

25th Percentile RVW: **2.55** 75th Percentile RVW: **8.12** Low: **1.16** High: **20.00**

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

25th Percentile Intra-Svc Time: **71.25 minutes** 75th Percentile Intra-Svc Time: **180 minutes**
Low: **10 minutes** High: **210 minutes**

Median Post-Service Time:

Level of Service by CPT Code
Total Time (List CPT Code & # of Visits)

Immediate Post Service Time: 15 _____

Critical Care: _____

Other Hospital Visits: _____

Discharge Day Mgmt.: _____

Office Visits: _____

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
76360	Computerized tomography guidance for needle placement 1.16 (eg, biopsy, aspiration, injection, localization device), 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 existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

<u>TIME ESTIMATES (Median)</u>	New/Revis. CPT Code:	Key Reference CPT Code:
	7637X	76360
Median Pre-Time	20 minutes	
Median Intra-Time	120 minutes	
Median Immediate Post-service Time	15 minutes	
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.88	2.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.13	2.61
Urgency of medical decision making	3.29	2.72

Technical Skill/Physical Effort (Mean)

Technical skill required	4.54	3.00
Physical effort required	4.08	2.78

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.33	2.72
Outcome depends on the skill and judgement of physician	4.83	2.83
Estimated risk of malpractice suit with poor outcome	3.70	2.78

INTENSITY/COMPLEXITY MEASURES

CPT Code: Reference Service 1

7637X 76360

Time Segments (Mean)

Pre-Service intensity/complexity	3.75	2.61
Intra-Service intensity/complexity	4.67	2.67
Post-Service intensity/complexity	3.17	2.61

ADDITIONAL RATIONALE

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

The process used consisted of a survey of physicians (panel sample) who typically perform this service. Final recommendation and work values were reviewed by physicians representing SCVIR and ACR. These physicians reviewed all components of work for the newly proposed CPT code, 7637X, as well as the information provided for the reference procedure. The recommended RVW (4.0) is the median RVW of the polled respondents (n=24) from SCVIR and ACR surveys.

FREQUENCY INFORMATION

How was this service previously reported? **76360-22** (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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 **Interventional 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.

There are approximately 100,000 patients per year who have metastatic disease and/or primary hepatic tumors, who would be candidates for treatment. An estimated 5 to 15 percent of these patients would be candidates for percutaneous radiofrequency ablation (PRA). CT is one of three guidance modalities used for guidance and monitoring of PRA. At this time, we are unable to ascertain accurate percentages of utilization by guidance modality for PRA procedures.

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.

Unable to quantify. (See estimate of services for general population, above.)

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

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

CPT Code: 7639X Tracking Number: F7 Global Period: XXX Recommended RVW: 4.25
No RUC Recommendation

CPT Descriptor: **Magnetic resonance guidance for, and monitoring of, tissue ablation
(For percutaneous radiofrequency ablation, use 4737X5)**

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 73 year old man with colon cancer developed two metastatic lesions to the liver. Lesions were 2 cm x 2 cm and 4 cm by 4 cm. Because the lesions were not surgically resectable due to their location, the patient's oncologist referred him for evaluation for radiofrequency (RF) ablation. The patient was evaluated by the treating physician, and the lesions were determined to be amenable to percutaneous RF ablation.

Description of Pre-Service Work:

- Review of any previous imaging studies
- Confirmation of patient positioning and imaging setup
- Determine need for intravascular contrast to identify liver masses

Description of Intra-Service Work:

- Preliminary MRI images acquired to access appropriate approach to the tumor(s)
- MRI guidance to direct RF needle electrode to tumor(s)
- MRI monitoring for needle electrode repositioning within lesion, if and as necessary for multiple ablations to coagulate the lesion
- MRI to confirm satisfactory coagulative necrosis of the lesion(s) and comparison to pre-ablation images
- MRI of liver for post-ablation bleeding

Description of Post-Service Work:

- Dictate, review and sign MRI report

SURVEY DATA:

Presenter(s): **James P. Borgstede, MD, ACR RUC advisor
Bibb Allen, Jr., MD, ACR Alternate RUC advisor
Robert L. Vogelzang, MD, SCVIR RUC advisor**

Specialty(s): **American College of Radiology
Society of Cardiovascular & Interventional Radiology**

Sample Size: **108** Response Rate: (%): **16% (n=18)** Median RVW: **4.25**

Type of Sample (Circle One): random, **panel**, convenience.

Explanation of sample size: **The panel of survey recipients included both SCVIR and ACR members.**

25th Percentile RVW: **3.00** 75th Percentile RVW: **8.12** Low: **1.60** High: **12**

Median Pre-Service Time: **20 minutes** Median Intra-Service Time: **165 minutes**

25th Percentile Intra-Svc Time: **120 minutes** 75th Percentile Intra-Svc Time: **180 minutes** Low: **30 minutes** High: **210 minutes**

Median Post-Service Time:	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>15</u>	_____
Critical Care:	_____	_____
Other Hospital Visits:	_____	_____
Discharge Day Mgmt.:	_____	_____
Office Visits:	_____	_____

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
76360	Computerized tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), 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 existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revis. CPT Code:</u>	<u>Key Reference CPT Code:</u>
	<u>7639X</u>	<u>76360</u>
Median Pre-Time	20 minutes	
Median Intra-Time	165 minutes	
Median Immediate Post-service Time	15 minutes	
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.92	3.17
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.46	3.17
Urgency of medical decision making	3.46	3.17

Technical Skill/Physical Effort (Mean)

Technical skill required	4.94	3.33
Physical effort required	4.06	2.67

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.44	3.33
Outcome depends on the skill and judgement of physician	4.94	3.33
Estimated risk of malpractice suit with poor outcome	3.72	3.50

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

CPT Code: 7649X Tracking Number: F8 Global Period: XXX Recommended RVW: 4.0
No RUC Recommendation

CPT Descriptor: **Ultrasound guidance for, and monitoring of, tissue ablation**
(Do not report 7649X in addition to 76986)
(For ablation, see codes 4737X1-4737X5)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The three clinical vignettes below describe typical patients referred for laparoscopic, open, and percutaneous procedures. Patients undergoing open or laparoscopic procedures may receive either radiofrequency or cryosurgical ablation.

Typical Patient Treated By Laparoscopic Cryosurgical Ablation

The patient is a 44-year old man who underwent a left colon resection for adenocarcinoma one and one-half years ago. Following the left colon surgery, he received systemic chemotherapy. After six months of treatment, the patient's CEA begins to rise. CT imaging of the liver reveals three lesions along the anterior, inferior surface of the right lobe of the liver. All three lesions were confirmed on ultrasound examination and were felt to be superficial and accessible by laparoscopy. The lesions measure 4 cm, 2.0 cm and 2.5 cm in diameter. The patient undergoes laparoscopy and cryosurgical ablation of all three liver tumors. NOTE: The ultrasound guidance, supervision and interpretation are separately reportable. Do not consider this work to complete this survey.

Typical Patient Treated By Open Radiofrequency Ablation

An 82-year-old gentleman was diagnosed with colon cancer and underwent a right hemi-colectomy in May of 1994. He had a Dukes C2 lesion with positive lymph nodes. Recently he was recently seen in follow-up and found to have an elevated CEA of 34. A CT scan revealed two hepatic metastases in the right lobe of the liver and one in the medial segment of the left lobe. The two lesions in the right lobe were 3 cm and 2 cm, and the lesion in the left lobe was 3.5 cm. These findings were confirmed by ultrasound. The remainder of the metastatic workup revealed no other spread in the abdomen, retroperitoneum, lung, bone, or brain. A recent follow-up colonoscopy was also negative for recurrent cancer. Because of the bilaterality and multiplicity of the lesions, biopsy and radiofrequency thermal ablation was determine most appropriate. The patient underwent an exploratory laparotomy and one of the liver lesions was proven malignant by core needle biopsy. No extra-hepatic disease was found. All three lesions were ablated with radiofrequency thermal technique, using sonographic guidance and confirmation of lesion destruction. NOTE: The ultrasound guidance, supervision and interpretation, are separately reportable. Do not consider this work to complete this survey.

Typical Patient Treated By Percutaneous Radiofrequency Ablation

A 73 year old man with colon cancer developed two metastatic lesions to the liver. Lesions were 2 cm x 2 cm and 4 cm x 4 cm. Because the lesions were not surgically resectable due to their location, the patient's oncologist referred him for evaluation for radiofrequency (RF) ablation. The patient was evaluated by the treating physician, and the lesions were determined to be amenable to percutaneous RF ablation.

Description of Pre-Service Work:

- Review of any previous imaging studies
- Supervise transport and set up of the ultrasound equipment in the OR, when necessary, assuring all necessary, transducers are available
- Confirmation of patient positioning and imaging setup

Description of Intra-Service Work:

- Preliminary ultrasound to assess percutaneous or the various intraoperative transhepatic approach(es) to the tumor(s)
- Perform intraoperative ultrasound examination of each hepatic segment until satisfactory exposure has been achieved to confirm expected location(s) of the lesion(s)
- Ultrasound guidance to direct RF or cryosurgical needle electrode(s) to tumor(s), percutaneous or intraoperative transhepatic
- Ultrasound monitoring of needle electrode repositioning within lesion, if and as necessary for each of the multiple ablations or freeze-thaw cycles required to completely ablate the lesion
- Ultrasound to confirm satisfactory ablation of the lesion(s) and comparison to pre-ablation images
- Imaging of liver for post-ablation bleeding

Description of Post-Service Work:

Dictate, review and sign ultrasound report

SURVEY DATA:

Presenter(s): **James P. Borgstede, MD, ACR RUC advisor**
Bibb Allen, Jr., MD, ACR Alternate RUC advisor
Robert L. Vogelzang, MD, SCVIR RUC advisor

Specialty(s): **American College of Radiology**
Society of Cardiovascular & Interventional Radiology

Sample Size: 178 Response Rate: (%): 29.2% (n=52) Median RVW: 3.00

Type of Sample (Circle One): random, **panel**, convenience.

Explanation of sample size: The panel of survey recipients included both SCVIR and ACR members.

25th Percentile RVW: 2.15 75th Percentile RVW: 4.75 Low: .75 High: 15.49

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

25th Percentile Intra-Svc Time: 60 minutes 75th Percentile Intra-Svc Time: 150 minutes
 Low: 10 minutes High: 240 minutes

Jian Post-Service Time:

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

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	.67

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)

	<u>CPT Code</u> 7649X	<u>Reference Service 1 CPT</u> 76942
Median Pre-Time	20 minutes	
Median Intra-Time	120 minutes	
Median Immediate Post-service Time	15 minutes	
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		
Total Time	155 minutes	30 minutes

Source of time for 76942 is RUC

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.54	2.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.71	2.45
Urgency of medical decision making	3.38	2.50

Technical Skill/Physical Effort (Mean)

Technical skill required	4.48	2.77
Physical effort required	3.75	2.45

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.77	2.59
Outcome depends on the skill and judgement of physician	4.63	2.68
Estimated risk of malpractice suit with poor outcome	3.37	2.73

INTENSITY/COMPLEXITY MEASURES

CPT Code: Reference Service 1

	<u>7649X</u>	<u>76942</u>
Time Segments (Mean)		
Pre-Service intensity/complexity	3.29	2.41
Intra-Service intensity/complexity	4.42	2.64
Post-Service intensity/complexity	2.90	2.27

ADDITIONAL RATIONALE

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

The process used consisted of a survey of physicians (panel sample) from ACR, ACS, and SCVIR who perform this service. Given the scope of physician work represented by code 7694X and the procedure’s time, the appropriate RVW for the procedure was judged to be between that of the median (3.0) and the 75th percentile (4.75) estimates from the survey. In addition, the recommended RVW for 7694X should be consistent with those for the other imaging guidance codes 7637X (4.0) and 7639X (4.25). Therefore, given these considerations, the recommended RVW for 7694X is 4.0.

Code 7694X encompasses the physician work associated with the performance and interpretation of ultrasound studies of the liver and surrounding anatomy, the liver’s vasculature, electrode guidance and repositioning in and around the tumor(s), and monitoring of the ablation. Using a building-block approach, code 7694X’s RVW could be thought of in terms of the RVWs assigned to codes for liver ultrasound (76705; RVW = 0.59), intraoperative ultrasound (76986; RVW = 1.20), vascular ultrasound (93976; RVW = 1.21), and ultrasound guidance per lesion (76942; 0.67). There is not a suitable “building block” for ultrasonic monitoring of tissue ablation and this approach does not fully account for added physician time, complexity, and risk over and above that associated with code 76942. The 75th percentile RVW, therefore, was felt to be commensurate with the physician work associated with the services in aggregate and the added time and complexity of the procedure.

FREQUENCY INFORMATION

How was this service previously reported? **76942-22** (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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 **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.

There are approximately 100,000 patients per year who have metastatic disease and/or primary hepatic tumors, who would be candidates for treatment. An estimated 5 to 15 percent of these patients would be candidates for

percutaneous radiofrequency ablation (PRA). Ultrasound is one of three guidance modalities used for guidance and monitoring of PRA. At this time, we are unable to ascertain accurate percentages of utilization by guidance modality for PRA procedures.

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.

Unable to quantify. (See estimate of services for general population, above.)

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

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

April 2001

Repair Inguinal Hernia (less than 37 weeks gestation)

Two new CPT codes were developed and the two existing codes were editorially modified, to distinguish between infants and premature infants who require repair of initial inguinal hernia. The creation of these new codes allows for more specificity due to a change in the population mix for these types of procedures.

The RUC initially reviewed codes 49495 *Repair initial inguinal hernia, under age 6 months, with or without hydrocelectomy; reducible* (work RVU = 5.89), and 49496 *Repair initial inguinal hernia, under age 6 months, with or without hydrocelectomy; incarcerated or strangulated* (work RVU = 8.79) during the August 2000 5-Year Review. The RUC at that time, recommended no change in the work relative values, but understood that in current practice the patient population and ratio of premature to term babies had changed. Repair of hernia in premature babies is now recommended prior to discharge from the NICU, and the typical patient is now a premature neonate with a very difficult anatomy requiring repair with extensive post operative care. At the August 2000 5-Year Review, the RUC recommended that the specialty make a request to CPT to create new codes specifically for premature infants. As a result, these two new CPT codes were created and the existing codes were modified, to distinguish between full term infant and premature infant repair of inguinal hernia.

49491 Repair, initial inguinal hernia, preterm infant (less than 37 weeks gestation at birth), performed from birth up to 50 weeks post-conceptual age, with or without hydrocelectomy; reducible

The RUC based their recommendation on their understanding that, at the August 2000 5-Year Review, the RUC thoroughly reviewed the specialty society's survey results and approved the values recommended by the specialty, directing the specialty society to return to CPT to create codes for the premature infant population. During the August 2000 5-Year Review, the RUC agreed that the values based on the survey would be appropriate for this procedure performed on premature infants. Premature infants, the specialty argued, have more difficult anatomy's and require more extensive and intensive post operative care than for the full term infants. In addition, the RUC compared the intra-service work and intensity of 49491 to the reference code 44950 *Appendectomy* (work RVU = 8.70), and believed they were similar. Code 49491 was reported to have 10 minutes more intra-service physician time, and more extensive post-operative care than 44950. The RUC agreed with the specialty society's recommendation to value this code at the 25th percentile of the specialty's survey results. **The RUC recommends a relative work value of 11.13 for CPT code 4941.**

Practice Expense

The RUC recommended the standard 090 day global practice expense package for code 49491. The details of the practice expense direct input recommendation are attached.

49492 Repair, initial inguinal hernia, preterm infant (less than 37 weeks gestation at birth), performed from birth up to 50 weeks post-conceptual age, with or without hydrocelectomy; incarcerated or strangulated

The RUC based their recommendation on their understanding that, at the August 2000 5-Year Review, the RUC thoroughly reviewed the specialty society's survey results and approved the values recommended by the specialty, directing the specialty society to return to CPT to create codes for the premature infant population. During the August 2000 5-Year Review, the RUC agreed that the values based on the survey would be appropriate for this procedure performed on premature infants. Premature infants, the specialty argued, have more difficult anatomy's and require more extensive and intensive post operative care than for the full term infants. In addition, the RUC compared the intra-service work and intensity of 49492 to the reference code 44950 *Appendectomy* (work RVU = 8.70), and believed they were similar. Code 49492 was reported to have 10 minutes more intra-service physician time, and more extensive post-operative care than 44950. CPT code 49492 in addition has more pre and post service time and intensity than its anchor code 49491 due to compromised bowel and gonad, these may require one more hospital day. The RUC agreed with the specialty society's recommendation to value this code in relation to code 49491. **The RUC recommends a relative work value of 14.03 for CPT code 49492.**

Practice Expense

The RUC recommended the standard 090 day global practice expense package for code 49491. The details of the direct inputs recommendation are attached.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•49491	NN1	Repair, initial inguinal hernia, preterm infant (less than 37 weeks gestation at birth), performed from birth up to 50 weeks post-conceptual age, with or without hydrocelectomy; reducible	090	11.13
•49492	NN2	incarcerated or strangulated <u>(Post-conceptual age equals gestational age at birth plus age of infant in weeks at the time of the hernia repair. Initial inguinal hernia repairs that are performed on preterm infants who are over 50 weeks postconceptual</u>	090	14.03

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		<u>age and under age 6 months at the time of surgery, should be reported using codes 49495, 49496)</u>		
▲49495	NN3	Repair, initial inguinal hernia, <u>full term infant under age 6 months, or preterm infants over 50 weeks postconceptual age and under age 6 months at the time of surgery, with or without hydrocelectomy; reducible</u>	090	5.89 (No Change)
▲49496	NN4	incarcerated or strangulated <u>(Post-conceptual age equals gestational age at birth plus age in weeks at the time of the hernia repair. Initial inguinal hernia repairs that are performed on preterm infants who are under or up to 50 weeks postconceptual age but under 6 months of age since birth, should be reported using codes 4949X1, 4949X2. Inguinal hernia repairs on infants age 6 months to under 5 years should be reported using codes 49500-49501)</u>	090	8.79 (No Change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

(April 2001)

Survey CPT Code: 4949X1

Global: 090

8/2000 RUC approved RVW: 11.13

CPT Descriptor: Repair, initial inguinal hernia, preterm infant (less than 37 weeks gestation at birth), performed from birth up to 50 weeks post-conceptual age, with or without hydrocelectomy; reducible

Family CPT Code: 4949X2

Global: 090

8/2000 RUC approved RVW: 14.03

CPT Descriptor: incarcerated or strangulated

(Post-conceptual age equals gestational age at birth plus age of infant in weeks at the time of the hernia repair. Initial inguinal hernia repairs that are performed on preterm infants who are over 50 weeks postconceptual age and under age 6 months at the time of surgery, should be reported using codes 49495, 49496)

Typical Patient (*Survey Vignette*): An 1800 gram former 33 week, now 48 week post conceptual infant in the neonatal intensive care unit, who has been weaned from the ventilator, has a large unilateral inguinal hernia requiring repair. He has BPD on steroids, diuretics and oxygen. Most of the intestine is in the hernia sac. High ligation is accomplished after dissection of a very large sac with multiple vascular adhesions to the cord structures. A floor repair is also required. Postoperative management includes careful pulmonary and hemodynamic observation until ready for discharge from the NICU. Postoperative office management of a hematoma is performed.

CLINICAL DESCRIPTION OF SERVICE:

Pre-service work - Day before surgery:

- Evaluate patient by taking detailed history including prenatal, past, present, and family history. Check the status of the apnea monitor.
- Examine the patient in detail including heart, lung, and check the site, the size and the reducibility of the hernia.
- Order preoperative tests if needed.

- Write preoperative orders, medications including prophylactic antibiotics, G.E. reflux, and asthma medications.
- Review the preoperative work-up.
- Review the surgical procedure with parents, discuss alternatives, complications, and obtain informed consent.
- Call the OR and schedule the surgical procedure.
- Confirm OR start time and notify family.
- Ask the office insurance staff to call the insurance company to obtain pre-certification and authorization.

Pre-service work - Day of surgery:

- Change into scrub clothes.
- Confirm the surgical procedure and mark the side with parents.
- Guide them to the waiting area.
- Review length and type of anesthesia with anesthesiologist.
- Verify all necessary surgical instruments and supplies are readily available in the operative suite.

- Monitor patient positioning and draping and assist the nurses with positioning and the anesthesiologist with starting an IV line.
- Scrub and gown.

Intra-service work - Skin to skin:

- Skin incision is made in the groin at the site of the hernia.
- All layers of skin are opened and the inguinal canal is exposed and opened.
- The cord contents are dissected, the Vas, which is fine, is identified and protected.
- The hernia sac, which is very large, thin, and tears easily, is separate from the cord up to the pro-peritoneal fat.
- The hernia sac is twisted and highly ligated, doubly ligated, and resected.
- The floor of the inguinal canal is evaluated. The floor is usually weak and is reinforced with sutures.
- The testes is placed securely in the scrotum, fixation is sometimes necessary.
- The ileoinguinal and the ileohypogastric nerves are identified and infiltrated with long-acting local anesthesia for post-op analgesia.
- The inguinal canal is reconstructed.
- The skin is closed.

Post-op Same day work through discharge from operating suite to NICU Write and operative note in the patient's record.

- Sign the pathology reports.
- Write orders for post-op medications, diet, and patient monitoring in the NICU.
- Order apnea monitor for 24-hours for premature infants.
- Dictate the postop note.
- Determine oxygen therapy and ventilator.
- Examine patient, check wound/wounds, and write progress note.
- Call the office and inform the insurance staff of the procedure.

Post-op Other Hospital work - Beginning on post-op day 1/ Discharge Day

- Examine patient and check the wound and scrotal swelling..
- Answer parents questions.
- Chart patient progress notes.
- Determine need for oxygen therapy and continued apnea monitor.

Discharge day work:

- Examine patient.
- Talk with family, answer questions.
- Carefully explain to family dietary management, wound care, activity permitted, bathing, return appointments.
- Check wound, review postoperative wound care with family.
- Discuss scrotal swelling expectations
- Discuss signs of recurrence.
- Review nursing and other staff questions.
- Answer family questions.
- Answer nursing/other staff questions.
- Answer insurance staff questions.
- Write orders for post-discharge labs and medication.
- Arrange home nursing.

Post-op Office work - After discharge from hospital

- Examine patient and check the wound and scrotum.

- Check need for continued apnea monitoring.
- Answer parents questions re scrotal swelling and hydrocele.
- Answer insurance staff questions.
- Dictate patient progress notes in the medical chart.
- Dictate letter to referring physician.
- Office staff to transcribe and to mail letter to the referring physician.

SURVEY DATA

Presenter(s): Eugene Wiener, MD, Sam Smith, MD

Specialty(s): American Pediatric Surgical Association

Sample Size: 54 **Response Rate:** 31 (57%)

Type of Sample: Random

	<u>Low</u>	<u>25th pctl</u>	<u>Median</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW	8.76	11.13	12.00	13.80	21.15
Pre-Service			90		
Intra-Service	40	45	60	85	150
Post-Service:	Total Time	CPT code / # of visits			
Immed. Post-Service	30				
Critical Care	74	99291 x1			
Other Hospital	71-41	99233x1 99232x1			
Discharge Day Mgmt	30	99238			
Office Visits	53	99213x1 99212x2			

	Time	Intensity	Work RVU (=time x intensity)
PRE total	90	0.0224	2.02
Immed post	30	0.0224	0.67
HV post:	<u>Visit n</u>	<u>E/M RVU</u>	<u>(=n x E/M RVU)</u>
99291	1	4.00	4.00
99233	1	1.51	1.51
99238	1	1.28	1.28
99213	1	0.65	0.65
99212	2	0.43	0.86
OV post:	<u>Visit n</u>	<u>E/M RVU</u>	<u>(=n x E/M RVU)</u>
99213	1	0.65	0.65
99212	2	0.43	0.86
Post Total	RVU	8.97	
	intra time	60.00	iwput
Survey 25thpct	RVW	11.13	0.002

KEY REFERENCE SERVICE(S):

'00 RVW	Global	CPT	Descriptor
8.70	90	44950	Appendectomy;
12.87	90	62223	Creation of shunt; ventriculo-peritoneal, -pleural, other terminus

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 49493 (n=31)	Ref CPT 44950 (n=4)	Ref CPT 62223 (n=3)
Pre-service time	90	80	108
Intra-service time	60	48	55
Immediate Post-service time	30	20	33
Total critical care time	90	0	0
Total other hospital visit time	71	49	90
Discharge management time	30	35	35
Total office visit time	53	23	53

INTENSITY/COMPLEXITY MEASURES (mean)**TIME SEGMENTS**

Pre-service	3.48	3.50	3.50
Intra-service	4.10	3.00	4.00
Post-service	3.52	3.00	3.50

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.17	3.25	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.57	3.00	3.50
Urgency of medical decision making	3.27	3.50	3.50

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.40	3.00	4.00
Physical effort required	3.43	3.00	3.50

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.87	3.00	4.00
Outcome depends on the skill and judgment of physician	4.07	3.00	4.50
Estimated risk of malpractice suit with poor outcome	3.50	3.25	3.50

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. Your rationale should also describe how the work of performing the service has changed over the past five years

A RUC survey was performed. A consensus panel reviewed the survey and made final recommendation.

In current practice, the patient population and ratio of premature to term babies have changed considerably than described in 1993. Due to the high risk of incarceration in the premature infant, repair is now recommended prior to discharge from the NICU. Also significantly more preemies survive to undergo repair. Thus the "typical" patient is a premature neonate with more difficult anatomy and repair and requires postop NICU care. The intraop work of 49493 is similar to 62223 and the total work is much greater than an appendectomy for the "typical" patient. The consensus panel believed that the actual median non-NICU days should be reduced by 1. **We therefore recommend the survey 25th percentile RVW of 11.13 for 49493.** This value is somewhat lower than 62223 and appropriately higher than 44950. We note that this recommended value results in a very low IWPUR for the intraop work.

FAMILY CODE RECOMMENDATION (49494)

Relative to CPT 49493 (as the anchor code), CPT 49494 pre service time and post visits are higher. Due to compromised bowel and gonad, these may require 1 more hospital day. There is also an increased intensity of the procedure itself. **We recommend an RVW of 14.03 for 49496.** This RVW maintains the previous difference between 49495 and 49496. [old RVW difference (5.84/8.79) = 2.90

FREQUENCY INFORMATION

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

Specialty: Pediatric Surgery Sometimes

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: Pediatric Surgery 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: Pediatric Surgery Frequency: 50

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

FIVE-YEAR REVIEW SPECIFIC QUESTIONS

Please indicate the number of survey respondents responding to each of the following questions:

a. **Has the work of performing this service changed in the past 5 years?**

12 Yes

8 No

b. **This service represents new technology that has become more familiar (i.e., less work).**

1 I agree

11 I do not agree

c. **Patients requiring this service are now:**

10 more complex (more work)

0 less complex (less work)

2 no change

d. **The usual site-of-service has changed:**

2 from outpatient to inpatient

0 from inpatient to outpatient

10 no change

CPT: 4949X1 4949X2

Specialty: APSA

**AMA/Specialty Society Update Process
RUC Summary of Recommendation
Out-Of-Office Direct Inputs [In-Office Not Applicable]**

American Pediatric Surgical Association

CPT Code: 4949X1

Global: 090

Repair, initial inguinal hernia, preterm infant (less than 37 weeks gestation at birth), performed from birth up to 50 weeks post-conceptual age, with or without hydrocelectomy; reducible

CPT Code: 4949X2

Global: 090

Repair, initial inguinal hernia, preterm infant (less than 37 weeks gestation at birth), performed from birth up to 50 weeks post-conceptual age, with or without hydrocelectomy; incarcerated or strangulated

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

A consensus panel of 14 pediatric surgeons representing all geographic settings and types of practice met via phone conference to consider the clinical staff work and supplies associated with these three new congenital atresia codes.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The PEAC approved time of 60 minutes is being recommended. These babies are sick prior to surgery and are often born to young mothers. The mother and her family will require considerable time for explanations and counseling of the procedure and the expected extended hospital stay. The other aspects of approved time appear reasonable to the APSA consensus panel for E1 and E2.

Intra-Service Clinical Labor Activities:

These babies are in the hospital for 21 days (E1) and 26 days (E2). Phone discussions with the mother and her parents and the insurance clinical staff to explain the lengthy stay and the baby's progress. The clinical staff is involved in discharge coordination that will begin several days prior to discharge and we estimate this to require 10 minutes.

Post-Service Clinical Labor Activities

The PEAC approved typical times and medical supplies for EM services and postoperative incision care are recommended.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1	Clinical Labor, Medical Supplies, and Procedure Equipment Practice Expense Data						CPT					4949X1	4949X1	4949X2	4949X2
2							Global					090	090	090	090
3							Number/Level of Post OV:					N/A	99213x1 99212x2	N/A	99213x1 99212x2
4	CLINICAL LABOR						Code	staff desc	Price	IN Off	OUT off	IN Off	OUT off		
5	TOTAL TYPICAL TIME						1130	RN/LPN/MA	\$ 0.317	0	160	0	160		
6	PRE-service time						1130	RN/LPN/MA	\$ 0.317	0	60	0	60		
7	SERVICE time						1130	RN/LPN/MA	\$ 0.317	0	10	0	10		
8	POST-service time						1130	RN/LPN/MA	\$ 0.317	0	90	0	90		
9	PRE-SERVICE														
10	BEGINS after procedure consult. (In/out)									Min	Min	Min	Min		
11	Complete pre-service diagnostic & referral forms (5/5)						1130	RN/LPN/MA	\$ 0.317	0	5	0	5		
12	Coord pre-proc services/review test/exam results (10/20)						1130	RN/LPN/MA	\$ 0.317	0	20	0	20		
13	Schedule space and equipment in facility (0/8)						1130	RN/LPN/MA	\$ 0.317	0	8	0	8		
14	OV before surgery/procedure - review test/exam results (0/0)						1130	RN/LPN/MA	\$ 0.317	0	0	0	0		
15	Provide pre-service education/obtain consent (10/20)						1130	RN/LPN/MA	\$ 0.317	0	20	0	20		
16	Follow-up phone calls & prescriptions (10/7)						1130	RN/LPN/MA	\$ 0.317	0	7	0	7		
17	Other Pre-Service Activities (please specify):														
18							1130	RN/LPN/MA	\$ 0.317	0	0	0	0		
19	ENDS with admission to facility/office														
20	SERVICE PERIOD														
21	Starts with admission to facility/office									Min	Min	Min	Min		
22	pre discharge counseling and coordination (@10 min)						1130	RN/LPN/MA	\$ 0.317	0	10	0	10		
23							1130	RN/LPN/MA	\$ 0.317	0	0	0	0		
24	Ends with discharge from facility/office														
25	POST-SERVICE														
26	Begins after discharge from facility/office									Min	Min	Min	Min		
27	Postop OV total time (E/M standards)		-211 (16)	-212 (27)	-213 (36)	-214 (53)	-215 (63)	1130	RN/LPN/MA	\$ 0.317	0	90	0	90	
39	Other Activities (please specify):														
40							1130	RN/LPN/MA	\$ 0.317	0	0	0	0		
41	ENDS after 90 days from day of procedure.														
42	MEDICAL SUPPLIES						Code	Unit Size	Unit Cnt	Price	Out Off QTY	Out Off QTY	Out Off QTY	Out Off QTY	
43	PEAC Minimum visit package (multi-specialty):						PEAC	PKG	1	\$ 1,310	0	3	0	3	
45	exam table paper (7 ft)						11111	foot	1	\$ 0.015					
46	gloves, non-sterile (2 pair)						11302	pair	1	\$ 0.120					
47	patient gown, disposable						11107	item	1	\$ 0.570					
48	pillow case, disposable						11112	item	1	\$ 0.320					
49	thermometer probe cover, disposable						11509	item	1	\$ 0.069					
50	Add'l visit supplies:														
51	patient education booklet						11115	item	1	\$ 0.920	0	1	0	1	
52	PEAC Postop incision care kit:						PEAC	PKG	1	\$ 15,034	0	1	0	1	
53	betadine						52310	ml	20	\$ 0.140					
54	gauze, sterile 4x4 (10 pack)						31505	pack	2	\$ 2.940					
55	gloves, sterile						14005	pair	1	\$ 0.890					
56	staple remover kit						31702	item	1	\$ 6.830					
57	steri-stmp						31513	stmp	12	\$ 3.580					
58	swab Alcohol						11302	item	2	\$ 0.034					
59	tape						31514	inch	12	\$ 0.300					
60	tincture benzen swab						52308	item	1	\$ 0.320					
61	Add'l supplies:														
62											0	0	0	0	
63	PROCEDURE SPECIFIC EQUIPMENT														
64	Exam table						E11001	1		\$ 1,360	0	1	0	1	

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

April 2001

Cystourethroscopy

Code 52001 *Cystourethroscopy with irrigation and evacuation of clots* was developed to capture the work and time involved in irrigating the clots and decompressing the bladder, while code 52347 *Cystourethroscopy with transurethral resection or incision of ejaculatory ducts* was developed to record the transurethral resection or incision of ejaculatory ducts.

The RUC reviewed the specialty society's survey and consensus panel results, and concluded that the specialty recommendations for both codes seemed reasonable considering the physician work and time required.

52001 *Cystourethroscopy with irrigation and evacuation of clots (Do not report with code 52000)*

The RUC believed the specialty society's survey responses from 56 practicing urologists tightly clustered in on the recommended median value. The RUC also believed reference code 52315 *Cystourethroscopy, with removal of foreign body, calculus, or urethral stent from urethra or bladder (separate procedure); complicated* (work relative value of 5.21), represented similar physician work and complexity. **The RUC recommended a work relative value of 5.45 for CPT code 52001.**

Practice Expense

The RUC recommended 4 minutes of clinical labor staff time for the completion of pre-service diagnostic & referral forms in the out of office setting. The direct practice expense inputs are attached to this recommendation. These services are only performed in a facility setting.

52347 *Cystourethroscopy with transurethral resection or incision of ejaculatory ducts*

The RUC recognized that the mixed-panel/random sample of 73 practicing urologists overvalued the code and that a lower value was more appropriate. The physician time of reference code 52277 *Cystourethroscopy, with resection of external sphincter (sphincterotomy)* (work relative value of 6.17), was significantly higher than the surveyed median time, and a more complex, and

intense procedure. The specialty society's panel of urologists came to same conclusion as the RUC and recommended the 25th percentile of their survey results rather than their median value. In addition the RUC believed the physician time for this new code should be recorded as the median surveyed time and not the 25th percentile physician time. **The RUC recommended a relative work value of 5.28 for CPT code 52347.**

Practice Expense

The RUC recommended 4 minutes of clinical labor staff time for the completion of pre-service diagnostic & referral forms in the out of office setting for both codes. The direct practice expense inputs are attached to this recommendation. These services are only performed in a facility setting.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●52001	J1	Cystourethroscopy with irrigation and evacuation of clots (Do not report 52001 in addition to code 52000)	000	5.45
●52347	J2	Cystourethroscopy with transurethral resection or incision of ejaculatory ducts	000	5.28

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

(April 2001)

CPT Code: 5200X

Global: 000

Survey Median RVW: 5.45
Recommended RVW: 5.45

CPT Descriptor: Cystourethroscopy with irrigation and evacuation of clots

Tracking Code: J1

Survey Vignette (Typical Patient)

A 65-year-old male presents to the emergency room with lower abdominal pain and voiding small amounts of grossly bloody urine with clots. On physical examination, his bladder is tender and distended. Several urethral catheters are placed, however, they rapidly obstruct secondary to clots. Because of inadequate bladder drainage the patient is taken to the OR.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service Work- Day before surgery:

- Review pre-op lab results
- Review medical record
- Write pre-op orders (to be faxed to hospital)
- Check to be sure necessary equipment/supplies are at hospital

Pre-service work- Day of surgery:

- Change into scrub cloths
- Review surgical procedure, post-op recovery in and out of hospital with patient and family
- Answer patient and family questions, be sure informed consent is in record
- Speak to anesthesiologist about expected length of procedure and any special concerns about this particular patient (teeth, positioning, unusual medical problems)
- Position patient on operating table
- Verify that all necessary instruments are available

Intra-service work- Skin to skin:

- Cystoscope is introduced through urethra under direct vision
- Vision is very poor, and large clots are seen
- A 27 French resectoscope is introduced
- The loop of the resectoscope is used to break up the multiple clots
- An Ellik evacuator is used repeatedly using 6 liters of saline bladder irrigating fluid to remove all of the clots
- Clots that will not irrigate out are pulled out through the urethra with the resectoscope loop
- The bladder is confirmed by direct vision to be free of clots
- A 3-way hematuria catheter is placed to continuous bladder irrigation

Post-op Same day work through discharge from recovery

-
- Apply dressings
 - Assist in transfer of patient from operating table to post-op stretcher
 - Accompany anesthesiologist with patient to recovery area
 - Assist in transfer of patient to recovery area bed
 - Write post-op orders
 - Review recovery area care and medications with staff
 - Meet with family and discuss the procedure, expected outcome, planned post operative care in hospital and out of hospital
 - Discuss procedure with patient as necessary in recovery area when awake
 - Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)
 - Dictate detailed operative narrative

Post-op Same day work after discharge from recovery

- Examine patient, check wound and patient progress
- Review patient hospital medical record notes (nursing, pharmacy, dietary, discharge planner)
- Answer patient and family questions
- Answer nursing and other staff questions
- Write any further necessary orders
- Write note in progress note section of medical record

Discharge day work:

- Examine and talk with patient and family
- Check catheter and urine flow and patient progress
- Review all patient hospital medical records
- Answer patient and family questions
- Write orders for post-discharge care
- Write prescriptions for post-op medications
- Dictate detailed hospital discharge summary

SURVEY DATA:**Presenters:** James B. Regan, MD & Jeffrey A. Dann, MD**Specialty:** American Urological Association**Type of Sample:** Mixed-panel/random**Sample Size:** 123**Response Rate:** 46% (56/123)

	Low	25 th %	Median	75 %	High
Survey RVW	3.20	5.00	5.45	6.00	8.00
Pre-Service Time	30	40	50	90	150
Intra-Service Time	40	45	60	60	90

Post-Service:	Total Time	CPT code/# of visits
Immed. Post-Service	20	
Critical Care		0
Other Hospital		
Discharge Day Mgmt		
Office Visits		0

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	% RESP	GLOBE
52315	Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); complicated	5.21	48%	000
52235	Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); complicated	5.45	26%	000
52234	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 to 2.0 cm)	4.63	13%	000

RELATIONSHIP OF CODE BRING REVIEWED TO KEY REFERENCE SERVICE(S):**INTENSITY/COMPLEXITY MEASURES (mean)****TIME SEGMENTS**

	Svy CPT 5200X	Reference CPT 52315
Pre-service	3.38	3.00
Intra-service	3.17	2.87
Post-service	4.41	3.10

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.41	3.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.43	2.87
Urgency of medical decision making	3.41	3.10

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.26	3.26
Physical effort required	2.87	2.87

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.84	2.92
Outcome depends on the skill and judgment of physician	3.59	3.18
Estimated risk of malpractice suit with poor outcome	3.03	2.54

ADDITIONAL RATIONALE-

IWPUT/BUILDING BLOCK METHOD

PROPOSED RVW =	RVW 5.45
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PRE-SERVICE	TIME	INTENSITY	(= time x intensity)
Day prior evaluation	0	0.0224	0.00
Same day evaluation	30	0.0224	0.67
Scrub, prep	20	0.0081	0.16
TOTAL PRE-SERVICE		RVW=	0.83

POST SERVICE			
Immediate hospital	20	0.0224	0.45
	Visit n	E&M RVW	(= n x E&M RVW)
Subsequent hospital			
ICU 99291	0.0	4.00	0.00
Room 99233	0.0	1.51	0.00
Room 99232	0.0	1.06	0.00
Room 99231	0.0	0.64	0.00
Discharge 99238	1.0	1.28	1.28
Subsequent office			
99215	0.0	1.77	0.00
99214	0.0	1.10	0.00
99213	0.0	0.67	0.00
99212	0.0	0.45	0.00
99211	0.0	0.17	0.00
TOTAL POST SERVICE		RVW =	1.73

	TIME	IWPUT	
INTRASERVICE	60	0.048	2.89

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

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.

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 Medicare Frequency: 1,000

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

Practice Expense Summary – Clinical Labor	
CPT code: 5200X – <i>Cystourethroscopy with irrigation and evacuation of clots</i>	
Tracking #: J1	
Global Period: 000	
	Out-of-Office
Staff Type	RN/LPN/MA
Pre-service time	4
Service period	
Coordination of Care by staff in the physician's office during the service period (for facility services)	
Post-service time (excluding time of office visits)	
Total Number of office visits	0
Total time of office visits	
PRE-SERVICE PERIOD	
Start: Following visit when decision for surgery or procedure made	
1. Complete pre-service diagnostic & referral forms	4
2. Coordinate pre-procedure or pre-surgery services	
3. Schedule space and equipment in facility	
4. Office visit before surgery/procedure to review test and exam results	
5. Provide pre-service education/obtain consent	
6. Follow-up phone calls & prescriptions	
Other Pre-Service Activities (please specify):	
End: When patient enters hospital or office for surgery/procedure	
SERVICE PERIOD	
Start: With admission to hospital, ASC, or office for procedure	
<i>Pre-service services</i>	
1. Review charts	
2. Greet patient and provide gowning	
3. Obtain vital signs	
4. Provide pre-service education/obtain consent	
5. Prepare room, equipment, supplies	
6. Prepare and position patient/monitor patient/set up IV	
7. Sedate/apply anesthesia	
<i>Intra-service</i>	
8. Assist physician in performing procedure/surgery	
<i>Post-service</i>	
9. Monitor patient following service/check tubes, monitors, drains	
10. Clean room/equipment	
11. Assist with ICU or hospital visits	
12. Complete diagnostic forms, lab & x-ray requisitions	
13. Review/read x-ray, lab, and pathology reports	
14. (Discharge day mgmt services) Check dressings & wound/home care instructions/coordinate office visits/prescriptions	
15. Coordination of in-facility care by staff in office	
Other service period activities (please specify):	
End: With discharge from hospital, ASC, or office	
POST-SERVICE PERIOD	
Start: After discharge from hospital, ASC, or office	
1. Conduct phone calls/call in prescriptions	
2. 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/equipment, check supplies	
Coordinate home or outpatient care	
3. Conduct phone calls between office visits	
Other post-service activities (please specify):	
End: With last office visit before end of global period	

Practice Expense Summary – Supplies & Equipment Out of Office

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	none			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	none				

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

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

(April 2001)

CPT Code: 5234X

Global: 000

Survey Median RVW: 6.17

Recommended (25th percentile) RVW: 5.28

CPT Descriptor: Cystourethroscopy with transurethral resection or incision of ejaculatory ducts

Tracking Code: J2

Survey Vignette (Typical Patient)

A 22-year-old male undergoes an infertility evaluation and is found to have a low volume ejaculate with oligasthenospermia and a low PH. Transrectal ultrasound demonstrates fibrosis of the distal ejaculatory ducts with distention of the seminal vesicles all the way to the veru montanum consistent with ejaculatory duct obstruction.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service Work- *Day before surgery:*

- Review pre-op lab results
- Review medical record
- Write pre-op orders (to be faxed to hospital)
- Check to be sure necessary equipment/supplies are at hospital

Pre-service work- *Day of surgery:*

- Change into scrub cloths
- Review surgical procedure, post-op recovery in and out of hospital with patient and family
- Answer patient and family questions, be sure informed consent is in record
- Speak to anesthesiologist about expected length of procedure and any special concerns about this particular patient (teeth, positioning, unusual medical problems)
- Position patient on operating table
- Verify that all necessary instruments are available

Intra-service work- *Skin to skin:*

- Panendoscope is introduced under direct vision
- The veru monatanum, ejaculatory ducts, prostatic urethra and prostate are inspected and the anatomy is carefully identified including the external urinary sphincter which is immediately adjacent to the ejaculatory ducts
- The panendoscope is removed
- A 24 French resectoscope with a Collins Knife (electrical current) is placed
- The Veru is delicately incised until clearly open if necessary, a loop is used to resect (electrical current) the Veru and openings of the ejaculatory ducts
- Bleeders are coagulated
- Inspect urinary sphincter for injury
- A Foley catheter is placed

Post-op Same day work through discharge from recovery

AUA

-
- Apply dressings
 - Assist in transfer of patient from operating table to post-op stretcher
 - Accompany anesthesiologist with patient to recovery area
 - Assist in transfer of patient to recovery area bed
 - Write post-op orders
 - Review recovery area care and medications with staff
 - Meet with family and discuss the procedure, expected outcome, planned post operative care in hospital and out of hospital
 - Discuss procedure with patient as necessary in recovery area when awake
 - Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)
 - Dictate detailed operative narrative

Post-op Same day work after discharge from recovery

- Examine patient, check wound and patient progress
- Review patient hospital medical record notes (nursing, pharmacy, dietary, discharge planner)
- Answer patient and family questions
- Answer nursing and other staff questions
- Write any further necessary orders
- Write note in progress note section of medical record

Discharge day work:

- Examine and talk with patient and family
- Check wounds and patient progress
- Review all patient hospital medical records
- Answer patient and family questions
- Write orders for post-discharge care
- Write prescriptions for post-op medications
- Dictate detailed hospital discharge summary

SURVEY DATA:

Presenters: James B Regan, MD & Jeffrey A. Dann, MD**Specialty:** American Urological Association**Type of Sample:** Mixed-panel/random **Sample Size:** 73**Response Rate:** 52% (38/73)

	Low	25 th %	Median	75 %	High
Survey RVW	3.95	5.28	6.17	6.45	8
Pre-Service Time	10	20	30	60	240
Intra-Service Time	20	45	50	60	120

Post-Service:	Total Time	CPT code/# of visits
Immed. Post-Service	15 minutes	
Critical Care		0
Other Hospital		0
Discharge Day Mgmt		
Office Visits		0

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	% RESP	GLOBE
52277	Cystourethroscopy, with resection of external sphincter (sphincterotomy)	6.17	71%	000
52276	Cystourethroscopy with direct vision internal urethrotomy	5.00	24%	000
52214	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands	3.71	5%	000

RELATIONSHIP OF CODE BRING REVIEWED TO KEY REFERENCE SERVICE(S):**INTENSITY/COMPLEXITY MEASURES (mean)****TIME SEGMENTS**

	Svy CPT 5234X	Reference CPT 52277
Pre-service	3.45	3.13
Intra-service	3.47	3.29
Post-service	2.95	2.76

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.71	3.37
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.76	3.45
Urgency of medical decision making	2.37	2.58

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.82	3.55
Physical effort required	2.97	3.00

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.50	3.24
Outcome depends on the skill and judgment of physician	3.79	3.50
Estimated risk of malpractice suit with poor outcome	3.24	2.97

ADDITIONAL RATIONALE

The median survey data suggests an IWPUT of 0.083, which the work group felt was too high. The work group therefore recommends the 25th percentile RVW of 5.28 which yields an IWPUT of 0.073.

IWPUT/BUILDING BLOCK METHOD

			RVW
SURVEY RVW =			6.17
PRE-SERVICE	TIME	INTENSITY	(= time x intensity)
Day prior evaluation	0	0.0224	0.00
Same day evaluation	10	0.0224	0.22
Scrub, prep	20	0.0081	0.16
TOTAL PRE-SERVICE		RVW=	0.38
POST SERVICE			
Immediate hospital	15	0.0224	0.34
	Visit n	E&M RVW	(= n x E&M RVW)
Subsequent hospital			
ICU 99291	0.0	4.00	0.00
Room 99233	0.0	1.51	0.00
Room 99232	0.0	1.06	0.00
Room 99231	0.0	0.64	0.00
Discharge 99238	1.0	1.28	1.28
Subsequent office			
99215	0.0	1.77	0.00
99214	0.0	1.10	0.00
99213	0.0	0.67	0.00
99212	0.0	0.45	0.00
99211	0.0	0.17	0.00
TOTAL POST SERVICE		RVW =	1.62
	TIME	IWPUT	
INTRASERVICE	50	0.083	4.17

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

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

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 Medicare Frequency: 1,000

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

REFERENCE SERVICE LIST- Please see AUA Master Reference Service List

Practice Expense Summary – Clinical Labor		
CPT code: 5234X – <i>Cystourethroscopy with transurethral resection or incision of ejaculatory ducts</i>		
Tracking #: J2		
Global Period: 000		
	In Office	Out-of-Office
Staff Type	RN/LPN/MA	RN/LPN/MA
Pre-service time		4
Service period		
Coordination of Care by staff in the physician's office during the service period (for facility services)		
Post-service time (excluding time of office visits)		
Total Number of office visits		
Total time of office visits		
PRE-SERVICE PERIOD		
Start: Following visit when decision for surgery or procedure made		
1. Complete pre-service diagnostic & referral forms		4
2. Coordinate pre-procedure or pre-surgery services		
3. Schedule space and equipment in facility		
4. Office visit before surgery/procedure to review test and exam results		
5. Provide pre-service education/obtain consent		
6 Follow-up phone calls & prescriptions		
Other Pre-Service Activities (please specify):		
End: When patient enters hospital or office for surgery/procedure		
SERVICE PERIOD		
Start: With admission to hospital, ASC, or office for procedure		
Pre-service services		
1. Review charts		
2. Greet patient and provide gowning		
3. Obtain vital signs		
4. Provide pre-service education/obtain consent		
5. Prepare room, equipment, supplies		
6 Prepare and position patient/monitor patient/set up IV		
7. Sedate/apply anesthesia		
Intra-service		
8. Assist physician in performing procedure/surgery		
Post-service		
9. Monitor patient following service/check tubes, monitors, drains		
10 Clean room/equipment		
11. Assist with ICU or hospital visits		
12. Complete diagnostic forms, lab & x-ray requisitions		
13. Review/read x-ray, lab, and pathology reports		
14. (Discharge day mgmt services) Check dressings & wound/home care instructions/coordinate office visits/prescriptions		
15. Coordination of in-facility care by staff in office		
Other service period activities (please specify):		
End: With discharge from hospital, ASC, or office		
POST-SERVICE PERIOD		
Start: After discharge from hospital, ASC, or office		
1. Conduct phone calls/call in prescriptions		
2. 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/equipment, check supplies		
Coordinate home or outpatient care		
3. Conduct phone calls between office visits		
Other post-service activities (please specify):		
End: With last office visit before end of global period		

Practice Expense Summary – Supplies & Equipment Out of Office

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	none			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	none				

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2001

Insertion of Tandem Cuff

A new CPT code 53444 *Insertion of tandem cuff (dual cuff)* has been created to provide more specificity in coding and to describe the insertion of a second cuff.

The RUC reviewed the survey data from 35 urologists and believed that the physician work involved in comparison to the reference codes; 53447 *Removal, repair, or replacement of inflatable sphincter including pump and/or reservoir and/or cuff*, (work RVU = 13.17) and 53445 *Operation for correction of urinary incontinence with placement of inflatable urethral or bladder neck sphincter, including placement of pump and/or reservoir*(work RVU = 14.06) had similar intensity and complexity. The RUC believed that the surveyed physician time reflected the work, intra-operatively and in total for this new code, and was similar to the reference codes. The RUC considered the specialty society's survey median to accurately represent the amount of work being performed. **The RUC recommends a work relative value of 13.40 for CPT code 53444.**

Practice Expense

The RUC recommended the standard 090 global clinical labor practice expense package, a minimum visit supply package, a basic post operative incision care kit (with suture removal), and an exam table for the out of office setting for this service. There are no in office practice expense recommendations as this service is typically performed in the hospital.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●53444	K1	Insertion of tandem cuff (dual cuff)	090	13.40

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

(April 2001)

CPT Code: 534X1

Global: 090

Survey Median RVW: 13.40
Recommended RVW: 13.40

CPT Descriptor: Insertion of tandem cuff (dual cuff)

Tracking Code: K1

Survey Vignette (Typical Patient)

Sixty-five-year-old male, status radical retropubic prostatectomy with subsequent postoperative urinary incontinence. Primary workup leads to the implantation of a urinary sphincter, which remains in place for five years adequately functioning. Over the last six months, the patient's incontinence has been progressively worse. The incontinence is mainly related to stress induced activities. Exam reveals incontinence without sphincter activated. With sphincter activated, the incontinence is worse. There is no evidence of edema or erythema around the sphincteric components. The device cycles well.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service Work- Day before surgery:

- Review pre-op lab results
- Review medical record
- Write pre-op orders (to be faxed to hospital)
- Check to be sure necessary equipment/supplies are at hospital

Pre-service work- Day of surgery:

- Change into scrub cloths
- Review surgical procedure, post-op recovery in and out of hospital with patient and family
- Answer patient and family questions, be sure informed consent is in record
- Speak to anesthesiologist about expected length of procedure and any special concerns about this particular patient (teeth, positioning, unusual medical problems)
- Position patient on operating table
- Verify that all necessary instruments are available

Intra-service work- Skin to skin:

- A Foley catheter is placed
- With patient in lithotomy position incision is made over the cuff at the level of the bulbous urethra
- The urethral cuff is delicately mobilized
- Cuff and tubing are freed from urethra
- The tubing is clamped
- The old cuff is removed
- The urethral diameter is measured
- Two new cuffs are selected and delicately placed around the atrophied urethra
- Connections are made to the existing tubing
- The system is activated and tested
- The bladder is filled and leakage is tested with the two cuffs
- The wound is irrigated throughout with antibiotic spray
- The wound is closed in usual fashion

Post-op Same day work through discharge from recovery

AUA

- Apply dressings
- Assist in transfer of patient from operating table to post-op stretcher
- Accompany anesthesiologist with patient to recovery area
- Assist in transfer of patient to recovery area bed
- Write post-op orders
- Review recovery area care and medications with staff
- Meet with family and discuss the procedure, expected outcome, planned post operative care in hospital and out of hospital
- Discuss procedure with patient as necessary in recovery area when awake
- Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)
- Dictate detailed operative narrative

Post-op Same day work after discharge from recovery

- Examine patient, check wound and patient progress
- Review patient hospital medical record notes (nursing, pharmacy, dietary, discharge planner)
- Answer patient and family questions
- Answer nursing and other staff questions
- Write any further necessary orders
- Write note in progress note section of medical record

Post-op Other Hospital Work – Beginning on post op-day 1, until discharge day

- Examine and talk to patient
- Check wounds and dressings
- Discuss patient progress with patient and family
- Review all patient hospital medical record notes
- Discuss post operative care of wound
- Answer nursing and other staff questions
- Answer patient and family questions
- Write orders in medical record
- Write progress notes

Discharge day work:

- Examine and talk with patient and family
- Check wounds and patient progress
- Review all patient hospital medical records
- Answer patient and family questions
- Write orders for post-discharge care
- Write prescriptions for post-op medications
- Dictate detailed hospital discharge summary

Post-op Office work- After discharge from hospital:

- Examine patient, check vital signs
- Talk with patient and family
- Answer questions from patient and family
- Write necessary prescriptions
- Remove sutures
- Schedule next office visit
- Mark appropriate diagnosis and CPT code on Superbill
- Dictate patient progress notes for office medical record
- Dictate letter to referring physician

SURVEY DATA:**Presenters:** James B Regan, MD & Jeffrey A Dann, MD**Specialty:** American Urological Association**Type of Sample:** Mixed-panel/random **Sample Size:** 73**Response Rate:** 48% (35/73)

	Low	25 th %	Median	75 %	High
Survey RVW	9.7	13.00	13.40	14.06	20.00
Pre-Service Time	15	43	50	90	240
Intra-Service Time	60	90	120	140	240

Post-Service:	Total Time	CPT code/# of visits
Immed. Post-Service	30	
Critical Care		0
Other Hospital	19	1- 99231
Discharge Day Mgmt	36	1- 99238
Office Visits	61	1- 99212, 2- 99213

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	% RESP	GLOBE
53447	Removal, repair, or replacement of inflatable sphincter including pump and/or reservoir and/or cuff	13.17	57%	090
53445	Operation for correction of urinary incontinence with placement of inflatable urethral or bladder neck sphincter, including placement of pump and/or reservoir	14.06	31%	090
53449	Surgical correction of hydraulic abnormality of inflatable sphincter device	9.70	11%	090

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

<u>INTENSITY/COMPLEXITY MEASURES (mean)</u> <u>TIME SEGMENTS</u>	<u>Svy CPT</u>	<u>Reference CPT</u>
	<u>534X1</u>	<u>53447</u>
Pre-service	3.66	3.60
Intra-service	4.34	4.14
Post-service	3.40	3.37

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.03	3.89
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.71	3.71
Urgency of medical decision making	2.83	2.80

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.46	4.31
Physical effort required	3.77	3.74

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.31	4.03
Outcome depends on the skill and judgment of physician	4.69	4.54
Estimated risk of malpractice suit with poor outcome	4.00	3.97

ADDITIONAL RATIONALE-**IWPUT/BUILDING BLOCK METHOD**

PROPOSED RVW =	RVW 13.40
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PRE-SERVICE	TIME	INTENSITY	(= time x intensity)
Day prior evaluation	0	0.0224	0.00
Same day evaluation	20	0.0224	0.45
Scrub, prep	30	0.0081	0.24
TOTAL PRE-SERVICE		RVW=	0.69

POST SERVICE			
Immediate hospital	30	0.0224	0.67
	Visit n	E&M RVW	(= n x E&M RVW)
Subsequent hospital			
ICU 99291	0.0	4.00	0.00
Room 99233	0.0	1.51	0.00
Room 99232	0.0	1.06	0.00
Room 99231	1.0	0.64	0.64
Discharge 99238	1.0	1.28	1.28
Subsequent office			
99215	0.0	1.77	0.00
99214	0.0	1.10	0.00
99213	2.0	0.67	1.34
99212	1.0	0.45	0.45
99211	0.0	0.17	0.00
TOTAL POST SERVICE		RVW =	4.38

	TIME	IWPUT	
INTRASERVICE	120	0.069	8.33

FREQUENCY INFORMATION

How was this procedure 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

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.

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

Medicare Frequency 1,000

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

:

REFERENCE SERVICE LIST- Please see AUA Reference Service List

Practice Expense Summary – Clinical Labor	
CPT code: 534X1 - Insertion of tandem cuff	
Tracking #: K1	
Global Period: 090	
	Out-of-Office
Staff Type	RN/LPN/MA
Pre-service time	60
Service period	
Coordination of Care by staff in the physician's office during the service period (for facility services)	
Post-service time (excluding time of office visits)	8
Total Number of office visits	2-99213 1-99212
Total time of office visits	99
PRE-SERVICE PERIOD	
Start: Following visit when decision for surgery or procedure made	
1. Complete pre-service diagnostic & referral forms	5
2. Coordinate pre-procedure or pre-surgery services	20
3. Schedule space and equipment in facility	8
4. Office visit before surgery/procedure to review test and exam results	
5. Provide pre-service education/obtain consent	20
6. Follow-up phone calls & prescriptions	7
Other Pre-Service Activities (please specify):	
End: When patient enters hospital or office for surgery/procedure	
SERVICE PERIOD	
Start: With admission to hospital, ASC, or office for procedure	
<i>Pre-service services</i>	
1. Review charts	
2. Greet patient and provide gowning	
3. Obtain vital signs	
4. Provide pre-service education/obtain consent	
5. Prepare room, equipment, supplies	
6. Prepare and position patient/monitor patient/set up IV	
7. Sedate/apply anesthesia	
<i>Intra-service</i>	
8. Assist physician in performing procedure/surgery	
<i>Post-service</i>	
9. Monitor patient following service/check tubes, monitors, drains	
10. Clean room/equipment	
11. Assist with ICU or hospital visits	
12. Complete diagnostic forms, lab & x-ray requisitions	
13. Review/read x-ray, lab, and pathology reports	
14. (Discharge day mgmt services) Check dressings & wound/home care instructions/coordinate office visits/prescriptions	
15. Coordination of in-facility care by staff in office	
Other service period activities (please specify):	
End: With discharge from hospital, ASC, or office	
POST-SERVICE PERIOD	
Start: After discharge from hospital, ASC, or office	
1. Conduct phone calls/call in prescriptions	8
2. 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/equipment, check supplies	
Coordinate home or outpatient care	
3. Conduct phone calls between office visits	
Other post-service activities (please specify):	
End: With last office visit before end of global period	

Practice Expense Summary – Supplies & Equipment Out of Office

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	MMSP	3		
	Basic Post Operative Incision Care Kit (with suture removal kit)	1		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Exam Table	1			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2001

Urethral Sphincter Procedures

New urethral sphincter procedure CPT codes were developed to better describe the exact nature of the appropriate surgical procedures related to the repair, removal, and/or replacement of inflatable sphincter devices.

53446 *Removal of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff*

This new code was created to specifically describe the removal of the urethral/bladder neck sphincter, pump, reservoir, and cuff. The specialty society's surveyed median RVU = 13.17, is exactly the value of the reference code 53447 *Removal, repair, or replacement of inflatable sphincter including pump and/or reservoir and/or cuff* (work RVU = 13.17). The RUC and the specialty society, however, believed that there was more physician time and work was being performed in the reference code, and that 53446 should have a lower work RVU. The RUC also reviewed CPT code 53449 *Surgical correction of hydraulic abnormality of inflatable sphincter device* (work RVU = 9.70) compared to code 53446 in time and intensity, and concluded that the specialty's surveyed 25th percentile RVW correctly valued this new code. The RUC recommends a work relative value of 10.23 for code 52446.

Practice Expense

The RUC agreed to the standard PEAC 090 day global clinical staff package for the out of office setting, 3 minimum visit supply packages, post-operative incision care kits (1 Suture, 1 Staple), and an exam table. The practice expense inputs are attached to this recommendation.

53447 *Removal and replacement of inflatable Urethral/bladder neck sphincter including pump, resevoir, and cuff at the same operative session.*

The RUC reviewed the survey results and concluded that the recommended relative value of 14.08 was too high in comparison of similarly valued codes across specialties such as 32500 *Removal of lung, other than total pneumonectomy; wedge resection, single or multiple* (work relative value of 14.30). The RUC reviewed several similar procedures, and found that code 36830 *Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft* (work RVU = 12.00) was similar in intra-service work. However, the RUC believed that there was additional work associated with the hospital visits and office visits with code 53447. Code 36830 did not require hospital visits, and includes only 1 office visit. Code 53447 was reported to have 1 hospital visit, a discharge day, and 3 office visits. The RUC also compared code 62143 *Replacement of bone flap or prosthetic plate of skull* (work relative value of 13.50) and code 42200 *Palatoplasty for cleft palate, soft and/or hard palate only* (work relative value of 12.00), as codes with similar or less physician work. This provided further evidence in supporting a value above 12.00 RVUs. Based on the belief that more physician time and effort was involved in code 53447 than in 36830, the committee recommended the 25th percentile survey value. **The RUC recommends a work relative value of 13.49 for CPT code 53447.**
CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Practice Expense

The RUC agreed to the standard PEAC 090 day global clinical staff package for the out of office setting, 3 multi-specialty minimum supply packages, 2 post operative incision care kit (1 Suture, 1 Staple), and an exam table. The direct practice expense inputs are attached to this recommendation.

53448 Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir, and cuff through an infected field at the same operative session including irrigation and debridement of infected tissue.

The RUC reviewed the survey results and concluded that the recommended work relative value of 24.86 was too high in comparison to similarly valued codes across specialties. Specifically, the RUC questioned the incremental relative value difference between this code and code 53447.

The RUC reviewed the survey results again, and recognized that code 27091- *Removal of hip prosthesis; (separate procedure) complicated, including total hip prosthesis, methylmethacrylate with or without insertion of spacer* (work relative value of 13.49) had similar work and intensity as code 53448. However, CPT code 27091 had less intra-service time and no hospital visits. The committee reviewed other orthopedic codes and found that code 27091 could be used as an initial building block code. The committee then added the physician work of the post operative hospital visits involved, as well as 30 more minutes of intra-service time to come up with a value of 21.18 RVUs, which is similar to the 75th percentile of the survey. Based on these calculations, the RUC recommended the 75th percentile of 21.15 RVUs. **The RUC recommends a work relative value of 21.15 for CPT code 53448.**

Practice Expense

The RUC agreed to the standard PEAC 090 day global clinical staff package for the out of office setting, 3 multi-specialty minimum visit supply packages, 2 post operative incision care kit (1 Suture, 1 Staple), and an exam table. The direct practice expense inputs are attached to this recommendation.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲53445	X1	Operation for correction of urinary incontinence with Placement <u>Insertion</u> of inflatable urethral/ or bladder neck sphincter, including placement of pump, and/or reservoir, <u>and cuff</u>	090	14.06 (no change)
●53446	X2	Removal of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff	090	10.23
▲53447	X3	Removal, repair, or and replacement of inflatable urethral/bladder neck sphincter including pump,	090	13.49

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		and/or reservoir, and/or cuff at the same operative session		
● 53448	X4	Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir, and cuff through an infected field at the same operative session including irrigation and debridement of infected tissue <u>(Do not report 11040-11043 in addition to 53448)</u>	090	21.15
▲ 53449	X5	Surgical correction of hydraulic abnormality of inflatable sphincter device <u>Repair of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff</u> <u>(Do not report 11040-11043 in addition to 53448)</u>	090	9.70 (no change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

(April 2001)

CPT Code: 534X1

Global: 090

Survey Median RVW: 13.17

Recommended (25th percentile) RVW: 10.23

CPT Descriptor: Removal of inflatable sphincter, including pump, reservoir and cuff

Tracking Code: X2

Survey Vignette (Typical Patient)

Middle-aged male, status post radical retropubic prostatectomy, who developed post-prostatectomy incontinence. Artificial urinary sphincter was placed for incontinence. The patient has now had prosthesis indwelling for approximately five years. There has been a slow recrudescence of the stress incontinence with activity. The patient desires sphincter removal due to loss of manual dexterity necessary to operate pump and need for nocturnal deactivation of the device because of detrusor overactivity occurring in the nocturnal timeframe. Exam reveals sphincter prosthesis to be well-seated and to cycle poorly. There was demonstrable stress incontinence with device fully inflated. With pump activated, there is further increased incontinence.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service Work- Day before surgery:

- Review pre-op lab results
- Review medical record
- Write pre-op orders (to be faxed to hospital)
- Check to be sure necessary prosthesis components are at hospital

Pre-service work- Day of surgery:

- Change into scrub cloths
- Review surgical procedure, post-op recovery in and out of hospital with patient and family
- Answer patient and family questions, be sure informed consent is in record
- Speak to anesthesiologist about expected length of procedure and any special concerns about this particular patient (teeth, positioning, unusual medical problems)
- Position patient on operating table
- Verify that all necessary instruments and prosthetic components are available

Intra-service work- Skin to skin:

- A Foley catheter is placed
- With patient in lithotomy position incision is made and urethral cuff is delicately mobilized
- Cuff and tubing are freed from urethra
- Patient is repositioned supine and re-prepped and draped
- Infra pubic incision is made
- Electrocautery dissection is done to avoid cutting the tubing
- Rectus muscles are opened and reservoir is removed
- Scrotal pouch is dissected and pump activation-deactivation valve is removed
- Wound is irrigated
- Closure is done in usual fashion

Post-op Same day work through discharge from recovery

AUA

- Apply dressings
- Assist in transfer of patient from operating table to post-op stretcher
- Accompany anesthesiologist with patient to recovery area
- Assist in transfer of patient to recovery area bed
- Write post-op orders
- Review recovery area care and medications with staff
- Meet with family and discuss the procedure, expected outcome, planned post operative care in hospital and out of hospital
- Discuss procedure with patient as necessary in recovery area when awake
- Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)
- Dictate detailed operative narrative

Post-op Same day work after discharge from recovery

- Examine patient, check wound and patient progress
- Review patient hospital medical record notes (nursing, pharmacy, dietary, discharge planner)
- Answer patient and family questions
- Answer nursing and other staff questions
- Write any further necessary orders
- Write note in progress note section of medical record

Post-op Other Hospital Work – *Beginning on post op-day 1, until discharge day*

- Examine and talk to patient
- Check wounds and dressings
- Discuss patient progress with patient and family
- Review all patient hospital medical record notes
- Discuss post operative care of wound and prosthesis at home
- Answer nursing and other staff questions
- Answer patient and family questions
- Write orders in medical record
- Write progress notes

Discharge day work:

- Examine and talk with patient and family
- Check wounds and patient progress
- Review all patient hospital medical records
- Answer patient and family questions
- Write orders for post-discharge care
- Write prescriptions for post-op medications
- Discuss post-op care of prosthesis with patient and family
- Dictate detailed hospital discharge summary

Post-op Office work- *After discharge from hospital:*

- Examine patient, check vital signs
- Talk with patient and family
- Answer questions from patient and family
- Write necessary prescriptions
- Remove sutures
- Schedule next office visit
- Mark appropriate diagnosis and CPT code on Superbill
- Dictate patient progress notes for office medical record
- Dictate letter to referring physician

SURVEY DATA:

AUA

Presenters: James B. Regan, MD & Jeffrey A. Dann, MD**Specialty:** American Urological Association**Type of Sample:** Mixed-panel/random **Sample Size:** 60**Response Rate:** 50% (30/60)

	Low	25 th %	Median	75 %	High
Survey RVW	6.6	10.23	13.17	13.21	14.00
Pre-Service Time	15	50	- 50	80	135
Intra-Service Time	45	90	100	118	140

Post-Service:	Total Time	CPT code/# of visits
Immed. Post-Service	30	
Critical Care		0
Other Hospital	19	1- 99231
Discharge Day Mgmt	36	1- 99238
Office Visits	61	1- 99212, 2-99213

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	% RESP	GLOBE
53447	Removal, repair, or replacement of inflatable sphincter including pump and/or reservoir and/or cuff	13.17	71%	090
54407	Removal, repair, or replacement of inflatable (multi-component) penile prosthesis, including pump and/or reservoir and/or cylinders	13.34	1%	090
53449	Surgical correction for hydraulic abnormality of inflatable sphincter device	9.70	1%	090

RELATIONSHIP OF CODE BRING REVIEWED TO KEY REFERENCE SERVICE(S):**INTENSITY/COMPLEXITY MEASURES (mean)****TIME SEGMENTS****Svy CPT****534X1****Reference CPT****53447**

Pre-service	3.32	3.41
Intra-service	3.10	3.10
Post-service	2.58	2.59

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.58	3.72
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.19	3.29
Urgency of medical decision making	3.35	3.55

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.42	3.66
Physical effort required	3.78	3.62

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.16	3.38
Outcome depends on the skill and judgment of physician	3.32	3.38
Estimated risk of malpractice suit with poor outcome	2.80	3.07

ADDITIONAL RATIONALE

The workgroup felt that the 25th percentile more accurately reflected the physician time and work.

IWPUT/BUILDING BLOCK METHOD

SURVEY RVW =	RVW 13.17
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PRE-SERVICE	TIME	INTENSITY	(= time x intensity)
Day prior evaluation	0	0.0224	0.00
Same day evaluation	20	0.0224	0.45
Scrub, prep	30	0.0081	0.24
TOTAL PRE-SERVICE		RVW=	1.17

POST SERVICE			
Immediate hospital	30	0.0224	0.67
	Visit n	E&M RVW	(= n x E&M RVW)
Subsequent hospital			
ICU 99291	0.0	4.00	0.00
Room 99233	0.0	1.51	0.00
Room 99232	0.0	1.06	0.00
Room 99231	1.0	0.64	0.64
Discharge 99238	1.0	1.28	1.28
Subsequent office			
99215	0.0	1.77	0.00
99214	0.0	1.10	0.00
99213	2.0	0.67	1.34
99212	1.0	0.45	0.45
99211	0.0	0.17	0.00
TOTAL POST SERVICE		RVW =	4.38

	TIME	IWPUT	
INTRASERVICE	90	0.057	5.16

FREQUENCY INFORMATION

How was this procedure 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

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.

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

Medicare frequency 1,000

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

REFERENCE SERVICE LIST- Please see the AUA Reference Service List

Practice Expense Summary – Clinical Labor	
CPT code: 534X1 – Removal of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff	
Tracking #: X2	
Global Period: 090	
	Out-of-Office
Staff Type	RN/LPN/MA
Pre-service time	60
Service period	
Coordination of Care by staff in the physician's office during the service period (for facility services)	
Post-service time (excluding time of office visits)	8
Total Number of office visits	1-99212 2-99213
Total time of office visits	99
PRE-SERVICE PERIOD	
Start: Following visit when decision for surgery or procedure made	
1. Complete pre-service diagnostic & referral forms	5
2. Coordinate pre-procedure or pre-surgery services	20
3. Schedule space and equipment in facility	8
4. Office visit before surgery/procedure to review test and exam results	
5. Provide pre-service education/obtain consent	20
6. Follow-up phone calls & prescriptions	7
Other Pre-Service Activities (please specify):	
End: When patient enters hospital or office for surgery/procedure	
SERVICE PERIOD	
Start: With admission to hospital, ASC, or office for procedure	
<i>Pre-service services</i>	
1. Review charts	
2. Greet patient and provide gowning	
3. Obtain vital signs	
4. Provide pre-service education/obtain consent	
5. Prepare room, equipment, supplies	
6. Prepare and position patient/monitor patient/set up IV	
7. Sedate/apply anesthesia	
<i>Intra-service</i>	
8. Assist physician in performing procedure/surgery	
<i>Post-service</i>	
9. Monitor patient following service/check tubes, monitors, drains	
10. Clean room/equipment	
11. Assist with ICU or hospital visits	
12. Complete diagnostic forms, lab & x-ray requisitions	
13. Review/read x-ray, lab, and pathology reports	
14. (Discharge day mgmt services) Check dressings & wound/home care instructions/coordinate office visits/prescriptions	
15. Coordination of in-facility care by staff in office	
Other service period activities (please specify):	
End: With discharge from hospital, ASC, or office	
POST-SERVICE PERIOD	
Start: After discharge from hospital, ASC, or office	
1. Conduct phone calls/call in prescriptions	8
2. 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/equipment, check supplies	
Coordinate home or outpatient care	
3. Conduct phone calls between office visits	
Other post-service activities (please specify):	
End: With last office visit before end of global period	

CPT code: 534X1, Removal of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff

American Urological Association

Practice Expense Summary – Supplies & Equipment Out of Office

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	MMSP	3		
	Basic Post-Operative Incision Care Kit (1 staple, 1 suture removal kit)	2		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Exam Table	1			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

CPT Code: 53447

Global: 090

Survey Median RVW: 14.08

RUC Recommended RVW: = 13.49

CPT Descriptor: Removal and replacement of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff at the same operative session

Tracking Code: X3

Survey Vignette (Typical Patient)

Sixty-year-old male, status post radical retropubic prostatectomy, for confined disease, who had an artificial urinary sphincter subsequently placed one year postoperatively. Five years postoperative, the patient has experienced increased incontinence. Incontinence is apparently stress related without evidence of a significant urgency component. There is no evidence of hematuria or urinary tract infection. Exam reveals a sphincter prosthesis with demonstrable stress incontinence without activation of the device. With activation, incontinence is worse. Sphincter cycles well without evidence of decompression.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service Work- Day before surgery:

- Review pre-op lab results
- Review medical record
- Write pre-op orders (to be faxed to hospital)
- Check to be sure necessary prosthesis components are at hospital

Pre-service work- Day of surgery:

- Change into scrub cloths
- Review surgical procedure, post-op recovery in and out of hospital with patient and family
- Answer patient and family questions, be sure informed consent is in record
- Speak to anesthesiologist about expected length of procedure and any special concerns about this particular patient (teeth, positioning, unusual medical problems)
- Position patient on operating table
- Verify that all necessary instruments and prosthetic components are available

Intra-service work- Skin to skin:

- A Foley catheter is placed
- With patient in lithotomy position, a perineal incision is made and urethral cuff is delicately mobilized
- Cuff and tubing are freed from urethra
- A new cuff is very carefully placed around the urethra
- The new tubing is placed alongside the old tubing through the inguinal ring
- Patient is repositioned supine and re-prepped and draped
- Infra pubic incision is made
- Electrocautery dissection is done to avoid cutting the tubing
- Rectus muscles are opened and reservoir is removed
- Scrotal pouch is dissected and the pump/activation-deactivation system is removed
- The wound and prosthetic components are irrigated throughout the procedure with antibiotic solution spray
- New reservoir is placed beneath rectus muscles, space is closed
- New pump/activation-deactivation system is placed
- System is filled with fluid and connections are made
- System is tested
- Wound is irrigated

- Closure is done in usual fashion

Post-op Same day work through discharge from recovery

- Apply dressings
- Assist in transfer of patient from operating table to post-op stretcher
- Accompany anesthesiologist with patient to recovery area
- Assist in transfer of patient to recovery area bed
- Write post-op orders
- Review recovery area care and medications with staff
- Meet with family and discuss the procedure, expected outcome, planned post operative care in hospital and out of hospital
- Discuss procedure with patient as necessary in recovery area when awake
- Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)
- Dictate detailed operative narrative

Post-op Same day work after discharge from recovery

- Examine patient, check wound and patient progress
- Review patient hospital medical record notes (nursing, pharmacy, dietary, discharge planner)
- Answer patient and family questions
- Answer nursing and other staff questions
- Write any further necessary orders
- Write note in progress note section of medical record

Post-op Other Hospital Work – Beginning on post op-day 1, until discharge day

- Examine and talk to patient
- Check wounds and dressings
- Discuss patient progress with patient and family
- Review all patient hospital medical record notes
- Discuss post operative care of wound and prosthesis at home
- Answer nursing and other staff questions
- Answer patient and family questions
- Write orders in medical record
- Write progress notes

Discharge day work:

- Examine and talk with patient and family
- Check wounds and patient progress
- Review all patient hospital medical records
- Answer patient and family questions
- Write orders for post-discharge care
- Write prescriptions for post-op medications
- Discuss post-op care of prosthesis with patient and family
- Dictate detailed hospital discharge summary

Post-op Office work- After discharge from hospital:

- Examine patient, check vital signs
- Talk with patient and family
- Answer questions from patient and family
- Write necessary prescriptions
- Remove sutures
- Schedule next office visit
- Mark appropriate diagnosis and CPT code on Superbill
- Dictate patient progress notes for office medical record
- Dictate letter to referring physician

SURVEY DATA:**Presenters:** James B. Regan, MD & Jeffrey A. Dann, MD**Specialty:** American Urological Association**Type of Sample:** Mixed-panel/random **Sample Size:** 60**Response Rate:** 52% (31/60)

	Low	25 th %	Median	75 %	High
Survey RVW	13.17	13.49	14.08	15.38	21.00
Pre-Service Time	15	46	50	85	160
Intra-Service Time	70	90	140	150	210

Post-Service:	Total Time	CPT code/# of visits
Immed. Post-Service	30	
Critical Care		0
Other Hospital	19	1- 99231
Discharge Day Mgmt	36	1- 99238
Office Visits	61	1- 99212, 2- 99213

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	% RESP	GLOBE
53447	Removal, repair, or replacement of inflatable sphincter including pump and/or reservoir and/or cuff	13.17	46%	090
53445	Operation for correction of urinary incontinence with placement of inflatable urethral or bladder neck sphincter, including placement of pump and/or reservoir	14.06	43%	090
54407	Removal, repair, or replacement of inflatable (multi-component) penile prosthesis, including pump and/or reservoir and/or cylinders	13.34	1%	090

RELATIONSHIP OF CODE BRING REVIEWED TO KEY REFERENCE SERVICE(S):**INTENSITY/COMPLEXITY MEASURES (mean)****TIME SEGMENTS**

	Svy CPT 53447	Reference CPT 53447
Pre-service	3.86	3.59
Intra-service	3.69	3.44
Post-service	2.69	2.67

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.24	3.89
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.76	3.59
Urgency of medical decision making	4.17	3.85

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.29	4.11
Physical effort required	3.70	3.71

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.52	4.10
Outcome depends on the skill and judgment of physician	3.74	3.41
Estimated risk of malpractice suit with poor outcome	3.30	2.97

ADDITIONAL RATIONALE-**IWPUT/BUILDING BLOCK METHOD**

SURVEY RVW =	RVW 14.08
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PRE-SERVICE	TIME	INTENSITY	(= time x intensity)
Day prior evaluation	0	0.0224	0.00
Same day evaluation	20	0.0224	0.45
Scrub, prep	30	0.0081	0.24
TOTAL PRE-SERVICE		RVW=	0.69

POST SERVICE			
Immediate hospital	30	0.0224	0.67
	Visit n	E&M RVW	(= n x E&M RVW)
Subsequent hospital			
ICU 99291	0.0	4.00	0.00
Room 99233	0.0	1.51	0.00
Room 99232	0.0	1.06	0.00
Room 99231	1.0	0.64	0.64
Discharge 99238	1.0	1.28	1.28
Subsequent office			
99215	0.0	1.77	0.00
99214	0.0	1.10	0.00
99213	2.0	0.67	1.34
99212	1.0	0.45	0.45
99211	0.0	0.17	0.00
TOTAL POST SERVICE		RVW =	4.38

	TIME	IWPUT	
INTRASERVICE	140	0.064	9.01

FREQUENCY INFORMATION

How was this 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

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

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 Medicare Frequency 1,000

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

REFERENCE SERVICE LIST- Please see AUA Reference Service List

Practice Expense Summary – Clinical Labor	
CPT code: 53447 – Removal of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff	
Tracking #: X3	
Global Period: 090	
	Out-of-Office
Staff Type	RN/LPN/MA
Pre-service time	60
Service period	
Coordination of Care by staff in the physician's office during the service period (for facility services)	
Post-service time (excluding time of office visits)	8
Total Number of office visits	1-99212 2-99213
Total time of office visits	99
PRE-SERVICE PERIOD	
Start: Following visit when decision for surgery or procedure made	
1. Complete pre-service diagnostic & referral forms	5
2. Coordinate pre-procedure or pre-surgery services	20
3. Schedule space and equipment in facility	8
4. Office visit before surgery/procedure to review test and exam results	
5. Provide pre-service education/obtain consent	20
6. Follow-up phone calls & prescriptions	7
Other Pre-Service Activities (please specify):	
End: When patient enters hospital or office for surgery/procedure	
SERVICE PERIOD	
Start: With admission to hospital, ASC, or office for procedure	
Pre-service services	
1. Review charts	
2. Greet patient and provide gowning	
3. Obtain vital signs	
4. Provide pre-service education/obtain consent	
5. Prepare room, equipment, supplies	
6. Prepare and position patient/monitor patient/set up IV	
7. Sedate/apply anesthesia	
Intra-service	
8. Assist physician in performing procedure/surgery	
Post-service	
9. Monitor patient following service/check tubes, monitors, drains	
10. Clean room/equipment	
11. Assist with ICU or hospital visits	
12. Complete diagnostic forms, lab & x-ray requisitions	
13. Review/read x-ray, lab, and pathology reports	
14. (Discharge day mgmt services) Check dressings & wound/home care instructions/coordinate office visits/prescriptions	
15. Coordination of in-facility care by staff in office	
Other service period activities (please specify):	
End: With discharge from hospital, ASC, or office	
POST-SERVICE PERIOD	
Start: After discharge from hospital, ASC, or office	
1. Conduct phone calls/call in prescriptions	8
2. 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/equipment, check supplies	
Coordinate home or outpatient care	
3. Conduct phone calls between office visits	
Other post-service activities (please specify):	
End: With last office visit before end of global period	

Practice Expense Summary – Supplies & Equipment Out of Office

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	MMSP	3		
	Basic Post-Op. Incision Care Kit (1 suture, 1 staple removal kit)	2		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Exam Table	1			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

(April 2001)

CPT Code: 534X2

Global: 090

Survey Median RVW: 15.00
75th Percentile RVW: 21.15

RUC Recommended RVW: 21.15

CPT Descriptor: Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir and cuff through an infected field at the same operative session including irrigation and debridement of infected tissue

Tracking Code: X4

Survey Vignette (Typical Patient)

Sixty-two-year-old male, status post sphincter implantation for post prostatectomy incontinence two years ago. The patient subsequently developed edema and erythema of the scrotum. The patient has a low-grade fever. Exam reveals some scrotal edema and skin fixation. The sphincter pump is notable, palpated, and apparently fixed to the skin. The patient has a low-grade fever, but is not systemically toxic.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service Work- Day before surgery:

- Review pre-op lab results
- Review medical record
- Write pre-op orders (to be faxed to hospital)
- Check to be sure necessary prosthesis components are at hospital

Pre-service work- Day of surgery:

- Change into scrub cloths
- Review surgical procedure, post-op recovery in and out of hospital with patient and family
- Answer patient and family questions, be sure informed consent is in record
- Speak to anesthesiologist about expected length of procedure and any special concerns about this particular patient (teeth, positioning, unusual medical problems)
- Position patient on operating table
- Verify that all necessary instruments and prosthetic components are available

Intra-service work- Skin to skin:

- A Foley catheter is placed
- With patient in lithotomy position incision is made and urethral cuff is delicately mobilized
- Cuff and tubing are freed from urethra
- The area is debrided as necessary
- The wound is irrigated with antibiotic solution
- Jackson Pratt drains are placed for irrigation with antibiotic solution
- A new cuff is very carefully placed around the urethra
- The new tubing is placed alongside the old tubing through the inguinal ring
- The perineal incision is closed
- Patient is repositioned supine and re-prepped and draped
- Infra pubic incision is made
- Electrocautery dissection is done to avoid cutting the tubing
- Rectus muscles are opened and reservoir is removed
- Scrotal pouch is dissected and the pump/activation-deactivation system is removed
- The wound and prosthetic components are irrigated throughout the procedure with antibiotic solution spray
- The entire wound is irrigated with 10 (ten) liters of antibiotic solution
- New reservoir is placed beneath rectus muscles, space is closed
- New pump/activation-deactivation system is placed
- System is filled with fluid and connections are made
- System is tested
- Wound is irrigated
- Closure is done in usual fashion

- A new reservoir is placed beneath the rectus muscles
- Jackson Pratt drains (3.2 mm round) are placed in appropriate areas for post operative irrigation with antibiotic solutions and drainage
- The subcutaneous tissues are closed
- Drains are brought out through separate stab wounds and sutured in place
The wound is closed in usual fashion

Post-op Same day work through discharge from recovery

- Apply dressings
- Assist in transfer of patient from operating table to post-op stretcher
- Accompany anesthesiologist with patient to recovery area
- Assist in transfer of patient to recovery area bed
- Write post-op orders
- Review recovery area care and medications with staff
- Meet with family and discuss the procedure, expected outcome, planned post operative care in hospital and out of hospital
- Discuss procedure with patient as necessary in recovery area when awake
- Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)
- Dictate detailed operative narrative

Post-op Same day work after discharge from recovery

- Examine patient, check wound and patient progress
- Review patient hospital medical record notes (nursing, pharmacy, dietary, discharge planner)
- Answer patient and family questions
- Answer nursing and other staff questions
- Write any further necessary orders
- Write note in progress note section of medical record

Post-op Other Hospital Work – *Beginning on post op-day 1, until discharge day*

- Examine and talk to patient
- Check wounds and dressings
- Discuss patient progress with patient and family
- Review all patient hospital medical record notes
- Discuss post operative care of wound and prosthesis at home
- Answer nursing and other staff questions
- Answer patient and family questions
- Write orders in medical record
- Write progress notes

Discharge day work:

- Examine and talk with patient and family
- Check wounds and patient progress
- Review all patient hospital medical records
- Answer patient and family questions
- Write orders for post-discharge care
- Write prescriptions for post-op medications
- Discuss post-op care of prosthesis with patient and family
- Dictate detailed hospital discharge summary

Post-op Office work- *After discharge from hospital:*

- Examine patient, check vital signs
- Talk with patient and family
- Answer questions from patient and family
- Write necessary prescriptions
- Remove sutures
- Schedule next office visit
- Mark appropriate diagnosis and CPT code on Superbill
- Dictate patient progress notes for office medical record
- Dictate letter to referring physician

SURVEY DATA:**Presenters:** James B. Regan, MD & Jeffrey A. Dann, MD**Specialty:** American Urological Association**Type of Sample:** Mixed-panel/random **Sample Size:** 60**Response Rate:** 50% (30/60)

	Low	25 th %	Median	75 %	High
Survey RVW	13.34	14.9	15.00	21.15	28.00
Pre-Service Time	25	45	60	65	180
Intra-Service Time	75	120	170	180	250

Post-Service:	Total Time	CPT code/# of visits
Immed. Post-Service	30	
Critical Care		0
Other Hospital	155	5- 99231, 2- 99232
Discharge Day Mgmt	30	1- 99238
Office Visits	84	2- 99213, 1- 99214

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	% RESP	GLOBE
53447	Removal, repair, or replacement of inflatable sphincter including pump and/or reservoir and/or cuff	13.17	48%	090
53445	Operation for correction of urinary incontinence with placement of inflatable urethral or bladder neck sphincter, including placement of pump and/or reservoir	14.06	31%	090
50220	Nephrectomy, including partial ureterectomy, an approach including rib resection	17.15	10%	090

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**INTENSITY/COMPLEXITY MEASURES (mean)****TIME SEGMENTS**

	Svy CPT 534X2	Reference CPT 53447
Pre-service	3.83	2.90
Intra-service	4.21	3.10
Post-service	4.22	2.69

MENTAL EFFORT AND JUDGMENT

	Svy CPT 534X2	Reference CPT 53447
The number of possible diagnosis and/or the number of management options that must be considered	4.10	3.07
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.83	2.86
Urgency of medical decision making	4.14	2.66

TECHNICAL SKILL/PHYSICAL EFFORT

	Svy CPT 534X2	Reference CPT 53447
Technical skill required	4.24	3.28
Physical effort required	4.10	3.00

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.82	3.31
Outcome depends on the skill and judgment of physician	4.31	3.48
Estimated risk of malpractice suit with poor outcome	5.00	3.10

ADDITIONAL RATIONALE- The workgroup felt that the surveyees did not recognize the work of the post op. visits. Even using the 75th percentile data the IWPUT is low at 0.058. The workgroup feels that the intensity of this procedure is about 0.080. This requires an RVW of 24.86.

IWPUT/BUILDING BLOCK METHOD

SURVEY (75th % percentile) RVW =	RVW 21.15
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PRE-SERVICE	TIME	INTENSITY	(= time x intensity)
Day prior evaluation	0	0.0224	0.00
Same day evaluation	30	0.0224	0.67
Scrub, prep	35	0.0081	0.28
TOTAL PRE-SERVICE		RVW=	0.96

POST SERVICE			
Immediate hospital	30	0.0224	0.67
	Visit n	E&M RVW	(= n x E&M RVW)
Subsequent hospital			
ICU 99291	0.0	4.00	0.00
Room 99233	0.0	1.51	0.00
Room 99232	2.0	1.06	2.12
Room 99231	5.0	0.64	3.20
Discharge 99238	1.0	1.28	1.28
Subsequent office			
99215	0.0	1.77	0.00
99214	1.0	1.10	1.10
99213	2.0	0.67	1.34
99212	0.0	0.43	0.00
99211	0.0	0.17	0.00
TOTAL POST SERVICE		RVW =	9.71

	TIME	IWPUT	
INTRASERVICE	180	0.058	10.48

FREQUENCY INFORMATION

How was this procedure 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 Sometimes

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

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

Medicare Frequency 1,000

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

REFERENCE SERVICE LIST- Please see AUA Reference Service List

Practice Expense Summary – Clinical Labor	
CPT code: 534X2 – Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir, and cuff through an infected field at the same operative session including irrigation and debridement of infected tissue.	
Tracking #: X4	
Global Period: 090	
	Out-of-Office
Staff Type	RN/LPN/MA
Pre-service time	60
Service period	
Coordination of Care by staff in the physician's office during the service period (for facility services)	
Post-service time (excluding time of office visits)	8
Total Number of office visits	1-99212 2-99213 1-99214
Total time of office visits	452 125
PRE-SERVICE PERIOD	
Start: Following visit when decision for surgery or procedure made	
1. Complete pre-service diagnostic & referral forms	5
2. Coordinate pre-procedure or pre-surgery services	20
3. Schedule space and equipment in facility	8
4. Office visit before surgery/procedure to review test and exam results	
5. Provide pre-service education/obtain consent	20
6. Follow-up phone calls & prescriptions	7
Other Pre-Service Activities (please specify):	
End: When patient enters hospital or office for surgery/procedure	
SERVICE PERIOD	
Start: With admission to hospital, ASC, or office for procedure	
<i>Pre-service services</i>	
1. Review charts	
2. Greet patient and provide gowning	
3. Obtain vital signs	
4. Provide pre-service education/obtain consent	
5. Prepare room, equipment, supplies	
6. Prepare and position patient/monitor patient/set up IV	
7. Sedate/apply anesthesia	
<i>Intra-service</i>	
8. Assist physician in performing procedure/surgery	
<i>Post-service</i>	
9. Monitor patient following service/check tubes, monitors, drains	
10. Clean room/equipment	
11. Assist with ICU or hospital visits	
12. Complete diagnostic forms, lab & x-ray requisitions	
13. Review/read x-ray, lab, and pathology reports	
14. (Discharge day mgmt services) Check dressings & wound/home care instructions/coordinate office visits/prescriptions	
15. Coordination of in-facility care by staff in office	
Other service period activities (please specify):	
End: With discharge from hospital, ASC, or office	
POST-SERVICE PERIOD	
Start: After discharge from hospital, ASC, or office	
1. Conduct phone calls/call in prescriptions	8
2. 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/equipment, check supplies	
Coordinate home or outpatient care	
3. Conduct phone calls between office visits	
Other post-service activities (please specify):	
End: With last office visit before end of global period	

Practice Expense Summary – Supplies & Equipment Out of Office

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)	
	MMSP	43			
	Basic Post-Op Incision Care Kit (1 suture, 1 staple removal kit)	2			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Exam Table				

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

April 2001

Transurethral Destruction of Prostate by Water-Induced Thermotherapy

A new CPT code 53853 *Transurethral destruction of prostate tissue; by water-induced thermotherapy* was developed to describe the new technology in the destruction of prostate tissue using water-induced thermotherapy.

The RUC reviewed the survey data from 45 urologist that perform the procedure and had some concerns about possible survey bias, as many or all of the survey respondents have used this particular device for the procedure. The intra-service time and intensity for this code in relation to its reference code 53850 *Transurethral destruction of prostate; by microwave thermotherapy* (work relative value = 9.45) and code 52310 *Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); simple* (work relative value = 2.81), could not support the specialty recommended work RVU of 9.45. The RUC also reviewed several different codes across specialties and believed that code 54670, *Suture or repair of testicular injury* (work relative value = 6.41), could be used as an anchor code with similar physician work and time, with 30 minutes pre-service, 60 minutes intra-service, and 43 minutes post service time. The pre, post, and intra-service time provided the committee a crosswalk to 53853. In addition to the relativity to 54670 in time, the code's inter-operative work per unit of time was similar to 53853 as well.

In addition, when 53853 is compared to its reference code, 53850, the survey results show 30 minutes less of pre, intra, and post service time for the new code. The RUC then viewed the value of 53853 at 2/3 of the value of the reference code, resulting in a relative value of 6.44. The 2/3 of the reference code value provided the RUC with further support for the crosswalk to code 54670. The RUC believed that since the work of 54670 was similar to code 53853, the RUC recommends a value of 6.41 RVUs for code 53853. **The RUC recommends a work relative value of 6.41 for CPT code 53853.**

Practice Expense

The direct practice expense inputs are attached to this recommendation. The practice expenses for CPT code 53853 were reviewed by the RUC and recommended that the following be excluded;

Gloves-non-sterile
30 cc syringe
10 cc syringe

Gloves - sterile

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
53850		Transurethral destruction of prostate tissue; by microwave thermotherapy	090	9.45 (No Change)
53852		by radiofrequency thermotherapy	090	9.88 (No Change)
• 53853	A1	Transurethral destruction of prostate tissue; by water-induced thermotherapy	090	6.41

CPT Code: 5385X

Global: 090

Surveyed Median RVW: 9.45

RUC Recommended RVW = 6.41

CPT Descriptor: Transurethral Destruction of Prostate Tissue (Water-Induced Thermotherapy)

Tracking Code: A1

Survey Vignette (Typical Patient)

A 65-year-old male complaining of frequent and urgent need to urinate while producing only a scant and weak flow. A PSA test was not remarkable. A transrectal ultrasound (TRUS) revealed an enlarged prostate. The patient has been informed about various treatment options.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service Work- Day before surgery:

- Review pre-op lab results
- Review medical record
- Check to be sure necessary equipment/supplies are available

Pre-service work- Day of surgery:

- Review surgical procedure, post-op recovery with patient and family
- Answer patient and family questions, be sure informed consent is in record
- Position patient
- Verify that all necessary instruments are available

Intra-service work- Skin to skin:

- Anesthetic Gel is placed into the urethra
- The WIT treatment catheter is introduced into the urethra and bladder
- The bladder locating catheter balloon is inflated with air
- The WIT Tiemann tip stylet is removed
- The catheter is taped to the patient's leg
- The pump is activated which circulates the 60 degree centigrade water through the catheter and treatment balloon positioned in the prostate
- Inject additional water into the treatment balloon
- Monitor the system console and the patient for 45 minute treatment cycle
- At regular intervals, check treatment catheter position
- Deflate air from locating balloon and treatment balloon and remove treatment catheter
- Place Foley catheter at end of procedure

Post-op Same day work through discharge from recovery

- Assist in transfer of patient from procedure table to post-op stretcher
- Assist in transfer of patient to recovery area
- Write post-op orders
- Review recovery area care and medications with staff
- Meet with family and discuss the procedure, expected outcome, planned post operative care
- Discuss procedure with patient as necessary
- Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)
- Dictate detailed operative narrative

Post-op Same day work after discharge from recovery

- Examine patient, check wound and patient progress
- Review patient hospital medical record notes (nursing, pharmacy, dietary, discharge planner)
- Answer patient and family questions
- Answer nursing and other staff questions
- Write any further necessary orders
- Write note in progress note section of medical record

Discharge day work:

- Examine and talk with patient and family
- Check wounds and patient progress
- Review all patient hospital medical records
- Answer patient and family questions
- Write orders for post-discharge care
- Write prescriptions for post-op medications
- Dictate detailed hospital discharge summary

Post-op Office work- *After discharge from hospital:*

- Examine patient, check vital signs
- Talk with patient and family
- Answer questions from patient and family
- Write necessary prescriptions
- Schedule next office visit
- Mark appropriate diagnosis and CPT code on Superbill
- Dictate patient progress notes for office medical record
- Dictate letter to referring physician

SURVEY DATA:

Presenters: James B. Regan, MD & Jeffrey A. Dann, MD

Specialty: American Urological Association

Type of Sample: Mixed-panel/random **Sample Size:** 68

Response Rate: 66% (45/68)

	Low	25 th %	Median	75 %	High
Survey RVW	2.3	8.75	9.45	9.83	12.00
Pre-Service Time	10	30	45	60	180
Intra-Service Time	20	55	60	78	120

Post-Service:	Total Time	CPT code/# of visits
Immed. Post-Service	15 minutes	
Critical Care		0
Other Hospital		0
Discharge Day Mgmt	18	.5- 99238
Office Visits	53	1- 99213, 2- 99212

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	% RESP	GLOBE
53850	Transurethral destruction of prostate tissue; by microwave thermotherapy	9.45	53%	090
53852	Transurethral destruction of prostate tissue; by radiofrequency thermotherapy	9.88	20%	090
52510	Transurethral balloon dialation of the prostatic urethra, any method	6.72	13%	090

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

INTENSITY/COMPLEXITY MEASURES (mean)

TIME SEGMENTS

Svy CPT

5385X

Reference CPT

53850

Pre-service	3.25	3.25
Intra-service	2.75	2.67
Post-service	2.58	2.58

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.50	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.5	3.42
Urgency of medical decision making	2.33	2.33

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	2.83	2.75
Physical effort required	2.33	2.33

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	2.75	2.67
Outcome depends on the skill and judgment of physician	3.25	3.00
Estimated risk of malpractice suit with poor outcome	2.67	2.58

ADDITIONAL RATIONALE- The AUA workgroup felt that the intensity (IWPUT) of 0.092 was too high and that the physician work was less than the reference procedure 53850. The 25th percentile RVW of 8.75 yields a lower IWPUT of 0.081.

IWPUT/BUILDING BLOCK METHOD

SURVEYED RVW =	RVW 9.45
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PRE-SERVICE	TIME	INTENSITY	(= time x intensity)
Day prior evaluation	10	0.0224	0.22
Same day evaluation	15	0.0224	0.34
Scrub, prep	20	0.0081	0.16
TOTAL PRE-SERVICE		RVW=	0.72

POST SERVICE			
Immediate hospital	15	0.0224	0.34
	Visit n	E&M RVW	(= n x E&M RVW)
Subsequent hospital			
ICU 99291	0.0	4.00	0.00
Room 99233	0.0	1.51	0.00
Room 99232	0.0	1.06	0.00
Room 99231	0.0	0.64	0.00
Discharge 99238	1.0	.64	.64
Subsequent office			
99215	0.0	1.77	0.00
99214	0.0	1.10	0.00
99213	1.0	0.67	0.67
99212	2.0	0.45	0.90
99211	0.0	0.17	0.00
TOTAL POST SERVICE		RVW =	3.19

	TIME	IWPUT	
INTRASERVICE	60	0.092	5.54

FREQUENCY INFORMATION

How was this procedure 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

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

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

Medicare Frequency, 15,000

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

REFERENCE SERVICE LIST- Please see the AUA Reference Service List

Practice Expense Summary – Clinical Labor		
CPT code: 5385X – <i>Water induced thermotherapy (WIT)</i>		
Tracking #: A1		
Global Period: 090		
	In Office	Out-of-Office
Staff Type	RN/LPN/MA	RN/LPN/MA
Pre-service time	35	60
Service period		
Coordination of Care by staff in the physician's office during the service period (for facility services)		
Post-service time (excluding time of office visits)	4	4
Total Number of office visits		1-99213 2-99212
Total time of office visits		90
PRE-SERVICE PERIOD		
Start: Following visit when decision for surgery or procedure made		
1. Complete pre-service diagnostic & referral forms	5	5
2. Coordinate pre-procedure or pre-surgery services	10	20
3. Schedule space and equipment in facility		8
4. Office visit before surgery/procedure to review test and exam results		
5. Provide pre-service education/obtain consent	10	20
6. Follow-up phone calls & prescriptions	10	7
Other Pre-Service Activities (please specify):		
End: When patient enters hospital or office for surgery/procedure		
SERVICE PERIOD		
Start: With admission to hospital, ASC, or office for procedure		
<i>Pre-service services</i>		
1. Review charts	2	
2. Greet patient and provide gowning	3	
3. Obtain vital signs	5	
4. Provide pre-service education/obtain consent		
5. Prepare room, equipment, supplies	5	
6. Prepare and position patient/monitor patient/set up IV	7	
7. Sedate/apply anesthesia		
<i>Intra-service</i>		
8. Assist physician in performing procedure/surgery	35	
<i>Post-service</i>		
9. Monitor patient following service/check tubes, monitors, drains	5	
10. Clean room/equipment	4	
11. Assist with ICU or hospital visits		
12. Complete diagnostic forms, lab & x-ray requisitions	3	
13. Review/read x-ray, lab, and pathology reports		
14. (Discharge day mgmt services) Check dressings & wound/home care instructions/coordinate office visits/prescriptions	10	
15. Coordination of in-facility care by staff in office		
Other service period activities (please specify):		
End: With discharge from hospital, ASC, or office		
POST-SERVICE PERIOD		
Start: After discharge from hospital, ASC, or office		
1. Conduct phone calls/call in prescriptions	4	4
2. 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/equipment, check supplies		
Coordinate home or outpatient care		
3. Conduct phone calls between office visits		
Other post-service activities (please specify):		
End: With last office visit before end of global period		

Practice Expense Summary – Supplies & Equipment In Office

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	MMSP	4		
	Treatment catheter	1		
	Foley catheter	1		
	Cysto pack	1		
	60 Ccc Toomey syringe	1		
	Tape	12	Inches	
	30 cc syringe	4		
	10 cc syringe	4		
	Gloves, non-sterile	2	Pair	
	Gloves, sterile	2	Pair	
	Urinary drainage bag – leg	1		
	Urinary drainage bag – night	1		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Microwave thermotherapy unit	1			
	Exam Table	1			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

Practice Expense Summary – Supplies & Equipment Out of Office

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	MMSP	3		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Exam Table	1			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

The RUC recommends the deletion of the following items from the practice expense of CPT code 5385X.

Tape

Gloves – non-sterile

30 cc syringe

10 cc syringe

Gloves - sterile

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

April 2001

Penile Procedures

Three new CPT codes were created to provide more specificity to procedures involving penile plastic surgery. These codes were appropriately reported using unlisted code 55899 Unlisted procedure, urinary system. Also, code 54161 *Circumcision, surgical excision other than clamp, device or dorsal slit; except newborn*, is a similar service, but would be inappropriate to use.

54162 Lysis or excision of penile post-circumcision adhesions

The RUC reviewed the work of the reference code 54161 *Circumcision, surgical excision other than clamp, device or dorsal slit; except newborn* (work RVU = 3.27), and believed the physician work was very similar, but took less slightly physician time and effort. The RUC thought that 25th percentile of the specialty's survey results correctly valued the code in this case. The RUC in addition, recommended to value this code identically to CPT code 54163 *Repair incomplete circumcision* to prevent any adverse procedural selection between 54162 and 54163. **The RUC recommends a work relative value of 3.00 for CPT code 54162.**

Practice Expense

The RUC recommends practice expense inputs for CPT code 54162 typically performed during an outpatient visit in the facility setting only, and are attached to this recommendation.

54163 Repair incomplete circumcision

The RUC reviewed the work of the reference code 54161 *Circumcision, surgical excision other than clamp, device or dorsal slit; except newborn* (work RVU = 3.27), and believed the physician work was very similar, but took slightly less physician time and effort. The RUC thought that the specialty society's median work RVU of 3.00 correctly valued the code, although the specialty had requested a higher work RVU. The RUC in addition, recommended to value this code identically to CPT code 54162 *Lysis or excision of penile post-circumcision adhesions*. **The RUC recommends a work relative value of 3.00 for CPT code 54163.**

Practice Expense

The RUC recommends the following practice expense inputs for CPT code 54163 typically performed during an outpatient visit in the facility setting only, and are attached to this recommendation.

54164 Frenulotomy of the penis

The RUC reviewed this new code in relation to its reference code 54001 *Slitting of prepuce, dorsal or lateral (separate procedure); except newborn* (work RVU = 2.19). The RUC believed that the work and intensity of the intra-operative work was similar to its reference code, but required more post-operative follow-up care. The RUC believed the that the specialty society's median survey results accurately valued this code. **The RUC recommends a work relative value of 2.50, for CPT codes 54164.**

Practice Expense

The RUC recommends the following practice expense inputs for CPT code 54164 typically performed during an outpatient visit in the facility setting only, and are attached to this recommendation.

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
●54162	L1	Lysis or excision of penile post-circumcision adhesions	010	3.00
●54163	L2	Repair incomplete circumcision	010	3.00
●54164	L3	Frenulotomy of the penis <u>(Do not report with circumcision code 54150-54161, 54162, 54163)</u>	010	2.50

CPT Code: 5416X1

Global: 010

Survey Median RVW: 3.27

RUC Recommended RVW: 3.00

CPT Descriptor: Lysis or excision of penile post-circumcision adhesions Tracking Code: L1

Survey Vignette (Typical Patient)

A four-year-old boy is noted to have a curved erection and an unusual appearing penis. Upon careful inspection it is noted, the foreskin has been incompletely excised and multiple skin bridges attach the left side of the glans penis to the penile shaft skin.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service Work- Day before surgery:

- Review pre-op lab results
- Review medical record
- Write pre-op orders (to be faxed to hospital)
- Check to be sure necessary equipment/supplies are at hospital

Pre-service work- Day of surgery:

- Change into scrub cloths
- Review surgical procedure, post-op recovery in and out of hospital with patient and family
- Answer patient and family questions, be sure informed consent is in record
- Speak to anesthesiologist about expected length of procedure and any special concerns about this particular patient (teeth, positioning, unusual medical problems)
- Position patient on operating table
- Verify that all necessary instruments are available

Intra-service work- Skin to skin:

- A local anesthetic block is administered for post op pain control (this is done after the patient is prepped and draped and under general anesthesia)
- Using loop magnification, multiple adhesions are freed up between the incompletely excised foreskin and the glans penis
- Smegma and debris are removed
- The area is cleansed intra-operatively with Betadine
- The skin bridges are incised
- Bleeders are coagulated
- The remaining foreskin is carefully excised
- Multiple absorbable sutures are placed to reapproximate the penile shaft skin to the mucous membrane skirt of the edge of the remaining foreskin
- Ointment, adaptic and a gauze dressing are applied

Post-op Same day work through discharge from recovery

- Apply dressings
- Assist in transfer of patient from operating table to post-op stretcher
- Accompany anesthesiologist with patient to recovery area
- Assist in transfer of patient to recovery area bed
- Write post-op orders
- Review recovery area care and medications with staff
- Meet with family and discuss the procedure, expected outcome, planned post operative care in hospital and out of hospital
- Discuss procedure with patient as necessary in recovery area when awake
- Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)
- Dictate detailed operative narrative

Post-op Same day work after discharge from recovery

- Examine patient, check wound and patient progress
- Review patient hospital medical record notes (nursing, pharmacy, dietary, discharge planner)
- Answer patient and family questions
- Answer nursing and other staff questions
- Write any further necessary orders
- Write note in progress note section of medical record

Discharge day work:

- Examine and talk with patient and family
- Check wounds and patient progress
- Review all patient hospital medical records
- Answer patient and family questions
- Write orders for post-discharge care
- Write prescriptions for post-op medications
- Dictate detailed hospital discharge summary

Post-op Office work- After discharge from hospital:

- Examine patient, check vital signs
- Talk with patient and family
- Answer questions from patient and family
- Write necessary prescriptions
- Remove sutures
- Schedule next office visit
- Mark appropriate diagnosis and CPT code on Superbill
- Dictate patient progress notes for office medical record
- Dictate letter to referring physician

SURVEY DATA:**Presenters:** James B. Regan, MD & Jeffrey A. Dann, MD**Specialty:** American Urological Association**Type of Sample:** Mixed-panel/random **Sample Size:** 123**Response Rate:** 46% (56/123)

	Low	25 th %	Median	75 %	High
Survey RVW	2.00	3.00	3.27	3.70	6.00
Pre-Service Time	0	20	25	45	90
Intra-Service Time	15	25	30	45	60

Post-Service:	Total Time	CPT code/# of visits
Immed. Post-Service	10	
Critical Care		0
Other Hospital		0
Discharge Day Mgmt	18	.5- 99238
Office Visits		1- 99213

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	% RESP	GLOBE
54161	Circumcision, surgical excision other than clamp, device or dorsal slit; except newborn	3.27	75%	010
54001	Slitting of prepuce, dorsal or lateral (separate procedure); except newborn	2.19	23%	010
54100	Biopsy of penis; cutaneous (separate procedure)	1.90	2%	000

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

<u>INTENSITY/COMPLEXITY MEASURES (mean)</u>	<u>Svy CPT</u>	<u>Reference CPT</u>
<u>TIME SEGMENTS</u>	<u>5416X</u>	<u>54161</u>
Pre-service	2.16	1.98
Intra-service	2.52	2.21
Post-service	2.02	1.19

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	2.70	2.02
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.82	1.79
Urgency of medical decision making	1.66	1.68

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	2.73	2.46
Physical effort required	2.20	2.13

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	2.43	2.20
Outcome depends on the skill and judgment of physician	2.88	2.61
Estimated risk of malpractice suit with poor outcome	2.95	2.91

ADDITIONAL RATIONALE

The intensity of an office visit is 0.031. In order to yield an intensity (IWPUT) of at least 0.031 an intraservice RVW of 0.93 is needed. This would yield a total RVW of 3.44.

IWPUT/BUILDING BLOCK METHOD

PROPOSED RVW =	RVW 3.27
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PRE-SERVICE	TIME	INTENSITY	(= time x intensity)
Day prior evaluation	0	0.0224	0.00
Same day evaluation	10	0.0224	0.22
Scrub, prep	15	0.0081	0.12
TOTAL PRE-SERVICE		RVW=	0.35

POST SERVICE			
Immediate hospital	10	0.0224	0.22
	Visit n	E&M RVW	(= n x E&M RVW)
Subsequent hospital			
ICU 99291	0.0	4.00	0.00
Room 99233	0.0	1.51	0.00
Room 99232	0.0	1.06	0.00
Room 99231	0.0	0.64	0.00
Discharge 99238	1.0	0.64	0.68
Subsequent office			
99215	0.0	1.77	0.00
99214	0.0	1.10	0.00
99213	1.0	0.67	0.67
99212	0.0	0.45	0.00
99211	0.0	0.17	0.00
TOTAL POST SERVICE		RVW =	2.17

	TIME	IWPUT	
INTRASERVICE	30	0.025	0.75

FREQUENCY INFORMATION

How was this procedure 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

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

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

Medicare Frequency. 1,000

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

REFERENCE SERVICE LIST- Please see AUA Master Reference Service List

Practice Expense Summary – Clinical Labor	
CPT code: 5416X1 – <i>Lysis or excision of penile post-circumcision adhesions</i>	
Tracking #: L1	
Global Period: 010	
	Out-of-Office
Staff Type	RN/LPN/MA
Pre-service time	4
Service period	
Coordination of Care by staff in the physician's office during the service period (for facility services)	
Post-service time (excluding time of office visits)	4
Total Number of office visits	1-99213
Total time of office visits	36
PRE-SERVICE PERIOD	
Start: Following visit when decision for surgery or procedure made	
1. Complete pre-service diagnostic & referral forms	4
2. Coordinate pre-procedure or pre-surgery services	
3. Schedule space and equipment in facility	
4. Office visit before surgery/procedure to review test and exam results	
5. Provide pre-service education/obtain consent	
6. Follow-up phone calls & prescriptions	
Other Pre-Service Activities (please specify):	
End: When patient enters hospital or office for surgery/procedure	
SERVICE PERIOD	
Start: With admission to hospital, ASC, or office for procedure	
<i>Pre-service services</i>	
1. Review charts	
2. Greet patient and provide gowning	
3. Obtain vital signs	
4. Provide pre-service education/obtain consent	
5. Prepare room, equipment, supplies	
6. Prepare and position patient/monitor patient/set up IV	
7. Sedate/apply anesthesia	
<i>Intra-service</i>	
8. Assist physician in performing procedure/surgery	
<i>Post-service</i>	
9. Monitor patient following service/check tubes, monitors, drains	
10. Clean room/equipment	
11. Assist with ICU or hospital visits	
12. Complete diagnostic forms, lab & x-ray requisitions	
13. Review/read x-ray, lab, and pathology reports	
14. (Discharge day mgmt services) Check dressings & wound/home care instructions/coordinate office visits/prescriptions	
15. Coordination of in-facility care by staff in office	
Other service period activities (please specify):	
End: With discharge from hospital, ASC, or office	
POST-SERVICE PERIOD	
Start: After discharge from hospital, ASC, or office	
1. Conduct phone calls/call in prescriptions	4
2. 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/equipment, check supplies	
Coordinate home or outpatient care	
3. Conduct phone calls between office visits	
Other post-service activities (please specify):	
End: With last office visit before end of global period	

Practice Expense Summary – Supplies & Equipment Out of Office

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	MMSP	1		
	Basic Post Operative Incision Care Kit suture	1		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Exam Table	1			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

CPT Code: 5416X2

Global: 010

Survey Median RVW: 3.00

RUC Recommended RVW: 3.00

CPT Descriptor: Repair incomplete circumcision for skin bridge adhesions

Tracking Code: L2

Survey Vignette (Typical Patient)

An 18-year-old male (post circumcision at age 2) presents with a broad based skin bridge emitting from the distal penile shaft and attaching to the corona of glans penis. Upon erections, the patient experiences penile discomfort because of these adhesions.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service Work- Day before surgery:

- Review pre-op lab results
- Review medical record
- Write pre-op orders (to be faxed to hospital)
- Check to be sure necessary equipment/supplies are at hospital

Pre-service work- Day of surgery:

- Change into scrub cloths
- Review surgical procedure, post-op recovery in and out of hospital with patient and family
- Answer patient and family questions, be sure informed consent is in record
- Speak to anesthesiologist about expected length of procedure and any special concerns about this particular patient (teeth, positioning, unusual medical problems)
- Position patient on operating table
- Verify that all necessary instruments are available

Intra-service work- Skin to skin:

- A local anesthetic block is administered for post op pain control (this is done after the patient is prepped and draped and under general anesthesia)
- Using loop magnification, multiple adhesions are freed up smegma and debris are removed
- The skin bridge is incised
- Closure of the now separated skin bridge is done in Heineke-Mikulicz fashion to ensure that there will be no post op chordee (curvature) with erection
- Bleeders are coagulated
- Any remaining foreskin is carefully excised
- Ointment, Adaptic and a gauze dressing is applied

Post-op Same day work through discharge from recovery

- Apply dressings
- Assist in transfer of patient from operating table to post-op stretcher
- Accompany anesthesiologist with patient to recovery area
- Assist in transfer of patient to recovery area bed
- Write post-op orders
- Review recovery area care and medications with staff
- Meet with family and discuss the procedure, expected outcome, planned post operative care in hospital and out of hospital
- Discuss procedure with patient as necessary in recovery area when awake
- Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)
- Dictate detailed operative narrative

Discharge day work:

- Examine and talk with patient and family
- Check wounds and patient progress
- Review all patient hospital medical records
- Answer patient and family questions
- Write orders for post-discharge care
- Write prescriptions for post-op medications
- Dictate detailed hospital discharge summary

Post-op Office work- After discharge from hospital:

- Examine patient, check vital signs
- Talk with patient and family
- Answer questions from patient and family
- Write necessary prescriptions
- Remove sutures
- Schedule next office visit
- Mark appropriate diagnosis and CPT code on Superbill
- Dictate patient progress notes for office medical record
- Dictate letter to referring physician

SURVEY DATA:**Presenters:** James B. Regan, MD & Jeffrey A. Dann, MD**Specialty:** American Urological Association**Type of Sample:** Mixed-panel/random **Sample Size:** 123**Response Rate:** 46% (56/123)

	Low	25 th %	Median	75 %	High
Survey RVW	1.00	2.19	3.00	7.50	3.44
Pre-Service Time	10	20	25	45	90
Intra-Service Time	10	20	30	40	60

Post-Service:	Total Time	CPT code/# of visits
Immed. Post-Service	10	
Critical Care		0
Other Hospital		0
Discharge Day Mgmt	18	.5- 99238
Office Visits	23	1- 99213

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	% RESP	GLOBE
54161	Circumcision, surgical excision other than clamp, device or dorsal slit; except newborn	3.27	43%	010
54001	Slitting of prepuce, dorsal or lateral (separate procedure); except newborn	2.19	36%	010
54100	Biopsy of penis; cutaneous (separate procedure)	1.90	1%	000

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**INTENSITY/COMPLEXITY MEASURES (mean)****TIME SEGMENTS**

	Svy CPT 541XX	Reference CPT 54161
Pre-service	2.15	2.06
Intra-service	2.24	2.09
Post-service	1.83	1.83

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	2.06	2.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.72	1.74
Urgency of medical decision making	1.70	1.80

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.19	2.28
Physical effort required	2.09	2.00

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	2.13	2.06
Outcome depends on the skill and judgment of physician	2.65	2.48
Estimated risk of malpractice suit with poor outcome	2.74	2.69

ADDITIONAL RATIONALE

The intensity of an office visit is 0.031. In order to yield an intensity slightly higher, approximately 0.040, an RVW of 3.70 is required.

IWPUT/BUILDING BLOCK METHOD

SURVEY RVW =	RVW 3.00
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PRE-SERVICE	TIME	INTENSITY	(= time x intensity)
Day prior evaluation	0	0.0224	0.00
Same day evaluation	10	0.0224	0.22
Scrub, prep	15	0.0081	0.12
TOTAL PRE-SERVICE		RVW=	0.35

POST SERVICE			
Immediate hospital	10	0.0224	0.22
	Visit n	E&M RVW	(= n x E&M RVW)
Subsequent hospital			
ICU 99291	0.0	4.00	0.00
Room 99233	0.0	1.51	0.00
Room 99232	0.0	1.06	0.00
Room 99231	0.0	0.64	0.00
Discharge 99238	1.0	1.28	1.28
Subsequent office			
99215	0.0	1.77	0.00
99214	0.0	1.10	0.00
99213	1.0	0.67	0.67
99212	0.0	0.45	0.00
99211	0.0	0.17	0.00
TOTAL POST SERVICE		RVW =	2.17

	TIME	IWPUT	
INTRASERVICE	30	0.016	0.48

FREQUENCY INFORMATION

How was this procedure 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

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

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

Medicare Frequency: 1,000

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

REFERENCE SERVICE LIST- Please see AUA Master Reference Service List

Practice Expense Summary – Clinical Labor		
CPT code: 5416X2 – <i>Repair incomplete circumcision</i>		
Tracking #: L2		
Global Period: 010		
	In Office	Out-of-Office
Staff Type	RN/LPN/MA	RN/LPN/MA
Pre-service time		4
Service period		
Coordination of Care by staff in the physician's office during the service period (for facility services)		
Post-service time (excluding time of office visits)		4
Total Number of office visits		1-99213
Total time of office visits		36
PRE-SERVICE PERIOD		
Start: Following visit when decision for surgery or procedure made		
1. Complete pre-service diagnostic & referral forms		4
2. Coordinate pre-procedure or pre-surgery services		
3. Schedule space and equipment in facility		
4. Office visit before surgery/procedure to review test and exam results		
5. Provide pre-service education/obtain consent		
6. Follow-up phone calls & prescriptions		
Other Pre-Service Activities (please specify):		
End: When patient enters hospital or office for surgery/procedure		
SERVICE PERIOD		
Start: With admission to hospital, ASC, or office for procedure		
Pre-service services		
1. Review charts		
2. Greet patient and provide gowning		
3. Obtain vital signs		
4. Provide pre-service education/obtain consent		
5. Prepare room, equipment, supplies		
6. Prepare and position patient/monitor patient/set up IV		
7. Sedate/apply anesthesia		
Intra-service		
8. Assist physician in performing procedure/surgery		
Post-service		
9. Monitor patient following service/check tubes, monitors, drains		
10. Clean room/equipment		
11. Assist with ICU or hospital visits		
12. Complete diagnostic forms, lab & x-ray requisitions		
13. Review/read x-ray, lab, and pathology reports		
14. (Discharge day mgmt services) Check dressings & wound/home care instructions/coordinate office visits/prescriptions		
15. Coordination of in-facility care by staff in office		
Other service period activities (please specify):		
End: With discharge from hospital, ASC, or office		
POST-SERVICE PERIOD		
Start: After discharge from hospital, ASC, or office		
1. Conduct phone calls/call in prescriptions		4
2. 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/equipment, check supplies		
Coordinate home or outpatient care		
3. Conduct phone calls between office visits		
Other post-service activities (please specify):		
End: With last office visit before end of global period		

Practice Expense Summary – Supplies & Equipment Out of Office

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	MMSP	1		
	Basic Post Operative Incision Care Kit suture	1		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Exam Table	1			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

CPT Code: 5416X3

Global: 010

Survey Median RVW: 2.50

RUC Recommended RVW: 2.50

CPT Descriptor: Frenulotomy of the penis

Tracking Code: L3

Survey Vignette (Typical Patient)

A 28-year-old man, circumcised at birth, reports painful tearing and bleeding from the frenulum of the penis when having intercourse. Conservative measures have failed. Even after prolonged periods of abstinence, the bleeding recurs when having intercourse.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service Work- Day before surgery:

- Review pre-op lab results
- Review medical record
- Write pre-op orders (to be faxed to hospital)
- Check to be sure necessary equipment/supplies are at hospital

Pre-service work- Day of surgery:

- Change into scrub cloths
- Review surgical procedure, post-op recovery in and out of hospital with patient and family
- Answer patient and family questions, be sure informed consent is in record
- Speak to anesthesiologist about expected length of procedure and any special concerns about this particular patient (teeth, positioning, unusual medical problems)
- Position patient on operating table
- Verify that all necessary instruments are available

Intra-service work- Skin to skin:

- A local anesthetic block is administered for post op pain control (this is done after the patient is prepped and draped and under general anesthesia)
- The frenulum of the penis is inspected with loop magnification and multiple old scars and tears are identified
- The central portion of the frenulum is excised including old scar tissue
- Bleeders are coagulated
- Lateral skin edges along each side of the frenulum is mobilized
- Closure is done with absorbable sutures in Heineke-Mikulicz fashion
- Ointment, Adaptic and dressing are applied.

Post-op Same day work through discharge from recovery

- Apply dressings
- Assist in transfer of patient from operating table to post-op stretcher
- Accompany anesthesiologist with patient to recovery area
- Assist in transfer of patient to recovery area bed
- Write post-op orders
- Review recovery area care and medications with staff
- Meet with family and discuss the procedure, expected outcome, planned post operative care in hospital and out of hospital
- Discuss procedure with patient as necessary in recovery area when awake
- Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)

- Dictate detailed operative narrative

Post-op Same day work after discharge from recovery

- Examine patient, check wound and patient progress
- Review patient hospital medical record notes (nursing, pharmacy, dietary, discharge planner)
- Answer patient and family questions
- Answer nursing and other staff questions
- Write any further necessary orders
- Write note in progress note section of medical record

Discharge day work:

- Examine and talk with patient and family
- Check wounds and patient progress
- Review all patient hospital medical records
- Answer patient and family questions
- Write orders for post-discharge care
- Write prescriptions for post-op medications
- Dictate detailed hospital discharge summary

Post-op Office work- After discharge from hospital:

- Examine patient, check vital signs
- Talk with patient and family
- Answer questions from patient and family
- Write necessary prescriptions
- Remove sutures
- Schedule next office visit
- Mark appropriate diagnosis and CPT code on Superbill
- Dictate patient progress notes for office medical record
- Dictate letter to referring physician

SURVEY DATA:

Presenters: James B Regan, MD & Jeffrey A. Dann, MD

Specialty: American Urological Association

Type of Sample: Mixed-panel/random **Sample Size:** 105

Response Rate: 33% (35/105)

	Low	25 th %	Median	75 %	High
Survey RVW	2.00	2.19	2.50	3.30	12.00
Pre-Service Time	15	20	25	45	65
Intra-Service Time	15	15	20	30	60

Post-Service:	Total Time	CPT code/# of visits
Immed. Post-Service	10	
Critical Care		0
Other Hospital		0
Discharge Day Mgmt	18	.5 - 99238
Office Visits	23	1- 99213

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	% RESP	GLOBE
54001	Slitting of prepuce, dorsal or lateral (separate procedure); except newborn	2.19	43%	010
54161	Circumcision, surgical excision other than clamp, device or dorsal slit; except newborn	3.27	31%	010
54160	Circumcision, surgical excision other than clamp, device or dorsal slit; newborn	2.48	1%	010

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

INTENSITY/COMPLEXITY MEASURES (mean)

TIME SEGMENTS	Svy CPT 5416X	Reference CPT 54001
Pre-service	1.91	1.91
Intra-service	2.12	2.15
Post-service	1.76	1.70

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	2.03	1.94
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.58	1.67
Urgency of medical decision making	1.55	1.61

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	2.58	2.39
Physical effort required	2.09	2.12

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	2.18	2.21
Outcome depends on the skill and judgment of physician	2.64	2.48
Estimated risk of malpractice suit with poor outcome	2.70	2.58

ADDITIONAL RATIONALE

The intensity of an office visit is 0.031. In order to yield an intensity of at least 0.031 an RVW of 3.10 would need to be assigned.

IWPUT/BUILDING BLOCK METHOD

SURVEY RVW =	RVW 2.50
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PRE-SERVICE	TIME	INTENSITY	(= time x intensity)
Day prior evaluation	0	0.0224	0.00
Same day evaluation	10	0.0224	0.22
Scrub, prep	15	0.0081	0.12
TOTAL PRE-SERVICE		RVW=	0.35

POST SERVICE			
Immediate hospital	10	0.0224	0.22
	Visit n	E&M RVW	(= n x E&M RVW)
Subsequent hospital			
ICU 99291	0.0	4.00	0.00
Room 99233	0.0	1.51	0.00
Room 99232	0.0	1.06	0.00
Room 99231	0.0	0.64	0.00
Discharge 99238	1.0	1.28	1.28
Subsequent office			
99215	0.0	1.77	0.00
99214	0.0	1.10	0.00
99213	1.0	0.67	0.67
99212	0.0	0.45	0.00
99211	0.0	0.17	0.00
TOTAL POST SERVICE		RVW =	2.17

	TIME	IWPUT	
INTRASERVICE	20	-0.001	-0.02

FREQUENCY INFORMATION

How was this procedure 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

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

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

Medicare Frequency: 1,000

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

REFERENCE SERVICE LIST- Please see AUA Master Reference Service List

Practice Expense Summary – Clinical Labor		
CPT code: 5416X3 – <i>Frenulotomy of the penis</i>		
Tracking #: L3		
Global Period: 010		
Staff Type	In Office RN/LPN/MA	Out-of-Office RN/LPN/MA
Pre-service time		
Service period		
Coordination of Care by staff in the physician's office during the service period (for facility services)		
Post-service time (excluding time of office visits)		
Total Number of office visits		1-99213
Total time of office visits		36
PRE-SERVICE PERIOD		
Start: Following visit when decision for surgery or procedure made		
1. Complete pre-service diagnostic & referral forms		4
2. Coordinate pre-procedure or pre-surgery services		
3. Schedule space and equipment in facility		
4. Office visit before surgery/procedure to review test and exam results		
5. Provide pre-service education/obtain consent		
6. Follow-up phone calls & prescriptions		
Other Pre-Service Activities (please specify):		
End: When patient enters hospital or office for surgery/procedure		
SERVICE PERIOD		
Start: With admission to hospital, ASC, or office for procedure		
Pre-service services		
1. Review charts		
2. Greet patient and provide gowning		
3. Obtain vital signs		
4. Provide pre-service education/obtain consent		
5. Prepare room, equipment, supplies		
6. Prepare and position patient/monitor patient/set up IV		
7. Sedate/apply anesthesia		
Intra-service		
8. Assist physician in performing procedure/surgery		
Post-service		
9. Monitor patient following service/check tubes, monitors, drains		
10. Clean room/equipment		
11. Assist with ICU or hospital visits		
12. Complete diagnostic forms, lab & x-ray requisitions		
13. Review/read x-ray, lab, and pathology reports		
14. (Discharge day mgmt services) Check dressings & wound/home care instructions/coordinate office visits/prescriptions		
15. Coordination of in-facility care by staff in office		
Other service period activities (please specify):		
End: With discharge from hospital, ASC, or office		
POST-SERVICE PERIOD		
Start: After discharge from hospital, ASC, or office		
1. Conduct phone calls/call in prescriptions		4
2. 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/equipment, check supplies		
Coordinate home or outpatient care		
3. Conduct phone calls between office visits		
Other post-service activities (please specify):		
End: With last office visit before end of global period		

Practice Expense Summary – Supplies & Equipment Out of Office

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	MMSP	1		
	Basic Post Operative Incision Care Kit suture	1		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Exam Table	1			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2001

Penile Prosthesis

Seven new CPT codes were created, and three codes were deleted, to better describe the various surgical procedures involving penile prosthesis. Codes 54402 *Removal or replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis*, 54407 *Removal, repair, or replacement of inflatable (multi-component) penile prosthesis, including pump and/or reservoir and/or cylinders*, 54409 *Surgical correction of hydraulic abnormality of inflatable (multi-component) prosthesis including pump and/or reservoir and/or cylinders*, were deleted at the request of the specialty society.

54405 Insertion, of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir (For reduced services, report 54405 with modifier '-52')

The RUC recommends no change in the work relative value for CPT code 54405 as there were only CPT editorial changes to the code descriptor, and no change in physician work. **The RUC recommends no change to the work relative value for CPT code 54405.**

54415 Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis

The RUC examined the survey results of 30 practicing urologists and believed that given the similarity of physician time and work effort in relation to the reference code 54400 *insertion of penile prosthesis; non-inflatable (semi-rigid)* (work RVU = 8.99), the median work RVU of 8.20 was appropriate. The RUC compared the new code's survey results of 50 minutes pre-service, 60 minutes intra-service, 30 minutes immediate post, and 3 follow up office visits, and believed the Harvard physician time for the reference code was quite similar. The Harvard physician time is slightly higher, indicating again that the relative value for this new code should be the survey median rather than closer to the reference code's work RVU. **The RUC recommends a work relative value of 8.20 for CPT code 54415.**

Practice Expense

The RUC utilized the standard direct practice expense input packages for 090 day procedures for this code, and all of the direct inputs listed separately following this document.

54416 Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session

The RUC examined the survey results for this code and compared them to the reference CPT codes; 54407 *Removal, repair, or replacement of inflatable (multi-component) penile prosthesis, including pump and/or reservoir and/or cylinders* (work relative value of 13.34), and 54401 *Insertion of penile prosthesis; inflatable (self-contained)* (work relative value of 10.28). The RUC believed that the work effort for 54416 was less

than code 54407 given the physician time, yet more physician time and effort than code 54401. The RUC supported the specialty society's recommended median survey results. **The RUC recommends a work relative value of 10.87 for CPT code 54416.**

Practice Expense

The RUC utilized the standard direct practice expense input packages for 090 day procedures for this code, and all of the direct inputs listed separately following this document.

54417 Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement

The RUC reviewed the survey data presented by the specialty society and had difficulty accepting the specialty's proposed 75th percentile survey results for a work relative value. The RUC examined the work across specialties, noting that code 35907 *Excision of infected graft; abdomen* (work relative value of 19.24) had significantly more intra-service time than code 54417, and therefore it was inappropriate to value the code at the surveyed 75th percentile, and recommended the survey median. The RUC noted that the physician time for this code was quite similar in the pre and intra service periods to code 54407 *Removal, repair, or replacement of inflatable (multi-component) penile prosthesis, including pump and /or reservoir and/or cylinders* (work RVU = 13.34), however, post operatively code 54417 included more hospital and office visit care. The RUC recognized that the specialty's median survey results represented the physician work involved. **The RUC recommends a relative work value for CPT code 54417 of 14.19.**

Practice Expense

The RUC utilized the standard direct practice expense input packages for 090 day procedures for this code, and all of the direct inputs listed separately following this document.

54406 Removal of all components of a multi-component ,inflatable penile prosthesis without replacement of prosthesis

The RUC examined the survey results and gained an understanding the physician time and work effort in relation to reference code 54405 *Insertion of inflatable (multi-component) penile prosthesis, including placement of pump, cylinders, and/or reservoir*, (work RVU = 13.43), code 54407 *Removal, repair, or replacement of inflatable (multi-component) penile prosthesis, including pump and/or reservoir and/or cylinders* (work RVU = 13.34), and the other codes in the family. In comparison to code 54406, the physician work effort and intensity of these reference codes were quite similar, however the post-operative care was less extensive. From this comparison, the RUC considered the specialty's survey median to be the appropriate work value. **The RUC recommends a work relative value of 12.10 for CPT code 54406.**

Practice Expense

The RUC utilized the standard direct practice expense input packages for 090 day procedures for this code, and all of the direct inputs listed separately following this document.

54408 Repair of component(s) of a multi-component, inflatable penile prosthesis

The RUC had difficulty accepting the specialty's survey median work RVU of 13.30 since the work intensity required for the repair of the components was less difficult than the removal of all of the components of a multi-component inflatable penile prosthesis, represented by code 54406. In addition, the RUC believed the post operative time was too high for such a procedure. The RUC recognized that this service had to be appropriately ranked within the other services already approved by the RUC. Code 54406 *Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis* was approved by the RUC at 12.10 RVWs. The services are similar except for 15 minutes additional intra-service time for 54408. After reviewing a number of different building block methodologies the committee felt that a relative value of 12.75 more appropriately reflected the work associated with this service, and placed the code in proper rank order within the family of codes. **The RUC recommends a work relative value of 12.75 for CPT code 54408.**

Practice Expense

The RUC utilized the standard direct practice expense input packages for 090 day procedures for this code, and all of the direct inputs listed separately following this document.

54410 Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session

The RUC examined the survey results and believed that given the physician time and work effort, and in relation to CPT code 54406 *Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis*, (recommended work relative value of 12.10), code 54410 would be appropriately valued at the survey median. Inter-operatively, code 54410 resulted in 50 more minutes of physician time than 54406 with similar or greater intensity. The RUC recognized the greater intra-operative work involved in 54410 than 54406 and agreed with the median of the specialty's survey results. **The RUC recommends a work relative value of 15.50 for CPT code 54410.**

Practice Expense

The RUC utilized the standard direct practice expense input packages for 090 day procedures for this code, and all of the direct inputs listed separately following this document.

54411 Removal and replacement of component(s) of a multi-component, inflatable penile prosthesis through an infected field an infected field at the same operative session including irrigation and debridement

The RUC reviewed the survey results and compared the work code 54411 to other codes within its family. The specialty had initially recommended a value above the 75th percentile of their survey of 22.50, requesting a work RVU of 26.07, as they concluded that the respondents did not factor in the extensive post operative work involved with these patients. However, the RUC did not agree that the 75th percentile, or any value above the 75th percentile, accurately reflected the work of this code. The RUC compared the intra-operative time and intensity of this new code to code 50220 *Nephrectomy, including partial ureterectomy, any approach including rib resection*; (work RVU = 17.15), and believed the specialty's recommended 75th percentile work RVU of 22.50 was still too high. Based on the concern over the intra service time associated with the 75th percentile of the specialty's survey results, the RUC recommended the specialty society's median survey results. **The RUC recommends a work relative value of 16.00.**

Practice Expense

The RUC utilized the standard direct practice expense input packages for 090 day procedures for this code, and all of the direct inputs listed separately following this document.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
54400		<i>Insertion of penile prosthesis; non-inflatable (semi-rigid)</i>	090	8.99 (No Change)
54401		<i>inflatable (self-contained)</i>	090	10.28 (No Change)
54402		Removal or replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis (54402 has been deleted. To report, see 54415 and 54416)	090	N/A
▲54405 ✓	Y1	Insertion of (multi-component) non- inflatable penile prosthesis, including placement of pump, cylinders, and/or reservoir (For reduced services, report 54405 with modifier -'52')	090	13.43 (No Change)
54407		Removal, repair, or replacement of inflatable (multi-component) penile prosthesis, including pump and/or reservoir and/or cylinders (54407 has been deleted. To report, see 54406, 54408 and 54410)	090	N/A
54409		Surgical correction of hydraulic abnormality of inflatable (multi-component) prosthesis, including	090	N/A

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		pump and/or reservoir and/or cylinders (54409 has been deleted. To report, use 54408)		
● 54415	Y2	Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis	090	8.20
● 54416	Y3	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session	090	10.87
● 54417	Y4	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue (Do not report 11040-11043 in addition to 54417)	090	14.19
● 54406	Y5	Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis (For reduced services, report 54406 with modifier –‘52’)	090	12.10
● 54408	Y6	Repair of component(s) of a multi-component, inflatable penile prosthesis	090	12.75
● 54410	Y7	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session	090	15.50
● 54411	Y8	Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session	090	16.00

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		including irrigation and debridement of infected tissue (For reduced services, report 54411 with modifier -'52') (Do not report 11040-11043 in addition to 54411)		

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

(April 2001)

CPT Code: 544X1

Global: 090

Survey Median RVW: 8.20
Recommended RVW: 8.20

CPT Descriptor: Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis

Tracking Code: Y2

Survey Vignette (Typical Patient)

A 65-year-old man had a semi-rigid penile prosthesis placed 16 years ago. He now has some discomfort in the penis and in addition is no longer sexually active. He wants the prosthesis removed. He does not want a new prosthesis.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service Work- Day before surgery:

- Review pre-op lab results
- Review medical record
- Write pre-op orders (to be faxed to hospital)
- Check to be sure necessary prosthesis components are at hospital

Pre-service work- Day of surgery:

- Change into scrub cloths
- Review surgical procedure, post-op recovery in and out of hospital with patient and family
- Answer patient and family questions, be sure informed consent is in record
- Speak to anesthesiologist about expected length of procedure and any special concerns about this particular patient (teeth, positioning, unusual medical problems)
- Position patient on operating table
- Verify that all necessary instruments and prosthetic components are available

Intra-service work- Skin to skin:

- A Foley catheter is placed
- A transverse infra-pubic incision is made
- The corpora cavernosa are exposed
- Lateral corporotomies are made
- Each prosthesis (right and left) are carefully removed
- The proximal corpus cavernosum on each side is probed and checked for remaining rear-tip extenders
- The corporotomies are irrigated
- The corporotomies are closed with running absorbable suture
- The wound is irrigated and closed in usual fashion

Post-op Same day work through discharge from recovery

- Apply dressings
- Assist in transfer of patient from operating table to post-op stretcher
- Accompany anesthesiologist with patient to recovery area
- Assist in transfer of patient to recovery area bed
- Write post-op orders
- Review recovery area care and medications with staff
- Meet with family and discuss the procedure, expected outcome, planned post operative care in hospital and out of hospital
- Discuss procedure with patient as necessary in recovery area when awake
- Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)
- Dictate detailed operative narrative

Post-op Same day work after discharge from recovery

- Examine patient, check wound and patient progress
- Review patient hospital medical record notes (nursing, pharmacy, dietary, discharge planner)
- Answer patient and family questions
- Answer nursing and other staff questions
- Write any further necessary orders
- Write note in progress note section of medical record

Discharge day work:

- Examine and talk with patient and family
- Check wounds and patient progress
- Review all patient hospital medical records
- Answer patient and family questions
- Write orders for post-discharge care
- Write prescriptions for post-op medications
- Discuss post-op care of prosthesis with patient and family
- Dictate detailed hospital discharge summary

Post-op Office work- *After discharge from hospital:*

- Examine patient, check vital signs
- Talk with patient and family
- Answer questions from patient and family
- Write necessary prescriptions
- Remove sutures
- Schedule next office visit
- Mark appropriate diagnosis and CPT code on Superbill
- Dictate patient progress notes for office medical record
- Dictate letter to referring physician

SURVEY DATA:**Presenters:** James B. Regan, MD & Jeffrey A. Dann, MD**Specialty:** American Urological Association**Type of Sample:** Mixed-panel/random **Sample Size:** 60**Response Rate:** 50% (30/60)

	Low	25 th %	Median	75 %	High
Survey RVW	4.50	7.50	8.20	9.00	13.50
Pre-Service Time	15	38	50	76	135
Intra-Service Time	15	38	60	83	120

Post-Service:	Total Time	CPT code/# of visits
Immed. Post-Service	30	
Critical Care		0
Other Hospital		0
Discharge Day Mgmt	18	4.5- 99238
Office Visits	61	1- 99212, 4 2- 99213

INPUT/BUILDING BLOCK METHOD**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	2001 RVW	% RESP	GLOBE
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)	8.99	57%	090
54401	Insertion of penile prosthesis; inflatable (self-contained)	10.28	10%	090
54407	Removal, repair, or replacement of inflatable (multi-component) penile prosthesis, including pump and/or reservoir and/or cylinders	13.34	10%	090

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

INTENSITY/COMPLEXITY MEASURES (mean)	Svy CPT	Reference CPT
TIME SEGMENTS	544X1	54400
Pre-service	2.54	3.16
Intra-service	2.43	3.60
Post-service	2.36	2.88

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	2.32	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.32	2.92
Urgency of medical decision making	2.03	2.46

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	2.43	3.12
Physical effort required	2.50	3.00

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	2.36	3.04
Outcome depends on the skill and judgment of physician	2.46	3.04
Estimated risk of malpractice suit with poor outcome	2.82	3.20

ADDITIONAL RATIONALE-~~None~~**IWPUT/BUILDING BLOCK METHOD****RVW**

SURVEY RVW =	8.20
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PRE-SERVICE	TIME	INTENSITY	(= time x intensity)
Day prior evaluation	0	0.0224	0.00
Same day evaluation	20	0.0224	0.45
Scrub, prep	30	0.0081	0.24
TOTAL PRE-SERVICE		RVW=	0.69

POST SERVICE			
Immediate hospital	30	0.0224	0.67
	Visit n	E&M RVW	(= n x E&M RVW)
Subsequent hospital			
ICU 99291	0.0	4.00	0.00
Room 99233	0.0	1.51	0.00
Room 99232	0.0	1.06	0.00
Room 99231	0.0	0.64	0.00
Discharge 99238	1.0	0.68	0.68
Subsequent office			
99215	0.0	1.77	0.00
99214	0.0	1.10	0.00
99213	2.0	0.67	1.34
99212	1.0	0.45	0.45
99211	0.0	0.17	0.00
TOTAL POST SERVICE		RVW =	3.74

	TIME	IWPUT	
INTRASERVICE	60	0.074	4.46

FREQUENCY INFORMATION

How was this procedure 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 Sometimes

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

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 Medicare Frequency of 500

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

REFERENCE SERVICE LIST - Please see AUA Reference Service List

Practice Expense Summary – Clinical Labor	
CPT code: 544X1 – Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis.	
Tracking #: Y2	
Global Period: 090	
	Out-of-Office
Staff Type	RN/LPN/MA
Pre-service time	60
Service period	
Coordination of Care by staff in the physician's office during the service period (for facility services)	
Post-service time (excluding time of office visits)	8
Total Number of office visits	1-99212 2-99213
Total time of office visits	99
PRE-SERVICE PERIOD	
Start: Following visit when decision for surgery or procedure made	
1. Complete pre-service diagnostic & referral forms	5
2. Coordinate pre-procedure or pre-surgery services	20
3. Schedule space and equipment in facility	8
4. Office visit before surgery/procedure to review test and exam results	
5. Provide pre-service education/obtain consent	20
6. Follow-up phone calls & prescriptions	7
Other Pre-Service Activities (please specify):	
End: When patient enters hospital or office for surgery/procedure	
SERVICE PERIOD	
Start: With admission to hospital, ASC, or office for procedure	
<i>Pre-service services</i>	
1. Review charts	
2. Greet patient and provide gowning	
3. Obtain vital signs	
4. Provide pre-service education/obtain consent	
5. Prepare room, equipment, supplies	
6. Prepare and position patient/monitor patient/set up IV	
7. Sedate/apply anesthesia	
<i>Intra-service</i>	
8. Assist physician in performing procedure/surgery	
<i>Post-service</i>	
9. Monitor patient following service/check tubes, monitors, drains	
10. Clean room/equipment	
11. Assist with ICU or hospital visits	
12. Complete diagnostic forms, lab & x-ray requisitions	
13. Review/read x-ray, lab, and pathology reports	
14. (Discharge day mgmt services) Check dressings & wound/home care instructions/coordinate office visits/prescriptions	
15. Coordination of in-facility care by staff in office	
Other service period activities (please specify):	
End: With discharge from hospital, ASC, or office	
POST-SERVICE PERIOD	
Start: After discharge from hospital, ASC, or office	
1. Conduct phone calls/call in prescriptions	8
2. 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/equipment, check supplies	
Coordinate home or outpatient care	
3. Conduct phone calls between office visits	
Other post-service activities (please specify):	
End: With last office visit before end of global period	

Practice Expense Summary – Supplies & Equipment Out of Office

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	MMSP	3		
	Basic Post-Op. Incision Care Kit (Suture)	1		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Exam Table	1			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

(April 2001)

CPT Code: 544X2

Global: 090

Survey Median RVW: 10.87
Recommended RVW: 10.87

CPT Descriptor: Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative setting

Tracking Code: Y3

Survey Vignette (Typical Patient)

The patient is taken to the operating room and given an anesthetic. An infra-pubic incision is made. The tunica albuginea is exposed and corporotomies are made. The prostheses are both removed. Measurements are taken and new prostheses are selected. On the left side, the distal portion of the corpus is tight and will not accept the prosthesis. The distal left corpus is blindly cut with a scissors and then dilated carefully so as not to perforate into the urethra. The new prostheses are placed and the corporotomies are closed. The wound is closed.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service Work- Day before surgery:

- Review pre-op lab results
- Review medical record
- Write pre-op orders (to be faxed to hospital)
- Check to be sure necessary prosthesis components are at hospital

Pre-service work- Day of surgery:

- Change into scrub cloths
- Review surgical procedure, post-op recovery in and out of hospital with patient and family
- Answer patient and family questions, be sure informed consent is in record
- Speak to anesthesiologist about expected length of procedure and any special concerns about this particular patient (teeth, positioning, unusual medical problems)
- Position patient on operating table
- Verify that all necessary instruments and prosthetic components are available

Intra-service work- Skin to skin:

- A Foley catheter is placed
- A transverse infra-pubic incision is made
- The corpora cavernosa are exposed
- Lateral corporotomies are made
- Each prosthesis (right and left) is carefully removed
- The proximal corpus cavernosum on each side is probed and checked for remaining rear-tip extenders
- The corporotomies are irrigated
- The length of each corpus cavernosum from the ischial tuberosity to the glan penis is carefully measured
- An appropriate size prosthesis is selected and opened
- The corpora are re-dilated to the proper diameter
- The prosthesis is inserted, an insertion tool and insertion suture may be utilized
- Rear Tip Extenders are added as necessary
- The prosthesis is checked fit
- The corporotomies are closed with absorbable suture
- Throughout the procedure the operative field is irrigated with antibiotic spray

- The subcutaneous tissues are closed
- The wound is closed in usual fashion

Post-op Same day work through discharge from recovery

- Apply dressings
- Assist in transfer of patient from operating table to post-op stretcher
- Accompany anesthesiologist with patient to recovery area
- Assist in transfer of patient to recovery area bed
- Write post-op orders
- Review recovery area care and medications with staff
- Meet with family and discuss the procedure, expected outcome, planned post operative care in hospital and out of hospital
- Discuss procedure with patient as necessary in recovery area when awake
- Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)
- Dictate detailed operative narrative

Post-op Same day work after discharge from recovery

- Examine patient, check wound and patient progress
- Review patient hospital medical record notes (nursing, pharmacy, dietary, discharge planner)
- Answer patient and family questions
- Answer nursing and other staff questions
- Write any further necessary orders
- Write note in progress note section of medical record

Post-op Other Hospital Work – *Beginning on post op-day 1, until discharge day*

- Examine and talk to patient
- Check wounds and dressings
- Discuss patient progress with patient and family
- Review all patient hospital medical record notes
- Discuss post operative care of wound and prosthesis at home
- Answer nursing and other staff questions
- Answer patient and family questions
- Write orders in medical record
- Write progress notes

Discharge day work:

- Examine and talk with patient and family
- Check wounds and patient progress
- Review all patient hospital medical records
- Answer patient and family questions
- Write orders for post-discharge care
- Write prescriptions for post-op medications
- Discuss post-op care of prosthesis with patient and family
- Dictate detailed hospital discharge summary

Post-op Office work- *After discharge from hospital:*

- Examine patient, check vital signs
- Talk with patient and family
- Answer questions from patient and family
- Write necessary prescriptions
- Remove sutures
- Schedule next office visit
- Mark appropriate diagnosis and CPT code on Superbill
- Dictate patient progress notes for office medical record
- Dictate letter to referring physician

SURVEY DATA:

Presenters: James B. Regan, MD & Jeffrey A. Dann, MD
Specialty: American Urological Association

Type of Sample: Mixed-panel/random **Sample Size:** 60

Response Rate: 50% (30/60)

	Low	25 th %	Median	75 %	High
Survey RVW	8.99	10.00	10.87	12.10	15.50
Pre-Service Time	20	41	50	80	145
Intra-Service Time	30	60	75	90	180

Post-Service:	Total Time	CPT code/# of visits
Immed. Post-Service	30	
Critical Care		0
Other Hospital	19	1- 99231
Discharge Day Mgmt	36	41- 99238
Office Visits	99	1- 99212, 2- 99213, 1- 99214

INPUT/BUILDING BLOCK METHOD

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	% RESP	GLOBE
54401	Insertion of penile prosthesis; inflatable (self-contained)	10.28	52%	090
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)	8.99	24%	090
54407	Removal, repair, or replacement of inflatable (multi-component) penile prosthesis, including pump and/or reservoir and/or cylinders	13.34	10%	090

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

INTENSITY/COMPLEXITY MEASURES (mean)

**Svy CPT
544X2**

Reference CPT

TIME SEGMENTS

Pre-service	3.00	3.16
Intra-service	3.43	3.24
Post-service	3.00	2.96

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.07	3.24
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.86	3.08
Urgency of medical decision making	2.54	2.28

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.46	3.48
Physical effort required	3.29	3.20

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.29	3.28
Outcome depends on the skill and judgment of physician	3.56	3.46
Estimated risk of malpractice suit with poor outcome	3.75	3.64

ADDITIONAL RATIONALE-

~~None~~

IWPUT/BUILDING BLOCK METHOD

RVW

SURVEY RVW =	10.87
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PRE-SERVICE	TIME	INTENSITY	(= time x intensity)
Day prior evaluation	0	0.0224	0.00
Same day evaluation	20	0.0224	0.45
Scrub, prep	30	0.0081	0.24
TOTAL PRE-SERVICE		RVW=	.69

POST SERVICE			
Immediate hospital	30	0.0224	0.67
	Visit n	E&M RVW	(= n x E&M RVW)
Subsequent hospital			

ICU 99291	0.0	4.00	0.00
Room 99233	0.0	1.51	0.00
Room 99232	0.0	1.06	0.00
Room 99231	1.0	0.64	0.64
Discharge 99238	1.0	0.68	0.68
Subsequent office			
99215	0.0	1.77	0.00
99214	1.0	1.10	1.10
99213	2.0	0.67	1.34
99212	1.0	0.45	0.45
99211	0.0	0.17	0.00
TOTAL POST SERVICE		RVW =	5.48

	TIME	IWPUT	
INTRASERVICE	75	0.063	4.70

FREQUENCY INFORMATION

How was this procedure 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 Sometimes

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

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 Medicare Frequency: 500

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

Practice Expense Summary – Clinical Labor	
CPT code: 544X2 – Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session.	
Tracking #: Y3	
Global Period: 090	
	Out-of-Office
Staff Type	RN/LPN/MA
Pre-service time	60
Service period	
Coordination of Care by staff in the physician's office during the service period (for facility services)	
Post-service time (excluding time of office visits)	8
Total Number of office visits	1-99212 1-99214 2-99213
Total time of office visits	152
PRE-SERVICE PERIOD	
Start: Following visit when decision for surgery or procedure made	
1. Complete pre-service diagnostic & referral forms	5
2. Coordinate pre-procedure or pre-surgery services	20
3. Schedule space and equipment in facility	8
4. Office visit before surgery/procedure to review test and exam results	
5. Provide pre-service education/obtain consent	20
6. Follow-up phone calls & prescriptions	7
Other Pre-Service Activities (please specify):	
End: When patient enters hospital or office for surgery/procedure	
SERVICE PERIOD	
Start: With admission to hospital, ASC, or office for procedure	
<i>Pre-service services</i>	
1. Review charts	
2. Greet patient and provide gowning	
3. Obtain vital signs	
4. Provide pre-service education/obtain consent	
5. Prepare room, equipment, supplies	
6. Prepare and position patient/monitor patient/set up IV	
7. Sedate/apply anesthesia	
<i>Intra-service</i>	
8. Assist physician in performing procedure/surgery	
<i>Post-service</i>	
9. Monitor patient following service/check tubes, monitors, drains	
10. Clean room/equipment	
11. Assist with ICU or hospital visits	
12. Complete diagnostic forms, lab & x-ray requisitions	
13. Review/read x-ray, lab, and pathology reports	
14. (Discharge day mgmt services) Check dressings & wound/home care instructions/coordinate office visits/prescriptions	
15. Coordination of in-facility care by staff in office	
Other service period activities (please specify):	
End: With discharge from hospital, ASC, or office	
POST-SERVICE PERIOD	
Start: After discharge from hospital, ASC, or office	
1. Conduct phone calls/call in prescriptions	8
2. 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/equipment, check supplies	
Coordinate home or outpatient care	
3. Conduct phone calls between office visits	
Other post-service activities (please specify):	
End: With last office visit before end of global period	

Practice Expense Summary – Supplies & Equipment Out of Office

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	MMSP	4		
	Basic Post-Op. Incision Care Kit (suture)	1		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Exam Table	1			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

(April 2001)

CPT Code: 544X3

Global: 090

Surveyed Median RVW: 14.19

~~Recommended (75th percentile) RVW: 19.25~~

RUC Recommended RVW: 14.19

CPT Descriptor: Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative sitting, including irrigation and debridement of infected tissue

Tracking Code: Y4

Survey Vignette (Typical Patient)

A 67-year-old man had an inflatable self-contained penile prosthesis placed four months ago. His penis has become swollen, red and tender. He has a low-grade fever. After appropriate testing, he is found to have an infected prosthesis. If the prosthesis is removed and not replaced, the corporal bodies will scar making future placement of a prosthesis difficult, if not impossible. Removal of the prosthesis and replacement through an infected field is planned.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service Work- Day before surgery:

- Review pre-op lab results
- Review medical record
- Write pre-op orders (to be faxed to hospital)
- Check to be sure necessary prosthesis components are at hospital

Pre-service work- Day of surgery:

- Change into scrub cloths
- Review surgical procedure, post-op recovery in and out of hospital with patient and family
- Answer patient and family questions, be sure informed consent is in record
- Speak to anesthesiologist about expected length of procedure and any special concerns about this particular patient (teeth, positioning, unusual medical problems)
- Position patient on operating table
- Verify that all necessary instruments and prosthetic components are available

Intra-service work- Skin to skin:

- A Foley catheter is placed
- A transverse infra-pubic incision is made
- The corpora cavernosa are exposed
- Lateral corporotomies are made
- Each prosthesis (right and left) are carefully removed
- The proximal corpus cavernosum on each side is probed and checked for remaining rear-tip extenders
- The corporotomies and entire wound are irrigated with 10 (ten) liters of a saline solution containing antibiotics for a total of 20 (twenty) minutes
- The length of each corpus cavernosum from the ischial tuberosity to the glans penis is carefully measured
- An appropriate size prosthesis is selected and opened
- The corpora are re-dilated to the proper diameter
- The prosthesis is inserted, an insertion tool and insertion suture may be utilized
- Rear Tip Extenders are added as necessary
- The prosthesis is checked fit
- Jackson Pratt drains (3.2 mm round) are placed in appropriate areas for post operative irrigation with antibiotic solutions and drainage
- The corporotomies are closed with absorbable suture
- Throughout the procedure the operative field is irrigated with antibiotic spray

- The subcutaneous tissues are closed
- Drains are brought out through separate stab wounds and sutured in place
- The wound is closed in usual fashion

Post-op Same day work through discharge from recovery

- Apply dressings
- Assist in transfer of patient from operating table to post-op stretcher
- Accompany anesthesiologist with patient to recovery area
- Assist in transfer of patient to recovery area bed
- Write post-op orders
- Review recovery area care and medications with staff
- Meet with family and discuss the procedure, expected outcome, planned post operative care in hospital and out of hospital
- Discuss procedure with patient as necessary in recovery area when awake
- Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)
- Dictate detailed operative narrative

Post-op Same day work after discharge from recovery

- Examine patient, check wound and patient progress
- Review patient hospital medical record notes (nursing, pharmacy, dietary, discharge planner)
- Answer patient and family questions
- Answer nursing and other staff questions
- Write any further necessary orders
- Write note in progress note section of medical record

Post-op Other Hospital Work – Beginning on post op-day 1, until discharge day

- Examine and talk to patient
- Check wounds and dressings
- Discuss patient progress with patient and family
- Review all patient hospital medical record notes
- Discuss post operative care of wound and prosthesis at home
- Answer nursing and other staff questions
- Answer patient and family questions
- Write orders in medical record
- Write progress notes

Discharge day work:

- Examine and talk with patient and family
- Check wounds and patient progress
- Review all patient hospital medical records
- Answer patient and family questions
- Write orders for post-discharge care
- Write prescriptions for post-op medications
- Discuss post-op care of prosthesis with patient and family
- Dictate detailed hospital discharge summary

Post-op Office work- After discharge from hospital:

- Examine patient, check vital signs
- Talk with patient and family
- Answer questions from patient and family
- Write necessary prescriptions
- Remove sutures
- Schedule next office visit
- Mark appropriate diagnosis and CPT code on Superbill
- Dictate patient progress notes for office medical record
- Dictate letter to referring physician

SURVEY DATA:**Presenters:** James B. Regan, MD & Jeffrey A. Dann, MD**Specialty:** American Urological Association**Type of Sample:** Mixed-panel/random **Sample Size:** 60 **Response Rate:** 50% (30/60)

	Low	25 th %	Median	75 %	High
Survey RWV	9.20	12.75	14.19	19.25	26.00
Pre-Service Time	25	35	50	75	195
Intra-Service Time	13	90	108	125	180

Post-Service:	Total Time	CPT code/# of visits
Immed. Post-Service	30	
Critical Care		0
Other Hospital	136	4- 99231, 2- 99232
Discharge Day Mgmt	36	1 99238
Office Visits	76	1- 99212, 1- 99213, 1- 99214

INPUT/BUILDING BLOCK METHOD**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	2001 RVW	% RESP	GLOBE
54401	Insertion of penile prosthesis; inflatable (self-contained)	10.28	21%	090
54407	Removal, repair, or replacement of inflatable (multi-component) penile prosthesis, including pump and/or reservoir and/or cylinders	13.34	21%	090
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)	8.99	18%	090
54405	Insertion of inflatable (multi-component) penile prosthesis, including placement of pump, cylinders, and/or reservoir	13.43	1%	090

RELATIONSHIP OF CODE BRING REVIEWED TO KEY REFERENCE SERVICE(S):**INTENSITY/COMPLEXITY MEASURES (mean)**

TIME SEGMENTS	Svy CPT 544X3	Reference CPT 54401/54407
Pre-service	3.54	2.86
Intra-service	3.86	2.86
Post-service	3.75	2.71

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.54	2.82
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be	3.39	2.86

reviewed and analyzed		
Urgency of medical decision making	4.14	2.36

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.82	3.00
Physical effort required	3.17	2.75

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.60	3.00
Outcome depends on the skill and judgment of physician	4.50	3.14
Estimated risk of malpractice suit with poor outcome	5.00	3.11

ADDITIONAL RATIONALE

The workgroup felt that the median RVW did not reflect all of the work associated with the post op care. Therefore recommends the 75th percentile as being more appropriate.

IWPUT/BUILDING BLOCK METHOD**RVW**

SURVEY RVW (75th percentile =	19.25
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PRE-SERVICE	TIME	INTENSITY	(= time x intensity)
Day prior evaluation	0	0.0224	0.00
Same day evaluation	20	0.0224	0.45
Scrub, prep	30	0.0081	0.24
TOTAL PRE-SERVICE		RVW=	0.69

POST SERVICE			
Immediate hospital	30	0.0224	0.67
	Visit n	E&M RVW	(= n x E&M RVW)
Subsequent hospital			
ICU 99291	0.0	4.00	0.00
Room 99233	0.0	1.51	0.00
Room 99232	2.0	1.06	2.12
Room 99231	4.0	0.64	2.56
Discharge 99238	1.0	1.28	1.28
Subsequent office			
99215	0.0	1.77	0.00
99214	1.0	1.10	1.10
99213	1.0	0.67	0.67
99212	1.0	0.45	0.45
99211	0.0	0.17	0.00
TOTAL POST SERVICE		RVW =	8.83

	TIME	IWPUT	
INTRASERVICE	125	0.078	9.71

FREQUENCY INFORMATION

How was this procedure previously coded? 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 Sometimes

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

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 Medicare Frequency 500

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

REFERENCE SERVICE LIST- Please see AUA Reference Service List

Practice Expense Summary – Clinical Labor	
CPT code: 544X3 – Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue.	
Tracking #: Y4	
Global Period: 090	
	Out-of-Office
Staff Type	RN/LPN/MA
Pre-service time	60
Service period	
Coordination of Care by staff in the physician's office during the service period (for facility services)	
Post-service time (excluding time of office visits)	8
Total Number of office visits	1-99212 1-99213 1-99214
Total time of office visits	116
PRE-SERVICE PERIOD	
Start: Following visit when decision for surgery or procedure made	
1. Complete pre-service diagnostic & referral forms	5
2. Coordinate pre-procedure or pre-surgery services	20
3. Schedule space and equipment in facility	8
4. Office visit before surgery/procedure to review test and exam results	
5. Provide pre-service education/obtain consent	20
6. Follow-up phone calls & prescriptions	7
Other Pre-Service Activities (please specify):	
End: When patient enters hospital or office for surgery/procedure	
SERVICE PERIOD	
Start: With admission to hospital, ASC, or office for procedure	
<i>Pre-service services</i>	
1. Review charts	
2. Greet patient and provide gowning	
3. Obtain vital signs	
4. Provide pre-service education/obtain consent	
5. Prepare room, equipment, supplies	
6. Prepare and position patient/monitor patient/set up IV	
7. Sedate/apply anesthesia	
<i>Intra-service</i>	
8. Assist physician in performing procedure/surgery	
<i>Post-service</i>	
9. Monitor patient following service/check tubes, monitors, drains	
10. Clean room/equipment	
11. Assist with ICU or hospital visits	
12. Complete diagnostic forms, lab & x-ray requisitions	
13. Review/read x-ray, lab, and pathology reports	
14. (Discharge day mgmt services) Check dressings & wound/home care instructions/coordinate office visits/prescriptions	
15. Coordination of in-facility care by staff in office	
Other service period activities (please specify):	
End: With discharge from hospital, ASC, or office	
POST-SERVICE PERIOD	
Start: After discharge from hospital, ASC, or office	
1. Conduct phone calls/call in prescriptions	8
2. 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/equipment, check supplies	
Coordinate home or outpatient care	
3. Conduct phone calls between office visits	
Other post-service activities (please specify):	
End: With last office visit before end of global period	

Practice Expense Summary – Supplies & Equipment Out of Office

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	MMSP	3		
	Basic Post-Op. Incision Care Kit (suture)	1		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Exam Table	1			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

CPT Code: 544X4

Global: 090

Survey Median RVW: 12.10
Recommended RVW: 12.10

CPT Descriptor: Removal of a multi-component inflatable penile prosthesis without replacement of prosthesis

Tracking Code: Y5

Survey Vignette (Typical Patient)

A 74-year-old diabetic male had an inflatable multi-component penile prosthesis placed 14 years ago. The prosthesis is somewhat uncomfortable, he is no longer sexually active and wants the prosthesis removed. He does not want it replaced.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service Work- Day before surgery:

- Review pre-op lab results
- Review medical record
- Write pre-op orders (to be faxed to hospital)
- Check to be sure necessary prosthesis components are at hospital

Pre-service work- Day of surgery:

- Change into scrub cloths
- Review surgical procedure, post-op recovery in and out of hospital with patient and family
- Answer patient and family questions, be sure informed consent is in record
- Speak to anesthesiologist about expected length of procedure and any special concerns about this particular patient (teeth, positioning, unusual medical problems)
- Position patient on operating table
- Verify that all necessary instruments and prosthetic components are available

Intra-service work- Skin to skin:

- A Foley catheter is placed
- A transverse infra-pubic incision is made
- The corpora cavernosa are exposed
- Lateral corporotomies are made
- Each prosthesis (right and left) are carefully removed
- The proximal corpus cavernosum on each side is probed and checked for remaining rear-tip extenders
- The pump is removed from the scrotum
- The rectus muscles are divided and the reservoir is removed
- Rectus muscles are closed
- Throughout the procedure the operative field is irrigated with antibiotic solution
- The subcutaneous tissues are closed
- Drains are brought out through separate stab wounds and sutured in place
- The wound is closed in usual fashion

Post-op Same day work through discharge from recovery

-
- Apply dressings
 - Assist in transfer of patient from operating table to post-op stretcher
 - Accompany anesthesiologist with patient to recovery area
 - Assist in transfer of patient to recovery area bed
 - Write post-op orders
 - Review recovery area care and medications with staff
 - Meet with family and discuss the procedure, expected outcome, planned post operative care in hospital and out of hospital
 - Discuss procedure with patient as necessary in recovery area when awake
 - Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)
 - Dictate detailed operative narrative

Post-op Same day work after discharge from recovery

- Examine patient, check wound and patient progress
- Review patient hospital medical record notes (nursing, pharmacy, dietary, discharge planner)
- Answer patient and family questions
- Answer nursing and other staff questions
- Write any further necessary orders
- Write note in progress note section of medical record

Post-op Other Hospital Work – *Beginning on post op-day 1, until discharge day*

- Examine and talk to patient
- Check wounds and dressings
- Discuss patient progress with patient and family
- Review all patient hospital medical record notes
- Discuss post operative care of wound and prosthesis at home
- Answer nursing and other staff questions
- Answer patient and family questions
- Write orders in medical record
- Write progress notes

Discharge day work:

- Examine and talk with patient and family
- Check wounds and patient progress
- Review all patient hospital medical records
- Answer patient and family questions
- Write orders for post-discharge care
- Write prescriptions for post-op medications
- Discuss post-op care of prosthesis with patient and family
- Dictate detailed hospital discharge summary

Post-op Office work- *After discharge from hospital:*

- Examine patient, check vital signs
- Talk with patient and family
- Answer questions from patient and family
- Write necessary prescriptions
- Remove sutures
- Schedule next office visit

- Mark appropriate diagnosis and CPT code on Superbill
- Dictate patient progress notes for office medical record
- Dictate letter to referring physician

SURVEY DATA:**Presenters:** James B. Regan, MD & Jeffrey A. Dann, MD**Specialty:** American Urological Association _____**Type of Sample:** Mixed-panel/random **Sample Size:** 60**Response Rate:** 50% (30/60)

	Low	25 th %	Median	75 %	High
Survey RVW	5.60	10.00	12.10	13.34	16.50
Pre-Service Time	20	35	50	80	135
Intra-Service Time	45	60	95	120	150

Post-Service:	Total Time	CPT code/# of visits
Immed. Post-Service	30	
Critical Care		0
Other Hospital	19	1- 99231
Discharge Day Mgmt	36	1- 99238
Office Visits	61	1- 99212, 2- 99213

~~INPUT/BUILDING BLOCK METHOD~~**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	2001 RVW	% RESP	GLOBE
54407	Removal, repair, or replacement of inflatable (multi-component) penile prosthesis, including pump and/or reservoir and/or cylinders	13.34	62%	090
54405	Insertion of inflatable (multi-component) penile prosthesis, including placement of pump, cylinders, and/or reservoir	13.43	17%	090
53447	Removal, repair, or replacement of inflatable sphincter including pump and/or reservoir and/or cuff	13.17	10%	090

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

INTENSITY/COMPLEXITY MEASURES (mean)	Svy CPT	Reference CPT
TIME SEGMENTS	544X4	54407
Pre-service	2.59	2.69
Intra-service	2.69	2.97
Post-service	2.38	2.59

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	2.48	2.62
The amount and/or complexity of medical records,	2.59	2.59

diagnostic tests, and/or other information that must be reviewed and analyzed		
Urgency of medical decision making	2.14	2.03

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.03	3.00
Physical effort required	2.76	2.97

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	2.66	2.93
Outcome depends on the skill and judgment of physician	2.76	2.97
Estimated risk of malpractice suit with poor outcome	2.86	3.07

**ADDITIONAL RATIONALE- None
IINPUT/BUILDING BLOCK METHOD**

PROPOSED RVW =	RVW 12.10
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PRE-SERVICE	TIME	INTENSITY	(= time x intensity)
Day prior evaluation	0	0.0224	0.00
Same day evaluation	20	0.0224	0.45
Scrub, prep	30	0.0081	0.24
TOTAL PRE-SERVICE		RVW=	0.69

POST SERVICE			
Immediate hospital	30	0.0224	0.67
	Visit n	E&M RVW	(= n x E&M RVW)
Subsequent hospital			
ICU 99291	0.0	4.00	0.00
Room 99233	0.0	1.51	0.00
Room 99232	0.0	1.06	0.00
Room 99231	1.0	0.64	0.64
Discharge 99238	1.0	1.28	1.28
Subsequent office			
99215	0.0	1.77	0.00
99214	0.0	1.10	0.00
99213	2.0	0.67	1.34
99212	1.0	0.45	0.45
99211	0.0	0.17	0.00
TOTAL POST SERVICE		RVW =	4.38

	TIME	IINPUT	
INTRASERVICE	95	0.074	7.03

FREQUENCY INFORMATION

How was this procedure previously coded? 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 Sometimes

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

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 Medicare Frequency: 500

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

REFERENCE SERVICE LIST: Please see the AUA Master Reference Service List

Practice Expense Summary – Clinical Labor	
CPT code: 544X4 – Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis.	
Tracking #: Y5	
Global Period: 090	
	Out-of-Office
Staff Type	RN/LPN/MA
Pre-service time	60
Service period	
Coordination of Care by staff in the physician's office during the service period (for facility services)	
Post-service time (excluding time of office visits)	8
Total Number of office visits	1-99212 2-99213
Total time of office visits	99
PRE-SERVICE PERIOD	
Start: Following visit when decision for surgery or procedure made	
1. Complete pre-service diagnostic & referral forms	5
2. Coordinate pre-procedure or pre-surgery services	20
3. Schedule space and equipment in facility	8
4. Office visit before surgery/procedure to review test and exam results	
5. Provide pre-service education/obtain consent	20
6. Follow-up phone calls & prescriptions	7
Other Pre-Service Activities (please specify):	
End: When patient enters hospital or office for surgery/procedure	
SERVICE PERIOD	
Start: With admission to hospital, ASC, or office for procedure	
<i>Pre-service services</i>	
1. Review charts	
2. Greet patient and provide gowning	
3. Obtain vital signs	
4. Provide pre-service education/obtain consent	
5. Prepare room, equipment, supplies	
6. Prepare and position patient/monitor patient/set up IV	
7. Sedate/apply anesthesia	
<i>Intra-service</i>	
8. Assist physician in performing procedure/surgery	
<i>Post-service</i>	
9. Monitor patient following service/check tubes, monitors, drains	
10. Clean room/equipment	
11. Assist with ICU or hospital visits	
12. Complete diagnostic forms, lab & x-ray requisitions	
13. Review/read x-ray, lab, and pathology reports	
14. (Discharge day mgmt services) Check dressings & wound/home care instructions/coordinate office visits/prescriptions	
15. Coordination of in-facility care by staff in office	
Other service period activities (please specify):	
End: With discharge from hospital, ASC, or office	
POST-SERVICE PERIOD	
Start: After discharge from hospital, ASC, or office	
1. Conduct phone calls/call in prescriptions	8
2. 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/equipment, check supplies	
Coordinate home or outpatient care	
3. Conduct phone calls between office visits	
Other post-service activities (please specify):	
End: With last office visit before end of global period	

Practice Expense Summary – Supplies & Equipment Out of Office

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	MOSP	3		
	Basic Post-Op. Incision Care Kit (suture)	1		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Exam Table	1			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

(April 2001)

CPT Code: 544X5

Global: 090

Survey Median RVW: 13.30

~~Recommended RVW: 13.30~~

RUC Recommended RVW: 12.75

CPT Descriptor: Repair of component(s) of multi-component inflatable penile prosthesis

Tracking Code: Y6

Survey Vignette (Typical Patient)

A 68-year-old man with severe peripheral vascular disease had an inflatable multi-component penile prosthesis placed 14 months ago. The right cylinder has buckled and slipped back from the glans penis. Repair of this problem is scheduled.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service Work- Day before surgery:

- Review pre-op lab results
- Review medical record
- Write pre-op orders (to be faxed to hospital)
- Check to be sure necessary prosthesis components are at hospital

Pre-service work- Day of surgery:

- Change into scrub cloths
- Review surgical procedure, post-op recovery in and out of hospital with patient and family
- Answer patient and family questions, be sure informed consent is in record
- Speak to anesthesiologist about expected length of procedure and any special concerns about this particular patient (teeth, positioning, unusual medical problems)
- Position patient on operating table
- Verify that all necessary instruments and prosthetic components are available

Intra-service work- Skin to skin:

- A Foley catheter is placed
- A transverse infra-pubic incision is made
- Dissection is done entirely with the electro-cautery so as not to cut the prosthesis and tubing
- A herniation of the right cylinder is noted through the old corporotomy incision causing a buckling of the right prosthesis
- The prosthesis is removed from the right cylinder and seen to be in good working order
- The prosthesis is replaced into normal position
- The defect in the corpus cavernosum is carefully repaired giving a good strong closure over the prosthesis
- The prosthesis is pumped and deflated to make sure they work properly.
- The wound is irrigated throughout the procedure with antibiotic spray
- The corporotomies are closed.
- The wound is irrigated and closed in usual fashion

Post-op Same day work through discharge from recovery

- Apply dressings
- Assist in transfer of patient from operating table to post-op stretcher
- Accompany anesthesiologist with patient to recovery area

AUA

-
- Assist in transfer of patient to recovery area bed
 - Write post-op orders
 - Review recovery area care and medications with staff
 - Meet with family and discuss the procedure, expected outcome, planned post operative care in hospital and out of hospital
 - Discuss procedure with patient as necessary in recovery area when awake
 - Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)
 - Dictate detailed operative narrative

Post-op Same day work after discharge from recovery

- Examine patient, check wound and patient progress
- Review patient hospital medical record notes (nursing, pharmacy, dietary, discharge planner)
- Answer patient and family questions
- Answer nursing and other staff questions
- Write any further necessary orders
- Write note in progress note section of medical record

Post-op Other Hospital Work – *Beginning on post op-day 1, until discharge day*

- Examine and talk to patient
- Check wounds and dressings
- Discuss patient progress with patient and family
- Review all patient hospital medical record notes
- Discuss post operative care of wound and prosthesis at home
- Answer nursing and other staff questions
- Answer patient and family questions
- Write orders in medical record
- Write progress notes

Discharge day work:

- Examine and talk with patient and family
- Check wounds and patient progress
- Review all patient hospital medical records
- Answer patient and family questions
- Write orders for post-discharge care
- Write prescriptions for post-op medications
- Discuss post-op care of prosthesis with patient and family
- Dictate detailed hospital discharge summary

Post-op Office work- *After discharge from hospital:*

- Examine patient, check vital signs
- Talk with patient and family
- Answer questions from patient and family
- Write necessary prescriptions
- Remove sutures
- Schedule next office visit
- Mark appropriate diagnosis and CPT code on Superbill
- Dictate patient progress notes for office medical record
- Dictate letter to referring physician

SURVEY DATA:**Presenters:** James B. Regan, MD & Jeffrey A. Dann, MD**Specialty:** American Urological Association**Type of Sample:** Mixed-panel/random **Sample Size:** 60**Response Rate:** 50% (30/60)

	Low	25 th %	Median	75 %	High
Survey RVW	8.00	12.20	13.30	15.25	18.00
Pre-Service Time	20	40	50	83	180
Intra-Service Time	45	60	110	140	180

Post-Service:	Total Time	CPT code/# of visits
Immed. Post-Service	30	
Critical Care		0
Other Hospital	19	1- 99231
Discharge Day Mgmt	36	1- 99238
Office Visits	61	1- 99214, 2- 99213

INPUT/BUILDING BLOCK METHOD**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	2001 RVW	% RESP	GLOBE
54407	Removal, repair, or replacement of inflatable (multi-component) penile prosthesis, including pump and/or reservoir and/or cylinders	13.34	52%	090
54409	Surgical correction of hydraulic abnormality of inflatable (multi-component) prosthesis including pump and/or reservoir and/or cylinders	12.20	35%	090
54405	Insertion of inflatable (multi-component) penile prosthesis, including placement of pump, cylinders, and/or reservoir	13.03	1%	090

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**INTENSITY/COMPLEXITY MEASURES (mean)****TIME SEGMENTS**

	Svy CPT 544X5	Reference CPT 54407
Pre-service	3.10	2.69
Intra-service	3.59	3.03
Post-service	2.90	2.55

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.24	2.76
The amount and/or complexity of medical records,	3.07	2.62

diagnostic tests, and/or other information that must be reviewed and analyzed		
Urgency of medical decision making	2.72	2.38

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.79	2.97
Physical effort required	3.24	2.76

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.45	2.79
Outcome depends on the skill and judgment of physician	3.86	3.14
Estimated risk of malpractice suit with poor outcome	3.66	3.03

**ADDITIONAL RATIONALE- None
IINPUT/BUILDING BLOCK METHOD**

SURVEY RVW =	RVW 13.30
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PRE-SERVICE	TIME	INTENSITY	(= time x intensity)
Day prior evaluation	0	0.0224	0.00
Same day evaluation	20	0.0224	0.45
Scrub, prep	30	0.0081	0.24
TOTAL PRE-SERVICE		RVW=	0.69

POST SERVICE			
Immediate hospital	30	0.0224	0.67
	Visit n	E&M RVW	(= n x E&M RVW)
Subsequent hospital			
ICU 99291	0.0	4.00	0.00
Room 99233	0.0	1.51	0.00
Room 99232	0.0	1.06	0.00
Room 99231	1.0	0.64	0.64
Discharge 99238	1.0	1.28	1.28
Subsequent office			
99215	0.0	1.77	0.00
99214	1.0	1.10	1.10
99213	2.0	0.67	1.34
99212	0.0	0.45	0.00
99211	0.0	0.17	0.00
TOTAL POST SERVICE		RVW =	5.03

	TIME	IINPUT	
INTRASERVICE	110	0.069	7.58

FREQUENCY INFORMATION

How was this procedure previously coded? 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 Sometimes

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

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 Medicare Frequency 500

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

REFERENCE SERVICE LIST- Please see AUA Reference Service List

Practice Expense Summary – Clinical Labor	
CPT code: 544X5 – Repair of component(s) of a multi-component, inflatable penile prosthesis	
Tracking #: Y6	
Global Period: 090	
	Out-of-Office
Staff Type	RN/LPN/MA
Pre-service time	60
Service period	
Coordination of Care by staff in the physician's office during the service period (for facility services)	
Post-service time (excluding time of office visits)	8
Total Number of office visits	1-99214 2-99213
Total time of office visits	125
PRE-SERVICE PERIOD	
Start: Following visit when decision for surgery or procedure made	
1. Complete pre-service diagnostic & referral forms	5
2. Coordinate pre-procedure or pre-surgery services	20
3. Schedule space and equipment in facility	8
4. Office visit before surgery/procedure to review test and exam results	
5. Provide pre-service education/obtain consent	20
6. Follow-up phone calls & prescriptions	7
Other Pre-Service Activities (please specify):	
End: When patient enters hospital or office for surgery/procedure	
SERVICE PERIOD	
Start: With admission to hospital, ASC, or office for procedure	
<i>Pre-service services</i>	
1. Review charts	
2. Greet patient and provide gowning	
3. Obtain vital signs	
4. Provide pre-service education/obtain consent	
5. Prepare room, equipment, supplies	
6. Prepare and position patient/monitor patient/set up IV	
7. Sedate/apply anesthesia	
<i>Intra-service</i>	
8. Assist physician in performing procedure/surgery	
<i>Post-service</i>	
9. Monitor patient following service/check tubes, monitors, drains	
10. Clean room/equipment	
11. Assist with ICU or hospital visits	
12. Complete diagnostic forms, lab & x-ray requisitions	
13. Review/read x-ray, lab, and pathology reports	
14. (Discharge day mgmt services) Check dressings & wound/home care instructions/coordinate office visits/prescriptions	
15. Coordination of in-facility care by staff in office	
Other service period activities (please specify):	
End: With discharge from hospital, ASC, or office	
POST-SERVICE PERIOD	
Start: After discharge from hospital, ASC, or office	
1. Conduct phone calls/call in prescriptions	8
2. 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/equipment, check supplies	
Coordinate home or outpatient care	
3. Conduct phone calls between office visits	
Other post-service activities (please specify):	
End: With last office visit before end of global period	

Practice Expense Summary – Supplies & Equipment Out of Office

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	MMSP	3		
	Basic Post-Op. Incision Care Kit (suture)	1		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Exam Table	1			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

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

(April 2001)

CPT Code: 544X6

Global: 090

Survey Median RVW: 15.50
Recommended RVW: 15.50

CPT Descriptor: Removal and replacement of components of a multi-component, inflatable penile prosthesis at the same operative sitting

Tracking Code: Y7

Survey Vignette (Typical Patient)

A 77-year-old man had a multi-component inflatable penile prosthesis placed 11 years ago. When having vigorous intercourse two days ago he heard a "pop" and suddenly lost his erection. On exam the prosthesis will not inflate when compressing the scrotal pump. An x-ray confirms loss of fluid from the system. The patient is anxious to correct the problem as soon as possible. Removal of all old components and replacement with all new components of a multi-component inflatable penile prosthesis is planned.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service Work- Day before surgery:

- Review pre-op lab results
- Review medical record
- Write pre-op orders (to be faxed to hospital)
- Check to be sure necessary prosthesis components are at hospital

Pre-service work- Day of surgery:

- Change into scrub cloths
- Review surgical procedure, post-op recovery in and out of hospital with patient and family
- Answer patient and family questions, be sure informed consent is in record
- Speak to anesthesiologist about expected length of procedure and any special concerns about this particular patient (teeth, positioning, unusual medical problems)
- Position patient on operating table
- Verify that all necessary instruments and prosthetic components are available

Intra-service work- Skin to skin:

- A Foley catheter is placed
- A transverse infra-pubic incision is made
- Dissection is done entirely with the electro-cautery so as not to cut the prosthesis and tubing
- Fluid from the prosthesis is noted tracking along the tubing
- The tubing is traced to the cylinders in the corpora cavernosa
- Longitudinal corporotomies are made
- Both cylinders are delivered into the wound
- The right cylinder is noted to have a crack at the level of the tubing exit
- A leak in the system is identified at the tubing exit from the cylinder
- Tubing is divided from both cylinders
- New measurements of the corporal length are made
- Appropriate new penile prosthesis cylinders are selected and opened
- New connections to the old tubing are made and the system is carefully refilled with fluid to the exact amount necessary. The prostheses are pumped and deflated to make sure they work properly.
- The prostheses are then replaced in the corpora
- Rear Tip Extenders are added as necessary
- The wound is irrigated throughout the procedure with antibiotic spray

AUA

- The corporotomies are closed.
- The wound is irrigated and closed in usual fashion

Post-op Same day work through discharge from recovery

- Apply dressings
- Assist in transfer of patient from operating table to post-op stretcher
- Accompany anesthesiologist with patient to recovery area
- Assist in transfer of patient to recovery area bed
- Write post-op orders
- Review recovery area care and medications with staff
- Meet with family and discuss the procedure, expected outcome, planned post operative care in hospital and out of hospital
- Discuss procedure with patient as necessary in recovery area when awake
- Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)
- Dictate detailed operative narrative

Post-op Same day work after discharge from recovery

- Examine patient, check wound and patient progress
- Review patient hospital medical record notes (nursing, pharmacy, dietary, discharge planner)
- Answer patient and family questions
- Answer nursing and other staff questions
- Write any further necessary orders
- Write note in progress note section of medical record

Post-op Other Hospital Work – *Beginning on post op-day 1, until discharge day*

- Examine and talk to patient
- Check wounds and dressings
- Discuss patient progress with patient and family
- Review all patient hospital medical record notes
- Discuss post operative care of wound and prosthesis at home
- Answer nursing and other staff questions
- Answer patient and family questions
- Write orders in medical record
- Write progress notes

Discharge day work:

- Examine and talk with patient and family
- Check wounds and patient progress
- Review all patient hospital medical records
- Answer patient and family questions
- Write orders for post-discharge care
- Write prescriptions for post-op medications
- Discuss post-op care of prosthesis with patient and family
- Dictate detailed hospital discharge summary

Post-op Office work- *After discharge from hospital:*

- Examine patient, check vital signs
- Talk with patient and family
- Answer questions from patient and family
- Write necessary prescriptions
- Remove sutures
- Schedule next office visit
- Mark appropriate diagnosis and CPT code on Superbill
- Dictate patient progress notes for office medical record
- Dictate letter to referring physician

SURVEY DATA:

Presenters: James B. Regan, MD & Jeffrey A. Dann, MD
Specialty: American Urological Association

Type of Sample: Mixed-panel/random **Sample Size:** 60

Response Rate: 50% (30/60)

	Low	25 th %	Median	75 %	High
Survey RVW	12.00	13.34	15.50	19.28	25.00
Pre-Service Time	20	40	50	80	175
Intra-Service Time	75	90	145	180	210

Post-Service:	Total Time	CPT code/# of visits
Immed. Post-Service	30	
Critical Care		0
Other Hospital	19	1- 99231
Discharge Day Mgmt	36	1- 99238
Office Visits	61	1- 99214, 2- 99213

INPUT/BUILDING BLOCK METHOD**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	2001 RVW	% RESP	GLOBE
54407	Removal, repair, or replacement of inflatable (multi-component) penile prosthesis, including pump and/or reservoir and/or cylinders	13.34	64%	090
54405	Insertion of inflatable (multi-component) penile prosthesis, including placement of pump, cylinders, and/or reservoir	13.43	21%	090
53447	Removal, repair, or replacement of inflatable sphincter including pump and/or reservoir and/or cuff	13.17	1%	090

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

<u>INTENSITY/COMPLEXITY MEASURES (mean)</u> <u>TIME SEGMENTS</u>	<u>Svy CPT</u> <u>544X6</u>	<u>Reference CPT</u> <u>54407/54405</u>
Pre-service	3.03	2.76
Intra-service	3.69	3.03
Post-service	2.93	2.59

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.21	2.86
The amount and/or complexity of medical records,	3.07	2.72

diagnostic tests, and/or other information that must be reviewed and analyzed		
Urgency of medical decision making	2.52	2.21

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.86	3.24
Physical effort required	3.59	2.93

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.59	3.03
Outcome depends on the skill and judgment of physician	3.79	3.21
Estimated risk of malpractice suit with poor outcome	3.83	3.21

**ADDITIONAL RATIONALE- None
IINPUT/BUILDING BLOCK METHOD**

SURVEY RVW =	RVW 15.50
---------------------	---------------------

PRE-SERVICE	TIME	INTENSITY	(= time x intensity)
Day prior evaluation	0	0.0224	0.00
Same day evaluation	20	0.0224	0.45
Scrub, prep	30	0.0081	0.24
TOTAL PRE-SERVICE		RVW=	0.69

POST SERVICE	TIME	INTENSITY	(= time x intensity)
Immediate hospital	30	0.0224	0.67
	Visit n	E&M RVW	(= n x E&M RVW)
Subsequent hospital			
ICU 99291	0.0	4.00	0.00
Room 99233	0.0	1.51	0.00
Room 99232	0.0	1.06	0.00
Room 99231	1.0	0.64	0.64
Discharge 99238	1.0	1.28	1.28
Subsequent office			
99215	0.0	1.77	0.00
99214	1.0	1.10	1.10
99213	2.0	0.67	1.34
99212	0.0	0.45	0.00
99211	0.0	0.17	0.00
TOTAL POST SERVICE		RVW =	5.03

	TIME	IINPUT	
INTRASERVICE	145	0.067	9.78

FREQUENCY INFORMATION

How was this procedure previously coded? 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 Sometimes

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

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 Medicare Frequency 500

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

REFERENCE SERVICE LIST- Please see AUA Reference Service List

Practice Expense Summary – Clinical Labor	
CPT code: 544X6 – Removal and replacement of component(s) of a multi-component, inflatable penile prosthesis at the same operative session.	
Tracking #: Y7	
Global Period: 090	
	Out-of-Office
Staff Type	RN/LPN/MA
Pre-service time	60
Service period	
Coordination of Care by staff in the physician's office during the service period (for facility services)	
Post-service time (excluding time of office visits)	8
Total Number of office visits	1-99214 2-99213
Total time of office visits	125
PRE-SERVICE PERIOD	
Start: Following visit when decision for surgery or procedure made	
1. Complete pre-service diagnostic & referral forms	5
2. Coordinate pre-procedure or pre-surgery services	20
3. Schedule space and equipment in facility	8
4. Office visit before surgery/procedure to review test and exam results	
5. Provide pre-service education/obtain consent	20
6. Follow-up phone calls & prescriptions	7
Other Pre-Service Activities (please specify):	
End: When patient enters hospital or office for surgery/procedure	
SERVICE PERIOD	
Start: With admission to hospital, ASC, or office for procedure	
<i>Pre-service services</i>	
1. Review charts	
2. Greet patient and provide gowning	
3. Obtain vital signs	
4. Provide pre-service education/obtain consent	
5. Prepare room, equipment, supplies	
6. Prepare and position patient/monitor patient/set up IV	
7. Sedate/apply anesthesia	
<i>Intra-service</i>	
8. Assist physician in performing procedure/surgery	
<i>Post-service</i>	
9. Monitor patient following service/check tubes, monitors, drains	
10. Clean room/equipment	
11. Assist with ICU or hospital visits	
12. Complete diagnostic forms, lab & x-ray requisitions	
13. Review/read x-ray, lab, and pathology reports	
14. (Discharge day mgmt services) Check dressings & wound/home care instructions/coordinate office visits/prescriptions	
15. Coordination of in-facility care by staff in office	
Other service period activities (please specify):	
End: With discharge from hospital, ASC, or office	
POST-SERVICE PERIOD	
Start: After discharge from hospital, ASC, or office	
1. Conduct phone calls/call in prescriptions	8
2. 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/equipment, check supplies	
Coordinate home or outpatient care	
3. Conduct phone calls between office visits	
Other post-service activities (please specify):	
End: With last office visit before end of global period	

Practice Expense Summary – Supplies & Equipment Out of Office

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	MMSP	3		
	Basic Post-Op. Incision Care Kit (suture)	1		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Exam Table	1			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

(April 2001)

CPT Code: 544X7

Global: 090

Survey Median RVW: 16.00

75th percentile RVW: 22.50

~~Recommended RVW: 26.07~~

RUC Recommended RVW: 16.00

CPT Descriptor: Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session including irrigation and debridement of infected tissue

Tracking Code: Y8

Survey Vignette (Typical Patient)

A 67-year-old man had a multi-component inflatable penile prosthesis placed five months ago. Over the past month he has developed low-grade fevers, penile swelling, mild erythema of the penis and scrotum, scrotal aching and generalized pelvic discomfort. Two days ago a red area at the left aspect of his infrapubic incision opened and pus drained out. After appropriate exam and testing it is determined that his prosthesis is infected. If the infected prosthesis is removed, the "dead space" will scar, making future placement of a new prosthesis difficult, if not impossible. Salvage of the prosthesis through an infected field is planned.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service Work- Day before surgery:

- Review pre-op lab results
- Review medical record
- Write pre-op orders (to be faxed to hospital)
- Check to be sure necessary prosthesis components are at hospital

Pre-service work- Day of surgery:

- Change into scrub cloths
- Review surgical procedure, post-op recovery in and out of hospital with patient and family
- Answer patient and family questions, be sure informed consent is in record
- Speak to anesthesiologist about expected length of procedure and any special concerns about this particular patient (teeth, positioning, unusual medical problems)
- Position patient on operating table
- Verify that all necessary instruments and prosthetic components are available

Intra-service work- Skin to skin:

- A Foley catheter is placed
- A transverse infra-pubic incision is made
- The corpora cavernosa are exposed
- Lateral corporotomies are made
- Each prosthesis (right and left) are carefully removed
- The proximal corpus cavernosum on each side is probed and checked for remaining rear-tip extenders
- The corporotomies and entire wound are irrigated with 10 (ten) liters of a saline solution containing antibiotics for a total of 20 (twenty) minutes
- The length of each corpus cavernosum from the ischial tuberosity to the glans penis is carefully measured
- An appropriate size prosthesis is selected and opened
- The corpora are re-dilated to the proper diameter
- The prosthesis is inserted, an insertion tool and insertion suture may be utilized
- Rear Tip Extenders are added as necessary
- The prosthesis is checked fit
- A new pump is selected and placed in the scrotum
- A new reservoir is placed beneath the rectus muscles

AUA

- Pump and reservoir spaces are copiously irrigated
- Jackson Pratt drains (3.2 mm round) are placed in appropriate areas for post operative irrigation with antibiotic solutions and drainage
- The corporotomies are closed with absorbable suture
- The rectus muscles are reapproximated
- Throughout the procedure the operative field is irrigated with antibiotic spray
- The subcutaneous tissues are closed
- Drains are brought out through separate stab wounds and sutured in place
- The wound is closed in usual fashion

Post-op Same day work through discharge from recovery

- Apply dressings
- Assist in transfer of patient from operating table to post-op stretcher
- Accompany anesthesiologist with patient to recovery area
- Assist in transfer of patient to recovery area bed
- Write post-op orders
- Review recovery area care and medications with staff
- Meet with family and discuss the procedure, expected outcome, planned post operative care in hospital and out of hospital
- Discuss procedure with patient as necessary in recovery area when awake
- Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)
- Dictate detailed operative narrative

Post-op Same day work after discharge from recovery

- Examine patient, check wound and patient progress
- Review patient hospital medical record notes (nursing, pharmacy, dietary, discharge planner)
- Answer patient and family questions
- Answer nursing and other staff questions
- Write any further necessary orders
- Write note in progress note section of medical record

Post-op Other Hospital Work – *Beginning on post op-day 1, until discharge day*

- Examine and talk to patient
- Check wounds and dressings
- Discuss patient progress with patient and family
- Review all patient hospital medical record notes
- Discuss post operative care of wound and prosthesis at home
- Answer nursing and other staff questions
- Answer patient and family questions
- Write orders in medical record
- Write progress notes

Discharge day work:

- Examine and talk with patient and family
- Check wounds and patient progress
- Review all patient hospital medical records
- Answer patient and family questions
- Write orders for post-discharge care
- Write prescriptions for post-op medications
- Discuss post-op care of prosthesis with patient and family
- Dictate detailed hospital discharge summary

Post-op Office work- *After discharge from hospital:*

- Examine patient, check vital signs
- Talk with patient and family
- Answer questions from patient and family
- Write necessary prescriptions
- Remove sutures
- Schedule next office visit
- Mark appropriate diagnosis and CPT code on Superbill

- Dictate patient progress notes for office medical record
- Dictate letter to referring physician

SURVEY DATA:

Presenters: James B. Regan, MD & Jeffrey A. Dann, MD

Specialty: American Urological Association

Type of Sample: Mixed-panel/random **Sample Size:** 60 **Response Rate:** 50% (30/60)

	Low	25 th %	Median	75 %	High
Survey RVW	13.00	15.00	16.00	22.50	28.00
Pre-Service Time	25	35	50	90	210
Intra-Service Time	60	120	180	190	240

Post-Service:	Total Time	CPT code/# of visits
Immed. Post-Service	30	
Critical Care		0
Other Hospital	155	5- 99231, 2- 99232
Discharge Day Mgmt	36	1-99238
Office Visits	99	1- 99212, 2- 99213, 1- 99214

INPUT/BUILDING BLOCK METHOD

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	% RESP	GLOBE
54407	Removal, repair, or replacement of inflatable (multi-component) penile prosthesis, including pump and/or reservoir and/or cylinders	13.34	48%	090
54405	Insertion of inflatable (multi-component) penile prosthesis, including placement of pump, cylinders, and/or reservoir	13.43	24%	090
50220	Nephrectomy, including partial ureterectomy, any approach including rib resection;	17.15	10%	090

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

INTENSITY/COMPLEXITY MEASURES (mean)

TIME SEGMENTS	Svy CPT	Reference CPT
	544X7	54407
Pre-service	3.93	2.86
Intra-service	4.38	3.31
Post-service	4.10	2.79

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.14	3.17
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.93	3.14

Urgency of medical decision making	4.52	2.69
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TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.28	3.28
Physical effort required	4.14	3.10

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	5.00	3.24
Outcome depends on the skill and judgment of physician	4.86	3.34
Estimated risk of malpractice suit with poor outcome	5.00	3.93

ADDITIONAL RATIONALE

The workgroup felt that the respondents did not give credit for the extensive post op. care. Even using the 75th percentile, the IWPUT is low at 0.061. The workgroup feels the intensity of this procedure is about 0.080. This requires an RVW of 26.07.

IWPUT/BUILDING BLOCK METHOD

SURVEY (75th percentile) RVW =	RVW <u>22.50</u>
--------------------------------------------------	----------------------------

PRE-SERVICE	TIME	INTENSITY	(= time x intensity)
Day prior evaluation	0	0.0224	0.00
Same day evaluation	20	0.0224	0.45
Scrub, prep	30	0.0081	0.24
TOTAL PRE-SERVICE		RVW=	0.69

POST SERVICE			
Immediate hospital	30	0.0224	0.67
	Visit n	E&M RVW	(= n x E&M RVW)
Subsequent hospital			
ICU 99291	0.0	4.00	0.00
Room 99233	0.0	1.51	0.00
Room 99232	2.0	1.06	2.12
Room 99231	5.0	0.64	3.20
Discharge 99238	1.0	1.28	1.28
Subsequent office			
99215	0.0	1.77	0.00
99214	1.0	1.10	1.10
99213	2.0	0.67	1.34
99212	1.0	0.45	0.45
99211	0.0	0.17	0.00
TOTAL POST SERVICE		RVW =	10.16

	TIME	IWPUT	
INTRASERVICE	190	0.061	11.65

FREQUENCY INFORMATION

How was this procedure previously coded? 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 Sometimes

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

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 Medicare Frequency 500

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

REFERENCE SERVICE LIST- Please see AUA Reference Service List

Practice Expense Summary – Clinical Labor	
CPT code: 544X7 – Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session including irrigation and debridement of infected tissue.	
Tracking #: Y8	
Global Period: 090	
	Out-of-Office
Staff Type	RN/LPN/MA
Pre-service time	60
Service period	
Coordination of Care by staff in the physician's office during the service period (for facility services)	
Post-service time (excluding time of office visits)	8
Total Number of office visits	1-99212 2-99213 1-99214
Total time of office visits	152
PRE-SERVICE PERIOD	
Start: Following visit when decision for surgery or procedure made	
1. Complete pre-service diagnostic & referral forms	5
2. Coordinate pre-procedure or pre-surgery services	20
3. Schedule space and equipment in facility	8
4. Office visit before surgery/procedure to review test and exam results	
5. Provide pre-service education/obtain consent	20
6. Follow-up phone calls & prescriptions	7
Other Pre-Service Activities (please specify):	
End: When patient enters hospital or office for surgery/procedure	
SERVICE PERIOD	
Start: With admission to hospital, ASC, or office for procedure	
<i>Pre-service services</i>	
1. Review charts	
2. Greet patient and provide gowning	
3. Obtain vital signs	
4. Provide pre-service education/obtain consent	
5. Prepare room, equipment, supplies	
6. Prepare and position patient/monitor patient/set up IV	
7. Sedate/apply anesthesia	
<i>Intra-service</i>	
8. Assist physician in performing procedure/surgery	
<i>Post-service</i>	
9. Monitor patient following service/check tubes, monitors, drains	
10. Clean room/equipment	
11. Assist with ICU or hospital visits	
12. Complete diagnostic forms, lab & x-ray requisitions	
13. Review/read x-ray, lab, and pathology reports	
14. (Discharge day mgmt services) Check dressings & wound/home care instructions/coordinate office visits/prescriptions	
15. Coordination of in-facility care by staff in office	
Other service period activities (please specify):	
End: With discharge from hospital, ASC, or office	
POST-SERVICE PERIOD	
Start: After discharge from hospital, ASC, or office	
1. Conduct phone calls/call in prescriptions	8
2. 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/equipment, check supplies	
Coordinate home or outpatient care	
3. Conduct phone calls between office visits	
Other post-service activities (please specify):	
End: With last office visit before end of global period	

Practice Expense Summary – Supplies & Equipment Out of Office

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	MMSP	4		
	Basic Post-Op. Incision Care Kit (suture)	1		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Exam Table	1			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

**AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS**

February 2001

Lesion of Testes

The RUC reviewed this issue to ensure that 54512 *Excision of extraparenchymal lesion of testis* (work RVU = 8.58) was appropriately valued as 54510 *Excision of local lesion of testis* (work RVU = 5.45) will now be deleted and physicians will be instructed to report code 54512. The RUC noted that the deleted code 54510 is infrequently performed (1999 Medicare Utilization = 165). The CPT Editorial Panel had acted to create a new code 54512 for *CPT 2001*, but did not realize that 54510 should be deleted as it described a duplicative procedure. The AUA conducted a RUC survey for 54512 and the survey median was accepted by the RUC. The RUC agreed that this value is appropriate and the deletion of 54510 should have no effect on this code.

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
54510 (D)		Excision of local lesion of testis <u>54510 has been deleted. To report, use 54512</u>	090	N/A
54512	O1	Excision of extraparenchymal lesion of testis	090	8.58 (no change)

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December 8, 2000

James Hoehn, MD
Chair
Relative Value System Update Committee
American Medical Association
515 North State Street
Chicago, IL 60610

Dear Dr. Hohen:

The American Urological Association (AUA) is scheduled to present data for CPT code 54512 at the February 2001 RUC meeting. However, a value for this code was presented and accepted by the RUC at the February 2000 meeting. Therefore, the AUA will not represent these data.

The reason behind this confusion is as follows. During the November 1999 CPT Editorial Panel meeting, the AUA was asked to describe what is involved in CPT code 54510, Excision of local lesion of testis. In our answer, we noted that this procedure is for an extraparenchymal lesion of testis and that an editorial change reflecting this might be helpful. However, due to a misunderstanding, rather than an editorial change, an entirely new code was created (54512, Excision of extraparenchymal lesion of testis).

A RUC survey was duly conducted and the data presented and accepted by the RUC at the February 2000 meeting.

Unfortunately, the old code (54510) was not deleted. When the AUA realized that there were now two codes for essentially the same service, we requested that the AMA delete one. The AMA agreed with our recommendation and at its November 2000 meeting, the CPT Editorial Panel voted to delete 54510. However, upon receiving the Level of Interest form for the February 2001 RUC meeting, we noticed that 54512 was listed as a new code to be surveyed.

As this is not a new code, and was just surveyed in February, the AUA will not conduct another survey. I hope that this explanation is helpful. If you have any questions, please call me or Ms. Robin Hudson at 410-223-4325. Thank you.

Sincerely,

William F. Gee, M.D.

William F. Gee, MD
AUA RUC Representative

cc: Patrick Gallagher
Mary O'Heron



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AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

February/April 2001

Gynecological Oncology Procedures

The CPT Editorial Panel approved four new gynecological oncology procedures for CPT 2002 to correct current gaps in coding that would 1) allow the physicians who insert uterine tandems, vaginal ovoids, or Heyman capsules so that a radioelement for brachytherapy may be inserted by the radiation oncologist to report their services; and 2) provide more accurate description of bilateral salpingo-oophorectomy procedures.

57155 Insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy:

The RUC reviewed survey data from 24 gynecologists for 57155. This data indicates that this service requires 47.5 minutes pre-time, 55 minutes intra-time, 20 minutes immediate post, 2 hospital visits, discharge day management, and 2 office visits. The survey respondents had indicated that the work was nearly twice that of CPT code 58120 *Dilation and curettage, diagnostic or therapeutic* (work RVU = 3.27) (35 minutes pre-time, 25 minutes intra-time, 27 minutes post-time, 1 hospital visit, discharge day management, and 1 office visit – per RUC database). The specialty indicated that the placement of tandems and ovoids requires repeated manipulation of the devices, as well as careful packing to ensure that the tandems and ovoids remain securely in place. This activity requires a significantly higher level of technical skill than the service described in 58120. The survey indicated that this service was more intense than 58120 in each category. The RUC agreed that the survey median was appropriate. **The RUC recommends a work value of 6.27 for CPT code 57155.**

Practice Expense:

This service is only performed in the facility setting. The RUC recommends the PEAC proposed standardized package for 90 day global major surgical procedures as described on the attached summary. The ob-gyn supply package for an office visit (ob/by min. supply for office visit + pelvic exam + drape sheet) should be used in lieu of the standard minimum supply package.

58346 Insertion of Heyman capsules for clinical Brachytherapy:

The RUC reviewed survey data from 22 gynecologists for 58346. This data indicates that this service requires 50 minutes pre-time, 60 minutes intra-time, 20 minutes immediate post, 2 hospital visits, discharge day management, and 2 office visits. The survey respondents had indicated that the work was nearly twice that of CPT code 58120 *Dilation and curettage, diagnostic or therapeutic* (work RVU = 3.27) (35 minutes pre-time, 25 minutes intra-time, 27 minutes post-time, 1 hospital visit, discharge day management, and 1 office visit – per RUC database). The specialty indicated that the placement of tandems and ovoids requires repeated manipulation of the devices, as well as careful packing to ensure that the capsules remain securely in place. This activity requires a significantly higher level of technical skill than the service described in 58120. The survey indicated that this service was more intense than 58120 in each category. The specialty felt that the survey median of 8.34 was overstated as the procedure is rare and the survey respondents may have been unfamiliar with the procedure. 58346 requires slightly more work than 57155, therefore, the RUC recommends the 25th percentile of the survey. **The RUC recommends a work value of 6.75 for CPT code 58346.**

Practice Expense:

This service is only performed in the facility setting. The RUC recommends the PEAC proposed standardized package for 90 day global major surgical procedures as described on the attached summary. The ob-gyn supply package for an office visit should be used in lieu of the standard minimum supply package.

58953 Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking:

The CPT Editorial Panel created new code 58953 to accurately describe a service that is not currently described in CPT. Currently, this services is reported as follows:

58952	Resect ovarian malignancy	25.01
58150-51	Total hysterectomy (15.24*.50)	<u>7.62</u>
Total current value when performing this service		32.63

The RUC reviewed the survey data from 51 gynecology oncologists and determined that the survey median of 32.00 was appropriate and compared to the total work relative value listed above. The RUC did not accept the pre-service time of 150 minutes as typical, however, and adjusted this time to 90 minutes. **The RUC recommends a work RVU of 32.00 for 58953.**

Practice Expense:

This service is only performed in the facility setting. The RUC recommends the PEAC proposed standardized package for 90 day global major surgical procedures as described on the attached summary. The ob-gyn supply package for an office visit should be used in lieu of the standard minimum supply package.

58954 Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking; with pelvic lymphadenectomy and limited para-aortic lymphadenectomy:

The CPT Editorial Panel created new code 58954 to accurately describe a service that is not currently described in CPT. Currently, this services is reported as follows:

58952	Resect ovarian malignancy	25.01
58150-51	Total hysterectomy (15.24*.50)	7.62
38770-51	Remove pelvis lymph nodes (13.23*.50)	<u>6.62</u>
Total current value when performing this service		39.25

The RUC reviewed the survey data from 41 gynecology oncologists and determined that the survey median of 35.00 was appropriate and compared to the total work relative value listed above. The RUC did not accept the pre-service time of 150 minutes as typical, however, and adjusted this time to 90 minutes. **The RUC recommends a work RVU of 35.00 for 58954.**

Practice Expense:

This service is only performed in the facility setting. The RUC recommends the PEAC proposed standardized package for 90 day global major surgical procedures as described on the attached summary. The ob-gyn supply package for an office visit should be used in lieu of the standard minimum supply package.

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
●57155	M3	Insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy (For insertion of radioelement sources or ribbons, see 77761-77763, 77781-77784)	090	6.27 (Approved at the February 2001 RUC Meeting)
●58346	M4	Insertion of Heyman capsules for clinical Brachytherapy (For insertion of radioelement sources or ribbons, see 77761-77763, 77781-77784)	090	6.75 (Approved at the February 2001 RUC Meeting)
●58953	M1	Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking;	090	32.00 (Approved at April 2001 RUC meeting)
●58954	M2	with pelvic lymphadenectomy and limited para-aortic lymphadenectomy	090	35.00 (Approved at April 2001 RUC meeting)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 571XX Tracking Number: M3 Global Period: 90 Recommended RVW: 6.27

CPT Descriptor: Insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 49-year-old patient with stage 2 B cervical cancer has completed her external beam radiation and is now scheduled for placement of tandems and ovoids for brachytherapy for completion of her radiation therapy. [Note: Consider only your work related to placing the tandems and ovoids. The work of loading the radioactive elements is captured in another, separately reported code.]

Pre-service work: The pre-service work includes dictating an admission history and physical and writing the admission orders. The patient is greeted in the preoperative holding area with appropriate consents verified or taken. All preoperative laboratory and x-ray studies are reviewed. The patient is placed in the lithotomy position and prepped and draped.

Intra-service work: The cervix is dilated using Hegar dilators and the uterus is sounded. A tandem (hollow cylinder) is inserted into the uterus, the other end of which protrudes through the vaginal opening. Two ovoids then are placed in the upper part of the vagina the other end of which protrude through the vaginal opening. The ovoids and tandem are packed carefully in place to protect the bladder and rectum from radiation damage and to prevent any movement of the devices. [Note: Both the tandems and ovoids are loaded at a later time by the radiation oncologist. This will deliver a high dose of potentially curative radiation to the cervix from an intracavitary location.]

Postoperative work: The patient is accompanied to the recovery room where postoperative orders are written and the operative report is dictated. Typically these patients are hospitalized for 2 days following the operation and must be rounded on twice daily to assess patient comfort and stability of the afterloading device. The patient is counseled postoperatively concerning any additional required radiation therapy as well as for the need for post operative follow-up. The patient is followed on an ambulatory basis with 2 office visits during the 90 day global period.

SURVEY DATA:

Presenter(s) Michael Berman, MD

Specialty(s): ACOG

Sample Size: 106 Response Rate: (%): 24 (23%) Median RVW: 6.27

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

25th Percentile RVW: 5.25 75th Percentile RVW: 9.48 Low: 2.75 High: 15

Median Pre-Service Time: 47.5 Median Intra-Service Time: 55

25th Percentile Intra-Svc Time: 30 75th Percentile Intra-Svc Time: 60 Low: 20 High: 90

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	3.04	2.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.24	2.40
Urgency of medical decision making	3.16	2.36

Technical Skill/Physical Effort (Mean)

Technical skill required	3.36	2.32
Physical effort required	2.60	2.08

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.44	2.32
Outcome depends on the skill and judgement of physician	3.48	2.56
Estimated risk of malpractice suit with poor outcome	3.16	2.40

INTENSITY/COMPLEXITY MEASURES

CPT Code Reference
Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3	2.4
Intra-Service intensity/complexity	3.32	2.24
Post-Service intensity/complexity	2.83	2.16

ADDITIONAL RATIONALE

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

571XX requires almost twice as much intra-service time as 58120. Placement of the tandems and ovoids requires repeated manipulation of the devices, as well as careful packing to ensure that the tandems and ovoids remain securely in place. These tasks demand a significantly higher level of technical skill than the performance of a D&C. Postoperatively, 571XX has a 90 day global period which encompasses two office visits, while 58120 has

only 1 office visit within its 10 day global period. Overall, ACOG's RUC committee felt that the survey median of 6.27 RVUs was justified.

FREQUENCY INFORMATION

How was this service previously reported? 58999 when performed alone

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/gyn oncology 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 Ob-gyn/gyn oncology Frequency 18,000

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 Ob-gyn/gyn oncology Frequency: an unknown percentage of cases will be Medicare patients

Specialty _____ Frequency _____

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

**AMA/Specialty Society Update Process
RUC Summary of Recommendation
010 or 090 Day Global Periods
Out-Of-Office Direct Inputs**

Sample Size: na Response Rate: (%): na Global Period: 90

Tracking Number: M3 Reference Code 1 58120 Reference Code 2 _____

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

A consensus panel of 6 ACOG Fellows representing a range of ob-gyn specialists from various geographic locations met to determine standardized direct practice inputs for ob-gyn procedures. The recommendation originally submitted has been revised to use the standard pre- and post-service times for 90 day global procedures approved by the PEAC this week. We have made the following adjustments to the standard PEAC post-service package:

- We added 14 minutes under “Other activity in the pre-service period.” Two phone calls by clinical staff are required to coordinate the schedules and activities of the surgeon and the radiation oncologists.
- Clinical staff times for the post-op visits have been increased over the standard E&M times by 7 minutes to reflect the additional staff time for chaperone and cleanup services associated with a pelvic examination. The PEAC previously approved this adjustment.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Standard activities described in the PEAC 90 day package for pre-service clinical activities (out of office). That is, completing pre-service diagnostic and referral forms, coordinatin pre-surgery services and reviewing test results, scheduling space and equipment in the facility, providing pre-service education, obtaining consent, conducting follow-up phone calls, and coordinating clinical activities of the surgeon and the radiation oncologist.

Intra-Service Clinical Labor Activities:

None.

Post-Service Clinical Labor Activities:

Assist with 2 post-operative visits.

HCFA's Staff Type Code***	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	Cost Estimate and Source (if applicable)
1130	RN/LPN/MA	60	0	0		2	63	

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

**Excluding Time of Office Visits

*** From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	Standard ob-gyn supply package for an office visit with pelvic exam as approved by PEAC April 2000. Items and total quantities are the following:			
11107	Patient gown, disposable	2 item		
11111	Exam table paper	14 foot		
11112	Pillowcase, disposable	2 item		
11302	Gloves, non-sterile	4 pair		
11509	Thermometer probe cover, disposable	2 item		
52314	Disinfectant solution	0.4 oz		
31105	KY jelly, single use pack, 5 grams	2 item		
31511	Mini pad	2 item		
11507	Speculum, disposable	2 item		
11513	Swabs, procto	4 item		
11106	drape sheet	2 item		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
E11001	Exam table	1			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

**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	5	RN/LPN/MA, Other _____
Coordinate pre-surgery services	<u>20</u>	RN/LPN/MA, Other _____
Schedule space and equipment in facility	<u>8</u>	RN/LPN/MA, Other _____
Office visit before surgery/procedure Review test and exam results	<u>0</u>	RN, LPN, MA, Other _____
Provide pre-service education/obtain consent	<u>20</u>	RN/LPN/MA, Other _____
Follow-up phone calls & prescriptions	<u>7</u>	RN/LPN/MA Other _____
Other Activity (please specify) Coordinating schedules with surgeon and radiation oncologist.	_____	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	<u>0</u>	RN, LPN, MA, Other _____
Greet patient and provide gowning	<u>0</u>	RN, LPN, MA, Other _____
Obtain vital signs	<u>0</u>	RN, LPN, MA, Other _____
Provide pre-service education/obtain consent	<u>0</u>	RN, LPN, MA, Other _____
Prepare room, equipment, supplies	<u>0</u>	RN, LPN, MA, Other _____
Prepare and position patient/ monitor patient/ set up IV	<u>0</u>	RN, LPN, MA, Other _____
Sedate/apply anesthesia	<u>0</u>	RN, LPN, MA, Other _____
<i>Intra-service</i>	<u>0</u>	
Assist physician in performing surgery/procedure		RN, LPN, MA, Other _____

Post-service

Monitor pt. following service/check tubes, monitors, drains	<u>0</u>	RN, LPN, MA, Other _____
Clean room/equipment by physician staff	<u>0</u>	RN, LPN, MA, Other _____
Assist with ICU or hospital visits	<u>0</u>	RN, LPN, MA, Other _____
Total Number of ICU visits	<u>0</u>	
Total Number of hospital visits	<u>0</u>	
Complete diagnostic forms, lab & X-ray requisitions	<u>0</u>	RN, LPN, MA, Other _____
Review/read X-ray, lab, and pathology reports	<u>0</u>	RN, LPN, MA, Other _____
Discharge day management services, check dressings & wound/ home care instructions/coordinate office visits/prescriptions	<u>0</u>	RN, LPN, MA, Other _____
Coordination of care by staff in office	<u>0</u>	RN, LPN, MA, Other _____
Other Activity (please specify)	<u>0</u>	RN, LPN, MA, Other _____
_____	<u>0</u>	RN, LPN, MA, Other _____

End: Patient discharge from hospital

Post-Service Period

Start: Patient discharge from hospital

Conduct phone calls/call in prescriptions	_____	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	<u>A1 36 (99213)</u>	
Coordinate home or outpatient care	<u>A2 27 (99212)</u>	RN, LPN, MA, Other _____
List total number of office visits	B <u>2</u>	
Total office visit time (A1+A2)	<u>63</u>	
Conduct phone calls between office visits	_____	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 PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 583XX Tracking Number: M4 Global Period: 90 Recommended RVW: 6.75

CPT Descriptor: Insertion of Heyman capsules for clinical brachytherapy

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75-year-old patient with severe cardiac disease is diagnosed with uterine cancer. She is found not to be a candidate for surgery and the decision is made to treat her cancer with radiation therapy including clinical brachytherapy. The patient is scheduled for insertion of Heyman capsules. [Note: Consider only your work related to placing the Heyman capsules. The work of loading the radioactive elements is captured in another, separately reported code.]

Pre-service work: The pre-service work includes dictating an admission history and physical and writing the admission orders. The patient is greeted in the preoperative holding area with appropriate consents verified or taken. All preoperative laboratory and x-ray studies are reviewed. The patient is placed in the lithotomy position and prepped and draped.

Intra-service work: After induction of appropriate anesthesia, the cervix is dilated using Hegar dilators and the uterus is sounded. The Heyman (afterloading) capsules are then inserted into the uterine cavity. The number of capsules will vary from patient to patient and depends solely on the size of the uterine cavity. As few as 4-5 or as many as 12-15 capsules may be inserted. Long tubes connect with capsules to the outside of vaginal outlet. [Note: The radiation oncologist will apply the radioactive element through these tubes into the capsules at the same session or a later session. This will deliver a high dose of potentially curative radiation to the uterine corpus from an intracavitary location.]

Postoperative work: The patient is accompanied to the recovery room where postoperative orders are written and the operative report is dictated. Typically these patients are hospitalized for 2 days following the operation and must be rounded on twice daily to assess patient comfort and stability of the afterloading device. The patient is counseled postoperatively concerning any additional required radiation therapy as well as for the need for post operative follow-up. The patient is followed on an ambulatory basis with 2 office visits during the 90 day global period.

SURVEY DATA:

Presenter(s) Michael Berman, MD

Specialty(s): ACOG

Sample Size: 106 Response Rate: (%): 22 (21%) Median RVW: 8.34

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

25th Percentile RVW: 6.75 75th Percentile RVW: 11.23 Low: 1 High: 14.45

Median Pre-Service Time: 50 Median Intra-Service Time: 60

25th Percentile Intra-Svc Time: 35 75th Percentile Intra-Svc Time: 75 Low: 30 High: 150

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	3.43	2.72
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.71	3
Urgency of medical decision making	3.3	2.82

Technical Skill/Physical Effort (Mean)

Technical skill required	3.5	2.82
Physical effort required	3.05	2.5

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.62	2.77
Outcome depends on the skill and judgement of physician	3.57	2.77
Estimated risk of malpractice suit with poor outcome	3.19	2.64

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.24	2.91
Intra-Service intensity/complexity	3.47	2.77
Post-Service intensity/complexity	3.1	2.59

ADDITIONAL RATIONALE

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

583XX requires twice as much intra-service time as 58120. Placement of the tandems and ovoids requires repeated manipulation of the devices, as well as careful packing to ensure that the capsules remain securely in place. These tasks demand a significantly higher level of technical skill than the performance of a D&C. Postoperatively, 583XX has a 90 day global period which encompasses two office visits, while 58120 has only 1 office visit within its 10 day global period. However, ACOG's RUC Committee felt the survey median of 8.34 Work recommendation for 583XX.doc

overstates the physician work for 583XX. The procedure is rarely performed and survey respondents were relatively unfamiliar with the procedure. 583XX requires little more work than 571XX, so ACOG recommended the 25th percentile RVU of 6.75

FREQUENCY INFORMATION

How was this service previously reported? 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 ob-gyn/gyn oncology _____ 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 ob-gyn/gyn oncology _____ Frequency 400-500 _____

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 ob-gyn/gyn oncology _____ Frequency unknown percentage will be Medicare patients

Specialty _____ Frequency _____

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

AMA/Specialty Society Update Process
RUC Summary of Recommendation
010 or 090 Day Global Periods
Out-Of-Office Direct Inputs

Sample Size: na Response Rate: (%): na Global Period: 90

Tracking Number: M4 Reference Code 1 58120 Reference Code 2 _____

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

A consensus panel of 6 ACOG Fellows representing a range of ob-gyn specialists from various geographic locations met to determine standardized direct practice inputs for ob-gyn procedures. The recommendation originally submitted has been revised to use the standard pre- and post-service times for 90 day global procedures approved by the PEAC this week. We have made the following adjustments to the standard PEAC post-service package:

- We added 14 minutes under “Other activity in the pre-service period.” Two phone calls by clinical staff are required to coordinate the schedules and activities of the surgeon and the radiation oncologists.
- Clinical staff times for the post-op visits have been increased over the standard E&M times by 7 minutes to reflect the additional staff time for chaperone and cleanup services associated with a pelvic examination. The PEAC previously approved this adjustment.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Standard activities described in the PEAC 90 day package for pre-service clinical activities (out of office). That is, completing pre-service diagnostic and referral forms, coordinating pre-surgery services and reviewing test results, scheduling space and equipment in the facility, providing pre-service education, obtaining consent, and conducting follow-up phone calls.

Intra-Service Clinical Labor Activities:

Coordination of care by clinical staff in the office.

Post-Service Clinical Labor Activities:

Assist with 2 post-operative visits.

HCFA's Staff Type Code***	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	Cost Estimate and Source (if applicable)
1130	RN/LPN/MA	60		0		2	63	

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

**Excluding Time of Office Visits

*** From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	Standard ob-gyn supply package for an office visit with pelvic exam as approved by PEAC April 2000. Items and total quantities are the following:			
11107	Patient gown, disposable	2 item		
11111	Exam table paper	14 foot		
11112	Pillowcase, disposable	2 item		
11302	Gloves, non-sterile	4 pair		
11509	Thermometer probe cover, disposable	2 item		
52314	Disinfectant solution	0.4 oz		
31105	KY jelly, single use pack, 5 grams	2 item		
31511	Mini pad	2 item		
11507	Speculum, disposable	2 item		
11513	Swabs, procto	4 item		
11106	drape sheet	2 item		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
E11001	Exam table	1			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

**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	5	RN/LPN/MA, Other _____
Coordinate pre-surgery services	<u>20</u>	RN/LPN/MA, Other _____
Schedule space and equipment in facility	<u>8</u>	RN/LPN/MA, Other _____
Office visit before surgery/procedure Review test and exam results	<u>0</u>	RN, LPN, MA, Other _____
Provide pre-service education/obtain consent	<u>20</u>	RN/LPN/MA, Other _____
Follow-up phone calls & prescriptions	<u>7</u>	RN/LPN/MA, Other _____
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	<u>0</u>	RN, LPN, MA, Other _____
Greet patient and provide gowning	<u>0</u>	RN, LPN, MA, Other _____
Obtain vital signs	<u>0</u>	RN, LPN, MA, Other _____
Provide pre-service education/obtain consent	<u>0</u>	RN, LPN, MA, Other _____
Prepare room, equipment, supplies	<u>0</u>	RN, LPN, MA, Other _____
Prepare and position patient/ monitor patient/ set up IV	<u>0</u>	RN, LPN, MA, Other _____
Sedate/apply anesthesia	<u>0</u>	RN, LPN, MA, Other _____
<i>Intra-service</i>	<u>0</u>	
Assist physician in performing surgery/procedure		RN, LPN, MA, Other _____

Post-service

Monitor pt. following service/check tubes, monitors, drains	<u>0</u>	RN, LPN, MA, Other _____
Clean room/equipment by physician staff	<u>0</u>	RN, LPN, MA, Other _____
Assist with ICU or hospital visits	<u>0</u>	RN, LPN, MA, Other _____
Total Number of ICU visits	<u>0</u>	
Total Number of hospital visits	<u>0</u>	
Complete diagnostic forms, lab & X-ray requisitions	<u>0</u>	RN, LPN, MA, Other _____
Review/read X-ray, lab, and pathology reports	<u>0</u>	RN, LPN, MA, Other _____
Discharge day management services, check dressings & wound/ home care instructions/coordinate office visits/prescriptions	<u>0</u>	RN, LPN, MA, Other _____
Coordination of care by staff in office	<u>0</u>	RN, LPN, MA, Other _____
Other Activity (please specify)	<u>0</u>	
_____		RN, LPN, MA, Other _____

End: Patient discharge from hospital

Post-Service Period

Start: Patient discharge from hospital

Conduct phone calls/call in prescriptions	_____	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	<u>A1 36 (99213)</u>	
Coordinate home or outpatient care	<u>A2 27 (99212)</u>	RN/LPN/MA Other _____
List total number of office visits	B <u>2</u>	
Total office visit time (A1+A2)	<u>63</u>	
Conduct phone calls between office visits	_____	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 PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 5895X1 ___ Tracking Number: M1_ Global Period: 090_ **Recommended RVW: 32.00**

CPT Descriptor: Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48-year-old woman presents with a distended abdomen from ascites with a pelvic mass and a ballotable abdominal mass. She is advised to undergo an exploratory laparotomy for a presumed advanced ovarian malignancy. At surgery she is found to have bilateral ovarian cancers with extensive pelvic tumor nodularity in the cul-de-sac of the pelvis in addition to extensive omental replacement with metastatic cancer. The patient undergoes a total abdominal hysterectomy with bilateral salpingo-oophorectomy, excision of the pelvic peritoneum with removal of the metastatic implants within the pelvis and an omentectomy. At completion of the operative procedure more than 98% of the cancer has been resected with only residual tumor studding in the region of the diaphragmatic and liver surfaces. The patient receives usual follow-up care in the hospital and office during the 90 day global period.

Description of Pre-Service Work: The pre-service work includes dictating an admission history and physical and writing the admission orders. It includes confirming that the patient has followed instructions for the bowel preparation and preoperative diet. The patient is greeted in the preoperative holding area with appropriate consents verified or taken. All preoperative laboratory and x-ray studies are reviewed. Proper positioning of the patient in the operating room is done.

Description of Intra-Service Work: An abdominal incision is made, exploration of the abdomen is performed and, if appropriate, peritoneal fluid is obtained for cytological investigation. Placement of an appropriate retractor, typically a Bookwalter retractor, is done with packing of the abdominal contents out of the pelvis. The hysterectomy, with removal of the uterus, ovaries, fallopian tubes, and excision of the pelvic peritoneum is completed. This step requires dissection of the ureters off their peritoneal attachments along their courses in the pelvis. The entire omentum then is removed by initially separating it from the transverse colon and developing the anatomical space between the omentum and the transverse mesocolon to the level of the lesser sac of the omentum. The gastroepiploic and short gastric vessels are divided permitting complete removal of the omentum. The abdomen is then closed in layers typically with the use of retention sutures. Where required, suction drainage is employed.

Description of Post-Service Work: The patient is accompanied to the recovery room where postoperative orders are written and the operative report is dictated. The patient's family is counseled about the findings and the surgical procedure. Typically these patients are monitored for a 6 day postoperative stay in the hospital requiring 1 or 2 daily hospital visits. The patient is counseled postoperatively concerning the operative findings. The patient is followed on an ambulatory basis with approximately 3 office visits during the 90 day global period.

SURVEY DATA:

Presenter(s) Michael Berman, MD

Specialty(s): American College of Obstetricians and Gynecologists

Sample Size: 75 Response Rate: (%): 41 (55%) Median RVW: 32.00

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

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	5	5
--------------------------------------------------------------------------------------------------	---	---

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	5	5
--------------------------------------------------------------------------------------------------------------------------------	---	---

Urgency of medical decision making	5	5
------------------------------------	---	---

Technical Skill/Physical Effort (Mean)

Technical skill required	5	5
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Physical effort required	5	5
--------------------------	---	---

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	5	5
-------------------------------------------------------------------	---	---

Outcome depends on the skill and judgement of physician	5	5
---------------------------------------------------------	---	---

Estimated risk of malpractice suit with poor outcome	4	4
------------------------------------------------------	---	---

INTENSITY/COMPLEXITY MEASURES

<u>CPT Code</u>	<u>Reference Service 1</u>
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Time Segments (Mean)

Pre-Service intensity/complexity	5	5
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Intra-Service intensity/complexity	5	5
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Post-Service intensity/complexity	5	5
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ADDITIONAL RATIONALE

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

In addition to the procedures enumerated for 58952, 5895X1 includes an abdominal hysterectomy (58150, 15.24 RVUs). The intraservice work of the hysterectomy performed for 5895X1 is more difficult than the work typically required for 58150 due to the anatomic distortion caused by cancer. Greater technical skill is required to dissect the bladder off the cervix because typically there is extensive tumor involving the bladder and peritoneum, thereby markedly distorting the anatomical relationships between the bladder and cervix. Likewise, the tumor

involvement typically agglutinating the cul de sac of the pelvis requires unusually difficult dissection of the space between the rectum and vagina in order to accomplish the operation without bowel injury. Finally, the extensive pelvic peritoneal infiltration with tumor which is characteristic of these cancers requires dissection of the distal ureters to avoid ureteral injury while performing the hysterectomy. Therefore, the survey median of 32.00 RVUs seemed quite reasonable.

FREQUENCY INFORMATION

How was this service previously reported? 58952, 58150-51 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty Gyn oncology/Ob-gyn 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 Gyn oncology/Ob-gyn

Frequency: A specific estimate for this code is unavailable. Total incidence of ovarian, tubal, and primary peritoneal cancers is 28,000 cases per year. These cases would be distributed among 58943, 58950, 58951, 58952, 5895X1 and 5895X2.

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 Gyn oncology/Ob-gyn Frequency Medicare frequency unknown.

Specialty _____

Frequency _____

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

CPT Code: 5895X1
Specialty Society('s) ACOG

AMA/Specialty Society Update Process
RUC Summary of Recommendation
010 or 090 Day Global Periods
Out-Of-Office Direct Inputs

Sample Size: NA Response Rate: (%): NA Global Period: 090

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

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

A committee of 6 ACOG Fellows representing all ob-gyn subspecialties and various practice types and locations met to review clinical staff times for all ob-gyn codes and now makes recommendations for new codes. The ACOG committee determined that the standard clinical staff time package approved by the PEAC for 90 global package surgical services was appropriate for this code. The times are consistent with the times approved by the PEAC in March for the vaginal hysterectomy codes (58260 – 58285). The clinical staff activities and practice expense issues are similar for 5895X1.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

**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	_____ 5	RN/LPN/MA _____
Coordinate pre-surgery services	_____ 20	RN/LPN/MA _____
Schedule space and equipment in facility	_____ 8	RN/LPN/MA _____
Office visit before surgery/procedure Review test and exam results	_____ 0	RN/LPN/MA _____
Provide pre-service education/obtain consent	_____ 20	RN/LPN/MA _____
Follow-up phone calls & prescriptions	_____ 7	RN/LPN/MA _____
Other Activity (please specify)	_____ 0	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	_____ 0	RN/LPN/MA _____
Greet patient and provide gowning	_____ 0	RN/LPN/MA _____
Obtain vital signs	_____ 0	RN/LPN/MA _____
Provide pre-service education/obtain consent	_____ 0	RN/LPN/MA _____
Prepare room, equipment, supplies	_____ 0	RN/LPN/MA _____
Prepare and position patient/ monitor patient/ set up IV	_____ 0	RN/LPN/MA _____
Sedate/apply anesthesia	_____ 0	RN/LPN/MA _____
<i>Intra-service</i>		
Assist physician in performing surgery/procedure	_____ 0	RN/LPN/MA _____

Post-service

Monitor pt. following service/check tubes, monitors, drains 0 RN/LPN/MA _____

Clean room/equipment by physician staff 0 RN/LPN/MA _____

Assist with ICU or hospital visits 0 RN/LPN/MA _____

Total Number of ICU visits _____

Total Number of hospital visits _____

Complete diagnostic forms, lab & X-ray requisitions 0 RN/LPN/MA _____

Review/read X-ray, lab, and pathology reports 0 RN/LPN/MA _____

Discharge day management services, check dressings & wound/ home care instructions/coordinate office visits/prescriptions 0 RN/LPN/MA _____

Coordination of care by staff in office 0 RN/LPN/MA _____

Other Activity (please specify) _____ RN/LPN/MA _____

End: Patient discharge from hospital

Post-Service Period

Start: Patient discharge from hospital

Conduct phone calls/call in prescriptions _____ 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

27 + 36+ 53

A _____ RN/LPN/MA _____

List total number of office visits B 3

Total office visit time (A * B) **116**

Conduct phone calls between office visits 0 RN/LPN/MA _____

Other Activity (please specify) _____ RN/LPN/MA _____

End: With last office visit before end of global period

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

CPT Code: 5895X2 Tracking Number: M2 Global Period: 090 Recommended RVW: 35.00

CPT Descriptor: Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking with pelvic lymphadenectomy and limited para-aortic lymphadenectomy

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48 year old woman presents with a distended abdomen from ascites with a pelvic mass and a ballotable abdominal mass. She is advised to undergo an exploratory laparotomy for a presumed advanced ovarian malignancy. At surgery she is found to have bilateral ovarian cancers with extensive pelvic tumor nodularity in the cul-de-sac of the pelvis in addition to extensive omental replacement with metastatic cancer. The patient undergoes a total abdominal hysterectomy with bilateral salpingo-oophorectomy, excision of the pelvic peritoneum with removal of the metastatic implants within the pelvis and an omentectomy. At completion of the operative procedure all of the visible cancer has been resected. Because of a high risk of pelvic or periaortic metastasis a pelvic lymphadenectomy including external iliac, hypogastric and obturator nodes is done and the lower periaortic lymph nodes (below the renal vessels) are biopsied or excised. The patient receives usual follow-up care in the hospital and office during the 90 day global period.

Description of Pre-Service Work: The pre-service work includes dictating an admission history and physical and writing the admission orders. It includes confirming that the patient has followed instructions for the bowel preparation and preoperative diet. The patient is greeted in the preoperative holding area with appropriate consents verified or taken. All preoperative laboratory and x-ray studies are reviewed. Proper positioning of the patient in the operating room is done.

Description of Intra-Service Work: An abdominal incision is made, exploration of the abdomen is performed and, if appropriate, peritoneal fluid is obtained for cytological investigation. Placement of an appropriate retractor, typically a Bookwalter retractor, is done with packing of the abdominal contents out of the pelvis. The hysterectomy, with removal of the uterus, ovaries, fallopian tubes, and excision of the pelvic peritoneum is completed. This step requires dissection of the ureters off their peritoneal attachments along their courses in the pelvis. Complete removal of the bilateral pelvic lymph nodes including the external iliac, obturator, hypogastric and common iliac lymph nodes in addition to sampling of the lymph nodes over the lower inferior vena cava and abdominal aorta. The entire omentum then is removed by initially separating it from the transverse colon and developing the anatomical space between the omentum and the transverse mesocolon to the level of the lesser sac of the omentum. The gastroepiploic and short gastric vessels are divided permitting complete removal of the omentum. The abdomen is then closed in layers typically with the use of retention sutures. Where required, suction drainage is employed.

Description of Post-Service Work: The patient is accompanied to the recovery room where postoperative orders are written and the operative report is dictated. The patient's family is counseled about the findings and the surgical procedure. Typically these patients are monitored for 1 day in the intensive care unit after which there is a 6 day postoperative stay in the hospital requiring 1 or 2 daily hospital visits. The patient is counseled postoperatively concerning the operative findings as well as the requirement for chemotherapy during the postoperative period. The patient is followed on an ambulatory basis with approximately 3 office visits during the 90 day global period.

SURVEY DATA:Presenter(s) Michael Berman, MDSpecialty(s): American College of Obstetricians and GynecologistsSample Size: _____ Response Rate: (%): 41 Median RVW: 35Type of Sample (Circle One): random, panel, **convenience**. Explanation of sample size: _____25th Percentile RVW: 33.75 75th Percentile RVW: 37.63 Low: 28 High: 44Median Pre-Service Time: 90 Median Intra-Service Time: 32025th Percentile Intra-Svc Time: 270 75th Percentile Intra-Svc Time: 340 Low: 180 High: 420

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code & # of Visits)</u>
Immediate Post Service Time:	<u>55</u>	
Critical Care:		
Other Hospital Visits:	<u>139</u>	<u>99233, 2-99232, 2-99231</u>
Discharge Day Mgmt.:	<u>36</u>	<u>99238</u>
Office Visits:	<u>76</u>	<u>99214, 99213, 99212</u>

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
58952	Resection of ovarian, tubal, or primary peritoneal malignancy, with bilateral salpingo-oophorectomy and omentectomy, with radical dissection for debulking	25.02

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 existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

TIME ESTIMATES (Median)

	<u>New/Revis. CPT Code: 5895X2</u>	<u>Key Reference CPT Code: 58952</u>
Median Pre-Time	<u>90</u>	<u>60</u>
Median Intra-Time	<u>320</u>	<u>240</u>

Median Immediate Post-service Time	55	60
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times	139	75
Median Discharge Day Management Time	36	30
Median of Aggregate Office Visit Times	76	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	5	5
--------------------------------------------------------------------------------------------------	---	---

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	5	5
--------------------------------------------------------------------------------------------------------------------------------	---	---

Urgency of medical decision making	5	5
------------------------------------	---	---

Technical Skill/Physical Effort (Mean)

Technical skill required	5	5
--------------------------	---	---

Physical effort required	5	5
--------------------------	---	---

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	5	5
-------------------------------------------------------------------	---	---

Outcome depends on the skill and judgement of physician	5	5
---------------------------------------------------------	---	---

Estimated risk of malpractice suit with poor outcome	4	4
------------------------------------------------------	---	---

INTENSITY/COMPLEXITY MEASURES

CPT Code
5895X2

Reference
Service 1
58952

Time Segments (Mean)

Pre-Service intensity/complexity	5	5
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Intra-Service intensity/complexity	5	5
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Post-Service intensity/complexity	5	5
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ADDITIONAL RATIONALE

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

In addition to the procedures enumerated for 58952, 5895X2 includes an abdominal hysterectomy (58150, 15 RVUs) and a pelvic lymphadenectomy (38770, 13.23 RVUs). The intraservice work of the hysterectomy performed for 5895X2 is more difficult than the work typically required for 58150 due to the anatomic distortion caused by cancer. Greater technical skill is required to dissect the bladder off the cervix because typically there is extensive tumor involving the bladder and peritoneum, thereby markedly distorting the anatomical relationships between the bladder and cervix. Likewise, the tumor involvement typically agglutinating the cul de sac of the pelvis requires unusually difficult dissection of the space between the rectum and vagina in order to accomplish the operation without bowel injury. Finally, the extensive pelvic peritoneal infiltration with tumor which is characteristic of these cancers requires dissection of the distal ureters to avoid ureteral injury while performing the hysterectomy. In addition, a pelvic and limited para-aortic lymphadenectomy is performed. Therefore, the survey median of 35.00 RVUs seemed appropriate.

FREQUENCY INFORMATION

How was this service previously reported? 58952, 58150-51, 38770-51 (if
unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

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

Specialty Gyn oncology/Ob-gyn 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 Gyn oncology/Ob-gyn Frequency: A specific estimate for this code is
unavailable. Total incidence of ovarian, tubal, and
primary peritoneal cancers is 28,000 cases per year.
These cases would be distributed among 58943,
58950, 58951, 58952, 5895X1 and 5895X2.

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 Gyn oncology/Ob-gyn Frequency Medicare frequency unknown.

Specialty _____ Frequency _____

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

CPT Code: 5895X2
Specialty Society('s) ACOG

AMA/Specialty Society Update Process
RUC Summary of Recommendation
010 or 090 Day Global Periods
Out-Of-Office Direct Inputs

Sample Size: NA Response Rate: (%): NA Global Period: 090

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

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

A committee of 6 ACOG Fellows representing all ob-gyn subspecialties and various practice types and locations met to review clinical staff times for all ob-gyn codes and now makes recommendations for new codes. The ACOG committee determined that the standard clinical staff time package approved by the PEAC for 90 global package surgical services was appropriate for this code. The times are consistent with the times approved by the PEAC in March for the vaginal hysterectomy codes (58260 – 58285). The clinical staff activities and practice expense issues are similar for 5895X2.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

HCFA's Staff Type Code***	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	Cost Estimate and Source (if applicable)
1130	RN/LPN/MA	60				3	116	

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

**Excluding Time of Office Visits

*** From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	Ob-gyn post-operative incision care visit package	1		
	pelvic exam package	2		
	Multi-specialty Minimum Supply Pkg.	3		
	drape sheet	2		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
E11003	Power table		116		

**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	_____ 5	RN/LPN/MA _____
Coordinate pre-surgery services	_____ 20	RN/LPN/MA _____
Schedule space and equipment in facility	_____ 8	RN/LPN/MA _____
Office visit before surgery/procedure Review test and exam results	_____ 0	RN/LPN/MA _____
Provide pre-service education/obtain consent	_____ 20	RN/LPN/MA _____
Follow-up phone calls & prescriptions	_____ 7	RN/LPN/MA _____
Other Activity (please specify)	_____ 0	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	_____ 0	RN/LPN/MA _____
Greet patient and provide gowning	_____ 0	RN/LPN/MA _____
Obtain vital signs	_____ 0	RN/LPN/MA _____
Provide pre-service education/obtain consent	_____ 0	RN/LPN/MA _____
Prepare room, equipment, supplies	_____ 0	RN/LPN/MA _____
Prepare and position patient/ monitor patient/ set up IV	_____ 0	RN/LPN/MA _____
Sedate/apply anesthesia	_____ 0	RN/LPN/MA _____

Intra-service

Assist physician in performing surgery/procedure	_____ 0	RN/LPN/MA _____
--------------------------------------------------	---------	-----------------

Post-service

Monitor pt. following service/check tubes, monitors, drains	0	RN/LPN/MA _____
Clean room/equipment by physician staff	0	RN/LPN/MA _____
Assist with ICU or hospital visits	0	RN/LPN/MA _____
Total Number of ICU visits	_____	
Total Number of hospital visits	_____	
Complete diagnostic forms, lab & X-ray requisitions	0	RN/LPN/MA _____
Review/read X-ray, lab, and pathology reports	0	RN/LPN/MA _____
Discharge day management services, check dressings & wound/ home care instructions/coordinate office visits/prescriptions	0	RN/LPN/MA _____
Coordination of care by staff in office	0	RN/LPN/MA _____
Other Activity (please specify)		
_____		RN/LPN/MA _____

End: Patient discharge from hospital

Post-Service Period

Start: Patient discharge from hospital

Conduct phone calls/call in prescriptions		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	A	RN/LPN/MA _____

27+36+53

List total number of office visits **B** 3

Total office visit time (A * B) **116**

Conduct phone calls between office visits	0	RN/LPN/MA _____
Other Activity (please specify)		
_____	0	RN/LPN/MA _____

End: With last office visit before end of global period

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2001

Therapeutic Amniotic Fluid Reduction

The CPT Editorial Panel created a new code 59001 *Amniocentesis; therapeutic amniotic fluid reduction (includes ultrasound guidance)* to describe the removal of large amounts of amniotic fluid for massive polyhydramnios and twin-twin transfusion. CPT code 59000 *Amniocentesis; diagnostic* was editorially revised to clarify that this service is a diagnostic service and the code had not been utilized for the services now described in 59001. **The RUC recommends a work relative value of 1.30 (no change – editorial revision) for code 59000.**

The RUC reviewed the survey results from 55 obstetricians and maternal-fetal medicine specialists and agreed that the survey median of 3.00 was appropriate. The RUC clarified that there is often no other CPT codes reported in conjunction with this service. This service requires 40 minutes pre-time, 45 minutes intra-time, and 20 minutes post-time. The RUC also compared this work RVU recommendation to existing codes from other specialties that have also been surveyed by the RUC. CPT code 52007 *Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with brush biopsy of ureter and/or renal pelvis* (work RVU = 3.02) has RUC survey time of 38 minutes pre-, 45 minutes intra-, and 30 minutes post-time. CPT code 43249 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with balloon dilation of esophagus (less than 30 mm diameter)* (2001 work RVU = 2.90; RUC 5-Year Review Rec.= 3.35) has RUC survey time of 42 minutes pre-, 39 minutes intra-, and 26 minutes post. Based on the review of all of this information, **the RUC recommends a work relative value of 3.00 for code 59001.**

Practice Expense:

This service is provided in a facility setting only. The RUC agreed with the specialties recommended direct practice expense inputs, which are 20 minutes of RN/LPN/MA time for pre-service counseling and coordination of care and no medical supplies or equipment.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲59000	001	Amniocentesis; <u>diagnostic</u>	000	1.30 (No change)
●59001	002	therapeutic amniotic fluid reduction (includes ultrasound guidance)	000	3.00

Urgency of medical decision making	4	4
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Technical Skill/Physical Effort (Mean)

Technical skill required	4	4
--------------------------	---	---

Physical effort required	4	3
--------------------------	---	---

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	5	4
-------------------------------------------------------------------	---	---

Outcome depends on the skill and judgement of physician	4	4
---------------------------------------------------------	---	---

Estimated risk of malpractice suit with poor outcome	4	4
------------------------------------------------------	---	---

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	4	4
----------------------------------	---	---

Intra-Service intensity/complexity	4	4
------------------------------------	---	---

Post-Service intensity/complexity	3	3
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ADDITIONAL RATIONALE

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

590XX requires more pre-service and intra-service time than 59000. In the pre-service period, more time is required to explain the procedure to the patient and to review previous records and studies. Intra-service work is more time consuming because of the need to drain a larger volume of fluid over a prolonged period of time. In addition, the work is more intense because the physician must continually monitor the status of both fetuses and the needle placement. Typically the physician must adjust the needle placement multiple times during the procedure due to changes in fetal position and uterine shape. Overall, therapeutic amniotic fluid reduction entails greater risk than diagnostic amniocentesis because it is performed in a complicated twin pregnancy. Thus, the survey median of 3.00 seemed appropriate.

FREQUENCY INFORMATION

How was this service previously reported? 59999 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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/Maternal-fetal medicine 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 Ob-gyn/Maternal-fetal medicine Frequency: 5,200 to 6940 pregnant women may develop the conditions treated by this procedure each year.

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/Maternal-fetal medicine Frequency: A precise estimate is unavailable. The number is likely to be less than 100.

Specialty _____ Frequency _____

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

**AMA/Specialty Society Update Process
RUC Summary of Recommendation
000 Day Global Period
Out-Of-Office Direct Inputs**

Sample Size: NA Response Rate: (%): NA Global Period: 000

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

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

A committee of 6 ACOG Fellows representing all ob-gyn subspecialties and various practice types and locations met to review clinical staff times for all ob-gyn codes. The committee established a standard package of pre-, intra-, and post-service times for 000 day global procedures. The clinical times recommended for 590XX are identical to the clinical staff times the PEAC approved in March for three other ob-gyn 000 day global procedures (59000, 59012, and 59015).

Please describe the clinical activities of your staff:

-Service Clinical Labor Activities: Coordination of pre-surgery services, provision of pre-service education, scheduling space and time in the facility

Intra-Service Clinical Labor Activities: Coordination of care by office staff.

HCFA's Staff Type Code**	Clinical Labor	Pre-Service Time	Service Period	Coordination of Care*	Cost Estimate and Source (if applicable)
	RN/LPN/MA	15		5	

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

**From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

Monitor patient following service/check tubes, monitors, drains	<u>0</u>	RN, LPN, MA, Other _____
Clean room/equipment by physician staff	<u>0</u>	RN, LPN, MA, Other _____
Complete diagnostic forms, lab & X-ray requisitions	<u>0</u>	RN, LPN, MA, Other _____
Review/read X-ray, lab, and pathology reports	<u>0</u>	RN, LPN, MA, Other _____
Check dressings & wound/ home care instructions/coordinate office visits/prescriptions	<u>0</u>	RN, LPN, MA, Other _____
Coordination of care by staff in office	<u>5</u>	RN, LPN, MA, Other _____
Other Clinical Activity (please specify)		
_____		RN, LPN, MA, Other _____

End: Patient leaves facility

	590XX Amniocentesis; therapeutic amniotic fluid reduction (includes ultrasound guidance)			
000 Day Global	In Office	Out of Office		
Pre-Service Period				
Complete pre-service diagnostic & referral forms	NA	0		
Coordinate pre-surgery services/review test/exam results	NA	4		
Schedule space and time in facility	NA	4		
Provide pre-service education/obtain consent	NA	7		
Follow-up phone calls & prescriptions	NA	0		
Total Pre-service	NA	15		
Service Period				
Pre-service services				
Review charts	NA	0		
Greet patient and provide gowning	NA	0		
Obtain vital signs	NA	0		
Provide pre-service education/obtain consent	NA	0		
Prepare room, equipment, supplies	NA	0		
Prepare and position patient/ monitor patient/ set up IV	NA	0		
Sedate/apply anesthesia	NA	0		
Intra-service				
Assist physician in performing procedure	NA	0		
Post-service				
Monitor pt. following service/check tubes, monitors, drains	NA	0		
Clean room/equipment	NA	0		
Complete diagnostic forms, lab & X-ray requisitions	NA	0		
Review/read X-ray, lab, and pathology reports	NA	0		
Check dressings & wound/ home care instructions/coordinate office visits/prescriptions	NA	0		
Coordination of care by office staff	NA	5		
Other Activity (please specify)	NA	0		
Total Service	NA	5		
Total Clinical Staff Time	NA	20		
SUPPLIES				
None				
EQUIPMENT (mln. of use)				

None					
Clinical staff times reflect ACOG's standard package for 000 day global procedures and are identical to the times approved by the PEAC in March for 59000 in the out of office setting.					

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

April 2001

Implantation of Sacral Nerve Neurostimulator Electrodes

One CPT code was editorially changed and two new CPT codes were created to reflect new technology for the implantation and incision for implantation of neurostimulators to control voiding dysfunction such as urge incontinence, urgency-frequency and nonobstructive retention.

64555 Percutaneous implantation of neurostimulator electrodes; peripheral nerve (excludes sacral nerve)

The RUC recommends no change in the work relative value for CPT code 64555, as there were only CPT editorial changes to the code descriptor, and no change in physician work. **The RUC recommends no change to the work relative value for CPT code 64555.**

64561 Percutaneous implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)

The RUC reviewed the survey results for this code and had concerns about the difference between the specialty society's recommended work value and their reference code 63650 *Percutaneous implantation of neurostimulator electrode array, epidural* (work relative value of 6.74). The RUC noted that the reference code and the new code have similar intra-operative physician time and physician work. In addition the RUC noted and that the reference code's current value was close to the 25th percentile of the survey results (work RVU = 6.87). RUC representatives stated that the work of this new code was more in line with the reference code, and in order to avoid a rank order anomaly between the two codes, the RUC recommended the same work relative value as the reference code. **The RUC recommends a work relative value of 6.74 for CPT code 64561.**

Practice Expense

The RUC reviewed the practice expense presented by the specialty society and found it to be appropriate for this 010 day global procedure. The RUC, however added an exam table to the in office medical equipment. The direct practice expense inputs are attached to this recommendation.

64581 Incision for implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)

The RUC examined the code in comparison to similar codes such as the reference code 63655 *Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural* (work relative value 10.29) and 63407 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral, with decompression of spinal cord, cauda equina and/or nerve root(s), (eg, spinal or lateral recess stenosis)), single vertebral segment; lumbar*

(work relative value 14.61), in regards to their intra-service work, and believed the work was similar. The RUC also gained an understanding of the work involved in the placement of electrodes through a scarred tract and re-performance of test stimulation to verify correct placement. This service essentially involves re-performance of 64561 *Percutaneous implantation of neurostimulator electrodes; peripheral nerve (excludes sacralnerve)* (RUC recommended work RVU = 6.74) together with the placement of new, permanent electrodes, and not the reutilization of existing electrodes or existing tracts.

In addition, the RUC reviewed several zero day global services: 37205 (*Transcatheter occlusion or embolization*) with an RVW of 8.28, without survey data; 32606 (*Thoracoscopy, diagnostic with biopsy*) with an RVW of 8.40 and an intra-service time of 90 minutes, and 52345 (*Cystourethroscopy with uretheroscopy; with treatment of uretheropelvic stricture*) surveyed in 2000 with an intra-service time of 90 minutes and an 8.20 RVW. The committee felt that the work involved with these services inter-operatively, was similar to the work of 64581 (median = 120 minutes intra-service). The RUC utilized a building block approach, by first using the zero day global codes as anchor codes and adding the pre and post service time and intensity from the reference codes, the RUC was able to justify the specialty's survey median. **The RUC recommends a work relative value of 13.50 for CPT code 64581.**

Practice Expense

The RUC reviewed the practice expense presented by the specialty society and found it to be appropriate for this 010 day global procedure. The RUC, however reduced the pre-service clinical labor time to 40 minutes from 60 minutes. The direct practice expense inputs are attached to this recommendation.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲64555		Percutaneous implantation of neurostimulator electrodes; peripheral nerve (<u>excludes sacralnerve</u>)	010	2.27 (no change)
●64561	N1	Percutaneous implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)	010	6.74
▲64555		Incision for implantation of neurostimulator electrodes; peripheral nerve (<u>excludes scral nerve</u>)	090	4.53 (no change)
●64581	N2	Incision for implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)	010	13.50

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

(April 2001)

CPT Code: 6456X (N1)

Global: 010

Survey Median RVW: 8.50
~~Recommended RVW: 8.50~~
RUC Recommended RVW: 6.74

CPT Descriptor: Percutaneous implantation of electrodes, sacral nerve, (transforaminal placement)

Survey Vignette (Typical Patient)

A 47-year-old female with intractable and debilitating urge incontinence is voiding over 50 times every 24 hours. She has been evaluated by history, physical examination, endoscopic, radiographic, and urodynamic testing. All available conservative remedies have been unsuccessful. A 72-hour voiding diary has been established as a baseline. A test stimulation is planned to determine the effectiveness of transsacral neuromodulation for control of her symptoms. Surgery is scheduled and performed for "percutaneous implantation of electrodes, sacral nerve, (transforaminal placement)." The procedure is performed under fluoroscopic control. After a routine post-operative course, the patient is discharged home, to be followed up in the office. The physician "work" includes any pre-service work the day before surgery, all work the day of the surgery (pre-op, intraoperative and post-op) and all patient visits (in or out of hospital) for 10 days following the procedure.

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service Work- Day before surgery:

- Review pre-op lab results
- Review medical record
- Write pre-op orders (to be faxed to hospital)
- Check to be sure necessary equipment/supplies are at hospital

Pre-service work- Day of surgery:

- Change into scrub cloths
- Review surgical procedure, post-op recovery in and out of hospital with patient and family
- Answer patient and family questions, be sure informed consent is in record
- Speak to anesthesiologist about expected length of procedure and any special concerns about this particular patient (teeth, positioning, unusual medical problems)
- Position patient on operating table
- Verify that all necessary instruments are available

Intra-service work- Skin to skin:

- Approximate levels of the sacral foramina using fluoroscopy
- Anesthetize skin and periosteum over and near chosen foramen
- Pass an electrically insulated 3 or 5 inch needle percutaneously into the foramen
- Connect an external screener (power source) to the foramen needle by a separate cable and grounding source
- Discern and document specific biologic responses to stimulation of S2 and no activity for S4
- Desired responses are S2 and S3
- A 3 - 0 temporary electrode is exchanged through the lumen of the foramen needle, leaving only the electrode in place
- Re-testing is performed to confirm response
- Dressing is placed to secure the electrode in place
- Hard X-ray is done to confirm lead position

Post-op Same day work through discharge from recovery

- Apply dressings
- Assist in transfer of patient from operating table to post-op stretcher
- Accompany anesthesiologist with patient to recovery area
- Assist in transfer of patient to recovery area bed
- Write post-op orders
- Review recovery area care and medications with staff
- Meet with family and discuss the procedure, expected outcome, planned post operative care in hospital and out of hospital
- Discuss procedure with patient as necessary in recovery area when awake
- Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)
- Dictate detailed operative narrative

Post-op Same day work after discharge from recovery

- Examine patient, check wound and patient progress
- Review patient hospital medical record notes (nursing, pharmacy, dietary, discharge planner)
- Answer patient and family questions
- Answer nursing and other staff questions
- Write any further necessary orders
- Write note in progress note section of medical record

Discharge day work:

- Examine and talk with patient and family
- Check wounds and patient progress
- Review all patient hospital medical records
- Answer patient and family questions
- Write orders for post-discharge care
- Write prescriptions for post-op medications
- Dictate detailed hospital discharge summary

Post-op Office work- After discharge from hospital:

- Examine patient, check vital signs
- Talk with patient and family
- Answer questions from patient and family
- Write necessary prescriptions
- Remove sutures
- Schedule next office visit
- Mark appropriate diagnosis and CPT code on Superbill
- Dictate patient progress notes for office medical record
- Dictate letter to referring physician

**AMERICAN UROLOGICAL ASSOCIATION & AMERICAN COLLEGE OF OBSTETRICIANS AND
GYNECOLOGISTS SURVEY DATA:**

Presenters: James B. Regan, MD & Jeffrey A. Dann, MD

Specialty: American Urological Association & American College of Obstetricians and Gynecologists _____

Type of Sample: Mixed-panel/random **Sample Size:** 115

Response Rate: 37% (43/115)

	Low	25 th %	Median	75 %	High
Survey RWV	4.00	6.87	8.50	11.90	17.00
Pre-Service Time	10	35	45	65	90
Intra-Service Time	30	45	70	90	110

Post-Service:	Total Time	CPT code/# of visits
Immed. Post-Service	30	
Critical Care		0
Other Hospital		0
Discharge Day Mgmt	18	5- 99238
Office Visits	38	1- 99214

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	% RESP	GLOBE
63650	Percutaneous implantation of neurostimulator electrode array, epidural	6.74	53%	010
49320	Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)	5.10	21%	010
57288	Sling operation for stress incontinence (eg, fascia or synthetic)	13.02	6%	090

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

INTENSITY/COMPLEXITY MEASURES (mean)

TIME SEGMENTS

	Svy CPT 6458X	Reference CPT 63650
Pre-service	5.03	3.33
Intra-service	4.55	3.67
Post-service	4.18	3.21

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.33	3.58
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.58	3.60
Urgency of medical decision making	2.88	2.76

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.58	3.97
Physical effort required	3.85	3.51

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.97	3.88
Outcome depends on the skill and judgment of physician	4.67	3.97
Estimated risk of malpractice suit with poor outcome	3.79	4.00

ADDITIONAL RATIONALE-**IWPUT/BUILDING BLOCK METHOD**

			RVW
SURVEY RVW =			8.50
PRE-SERVICE	TIME	INTENSITY	(= time x intensity)
Day prior evaluation	0	0.0224	0.00
Same day evaluation	25	0.0224	0.56
Scrub, prep	20	0.0081	0.16
TOTAL PRE-SERVICE		RVW=	0.72
POST SERVICE			
Immediate hospital	30	0.0224	0.67
	Visit n	E&M RVW	(= n x E&M RVW)
Subsequent hospital			
ICU 99291	0.0	4.00	0.00
Room 99233	0.0	1.51	0.00
Room 99232	0.0	1.06	0.00
Room 99231	0.0	0.64	0.00
Discharge 99238	1.0	1.28	1.28
Subsequent office			
99215	0.0	1.77	0.00
99214	1.0	1.10	1.10
99213	0.0	0.67	0.00
99212	0.0	0.45	0.00
99211	0.0	0.17	0.00
TOTAL POST SERVICE		RVW =	3.05
	TIME	IWPUT	
INTRASERVICE	70	0.067	4.73

FREQUENCY INFORMATION

How was this procedure 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/gynecology Sometimes

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

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/gynecology 1999 Medicare Frequency of

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

REFERENCE SERVICE LIST- Please see the AUA Master Reference Service List and ACOG Reference Service List- InterStim

Practice Expense Summary – Clinical Labor		
CPT code 6456X: <i>Percutaneous implantation of electrodes, sacral nerve, (transforaminal placement)</i>		
Tracking #: N1		
Global Period: 010		
	In Office	Out-of-Office
Staff Type	RN/LPN/MA	RN/LPN/MA
Pre-service time	12	10
Service period	100	
Coordination of Care by staff in the physician's office during the service period (for facility services)		
Post-service time (excluding time of office visits)	8	8
Total Number of office visits	1-99214	1-99214
Total time of office visits	53	53
PRE-SERVICE PERIOD		
Start: Following visit when decision for surgery or procedure made		
1. Complete pre-service diagnostic & referral forms	5	5
2. Coordinate pre-procedure or pre-surgery services		
3. Schedule space and equipment in facility		
4. Office visit before surgery/procedure to review test and exam results		
5. Provide pre-service education/obtain consent	7	5
6. Follow-up phone calls & prescriptions		
Other Pre-Service Activities (please specify):		
End: When patient enters hospital or office for surgery/procedure		
SERVICE PERIOD		
Start: With admission to hospital, ASC, or office for procedure		
<i>Pre-service services</i>		
1. Review charts	2	
2. Greet patient and provide gowning	3	
3. Obtain vital signs	5	
4. Provide pre-service education/obtain consent		
5. Prepare room, equipment, supplies	5	
6. Prepare and position patient/monitor patient/set up IV	7	
7. Sedate/apply anesthesia		
<i>Intra-service</i>		
8. Assist physician in performing procedure/surgery	56	
<i>Post-service</i>		
9. Monitor patient following service/check tubes, monitors, drains	5	
10. Clean room/equipment	4	
11. Assist with ICU or hospital visits		
12. Complete diagnostic forms, lab & x-ray requisitions	3	
13. Review/read x-ray, lab, and pathology reports		
14. (Discharge day mgmt services) Check dressings & wound/home care instructions/coordinate office visits/prescriptions	10	
15. Coordination of in-facility care by staff in office		
Other service period activities (please specify):		
End: With discharge from hospital, ASC, or office		
POST-SERVICE PERIOD		
Start: After discharge from hospital, ASC, or office		
1. Conduct phone calls/call in prescriptions	8	8
2. 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/equipment, check supplies		
Coordinate home or outpatient care		
3. Conduct phone calls between office visits		
Other post-service activities (please specify):		
End: With last office visit before end of global period		

Practice Expense Summary – Supplies & Equipment In Office

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	InterStim test stimulation kit	1	item	\$280 (Medtronic)
	Basic Post Operative Incision Care Kit	1		
	MMSP	2		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Exam Table	1			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

Practice Expense Summary – Supplies & Equipment Out of Office

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	MMSP	1		
	Basic Post Operative Incision Care Kit	1		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Exam Table	1			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

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

(April 2001)

CPT Code: 6458X (N2)

Global: 010

Survey Median RVW: 13.50
Recommended RVW: 13.50

CPT Descriptor: Incision for implantation of electrodes, sacral nerve, (transforaminal placement)

Survey Vignette (Typical Patient)

A 47-year-old female with intractable and debilitating urge incontinence has undergone a successful temporary test stimulation (new CPT code 6456X, *Percutaneous implantation of electrodes, sacral nerve, (transforaminal placement)*). The test stimulation documented the effectiveness of sacral nerve stimulation for control of her symptoms. There was a greater than 50% decrease in the incontinence severity score, number of incontinence episodes, or pads used per 24 hours. No other conservative remedies have been as successful in controlling her symptoms. Surgery is scheduled and performed for "incision for implantation of electrodes, sacral nerve, (transforaminal placement)". After a routine postoperative course the patient is discharged home, to be followed up in the office. The physician "work" includes any pre-service work the day before surgery, all work the day of surgery (pre-op, intraoperative and post-op) and all patient visits (in or out of hospital) for 10 days following the procedure.

VERY IMPORTANT, PLEASE NOTE !!!

The physician work of placing the implantable pulse generator (IPG) is billed separately using the already existing CPT code 64590, "*Incision and subcutaneous placement of peripheral neurostimulator pulse generator or receiver, direct or inductive coupling*" and is not to be considered as part of the work for CPT 6458X which is only for "incision for implantation of electrodes, sacral nerve, (transforaminal placement)".

CLINICAL DESCRIPTION OF SERVICE (This was NOT provided on the survey):

Pre-service Work- Day before surgery:

- Review pre-op lab results
- Review medical record
- Write pre-op orders (to be faxed to hospital)
- Check to be sure necessary equipment/supplies are at hospital

Pre-service work- Day of surgery:

- Change into scrub cloths
- Review surgical procedure, post-op recovery in and out of hospital with patient and family
- Answer patient and family questions, be sure informed consent is in record
- Speak to anesthesiologist about expected length of procedure and any special concerns about this particular patient (teeth, positioning, unusual medical problems)
- Position patient on operating table
- Verify that all necessary instruments are available

Intra-service work- Skin to skin:

- After general anesthesia the patient is placed in the prone position over a laminectomy frame on the OR table
- A midline incision is made over the sacrum
- The posterior surface of the sacrum on the side to be implanted is exposed
- Three inch foramen needles are placed and stimulated with power source
- Pattern of biologic response is noted
- Responses are compared to the written responses from the temporary needle placement record
- When the same foramen is identified an implant electrode is positioned in the foramen
- The implant electrode is retested to simulate each of four discrete contact points along the electrode
- Electrode must be replaced and retested until appropriate responses are noted at at least two contact points
- Implant electrode is then secured to sacral periosteum at multiple points
- Lead electrode is tunneled under presacral fascia and subcutaneous tissues to a separate incision

AUA

-
- The Implantable Pulse Generator (IPG) is then connected via a lead electrode extension
 - The fascia is closed over the lead electrode
 - Closure must be done to avoid seroma formation
 - Skin closure is done in usual fashion

Post-op Same day work through discharge from recovery

- Apply dressings
- Assist in transfer of patient from operating table to post-op stretcher
- Accompany anesthesiologist with patient to recovery area
- Assist in transfer of patient to recovery area bed
- Write post-op orders
- Review recovery area care and medications with staff
- Meet with family and discuss the procedure, expected outcome, planned post operative care in hospital and out of hospital
- Discuss procedure with patient as necessary in recovery area when awake
- Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)
- Dictate detailed operative narrative

Post-op Same day work after discharge from recovery

- Examine patient, check wound and patient progress
- Review patient hospital medical record notes (nursing, pharmacy, dietary, discharge planner)
- Answer patient and family questions
- Answer nursing and other staff questions
- Write any further necessary orders
- Write note in progress note section of medical record

Post-op Other Hospital Work – Beginning on post op-day 1, until discharge day

- Examine and talk to patient
- Check wounds and dressings
- Discuss patient progress with patient and family
- Review all patient hospital medical record notes
- Discuss post operative care of wound
- Answer nursing and other staff questions
- Answer patient and family questions
- Write orders in medical record
- Write progress notes

Discharge day work:

- Examine and talk with patient and family
- Check wounds and patient progress
- Review all patient hospital medical records
- Answer patient and family questions
- Write orders for post-discharge care
- Write prescriptions for post-op medications
- Dictate detailed hospital discharge summary

Post-op Office work- After discharge from hospital:

- Examine patient, check vital signs
- Talk with patient and family
- Answer questions from patient and family
- Write necessary prescriptions
- Remove sutures
- Schedule next office visit
- Mark appropriate diagnosis and CPT code on Superbill
- Dictate patient progress notes for office medical record
- Dictate letter to referring physician

AMERICAN UROLOGICAL ASSOCIATION & AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS COMBINED SURVEY DATA:

Presenters: James B Regan, MD & Jeffrey A Dann, MD

Specialty: American Urological Association & American College of Obstetricians and Gynecologists _____

Type of Sample: Mixed-panel/random **Sample Size:** 115

Response Rate: 37% (43/115)

	Low	25 th %	Median	75 %	High
Survey RVW	6.00	11.25	13.50	17.00	22.00
Pre-Service Time	5	35	60	80	150
Intra-Service Time	60	90	120	145	180

Post-Service:	Total Time	CPT code/# of visits
Immed. Post-Service	30	
Critical Care		0
Other Hospital	30	1- 99232
Discharge Day Mgmt	36	1- 99238
Office Visits	38	1- 99214

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	% RESP	GLOBE
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	10.29	57%	090
51840	Anterior vesicourethropexy, or urethropexy (Marshall-Marchetti-Krantz type); simple	10.71	23%	090
57288	Sling operation for stress incontinence (eg, fascia or synthetic)	13.02	8%	090

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

<u>INTENSITY/COMPLEXITY MEASURES (mean)</u> <u>TIME SEGMENTS</u>	<u>Svy CPT</u>	<u>Reference CPT</u>
	<u>6458X</u>	<u>63655</u>
Pre-service	5.03	3.33
Intra-service	4.55	3.67
Post-service	4.18	3.21

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.33	3.58
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.58	3.60
Urgency of medical decision making	2.88	2.76

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.58	3.97
Physical effort required	3.85	3.51

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	3.97	3.88
Outcome depends on the skill and judgment of physician	4.67	3.97
Estimated risk of malpractice suit with poor outcome	3.79	4.00

ADDITIONAL RATIONALE-**IWPUT/BUILDING BLOCK METHOD**

PROPOSED RVW =	RVW 13.50
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PRE-SERVICE	TIME	INTENSITY	(= time x intensity)
Day prior evaluation	0	0.0224	0.00
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
TOTAL PRE-SERVICE		RVW=	0.92

POST SERVICE			
Immediate hospital	30	0.0224	0.67
	Visit n	E&M RVW	(= n x E&M RVW)
Subsequent hospital			
ICU 99291	0.0	4.00	0.00
Room 99233	0.0	1.51	0.00
Room 99232	1.0	1.06	1.06
Room 99231	0.0	0.64	0.00
Discharge 99238	1.0	1.28	1.28
Subsequent office			
99215	0.0	1.77	0.00
99214	1.0	1.10	1.10
99213	0.0	0.67	0.00
99212	0.0	0.45	0.00
99211	0.0	0.17	0.00
TOTAL POST SERVICE		RVW =	4.11

	TIME	IWPUT	
INTRASERVICE	120	0.071	8.47

FREQUENCY INFORMATION

How was this procedure 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/gynecology Sometimes

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

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/gynecology Estimated Medicare frequency: 500

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

~~REFERENCE SERVICE LIST. Please see AUA Master Reference Service List and ACOG Reference Service List.~~
InterStim.

Practice Expense Summary – Clinical Labor	
CPT code: 6458X – Incision for implantation of electrodes, sacral nerve, (transforaminal placement)	
Tracking #: N2	
Global Period: 010	
	Out-of-Office
Staff Type	RN/LPN/MA
Pre-service time	25
Service period	
Coordination of Care by staff in the physician's office during the service period (for facility services)	
Post-service time (excluding time of office visits)	15
Total Number of office visits	1-99214
Total time of office visits	53
PRE-SERVICE PERIOD	
Start: Following visit when decision for surgery or procedure made	
1. Complete pre-service diagnostic & referral forms	5
2. Coordinate pre-procedure or pre-surgery services	
3. Schedule space and equipment in facility	
4. Office visit before surgery/procedure to review test and exam results	
5. Provide pre-service education/obtain consent	20
6. Follow-up phone calls & prescriptions	
Other Pre-Service Activities (please specify):	
End: When patient enters hospital or office for surgery/procedure	
SERVICE PERIOD	
Start: With admission to hospital, ASC, or office for procedure	
Pre-service services	
1. Review charts	
2. Greet patient and provide gowning	
3. Obtain vital signs	
4. Provide pre-service education/obtain consent	
5. Prepare room, equipment, supplies	
6. Prepare and position patient/monitor patient/set up IV	
7. Sedate/apply anesthesia	
Intra-service	
8. Assist physician in performing procedure/surgery	
Post-service	
9. Monitor patient following service/check tubes, monitors, drains	
10. Clean room/equipment	
11. Assist with ICU or hospital visits	
12. Complete diagnostic forms, lab & x-ray requisitions	
13. Review/read x-ray, lab, and pathology reports	
14. (Discharge day mgmt services) Check dressings & wound/home care instructions/coordinate office visits/prescriptions	
15. Coordination of in-facility care by staff in office	
Other service period activities (please specify):	
End: With discharge from hospital, ASC, or office	
POST-SERVICE PERIOD	
Start: After discharge from hospital, ASC, or office	
1. Conduct phone calls/call in prescriptions	15
2. 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/equipment, check supplies	
Coordinate home or outpatient care	
3. Conduct phone calls between office visits	
Other post-service activities (please specify):	
End: With last office visit before end of global period	

Practice Expense Summary – Supplies & Equipment Out of Office

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	MMSP	1		
	Basic post-operative incision care kit	1		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	exam table	1			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

April 2001

Ocular Photodynamic Therapy

The RUC will not submit recommendations on this issue at this time. The RUC is interested in reviewing this issue in two or three years, once the technology has become more widespread.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
67220		<i>Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), one or more session</i> <u>(For destruction of masclar drusen, photocoagulation, use category 111 CPT code 0017T)</u> <u>(For destruction of localized lesion of choroid by transpupillary thermotherapy, use category III CPT code 0016T)</u>	090	13.13 (no change)
67221		<i>photodynamic therapy (includes intravenous infusion)</i>	000	No RUC Rec. at this time- RUC will review again in 2-3 yrs as agreed to at the October 2000 RUC Meeting
•+67225	PP1	photodynamic therapy, second eye, at single session (List separately in addition to code for primary eye treatment) <u>(Use 67225 in conjunction with code 67221)</u>	ZZZ	No RUC Rec. at this time- RUC will review again in 2-3 yrs as agreed to at the October 2000 RUC Meeting

Radiology Editorial Revisions

The RUC recommends that the following radiology CPT revisions are editorial and do not reflect a change in the physician work.

10140 *Incision and drainage of hematoma, seroma or fluid collection*

(If imaging is performed, see 76360,76393, 76942)

10160 *Puncture aspiration of abscess, hematoma, bulla or cyst*

(If imaging is performed, see 76360, 76393, 76942)

19000 *Puncture aspiration of cyst of breast;*

19001 *each additional cyst (List separately in addition to code for primary procedure)*

(If imaging guidance is performed, see code 76095, 76096, 76393, 76942)

(Use 19001 in conjunction with code 19000)

19100 *Biopsy of breast; percutaneous, needle core, not using imaging guidance (separate procedure)*

(For fine needle aspiration, use 1002X1 88170)

(For image guided breast biopsy, see 19102, 19103, 1002X1 88170)

~~*(For radiologic guidance performed in conjunction with breast biopsy, see 76095, 76360, 76393, 76942)*~~

19101 *open, incisional*

19102 *percutaneous, needle core, using imaging guidance*

19103 *percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance.*

(For imaging guidance performed in conjunction with 19102, 19103, see 76095, 76096, 76360, 76393, 76942)

(For placement of percutaneous localization clip, use 19295)

19290 *Preoperative placement of needle localization wire, breast;*

- 19291 *each additional lesion (List separately in addition to code for primary procedure)*
(Use 19291 in conjunction with code 19290)
 (For radiologic supervision and interpretation, see 76095, 76096, 76942)
- 19295 *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 and 19103)
- 20206 *Biopsy, muscle, percutaneous needle*
 (For radiological supervision and interpretation, see 76360, 76393, 76942)
(If imaging guidance is performed for final needle aspiration, use 1002X1 and 1002X2)
 (For fine needle aspiration, see 1002X1 and 1002X2)
 (For evaluation of fine needle aspirate, see 88172-88173)
(For excision of muscle tumor, deep, see specific anatomic section)
- 20220 *Biopsy, bone, trocar, or needle; superficial (eg, ilium, sternum, spinous process, ribs)*
- 20225 *deep (eg, vertebral body, femur)*
 (For bone marrow biopsy, use ~~85102~~, 38221)
(For radiologic supervision and interpretation, see 76003, 76360, 76393)
- 20550 *Injection, tendon sheath, ligament, ganglion cyst, or trigger points*
(If imaging guidance is performed, see 76003, 76393, 76942)
- 20600 *Arthrocentesis, aspiration and/or injection; small joint, bursa or ganglion cyst (eg, fingers, toes)*
- 20605 *intermediate joint, bursa or ganglion cyst (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)*

- 27648 *Injection procedure for ankle arthrography*
- (For radiological supervision and interpretation, use 73615. Do not report 76003 in addition to 73580)
- 32000 *Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent*
- (If imaging guidance is performed, see 76003, 76360, 76942, 76934)
- (32001 has been deleted. To report, use 32997)
- 32002 *Thoracentesis with insertion of tube with or without water seal (eg, for pneumothorax)(separate procedure)*
- (For radiologic supervision and interpretation, see 76003, 76360, 76942)
- 32400 *Biopsy, pleura; percutaneous needle*
- (~~For radiological supervision and interpretation, If imaging guidance is performed, see, 71036, 76003, 76360, 76393, 76942~~)
- (For fine needle aspiration, use 10022)
- (For evaluation of fine needle aspirate, see 88172, 88173)
- 32405 *Biopsy, lung or mediastinum, percutaneous needle*
- (For radiological supervision and interpretation, see ~~71036~~ 76003, 76360, 76393, 76942)
- (~~For fine needle aspiration, preparation, and interpretation of smears, see 88170-88173~~)
- (For fine needle aspiration, use 10022)
- (For evaluation of fine needle aspirate, see 88172, 88173)

Codes for catheter placement and the radiologic supervision and interpretation should also be reported, in addition to the code(s) for the therapeutic aspect of the procedure.

35470 *Transluminal balloon angioplasty, percutaneous;*

Codes for catheter placement and the radiologic supervision and interpretation should also be reported, in addition to the code(s) for the therapeutic aspect of the procedure.

- 35490 *Transluminal peripheral atherectomy, percutaneous;*
~~(For radiological supervision and interpretation, see Radiology)~~
- ▲36005 *Injection procedure for ~~contrast~~ extremity venography (including introduction of needle or intracatheter)*
- 36488 *Placement of central venous catheter (subclavian, jugular, or other vein) (eg, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); percutaneous, age 2 years or under*
- 36489 *percutaneous, over age 2*
(If imaging guidance is performed, see 76000, 76003, 76942)
- 36530 *Insertion of implantable intravenous infusion pump*
(If imaging guidance is performed, see 76000, 76003, 76942)
- 36532 *Removal of implantable intravenous infusion pump*
~~(For radiologic supervision and interpretation, see 76003, 76942)~~
(If imaging guidance is performed, see 76000)
- 36533 *Insertion of implantable venous access device, with or without subcutaneous reservoir*
(For removal, use 36535)
~~(For radiologic supervision and interpretation, see 76003, 76942)~~
(If imaging guidance is performed, see 76000, 76003, 76942)
(For refilling and maintenance of an implantable venous access device reservoir, use 96530)
- 36535 *Removal of implantable venous access device, and/or subcutaneous reservoir*
(Use 36535 in conjunction with codes 36533, 36534, as appropriate)
(Do not use 36535 in conjunction with codes 36488-36491)
(If imaging guidance is performed, see 76000)

- 36860 *External cannula declotting (separate procedure); without
balloon catheter*
- 36861 *with balloon catheter*
- ~~(For radiologic supervision and interpretation, see 76003, 76942)~~
- (If imaging guidance is performed, see 76000)

Codes for catheter placement and the radiologic supervision and interpretation should also be reported, in addition to the code(s) for the therapeutic aspect of the procedure.

~~(For radiological supervision and interpretation, see Radiology)~~

- 37195 *Thrombolysis, cerebral, by intravenous infusion*
- 38500 *Biopsy of excision of lymph nodes; open, superficial (separate
procedure)*
- (Do not report 38500 with 38700-38780)*

- 38505 *by needle, superficial (eg, cervical, inguinal, axillary)*
- (For fine needle aspiration, use 1002X1 or 1002X2 ~~88170~~)*
- (If imaging guidance is performed, 76360, 76393, 76942)

42400 *Biopsy of salivary gland; needle*

- 42405 *incisional*
- (If imaging guidance used, see 76003, 76360, 76393, 76942)

- 43761 *Repositioning of the gastric feeding tube, any method, through
the duodenum for enteric nutrition*
- (43765 has been deleted. To report, use 43760)*
- (If imaging guidance is performed, use 75984)

- 47000 *Biopsy of liver, needle; percutaneous*
- ~~(For radiological supervision and interpretation~~ If imaging
guidance is performed, see 10021, 76003, 76360, 76393, 76942)

- 47001 *when done for indicated purpose at time of other major
procedure (List separately in addition to code for
primary procedure)*

~~(For radiologic supervision and interpretation If imaging guidance is performed, see 76003, 76360, 76393, 76942)~~

~~(For fine needle aspiration, preparation, and interpretation of smears, see 88170-88173)~~

(For fine needle aspiration, use 10021, 10022)

(For evaluation of fine needle aspirate, see 88172, 88173)

48102 *Biopsy of pancreas, percutaneous needle*

(For radiological supervision and interpretation, see 76003, 76360, 76393, 76942)

~~(For fine needle aspiration, preparation, and interpretation of smears, see 88170-88173)~~

(For fine needle aspiration, see 10022)

(For evaluation of fine needle aspirate, see 88172, 88173)

49080 *Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); initial*

49081 *subsequent*

(If imaging guidance is performed, see 76360, 76942)

49180 *Biopsy, abdominal or retroperitoneal mass, percutaneous needle*

~~(For radiological supervision and interpretation If imaging guidance is performed, see 76003, 76360, 76393, 76942)~~

~~(For fine needle aspiration, preparation, and interpretation of smears, see 88170-88173)~~

(For fine needle aspiration, use 10021 or 10022)

(For evaluation of fine needle aspirate, see 88172, 88173)

▲49424 *Contrast injection for assessment of abscess or cyst via previously placed drainage catheter or tube (separate procedure)*

(For radiological supervision and interpretation, use 76080)

50200 *Renal biopsy; percutaneous, by trocar or needle*

(For radiological supervision and interpretation, see 76003, 76360, 76393, 76942)

~~(For fine needle aspiration, preparation, and interpretation of smears, see 88170-88173)~~

(For fine needle aspiration, use 10022)

(For evaluation of fine needle aspirate, see 88172, 88173)

50390 *Aspiration and/or injection of renal cyst or pelvis by needle, percutaneous*

(For radiological supervision and interpretation, see 74425, 74470, 76003, 76360, 76393, ~~76938~~, ~~76860~~, 76942)

~~(For fine needle aspiration, preparation, and interpretation of smears, see 88170-88173)~~

(For fine needle aspiration, use 10022)

(For evaluation of fine needle aspirate, see 88172, 88173)

50398 *Change of nephrostomy or pyelostomy tube*

~~(For fluoroscopic guidance, use 76000)~~

(For radiological supervision and interpretation, use 75984)

51005 *Aspiration of bladder by needle; by trocar or intracatheter*

51010 *with insertion of suprapubic catheter*

(If imaging guidance is performed, see 76003, 76360, 76942)

55700 *Biopsy, prostate; needle or punch, single or multiple, any approach*

(If imaging guidance is performed, use 76942)

~~(For fine needle aspiration, preparation, and interpretation of smears, see 88170-88173)~~

(For fine needle aspiration, see 10021, 10022)

(For evaluation of fine needle aspiration, see 88172, 88173)

60001 *Aspiration and/or injection, thyroid cyst*

(For fine needle aspiration, see ~~88170, 88171~~ 1002X1-1002X2)

(If imaging guidance is performed, see 76360, 76942)

60100 *Biopsy thyroid, percutaneous core needle*

~~(For radiological supervision and interpretation. If imaging guidance is performed, see 76003, 76360, 76393, 76942)~~

~~(For fine needle aspiration, preparation, and interpretation of smears, see 88170-88173)~~

(For fine needle aspiration, use 10022)

(For evaluation of fine needle aspirate, see 88172, 88173)

60210

Partial thyroid lobectomy, unilateral; with or without isthmusectomy

~~(For fine needle aspiration, see 88170, 88171)~~

60212

with contralateral subtotal lobectomy, including isthmusectomy

~~(For fine needle aspiration, see 88170, 88171)~~

70332

Temporomandibular joint arthrography, radiological supervision and interpretation

(Do not report 76003 in addition to 70332)

71090

Insertion pacemaker, fluoroscopy and radiography, radiological supervision and interpretation

(For procedure, see appropriate organ or site)

73040

Radiologic examination, shoulder, arthrography, radiological supervision and interpretation

(Do not report 76003 in addition to 73040)

73085

Radiologic examination, elbow, arthrography, radiological supervision and interpretation

(Do not report 76003 in addition to 73085)

73115

Radiologic examination, wrist, arthrography, radiological supervision and interpretation

(Do not report 76003 in addition to 73115)

73615

Radiologic examination, ankle, arthrography, radiological supervision and interpretation

(Do not report 76003 in addition to 75315)

- ▲74230 Swallowing function, ~~pharynx and/or esophagus~~, with cineradiography/~~and/or~~ videoradiography
- ▲74305 Cholangiography and/or pancreatography; ~~post-operative~~ through existing catheter, radiological supervision and interpretation.
- 76003 *Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)*
(Do not report 76003 in addition to 70328-70332, 73040, 73085, 73115, 73525, 73542, 73580, 73615)
- ▲76078 Radiographic absorptiometry (eg, photodensitometry, radiogrammetry), one or more sites
- 76095 *Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation*
(For procedure, see 10022, 19000, 19001, ~~19100~~, 19102, 19103, 19290, 19291, ~~88170~~)
(For injection for sentinel node localization without lymphoscintigraphy, use 38792)
(For wire localization, see 19290, 19291)
- 76096 *Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation*
(For procedure, see 10022, 19000, 19102, 19103, 19290, 19291, ~~88170~~)
(For injection for sentinel node localization without lymphoscintigraphy, use 38792)
(For wire localization, see 19290, 19291)
- ▲76120 Cineradiography/~~or~~ videoradiography, except where specifically included
- ✚▲76125 Cineradiography/videoradiography to complement routine examination *(List separately in addition to code for primary procedure)*
(76127 has been deleted. The use of photographic media is not reported separately but is considered to be a component of the basic procedure)

(76130-76137 have been deleted. To report, use code for specific radiologic examination)

76393 *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~~)

▲76885 ~~Echography~~ *Ultrasound of infant hips, real time with imaging documentation; dynamic (eg, requiring physician manipulation)*

▲76886 *limited, static (eg, not requiring physician manipulation)*

▲77300 *Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during a course of treatment, only when prescribed by the treating physician*

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

April 2001

Radiotherapy

Code 77301 *Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications* was created to describe a new computer based method of planing for and delivering radiotherapy. Although the specialty society originally recommended a value greater than the survey median, the RUC concluded and the specialty society agreed that a more appropriate recommendation would be the survey median of 8.00. To validate the survey median, the RUC considered the following additional rationale:

Building Block of Current Codes:

77295	Set radiation therapy field	4.57
77331	Special radiation dosimetry (0.87 x 3)	2.61
76370	CAT scan for therapy guide	0.85
76375	3d/holograph reconstr add-on	<u>0.16</u>
	Total	8.19

The RUC also recommends that the CPT Editorial Panel consider adding a note to CPT to specifically exclude the reporting of the above codes in conjunction with 77301.

Intensity Calculation:

Median Survey Pre-Time 30 minutes x .0224 0.67

Intra-Service Time:

10-25 minutes:

- immobilize patient in treatment position for tumor volume localization CT

5-10 minutes:

- correlate planning CT scan used for tumor localization with other imaging studies, including MRI, PET, contrast enhanced plain film studies, and ultrasound imaging studies

10-15 minutes:

- enumerate critical normal tissues within and adjacent to tumor volume
- define partial dose/volume tolerances for these normal tissues

25-25 minutes:

- identify and segment tumor area on each CT slice within tumor volume
- identify and segment each critical normal tissue within each CT slice within and adjacent to tumor volume

5-10 minutes:

- explicitly develop normal tissue and tumor dose constraints for inverse planning algorithm
- for Peacock planning determine 1 or 2 cm index slice thickness
- for multi-leaf collimator IMRT work with physicist to suggest initial gantry and table angles for field families

20-30 minutes:

- evaluate initial plan for goodness of fit for tumor and normal tissue dose constraints

5-10 minutes:

- work with physicist to modify tumor and normal tissue dose constraints if necessary to re-run plan
- continue to iterate plan until dose constraints are acceptable

5-8 minutes:

- specifically compare dose volume histograms for tumor and critical normal tissues

10-15 minutes:

- review phantom/film, TLD, or diode dosimetry performed by physicist to confirm correct plan parameters compared with graphical plan

Total Physician Intra-Time as Reviewed in Detail (95-158 minutes)

75th Percentile of the Survey = 131 minutes

IWPUT 0.050 x 131 minutes = 6.55

Post-Service Time 35 minutes x .0224 = 0.78

Pre (0.67) + Intra (6.55) + Post (0.78) = 8.00 This comparison validates the survey median of 8.00.

The RUC recommends that 131 minutes be utilized as the intra-service time for this service.

The RUC recommends a work relative value of 8.00 for CPT code 77301.

Practice Expense

The RUC examined revised practice expense inputs from the specialty and recommends acceptance. The revisions included deletion of items considered to be overhead and not appropriate as direct cost inputs. The remaining supplies and equipment are directly related to the provision of this procedure. The RUC reviewed each element of clinical staff time in comparison to the activities performed by the physician.

The RUC recommends direct practice expense inputs for services performed in the office setting only.

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
●77301	V1	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications <u>(Dose plan is optimized using inverse or forward planning technique for modulated beam delivery (binary, dynamic MLC, etc.) to create highly conformal dose distribution. Computer plan distribution must be verified for positional accuracy based on dosimetric verification of the intensity map with verification of treatment setup and interpretation of verification methodology)</u>	XXX	8.00

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

CPT Code: 773xx Tracking Number: V1 Global Period: XXX Recommended RVW: 9.00 8.00

CPT Descriptor:

Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications

(Dose plan is optimized using inverse or forward planning technique for modulated beam delivery (binary, dynamic MLC, etc.) to create highly conformal dose distribution. Computer plan distribution must be verified for positional accuracy based on dosimetric verification of the intensity map with verification of treatment setup and interpretation of verification methodology)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

68 y/o male presenting with T1C adenocarcinoma of the prostate. Gleason score 6-7/10. Not surgical candidate because of morbid obesity. Patient set up for 3D conformal RT to 5040 cGy to pelvis. Subsequently scheduled for IMRT boost to 8100 cGy. Patient was immobilized and taken to CT for virtual simulation. Targets and critical avoidance structures outlined on axial images. IMRT plan obtained and verified with film phantom. Seventeen fractions with 3 arcs/fraction via Peacock or 5 fields with 5 intensity steps per field via MLC delivered to target at 180 cGy/fraction for total dose of 3060 cGy to gland, while keeping anterior rectal wall and bladder dose below tolerance levels.

Description of Pre-Service Work:

- review patient record and prior imaging studies

Description of Intra-Service Work:

- immobilize patient in treatment position for tumor volume localization CT
- correlate planning CT scan used for tumor localization with other imaging studies, including MRI, PET, contrast enhanced plain film studies, and ultrasound imaging studies
- enumerate critical normal tissues within and adjacent to tumor volume
- define partial dose/volume tolerances for these normal tissues
- identify and segment tumor area on each CT slice within tumor volume
- identify and segment each critical normal tissue within each CT slice within and adjacent to tumor volume
- explicitly develop normal tissue and tumor dose constraints for inverse planning algorithm
- for Peacock planning determine 1 or 2 cm index slice thickness
- for multi-leaf collimator IMRT work with physicist to suggest initial gantry and table angles for field families
- evaluate initial plan for goodness of fit for tumor and normal tissue dose constraints
- work with physicist to modify tumor and normal tissue dose constraints if necessary to re-run plan
- continue to iterate plan until dose constraints are acceptable
- specifically compare dose volume histograms for tumor and critical normal tissues
- review phantom/film, TLD, or diode dosimetry performed by physicist to confirm correct plan parameters compared with graphical plan

Description of Post-Service Work:

- dictate, review and sign report including graphical plan, dose volume histograms, set-up parameters, and setup diagrams
 - review and confirm set-up data transferred into record and verify computer
 - communicate with physicist, dosimetrist, radiation therapist/technician, and referring physician regarding intensity modulated plan development
-

SURVEY DATA:

Presenter(s): Paul Wallner, D.O.; Michael Steinberg, M.D.; Louis Potters, M.D.; James Hevezi, Ph.D.

Specialty(s): Radiation Oncology (ASTRO)

Sample Size: 182 Response Rate: (%): 19% (n=34) Median RVW: 8.00

Type of Sample (Circle One): random, **panel**, convenience. Explanation of sample size: ASTRO physician members working at facilities where IMRT is being performed were surveyed.

25th Percentile RVW: 6.125 75th Percentile RVW: 9.00 Low: 4.50 High: 11.57

Median Pre-Service Time: 30 Median Intra-Service Time: ~~60~~ 131 RUC approved intra-service time

25th Percentile Intra-Svc Time: 45 75th Percentile Intra-Svc Time: 131 Low: 20 High: 270

Median Post-Service Time: 35

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
77295	Therapeutic radiology simulation-aided field setting; three-dimensional	4.57

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

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

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 773xx</u>	<u>Key Reference CPT Code: 77295</u>
Median Pre-Time	30	20
Median Intra-Time	60 <u>131</u>	60
Median Post-service Time	35	20

INTENSITY/COMPLEXITY MEASURES (Mean)**Mental Effort and Judgement (Mean)**

The number of possible diagnoses and/or the number of management options that must be considered	4	4
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.5	3.85
Urgency of medical decision making	3.5	3.41

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	4.74	3.81
Outcome depends on the skill and judgement of physician	4.88	3.81
Estimated risk of malpractice suit with poor outcome	4.56	4.04

INTENSITY/COMPLEXITY MEASURES**CPT Code
773xx****Reference
Service 1
77295****Time Segments (Mean)**

Pre-Service intensity/complexity	4	4
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 median RVW derived from our survey data is 8.00. However, we are recommending the 75th percentile RVW of 9.00 because the vignette used in the survey represents the simplest use of IMRT and it will most frequently be more time- and labor-intensive than that vignette would suggest. In fact, it is important to note that nearly half of all survey respondents indicated that this vignette **did not** describe their typical patient for this procedure. Examples of more complex targets listed by respondents include colon, intracranial targets, concave shaped targets near the spinal cord, sacro-coccygeal and clivus chordomas, peri-orbital tumors, optic nerve tumors, acoustic neuromas, pancreas, retreatment of bony metastasis in patients whose spine has been previously irradiated, and opportunities to escalate the dose in these targets due to precision of IMRT technology.

The 75th percentile for pre-, intra-, and post-service time is also more accurate than the median times reported by respondents:

	Pre-service time	Intra-service time	Post-service time	Total time
25%	16.25	45.00	20.00	81.25
50%	30.00	60.00	35.00	125.00
75%	43.75	131.00	60.00	234.75
Mean	36.18	92.00	41.00	169.18

FREQUENCY INFORMATION

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

77295 Therapeutic radiology simulation-aided field setting; three-dimensional

77315 Teletherapy, isodose plan (whether hand or computer calculated); complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations) serialography, radiological supervision and interpretation

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

Specialty Radiation Oncology _____ 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 Radiation Oncology Frequency 3,000*

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 Radiation Oncology Frequency 1,500*

***We believe that many radiation oncologists have reported IMRT planning (773xx) with the following two codes that come closest to describing the procedure:**

**77295 Therapeutic radiology simulation-aided field setting; three-dimensional
77315 Teletherapy, isodose plan (whether hand or computer calculated); complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations)**

We estimate that when IMRT is fully implemented, 10% or 5,000 of the Medicare claims previously reported as 77295 will be reported as 773xx. Our estimate for 2002 is 3% of the 77295 Medicare claims.

Please note that IMRT is an advanced new form of three-dimensional conformal radiation therapy (CRT), which not only uses 3-D imaging and treatment delivery, but allows for varying intensities of radiation to produce dose distributions that are far more conformal than those possible with standard 3-D CRT. Although radiation oncologists have reported IMRT in the past with codes 77295 and 77315, IMRT should not be viewed as a subset of these codes because IMRT is a distinct new technology. In fact, when the work RVUs were assigned to 77295 in 1994, IMRT was being performed on a small number of patients in only a few research settings in the U.S. and Europe.

Do many physicians perform this service across the United States? _____ Yes X No

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

Sample Size: consensus panel Response Rate (%): n/a Global Period: XXX

Tracking Number: V1 Reference Code 1 77295

Geographic Practice Setting %: Rural 0 Suburban 56 Urban 44

Type of Practice %: 0 Solo Practice
67 Single Specialty Group
8 Multispecialty Group
25 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:

The practice expense survey was distributed to ASTRO physician members working at facilities where IMRT is performed. There was a 7% response rate (n=13) due to the complexity of the form and difficulty in cost-accounting the multifaceted and complex process of IMRT. A consensus panel was convened to review the survey data received. The consensus panel was comprised of members of the ASTRO Clinical Practice Committee, which includes physicians, physicists and an administrator with IMRT and/or health services experience. Several conference calls were conducted to discuss the data and to develop direct inputs for clinical labor, supplies and equipment. The panel reviewed the final recommendations during a final conference call.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

~~Radiation Therapist (Technologist): Schedule space and equipment in facility~~

Intra-Service Clinical Labor Activities:

~~Radiation Therapist (Technologist): Preparation, alignment and monitoring of patient, and data collection for planning of CT scan~~

Post-Service Clinical Labor Activities:

N/A

HCFA's Staff Type Code**	Clinical Labor	Pre-Service Time	Service Period	Coordination of Care*	Post-Service Time	Cost Estimate and Source (if applicable)
1031	Radiation Therapist (Technologist)	8	40			|

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

** From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	N/A			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	N/A				

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

**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	<u>8</u>	RN, LPN, MA, Other radiation therapist <u>(technologist)</u>
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. (i.e.: 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)

Preparation, alignment and monitoring of patient, and data collection for planning of CT scan	<u>40</u>	RN, LPN, MA, Other radiation therapist <u>(technologist)</u>
----------------------------------------------------------------------------------------------------------	-----------	----------------------------------------------------------------------------

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 _____
Other Activity (please specify)	_____	RN, LPN, MA, Other _____

End: When appointment for next office visit is made.

**AMA/Specialty Society Update Process
RUC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

Sample Size: consensus panel Response Rate (%): n/a Global Period: XXX

Tracking Number: V1 Reference Code 1 77295

Geographic Practice Setting %: Rural 0 Suburban 56 Urban 44

Type of Practice %: 0 Solo Practice
67 Single Specialty Group
8 Multispecialty Group
25 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:

The practice expense survey was distributed to ASTRO physician members working at facilities where IMRT is performed. There was a 7% response rate (n=13) due to the complexity of the form and difficulty in cost accounting the multifaceted and complex process of IMRT. A consensus panel was convened to review the survey data received. The consensus panel was comprised of members of the ASTRO Clinical Practice Committee, which includes physicians, physicists and an administrator with IMRT and/or health services experience. Several conference calls were conducted to discuss the data and to develop direct inputs for clinical labor, supplies and equipment. The panel reviewed the final recommendations during a final conference call.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

RN/LPN/MA: Review/read X-ray, lab and pathology reports

Physicist: Pre-planning

Intra-Service Clinical Labor Activities:

RN/LPN/MA: Greet patient and provide gowning; obtain vital signs; education/instruction/counseling, coordinate home or outpatient care

RN: Obtain vital signs; education/instruction/counseling; coordinate home or outpatient care

Radiation Therapist (Technologist): Prep and position patient; prepare room, equipment, supplies; clean room/equipment; immobilize for localization CT

Dosimetrist/Physicist: Correlate planning CT with other imaging studies; enumerate critical normal tissues adjacent to tumor volume

Physicist: Define partial dose/volume tolerances for normal tissues; identify and contour tumor area on CT slice within tumor volume; develop normal tissue and tumor constraints; for Peacock planning determine slice thickness or for MLC work with physicist to suggest initial gantry and table angles; evaluate initial plan for goodness of fit for tumor and normal tissue dose constraints; modify tumor and

normal tissue dose constraints if necessary; iterate plan until dose constraints are acceptable; compare final dose volume histograms for tumor and critical normal tissues; review phantom/film, TLD or diode dosimetry referenced to ion chamber to confirm correct dose delivery.

Post-Service Clinical Labor Activities:

RN/LPN/MA: Phone calls between visits with patient, family, pharmacy

HCFA's Staff Type Code*	Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
10331130	RN/LPN/MA	2.40	1816	10	
1031	Radiation Therapist (Technologist)		48		
1029	Physicist	10.30	350270		
1011/1029	Dosimetrist/Physicist		6045		
1020	Medical Assistant		3		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
11302	Gloves, nonsterile	4	pair	
73423	Film developer, cost per exposure	20	exposure	
	Kodak x-omat, 8x10 for phantoms	20	sheet	\$1.00/sheet Kodak
73606	Hypaque	50	ml	
73402	X-ray film, 14x17	6	sheet	
	TLD chips	25	item	\$15.00 ea. Harshaw
	Fiducial screws	4	item	\$558.00 per set NOMOS
	Styrofoam	1	sheet	\$3.10/sheet Radiation Products Design
11512	Bite block	1	item	
	Head rest, TMO	1	item	\$89.00 Radiation Products Design
	Fiducial markers	4	item	\$7.00 ea. Radiation Products Design
93102	Catheter Insertion Kit [Foley]	1	item	

	Xerox dry radiographic film for DRRs	6	sheet	\$2.50/sheet Xerox
75031	Photographic paper	20	sheet	
	Fuser Roller	1	Item	\$85.00 per month Xerox/Techtronie
	Printer ink techtronic cartridge-color	1	Item	\$250.00 ea. (use 4 per year) Xerox/Techtronie
	Printer ink techtronic cartridge black & white	1	Item	\$150.00 ea. (use 4 per year) Xerox/Techtronie
53002	Acetone	2	ounce	
11118	Paper towels	20	Item	
	Transparency	6	sheet	.52/sheet Miller's Office Products
73410	Floppy disk	1	item	
	Storage Optical Data tape	1	tape	\$15.00 \$5.00 (1/3 of tape) Sony

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Nomos-Corvus-Peregrine treatment planning system	1	400	40	\$350,000 NOMOS
	Peregrine Physics Support Package	1	400	40	\$12,500 NOMOS
	Annual Peacock/Peregrine Service Agreement	1	400	40	\$25,000 NOMOS
	IMRT Physics Tools (including RadCalc with IMRT Software, Water Phantom System, Solid Phantom with chamber, electronic level and wrench set)	1	60 15	40	\$55,485 \$27,742.50 NOMOS (Note: Total cost = \$55,485; 50% allocated to 773xx and 50% to 774xx.)
E51018	CT based virtual simulator	1	90	40	
E51048	TLD reader	1	90	20	
E51046	Solid water calibration phantom	1	20	1.5	
	TLD Oven/Annealing furnace	1	60	10	\$1960.00 Radiation Products Design

	NOMOS Film Dosimetry Equipment (includes RIT Software and PC, Vidar Dosimetry Pro)	1	60	5	\$28,500 NOMOS
	PC Server	1	20	40	\$25,000 Dell Computers
	Laser printer for CT	1	15	20	\$75,000 Xerox
	Sublimated dye printer	1	15	4	\$15,000 Seiko
	Precision calibrated film processor	1	15	2	\$25,000 Kodak
	MR/PET/CT fusion software	1	15	2	\$60,000 Marconi Medical Systems
	Optical disk reader	1	10	1	\$4,000 Hewlett-Packard

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

**SITE OF SERVICE: In-Office
Clinical Services**

	<u>Minutes</u>	<u>Staff Type – Circle</u>
Pre-Service Period		
<i>Start: When appointment for service is made</i>		
Review/read X-ray, lab, and pathology reports	<u>40 2</u>	RN, LPN, MA, Other _____ |
Other Clinical Activity (please specify)		
<u>Pre-planning</u>	<u>30 10</u>	RN, LPN, MA, Other <u>physicist</u> |
<i>End: Patient arrival at office for service</i>		
Service Period		
<i>Start: Patient arrival at office for service</i>		
Greet patient/provide gowning	<u>3</u>	RN, LPN, MA, Other _____ |
Obtain vital signs	<u>3</u>	RN, LPN, MA, Other _____ |
Prep and position patient	<u>15</u>	RN, LPN, MA, Other <u>radiation therapist (technologist)</u> |
Prepare room, equipment, supplies	<u>10</u>	RN, LPN, MA, Other <u>radiation therapist (technologist)</u> |
Assist physician during exam	<u>0</u>	RN, LPN, MA, Other _____ |
Education/instruction/ counseling	<u>10</u>	RN, LPN, MA, Other _____ |
Coordinate home or outpatient care	<u>5 0</u>	RN, LPN, MA, Other _____ |
Clean room/equipment	<u>3</u>	RN, LPN, MA, Other <u>radiation therapist (technologist)</u> |
Other Clinical Activity (please specify)		RN, LPN, MA, Other _____ |
Immobilize for localization CT	<u>20</u>	<u>Radiation Therapist (Technologist)</u> |
Correlate planning CT with other imaging studies	<u>30</u>	<u>Dosimetrist/Physicist *</u> |
Enumerate critical normal tissues adjacent to tumor volume	<u>30 15</u>	<u>Dosimetrist/Physicist *</u> |
Define partial dose/volume tolerances for normal tissues	<u>30 15</u>	<u>Physicist</u> |
Identify and contour tumor area on CT slice within tumor volume	<u>60</u>	<u>Physicist</u> |
Explicitly develop normal tissue and tumor constraints	<u>30 15</u>	<u>Physicist</u> |
For Peacock planning determine slice thickness, or, for multi-leaf collimator IMRT, work with physicist to suggest initial gantry and table angles for field families	<u>30 20</u>	<u>Physicist</u> |
Evaluate initial plan for goodness of fit for tumor and normal issue dose constraints	<u>20</u>	<u>Physicist</u> |
Modify tumor and normal tissue dose constraints if		

necessary to re-run plan	<u>20 #</u>	<u>Physicist</u>
Iterate plan until dose constraints are acceptable Evaluate next plan until dose constraints are acceptable	<u>20</u>	<u>Physicist</u>
Compare final dose volume histograms for tumor and critical normal tissues	<u>20</u>	<u>Physicist</u>
Review phantom/film, TLD, or diode dosimetry referenced to ion chamber single point dosimetry to confirm correct dose delivery compared with graphical plan	<u>120 80</u>	<u>Physicist</u>

End: Patient leaves office

Post-Service Period

Start: Patient leaves office

Phone calls between visits with patient, family pharmacy	<u>10</u>	RN, LPN, MA, Other _____
Other Activity (please specify) _____	_____	RN, LPN, MA, Other _____

End: When appointment for next office visit is made.

*** Initially this task would be performed solely by a physicist. Over time, this task might be performed 50% of the time by the physicist and 50% of the time by the dosimetrist. Our recommendation for this task takes into account the process that exists after experience with the procedure is gained and is, therefore, conservative.**

The time for this task would be longer (by a factor of 2-3) if reiterations are necessary.

**AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS**

April 2001

Radiation Treatment Delivery

The specialty society presented only practice expense direct inputs for code 77418 *Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams (binary, dynamic MLC, etc.), per treatment session* since there is no physician work associated with this code. This code was created to describe a new method of providing radiation treatment. The RUC made a number of changes to the inputs including using the standard staff mix of RN/LPN/MA for some activities and also deleting a number of supplies that were then grouped into the minimum supply package. Also the RUC agreed with the specialty that two radiation therapists are used for providing this service.

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
●77418	W1	Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams (binary, dynamic MLC, etc.), per treatment session (For intensity modulated treatment planning, use 77301)	XXX	N/A Practice Expense only

**AMA/Specialty Society Update Process
RUC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

Sample Size: consensus panel Response Rate (%): n/a Global Period: XXX

Tracking Number: W1 Reference Code 1 77413

Geographic Practice Setting %: Rural 0 Suburban 56 Urban 44

Type of Practice %: 0 Solo Practice
67 Single Specialty Group
8 Multispecialty Group
25 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:

The practice expense survey was distributed to ASTRO physician members working at facilities where IMRT is performed. There was a 7% response rate (n=13) due to the complexity of the form and difficulty in cost accounting the multifaceted and complex process of IMRT. A consensus panel was convened to review the survey data received. The consensus panel was comprised of members of the ASTRO Clinical Practice Committee, which includes physicians, physicists and an administrator with IMRT and/or health services experience. Several conference calls were conducted to discuss the data and to develop direct inputs for clinical labor, supplies and equipment. The panel reviewed the final recommendations during a final conference call.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Radiation Therapist (Technologist): Clean and prepare room for the patient

Intra-Service Clinical Labor Activities:

~~RN/LPN/MA Medical Assistant:~~ Greet patient and provide gowning

Radiation Therapist (Technologist): Prepare room and supplies; position patient and equipment; perform treatment delivery; take port films; provide patient education; clean room and equipment

Post-Service Clinical Labor Activities:

RN/LPN/MA: Phone calls between visits

Radiation Therapist: Charting

HCFA's Staff Type Code*	Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
1033 1130	RN/LPN/MA		<u>3</u>	3	
1031	Radiation Therapist (Technologist)	10	126 <u>123</u>	5	
1020	Medical Assistant		<u>3</u>		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, provide full description, estimated cost, and cost source

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
1111	Exam table paper	<u>7</u>	Foot	
HCFA to assign code	<u>Minimum supply package</u>	<u>1</u>		
31518	Gauze, nonsterile, 4" x 4"	4	item	
	Digital level	<u>1</u>	Item	\$95.00 Radiation Products Design
73402	Film, 14x17	2	sheet	
On HCFA supply list, but no # designated	Ear plugs	1	pair	\$0.20
	Traction straps	2	item	\$60.00 Radiation Products Design
31514	Masking tape	48	inch	
11107	Patient gown, disposable	<u>1</u>	Item	
75011	Alcohol	7	ml	
11302	Gloves, nonsterile	<u>2</u>	Pair	
31105	KY jelly, single use foil pack, 5 grams	2	item	
11118	Paper towel	<u>12</u>	Item	
75134	Marking ink	2	ml	
73407	Flash card	2	item	
11112	Pillowcase, disposable	<u>1</u>	Item	
11106	Drape, sheet	1	item	
93102	Catheter Insertion Kit # <u>[Foley]</u>	1	item	

93101	Foley catheter #	1	item	
53099	Normal Saline (NS)	50	ml	
73606	Hypaque	50	MI	

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, provide full description, estimated cost, and cost source.

The foley catheter is one way of performing target/organ immobilization; in the future, other non-invasive methods of target tracking will be employed that will be at least as expensive when amortized on a daily treatment basis.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Annual Peacock/Peregrine Service Agreement	1	60	40	\$30,000 NOMOS
	IMRT Physics Tools (including RadCalc with IMRT Software, Water Phantom System, Solid Phantom with chamber, electronic level and wrench set)	1	30 <u>15</u>	40	\$55,485 <u>\$27,742.50</u> NOMOS (Note: Total cost = \$55,485; 50% allocated to 773xx and 50% to 774xx.)
	MIMIC/Controllers/Crane	1	60	40	\$448,680 NOMOS
E51056	Linear accelerator – Clinac 2100	1	60	40	
E13405	<u>Diode Laser</u>	4	60	10	(MedTech, Gammex)
	Isoalign device	1	15	2	\$950.00 Radiation Products Design
E51022	Record and verify computer (Varian)	1	30	40	
	Portal imager	1	10	40	\$250,000 Varian
E51020	Digital camera	1	5	20	Sony \$800.00
E92020	Intercom	1	40	40	
E52010	Color printer	1	5	20	
E13635	Video camera	1	40	40	

**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

_____ RN, LPN, MA, Other _____

Other Clinical Activity (please specify)

_____ RN, LPN, MA, Other radiation
therapist (technologist) |

~~Clean and prepare room for patient~~

10 *

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

0 RN, LPN, MA, Other _____

Prep and position patient

(5) 10 * RN, LPN, MA, Other radiation
therapist (technologist) |

Prepare room, equipment, supplies

5 RN, LPN, MA, Other radiation
therapist (technologist)

Assist physician during exam

0 RN, LPN, MA, Other _____

Education/instruction/ counseling

3 6 * RN, LPN, MA, Other radiation
therapist (technologist) |

Coordinate home or outpatient care

0 RN, LPN, MA, Other _____

Clean room/equipment

5 RN, LPN, MA, Other radiation
therapist (technologist)

Other Clinical Activity (please specify)

_____ RN, LPN, MA, Other _____

Set up computerized treatment media

(3) 6 * Radiation Therapist (Technologist) |

Set up patient in immobilization device(s)

(5) 10 * Radiation Therapist (Technologist) |

Attach targeting devices

(1) 2 * Radiation Therapist (Technologist) |

Align vert., lat., long. isocenters

(3) 6 * Radiation Therapist (Technologist) |

Remove targeting devices

(1) 2 * Radiation Therapist (Technologist) |

Set gantry/field for first IMRT delivery	<u>(3) 6 *</u>	<u>Radiation Therapist (Technologist)</u>	
Preparation Index 1	<u>(3) 6 *#</u>	<u>Radiation Therapist (Technologist)</u>	
Index 1	<u>(5) 10 *#</u>	<u>Radiation Therapist (Technologist)</u>	
Preparation Index 2	<u>(3) 6 *#</u>	<u>Radiation Therapist (Technologist)</u>	
Index 2	<u>(5) 10 *#</u>	<u>Radiation Therapist (Technologist)</u>	
Preparation Index 3	<u>(3) 6 *#</u>	<u>Radiation Therapist (Technologist)</u>	
Index 3	<u>(5) 10 *#</u>	<u>Radiation Therapist (Technologist)</u>	
Remove patient from assemblies	<u>(5) 10 *</u>	<u>Radiation Therapist (Technologist)</u>	
Port film or other localization	<u>(5) 10 *</u>	<u>Radiation Therapist (Technologist)</u>	
<i>End: Patient leaves office</i>			
Post-Service Period			
<i>Start: Patient leaves office</i>			
Phone calls between visits with patient, family pharmacy	<u>3</u>	RN, LPN, MA, Other _____	
Other Activity (please specify)			
<u>Charting</u>	<u>5</u>	<u>Radiation Therapist (Technologist)</u>	
<i>End: When appointment for next office visit is made.</i>			

* The complexity of this treatment delivery necessitates the use of two (2) radiation therapists (technologists) working hand-in-hand to check each others set-ups and instructions so that errors in this complicated delivery will not be made. Additionally, many state regulations require 2 radiation therapists (technologists) per linear accelerator.

The three (3) table indices defined in this vignette are conservative. Other complex targets may require additional indices (a range of 4-8) and rotation of the table to cover even more complex targets conformally, thus increasing the time required to complete the procedure.

Please note that treatment time is 15-20 minutes for the conventional radiation therapy patient, but is 40-70 minutes for the IMRT patient. In addition, the monitor units (the actual ionizations measured at the treatment head representing the output of the linear accelerator) are four times that of conventional radiation therapy, thereby rendering four times the wear and tear on the linear accelerator.

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
February 2001

Immunization (Two or More Injections)

The RUC approved a recommendation from pediatrics that the new codes to describe intranasal or oral administration of vaccines should be assigned the same work relative value as the existing CPT codes for immunization administration as outlined in the attached letter. **The RUC recommends a work relative value of .17 for code 90473 and .15 for code 90474.**

The RUC also recommends that the direct practice expense inputs should be the same for these codes, with an exclusion of a band-aid (1), a syringe (1), and needles (2) on the medical supply list for codes 90473 and 90474.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲90471	B1	Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections and/or intranasal or oral administration); one vaccine (single or combination vaccine/toxoid)	XXX	.17 (previously accepted by RUC)
▲+90472	B2	each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure) (Use 90472 in conjunction with code 90471)	ZZZ	.15 (previously accepted by RUC)
●90473	B3	Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)	XXX	.17
+●90474	B4	each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure) (Use 90474 in conjunction with code 90473)	ZZZ	.15



January 9, 2001

James G. Hoehn, MD
Chair, AMA/Specialty Society RVS Update Committee
Relative Value Systems
American Medical Association
515 North State Street
Chicago, IL 60610

Dear Dr. Hoehn:

In May 2000, the American Academy of Pediatrics (AAP) agreed to survey the new/revised immunization administration codes 90471 (immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections ~~and/or intranasal or oral administration~~); one vaccine (single or combination vaccine/toxoid)), 90472 (immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections ~~and/or intranasal or oral administration~~); each additional vaccine (single or combination vaccine/toxoid)), 90473 (immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)), and 90474 (immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid)) for presentation during the February 2001 RUC meeting.

Following expert panel deliberations, the Academy recommends to the RUC that the 90471 and 90472 code descriptor changes approved during the May 2000 CPT Editorial Panel are editorial in nature. The Academy believes that the elimination of the oral and intranasal vaccines does not represent any difference in physician work or practice expense with regard to vaccine administration. Therefore, the Academy proposes no change in work or practice expense for 90471 and 90472 from previously accepted RUC values.

As you recall, the RUC recently accepted work and practice expense values for 90471 and 90472 during its April 1999 meeting. The RUC then accepted revised practice expense values for 90471 and 90472 presented by the Academy during the February 2000 PEAC meeting. Attached are copies of the Summary of Recommendation forms for 90471 and 90472 from both meetings. The Academy believes that the values presented in these documents still hold true for the revised vaccine administration codes, 90471 and 90472.

The Academy also proposes the same work values for the new vaccine administration codes, 90473 and 90474. The Academy believes that the physician work involved in administering vaccines via oral or intranasal routes is not different than the work involved in administering vaccines via percutaneous, intradermal, subcutaneous, intramuscular or jet injection routes. Therefore, the Academy proposes the same work values for 90473 and 90474 as it does for 90471 and 90472.

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Additionally, the Academy believes that the direct practice expense values for 90473 and 90474 are identical to those for 90471 and 90472 other than the inclusion of a band-aid (1), a syringe (1), and needles (2) on the medical supply list. The Academy recommends that these items be removed from 90473 and 90474's direct practice expense inputs. The other components of direct practice expense (clinical staff time, medical equipment) remain an accurate description of the resources involved in oral or intranasal routes of vaccine administration.

The Academy appreciates the opportunity to comment on the vaccine administration codes and looks forward to continuing its work with the RUC to ensure accurate values for all CPT codes.

Sincerely,

Joel Bradley, MD

Joel F. Bradley, Jr, MD, FAAP
AAP Representative to the RUC

JFB/ljw

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

April 2001

Revised Hemodialysis Access Flow Measurement

In May 2000, the RUC submitted direct practice expense inputs for CPT code 90940. HCFA did not mention these recommendations in the *Final Rule* for the 2001 Physician Payment Schedule, however, HCFA indicated that 90940 would be bundled into the monthly capitated payment for dialysis services. The specialty societies assumed that HCFA would treat new code 90939 in a similar fashion and, therefore, did not present recommendations to the RUC. The RUC requests that HCFA consider how these decisions may affect private payors who also use the RBRVS. As we have argued in the past, HCFA should publish relative values for services, regardless of HCFA's coverage policies, so that other payors may utilize this information.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 90939		Hemodialysis access flow study to determine blood flow in grafts and arteriovenous fistulae by an indicator dilution method, hook-up, transcutaneous measurement and disconnection	XXX	Physician work is bundled into monthly capitated payment. Direct expense inputs were recommended for 90940 in May 2000, but HCFA bundled into MCP.
▲ 90940	SS1	measurement and disconnection	XXX	

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

April 2001

Pulsed Irrigation Procedures of the Bowel

The specialty society initially proposed only practice expense inputs for code 91123 *Pulsed irrigation of fecal impaction* since there was no physician work associated with this procedure. The RUC agreed that this procedure is performed by non-physician clinical labor and not by physicians so there should be no physician work RVUs assigned to this code. Also, since the procedure is performed in a facility setting, not a physician's office, the RUC concluded that there should not be any direct practice expenses assigned to this code. **The RUC recommends a zero physician work value and zero practice expense inputs for the facility setting for code 91123.**

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
• 91123	C1	Pulsed irrigation of fecal impaction	XXX	No Physician Work No Practice Expense Inputs

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

April 2001

Noninvasive Anterior Chamber Biometry

Code 92136 *Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation* was created to describe optical coherence measurement for intraocular lens measurement and calculation. The RUC examined a request from the American Academy of Ophthalmology to cross walk the work relative value from code 76519 *Ophthalmic biometry by ultrasound echography, A-scan, with intraocular lens power calculation*. (work RVU = .54). The RUC agreed that the number of images, the mental effort and judgement, technical skill, time and iatrogenic risk are the same for both codes and therefore concluded for this code, crosswalking values was appropriate. **The RUC recommends a physician work value of .54 for code 92136.**

Practice Expense

The RUC recommends crosswalking the practice expense for code 76519 with the addition of a \$25,000 optical coherence biometer as the medical equipment.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•92136	RR1	Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation	XXX	0.54
76516		<i>Ophthalmic biometry by ultrasound echography, A-scan;</i>	XXX	0.54 (No change)
76519		<i>with intraocular lens power calculation</i> <u>(For partial coherence interferometry, use 92136)</u>	XXX	0.54 (No change)

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

April 2001

Continuous Glucose Monitoring System

The CPT Editorial Panel created a new code 95250 *Glucose monitoring for up to 72 hours by continuous recording and storage of glucose values from interstitial tissue fluid via a subcutaneous sensor (includes hook-up, calibration, patient initiation and training, recording, disconnection, downloading with printout of data)* to describe the technical portion of this service. The physician review, interpretation and written report associated with this service would be reported utilizing the Evaluation and Management service codes. **The RUC recommends zero physician work for 95250.**

The RUC revised the direct practice expense inputs for this service. The clinical staff time was reduced from the specialty's recommendation and the minimum supply kit was eliminated as that would be captured in the associated Evaluation and Management service. These revised practice expense inputs are included in an attachment to the recommendation.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 95250	BB1	<p>Glucose monitoring for up to 72 hours by continuous recording and storage of glucose values from interstitial tissue fluid via a subcutaneous sensor (includes hook-up, calibration, patient initiation and training, recording, disconnection, downloading with printout of data)</p> <p><u>(Do not report 95250 in conjunction with 99091)</u></p> <p><u>(To report physician review, interpretation and written report associated with code 95250, see Evaluation and Management service codes)</u></p>	XXX	No Physician Work Practice Expense only

CPT Code: _____
Specialty Society('s) _____

**AMA/Specialty Society Update Process
RUC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

Sample Size: 79 Response Rate: (%): 30 Global Period: _____

Tracking Number: 926X1 Reference Code 1 99199 Reference Code 2 93224, 93225,

Geographic Practice Setting %: Rural 16% Suburban 40% Urban 44%

Type of Practice %: 32% Solo Practice
28% Single Specialty Group
20% Multispecialty Group
20% 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:

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Obtaining referral/authorization, review blood sugar readings and other laboratory reports.

Intra-Service Clinical Labor Activities:

Greeting/rooming patients, obtaining vital signs including height, weight, temperature, blood pressure, pulse; preparing patient, preparing the room/equipment/supplies, educating the patient on how the monitor works and how to use the monitor; coordinating care; inserting the device; and initializing the monitor.

Post-Service Clinical Labor Activities:

Follow-up phone calls with patient/family, downloading the information from the monitor, and reviewing the data with the patient.

CPT Code: _____
 Specialty Society('s) _____

HCFA's Staff Type Code*	Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
1130	RN/LPN/MA	5	77	25	

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	Glucose Sensor (1)	1		299.50/10=29.95
	Shower Pack (1)	1		19.00/30 = .63
	Alcohol prep pads (4)	4		
	Gauze bandages (2 4x4's)	2		
	Poly-skin – transparent dressing (1)	1		34.00/50 = .68
	IV 3000 – transparent dressing (1)	1		49.50/100 =.50
	IV Prep – antiseptic skin prepping pad (1)	1		12.00/50 =.24
	Minimum supply kit	1		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Continuous Glucose Monitor (cable, com-station, cgms com-station software, senserter)	1	4427		2613.00

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

**SITE OF SERVICE: In-Office
 Clinical Services**

<u>Minutes</u>	<u>Staff Type – Circle</u>
Pre-Service Period	
<i>Start: When appointment for service is made</i>	
Review/read X-ray, lab, and pathology reports	RN, LPN, MA, Other _____
<u>5</u>	
Other Clinical Activity (please specify)	
<u>Review of self blood glucose monitoring measurements and preparation of supplies</u>	RN, LPN, MA, Other _____

<i>End: Patient arrival at office for service</i>	
Service Period	
<i>Start: Patient arrival at office for service</i>	
Greet patient/provide gowning	RN, LPN, MA, Other _____
<u>3</u>	
Obtain vital signs	RN, LPN, MA, Other _____
<u>3</u>	
Prep and position patient	RN, LPN, MA, Other _____
<u>2</u>	
Prepare room, equipment, supplies	RN, LPN, MA, Other _____
<u>5</u>	
Assist physician during exam	RN, LPN, MA, Other _____

Education/instruction/ counseling	RN, LPN, MA, Other _____
<u>30</u>	
Coordinate home or outpatient care	RN, LPN, MA, Other _____

Clean room/equipment	RN, LPN, MA, Other _____
<u>4</u>	
Other Clinical Activity (please specify)	
Inserting and initializing the device	RN, LPN, MA, Other _____
<u>30</u>	
<hr/>	
<i>End: Patient leaves office</i>	
Post-Service Period	
<i>Start: Patient leaves office</i>	
Phone calls between visits with patient, family pharmacy	RN, LPN, MA, Other _____
<u>10</u>	
Other Activity (please specify)	
Download information and review report	RN, LPN, MA, Other _____
<u>15</u>	
<i>End When appointment for next office visit is made</i>	

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

April 2001

Percutaneous Transluminal Coronary Thrombectomy

A new code was created to capture a new technique of removing thrombus in native coronary arteries and coronary saphenous vein grafts (SVG), for patients with AMI, unstable angina, and degenerated SVG disease.

The RUC reviewed the survey results from 28 practicing cardiologists, and believed that the work associated was quite similar to the reference code 92996 *Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)* (work RVU = 3.26). The specialty society valued this new code slightly higher than the reference code to avoid a rank order anomaly. The code's vignette drew attention by the RUC members as it described the entire process encompassing several separate codes, however the specialty society survey specifically asked for the incremental work associated to this add-on code. The description of intra-service work also indicated that there were other separately billable items, and this helped the RUC understand how the survey respondents valued the amount of work associated with this particular code. The RUC believed that the survey results indicating 40 minutes of intra-service time for the withdrawal, replacement, and multiple passes to remove the thrombus was reasonable. The RUC accepted the specialty society's survey median. **The RUC recommends a relative work value of 3.28 for CPT code 92973.**

Practice Expense

The RUC recommends no practice expense direct inputs for this ZZZ day global code.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
+•92973	TT1	Percutaneous transluminal coronary thrombectomy (List separately in addition to code for primary procedure) (Use 92973 in conjunction with 92980, 92982)	ZZZ	N/A	3.28

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

CPT Code: + 9297X Tracking Number: TT1 Global Period: ZZZ **Recommended RVW: 3.28**
 CPT Descriptor: Percutaneous transluminal coronary thrombectomy (List separately in addition to code for primary procedure) (Use 9297X in conjunction with 92980, 92982)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

The patient is a 70 year old man, 8 years status post-coronary artery bypass grafting who now presents with unstable angina and recent non-Q wave myocardial infarction. Coronary angiography demonstrates a high-grade stenosis in the SVG to the RCA with a large filling defect consistent with fresh thrombus. Percutaneous coronary intervention is indicated to preserve patency of the vein graft and prevent further myocardial infarction. Treatment of lesions that contain considerable intracoronary thrombus with either balloon angioplasty or stent placement is frequently complicated by fragmentation of thrombus with distal embolization, resulting in further myocardial injury. Therefore, some form of thrombectomy procedure is desirable to remove the thrombus before treating the underlying atherosclerotic plaque so as to reduce the risk of procedural complications.

Description of Intra-Service Work:

After defining the relevant anatomy by coronary angiography, a guiding catheter (separately billable) is introduced to the ostium of the coronary artery to be treated (or vein graft, in this case). Through the guiding catheter, a guidewire is used to cross the lesion and thrombus (separately billable) and the Angiojet thrombectomy catheter is advanced over the guidewire to a position distal to the thrombotic lesion. The catheter is activated by depressing a footpedal and manually withdrawn slowly across the lesion in order to remove the intracoronary thrombus. After deactivation, the thrombectomy catheter is again advanced distal to the initial lesion and a repeat withdrawal pass made. After several passes have been performed, the Angiojet catheter is removed, followed by definitive treatment of the original stenosis. This usually requires additional balloon angioplasty or stent placement (separately billable).

SURVEY DATA:

Presenter(s) James Maloney, M.D., and Joseph Babb, M.D.

Specialty(s): Cardiology

Sample Size: 64 Response Rate: (%): 28 (43.8%) Median RVW: 3.26

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

Survey was sent to a random sample of members of the ACC subspecialty, the Society for Cardiac Angiography and Interventions, all of whom are cardiologists.

25th Percentile RVW: 3.1 75th Percentile RVW: 3.75 Low: 1.2 High: 18.7

Median Pre-Service Time: N/A Median Intra-Service Time: 40

25th Percentile Intra-Svc Time: 25 75th Percentile Intra-Svc Time: 60 Low: 15 High: 120

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

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	
92996	Percutaneous transluminal coronary atherectomy, by mechanical or other method with or without balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)	3.26	ZZZ global

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

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

TIME ESTIMATES (Median)

<u>TIME ESTIMATES (Median)</u>	<u>New/Revis. CPT Code:</u>	<u>Key Reference CPT Code:</u>
Median Pre-Time	N/A	N/A
Median Intra-Time	40	Not available per database
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		

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	4.10	3.86
--------------------------------------------------------------------------------------------------	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.64	3.57
Urgency of medical decision making	4.39	3.76

Technical Skill/Physical Effort (Mean)

Technical skill required	4.36	4.33
Physical effort required	3.43	3.38

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.46	3.86
Outcome depends on the skill and judgement of physician	4.50	4.10
Estimated risk of malpractice suit with poor outcome	4.14	3.71

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	N/A	N/A
Intra-Service intensity/complexity	4.29	4.05
Post-Service intensity/complexity	N/A	N/A

ADDITIONAL RATIONALE

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

The American College of Cardiology has a Cardiovascular RUC Committee, representing cardiology and the cardiology subspecialties, who met by phone conference to discuss the recommended work RVU. The committee determined that patients undergoing thrombectomy are slightly more ill and unstable than patients undergoing atherectomy, the reference procedure (92996, atherectomy of a single vessel). Atherectomy currently has 3.26 work RVUs, the same result as the 50th percentile of the thrombectomy survey. In order to prevent a rank order anomaly between thrombectomy and atherectomy, the committee recommends that thrombectomy be valued slightly higher, at 3.28 RVUs.

FREQUENCY INFORMATION

How was this service previously reported? 93799 and 92995 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

93799 – unlisted cardiovascular service has a frequency of 15,542.

92995 – Percutaneous transluminal atherectomy (Medicare frequency approximately 11,500.)

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 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 12,000

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 7,000

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

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

April 2001

Transcatheter Placement of Radiation Delivery Device (Intravascular Coronary Brachytherapy)

A new code was created to identify the new technique of using catheter-based radiation (Gamma or Beta) to treat patients with restenosis of previously placed coronary stents. It is performed in an interventional cardiac catheterization laboratory as an adjunctive procedure to balloon angioplasty, atherectomy, or coronary stent placement.

The RUC reviewed the survey results for this new code and questioned whether or not the respondents valued the work increment correctly. The RUC understood that the work intensity of the cardiologist for this code, was similar to the intensity of other codes billed at the same time. The work of the cardiologist includes being careful not to let the radiation seeds drift away from the targeted area damaging healthy tissue, and therefore must monitor their placement frequently. The cardiologist also has the responsibility of placing the seeds which is the most intense time period of the procedure. Additionally, the RUC wanted to avoid a rank order anomaly within the code's family, noting that code 92973 *Percutaneous transluminal coronary thrombectomy (List separately in addition to code for primary procedure) (Use 92973 in conjunction with 92980, 92982 (RUC recommended value = 3.28) had been reviewed and accepted earlier that day. The RUC recommended a value below specialty's recommended value and survey median. The RUC recommends a work relative value of 3.00 for CPT code 92974.*

Practice Expense

The RUC recommended no practice expense direct inputs for this ZZZ global period code.

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
•+92974	UU1	Transcatheter placement of radiation delivery device for subsequent coronary intravascular brachytherapy (List separately in addition to code for primary procedure) <u>(Use 92974 in conjunction with code(s) 92980, 92982, 93508)</u> (For intravascular radioelement application, see 77781-77784)	ZZZ	3.00

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
92980		<i>Transcatheter placement of an intracoronary stent(s) percutaneous, with or without other therapeutic intervention, any method; single vessel</i>		
+92981		<i>each additional vessel (List separately in addition to code for primary procedure)</i>		
		<i>(Use 92981 in conjunction with code 92980)</i>		
		<i>(To report additional vessels treated by angioplasty or atherectomy only during the same session, see 92984, 92996)</i>		
		<u><i>(To report transcatheter placement of radiation delivery device for coronary intravascular brachytherapy, use code 92974)</i></u>		
		<u><i>(For intravascular radioelement application, use 77781-77784)</i></u>		
92982		<i>Percutaneous transluminal coronary balloon angioplasty; single vessel</i>		
+92984		<i>each additional vessel (List separately in addition to code for primary procedure)</i>		
		<i>(Use 92984 in conjunction with code(s) 92980, 92982, 92995)</i>		
		<i>(For stent placement following completion of angioplasty or atherectomy, see 92980, 92981)</i>		
		<u><i>(To report transcatheter placement of radiation delivery device for coronary intravascular brachytherapy, use code 92974)</i></u>		
		<u><i>(For intravascular radioelement application, use 77781-77784)</i></u>		
92995		<i>Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; single vessel</i>		

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
+92996		<p><i>each additional vessel (List separately in addition to code for primary procedure)</i></p> <p><i>(Use code 92996 in conjunction with code(s) 92980, 92982, 92995)</i></p> <p><i>(For stent placement following completion of angioplasty or atherectomy, see 92980, 92981)</i></p> <p><i>(To report additional vessels treated by angioplasty only during the same session, use 92984)</i></p> <p><u>(To report transcatheter placement of radiation delivery device for coronary intravascular brachytherapy, use code 92974)</u></p> <p><u>(For intravascular radioelement application, use 77799)</u></p>		

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: + 929XX Tracking Number:UU1 Global Period: ZZZ ~~Recommended RVW: 3.8~~
RUC Recommended RVW: 3.00

CPT Descriptor:

Transcatheter Placement of Radiation Delivery Device for intravascular Coronary Brachytherapy). (List separately in addition to code for primary procedure).

(Use 929XX in conjunction with 92980, 92982 and 93508)

(For intravascular radioelement application, see 77781, 77782, 77783, 77784)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

The patient is a 74-year old man with hypertension, diabetes mellitus and hypercholesteremia who quit tobacco use 15 years ago. He had previously undergone percutaneous transluminal coronary angioplasty and coronary stent placement of his left circumflex coronary artery. He presented with exertional chest pressure and had a positive exercise stress test at a low workload. He underwent coronary angiography which revealed a high-grade stenosis of the mid-portion of the true circumflex coronary artery within the previously stented segment. The patient was not considered for bypass surgery because of a lack of disease in his other vessels. Because of the severity and length of the restenosis, and the fact that it had recurred within three months of the initial procedure, the patient was considered to be at high risk of recurrent restenosis. Angioplasty with adjunctive intravascular brachytherapy was recommended as the treatment of choice, after consultation with the radiotherapist.

Staff Note: Survey participants are determining a work relative value unit for the work of the cardiologist involved in the transcatheter placement of the delivery device for intravascular coronary brachytherapy only. Do not report the work of codes reported in addition to the add-on, specifically codes 92980, 92982 and 93508. For intravascular radioelement application, see 77781, 77782, 77783 and 7784. These codes are not reported by the cardiologist.

Description of Intra-Service Work: **Work attributable to 992XX is in bold font.** Work done as separately coded procedures by the cardiologist is in regular font. *Work done and coded separately by the radiation oncologist is in italics.*

The relative risks and benefits of coronary intervention were explained to the patient prior to obtaining informed consent. **Risks and benefits specific to brachytherapy were discussed by the cardiologist and/or separately by the medical oncologist. The cardiologist previously had contacted the medical oncologist and arranged for medical oncology assistance at the time of the procedure.** The patient was brought to the cardiac catheterization laboratory in a fasting state. He was prepped and draped in the usual sterile manner. The right groin was infiltrated with 1% lidocaine to provide local anesthesia. Using a modified Seldinger technique, a femoral sheath was placed in the right femoral artery. Over a .035" J-tip wire, a guiding catheter was engaged in the left main coronary artery ostium. Heparin was dosed intermittently during the procedure to maintain an activated clotting time greater than 300 seconds. A 0.014" coronary guidewire was advanced and positioned with its tip in the distal circumflex artery. A 3.0 mm x15 mm coronary balloon was positioned across the lesion and inflated to six atmospheres (separately reported). The lesion length and vessel diameter were measured by on-line quantitative coronary angiography. Intravascular ultrasound (separately reported) was used to better define the vessel characteristics. *Using the imaging data obtained from quantitative angiography and intravascular ultrasound, the most appropriate brachytherapy device, seed train length and dwell-time of*

the radioactive source were determined in consultation with the radiotherapist. The interventional cardiologist then inserted and positioned the radiation delivery device across the lesion to be treated, assuring adequate proximal and distal treatment margins. The radiation oncologist determined the radiation prescription (dwell time) and deployed the source seeds through the catheter system. The seeds are left in place for the prescribed duration to deliver the appropriate radiation dose. The interventional cardiologist monitored the patient's heart rhythm, hemodynamics and seed train position periodically during the procedure, and gave additional heparin as needed for adequate anticoagulation. If the patient became ischemic from occlusion of the lumen by the large brachytherapy catheter, the cardiologist administered appropriate analgesia and vasodilators. The radioactive seed-train is removed by the radiation oncologist. The delivery catheter, a separate item, is removed at the end of the radiation delivery time by the cardiologist. Follow-up angiography was performed to assure that an excellent angiographic result achieved by angioplasty was maintained without evidence of damage to the vessel by the brachytherapy catheter. Guiding and angiographic catheters were removed and hemostasis was obtained. A loading dose of clopidogrel was given at the end of the procedure.

SURVEY DATA:

Presenter(s) James Maloney, M.D., and TBD.

Specialty(s): Cardiology

Sample Size: 127 Response Rate: (%): 38 (29.9%) Median RVW: 3.8

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

Survey was sent to a random sample of members of the ACC subspecialty, the Society for Cardiac Angiography and Interventions, all of whom are cardiologists. In addition, two manufacturers provided a list of cardiologists to survey.

25th Percentile RVW: 2.5 75th Percentile RVW: 5.2 Low: 0 High: 17.1

Median Pre-Service Time: N/A Median Intra-Service Time: 42.5

25th Percentile Intra-Svc Time: 30 75th Percentile Intra-Svc Time: 60 Low: 10 High: 120

Median Post-Service Time:

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

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
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 ZZZ global

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

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

TIME ESTIMATES (Median)

	<u>New/Revis. CPT Code:</u>	<u>Key Reference CPT Code:</u>
Median Pre-Time	N/A	N/A
Median Intra-Time	42.5	60 RUC
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	3.82	3.73
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.84	3.53
Urgency of medical decision making	3.63	3.87

Technical Skill/Physical Effort (Mean)

Technical skill required	3.95	4.20
Physical effort required	3.37	3.60

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.89	4.13
-------------------------------------------------------------------	------	------

Outcome depends on the skill and judgement of physician	4.11	4.40
---------------------------------------------------------	------	------

Estimated risk of malpractice suit with poor outcome	4.16	4.53
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INTENSITY/COMPLEXITY MEASURES

CPT Code

Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	N/A	N/A
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Intra-Service intensity/complexity	3.89	3.73
------------------------------------	------	------

Post-Service intensity/complexity	N/A	N/A
-----------------------------------	-----	-----

ADDITIONAL RATIONALE

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

The American College of Cardiology's Cardiovascular RUC Committee, representing cardiology and the cardiology subspecialties, held a phone conference to discuss the recommended work RVU. The committee determined that the median RVU of 3.8 was appropriate. This puts the value of this code in proper rank order to the reference procedure code 92981, with 4.17 RVUs. The Committee agreed that the brachytherapy code requires slightly less work than the reference code.

FREQUENCY INFORMATION

How was this service previously reported? 93799 or by attaching modifier -22 to one of the angioplasty, atherectomy or stent procedure codes (92980, 92981, 92982, 92984, 92995, 92996) (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

Note: 93799 has a frequency of 15,542.

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 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 Cardiology Frequency 10,000

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

Note: frequency (total and Medicare) and the number of physicians performing this procedure is expected to increase.

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

April 2001

Microvolt T-wave Alternans Assessment of Ventricular Arrhythmia

A new code was created to describe the new technology of a microvolt T-wave alternans test for the assessment of patients risk of patients at risk of ventricular tachyarrhythmias leading to sudden cardiac death.

93025 *Microvolt T-wave alternans for assessment of ventricular arrhythmias*

The RUC reviewed the specialty society's survey results of 26 practicing cardiologists who perform this procedure, and believed that the physician work involved was similar to the standard stress test code 93015 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report* (work RVU = 0.75), which is included on the RUC's multi-specialty points of comparison list. The RUC believed that this code would be appropriately valued at the same level as code 93015 considering its similarity in physician work. **The RUC recommends a relative value of 0.75 for CPT code 93025.**

Practice Expense

The RUC reviewed the practice expense direct inputs for code 93025 presented by the specialty society, and made the following changes;

- The clinical labor staff type was changed to RN/LPN/MA and the total clinical time was reduced to 53 minutes to reflect current PEAC standards and the actual time the staff assisted the physician during the test
- The skin marking pens were deleted since it can be used multiple times
- The minutes of use per procedure for the treadmill and CH2000 Alternans System were reduced to 15 minutes to reflect the actual time used

The full RUC recommended practice expense direct inputs for code 93025 is attached.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
• 93025	HH1	Microvolt T-wave alternans for assessment of ventricular arrhythmias	XXX	N/A	0.75

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

CPT Code: 93XXX Tracking Number: HH1 Global Period: XXX ~~Recommended RVW: 1.10~~
RUC Recommended RVW : 0.75

CPT Descriptor: Microvolt T-wave alternans for assessment of ventricular arrhythmias

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 50-year-old man with non-ischemic dilated cardiomyopathy and an ejection fraction of 20% undergoes a microvolt T-wave alternans test to help guide treatment decisions regarding potential cardiac arrhythmias. Standard ECG lead electrodes and specialized alternans sensors are applied to the patient's chest and the patient undergoes exercise using either a treadmill or a stationary bicycle. The data is monitored throughout the diagnostic test to insure complete data is collected and that artifact will not obscure interpretation. The patient is monitored during recovery, and a T-waves alternans trend report is developed. The microvolt T wave alternans recordings are analyzed to determine the presence of sustained alternans and onset heart rate. A final report is then generated, and information is communicated to the patient and referring physician.

Description of Pre-service work:

The rationale, indication, and procedure of the T-wave alternans test is discussed with the patient and informed consent obtained.

Description of Intra-service work:

The patient's skin is prepared meticulously, and seven specialized alternans sensors are applied in addition to 7 conventional ECG leads. The sensor's electrical impedance is assessed to ensure good electrical contact. Baseline sampling at rest is monitored and displayed. Careful selection of the exercise protocol is crucial to insure that the heart rate increases gradually between 90 and 110 bpm preferably over 3-4 minutes (this is the heart rate range in which T wave alternans is measured). The treadmill speed and grade is slowly increased to achieve a gradual ramp up of the patient's heart rate from between 90 and 110 beats per minute to over 110 beats per minute. After the start of exercise, if the heart rate increases too rapidly, the workload must be decreased in order to allow the heart rate to fall within the 90 – 110 bpm range for a few minutes. Alternatively, the test could be stopped and restarted using a different exercise protocol with a more gradual increase in workload. For the purposes of measuring T wave alternans, the target heart rate (after the patient has exercised for a few minutes with heart rates between 90 and 110 bpm) is 120 bpm. Throughout the test, the noise level of each sensor is monitored carefully to ensure sufficiently low noise levels. If the noise levels are too high, then the sensor placement may need to be readjusted and/or patient instruction given. T wave alternans is monitored throughout the diagnostic test to ensure complete data is collected and artifacts will not obscure the interpretation.

Once the heart rate reaches 120 bpm, the T wave alternans portion of the stress test is completed. At times, the stress test will be done for multiple reasons. In addition to the measurement of T wave alternans, the stress test may also be used as a symptom limited stress test to detect myocardial ischemia, or it may be used as a maximal exercise test to measure functional capacity and $\dot{V}O_2$ max. After the patient reaches a heart rate of 120 bpm, the workload can then be increased as necessary to complete the additional portions of the stress test.

Following the exercise portion of the test, the patient is monitored during recovery from exercise. An alternans trend report is then produced, and a determination is made of the presence of sustained alternans and the onset heart rate of this event. The results are classified as positive, negative, or indeterminate. The sensors are then removed and the test report is completed.

Description of Post-procedure work:

The results of the test are discussed with the patient including the implications of the test and if further procedures are required.

SURVEY DATA:

Presenter(s) James Maloney, M.D., and Daniel Bloomfield, M.D.

Specialty(s): Cardiology

Sample Size: 47 Response Rate: (%): 26 (55.3%) Median RVW: 1.10

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

Survey was sent to a random sample of members of the ACC subspecialty, the North American Society of Pacing and Electrophysiology. In addition, one manufacturer provided a list of physicians to survey.

25th Percentile RVW: 1.00 75th Percentile RVW: 1.40 Low: .75 High: 3.00

Median Pre-Service Time: 5 Median Intra-Service Time: 25

25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 30 Low: 0 High: 45

Median Post-Service Time:

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

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
93015	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report	.75 XXX global

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

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

<u>TIME ESTIMATES (Median)</u>	New/Revis. CPT Code:	Key Reference CPT Code:
Median Pre-Time	5	Not available per database
Median Intra-Time	25	Not available per database
Median Immediate Post-service Time	10	Not available per database
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	2.78
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.52	2.78
Urgency of medical decision making	3.36	3.11

Technical Skill/Physical Effort (Mean)

Technical skill required	3.52	2.83
Physical effort required	2.00	1.78

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.72	2.61
Outcome depends on the skill and judgement of physician	3.66	3.33
Estimated risk of malpractice suit with poor outcome	3.60	3.44

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.38	2.11
Intra-Service intensity/complexity	3.00	2.53
Post-Service intensity/complexity	3.04	2.63

ADDITIONAL RATIONALE

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

The American College of Cardiology has a Cardiovascular RUC Committee, representing cardiology and the cardiology subspecialties, who met by phone conference to discuss the recommended work RVU. The committee determined that the median RVU of 1.10 was an appropriate RVU and puts the value of this code in proper rank order to the reference procedure code 93015, with .75 RVUs.

FREQUENCY INFORMATION

How was this service previously reported? 93799 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

- Unlisted cardiovascular procedure. T-wave is reported approximately 3,500 times per year using this code.

Note: 93799 has a total frequency of 15,542.

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 6,000 _____

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 _____

Do many physicians perform this service across the United States? _____ Yes X No _____

**AMA/Specialty Society Update Process
RUC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

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

The ACC made its recommendations using a consensus panel through its CV RUC committee. There are 15 cardiologists on the CV RUC representing most of our cardiology subspecialties. Inputs were provided by a manufacturer.

Please describe the clinical activities of your staff:

Service Period Clinical Labor Activities:

Patient is greeted in the office, placed in examination room and instructed to put on patient exam gown and lie down on exam table. Vital signs are obtained and patient's chest and back is prepped for attachment of 7 standard ECG electrodes and 7 Micro-V Alternans™ Sensors. The patient is shaved (male) and skinned swabbed with gauze to remove oils. The area is then abraded to remove dead skin using One Step abrasion tape. Electrodes and Sensors are applied, the CH2000 is turned on and key data is entered into the monitor by the staff. Staff measure the sensors' electrical impedance to ensure good electrical contact. The Microvolt T-wave alternans device requires a separate step to analyze impedance. Additional skin prep may be required (3 – 20 minutes) if a sensor has to be replaced because of inadequate impedance before the procedure can commence. The nurse assists the physician during the monitoring session by ensuring proper sensor placement and assisting the patient through positional changes. Nurse also must take vital signs every 3 minutes during the 15-30 minute exercise test and recovery period. The nursing staff disconnects the patient from the monitor, removes the sensors, cleans the patient's skin, and spends further time educating the patient. The patient leaves the exam room and the exam table paper and pillow cases are changed, the used sensors are disposed, and the patient cables cleaned for the next patient use.

Total Staff Time In Office: ~~62-~~ 53minutes

Visits in Global Period: N/A

HCFA's Staff Type Code*	Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
1130	RN/LPN/MA		53		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
11107	Patient Gown	1		
11111	Exam Table Paper	1		
11112	Pillow Case	1		
11104	Razor	1		
11113	Sani-wipe	1		
71005	EKG paper (sheet)	10		
71006	ECG Electrodes	7		
31505	Gauze, Sterile 4 x 4	2		
Not available	One Step Skin Prep (3M) 2236	1		\$26 per patient
Not available	Micro-V Alternans™ Sensors	7 per patient		\$94 for 7 electrodes

• From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
E55020	Treadmill	1	15		
	CH2000 Alternans System	1	15		\$29,400

HCFA's Equipment Code*	Overhead Medical Equipment	No. of units in practice	Cost Estimate and Source (if applicable)
E11001	Exam table	1	

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

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

**SITE OF SERVICE: In-Office
Clinical Services**

Minutes Staff Type – Circle

Service Period

Start: Patient arrival at office for service

Greet patient/provide gowning

1

RN/LPN/MA

CPT Code: 93XXX
Specialty Society ACC

Obtain vital signs	3	RN/LPN/MA
Prep and position patient	15	RN/LPN/MA
Prepare room, equipment, supplies	5	RN/LPN/MA
Assist physician during exam (15 minutes + 6 minutes cool down)	21	RN/LPN/MA
Education/instruction/ counseling	4	RN/LPN/MA
Coordinate home or outpatient care	2	RN/LPN/MA
Clean room/equipment	2	RN/LPN/MA

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

April 2001

**Intracardiac Electrophysiology – Mapping, Comprehensive EP, &
Analysis of Pacing Cardioverter Defibrillators**

The CPT Editorial Panel for CPT 2002 deleted 3 codes, revised 3 codes to be add-on codes, editorially changed 2 codes, and created 1 new code, in order to provide further clarification of the use of certain cardiac electrophysiology procedures, update current terminology related to the technology involved, and to accurately depict the continued technologic changes.

93609 *Intraventricular and/or intra-atrial intracardiac electrophysiologic mapping of tachycardia site(s) with 3-dimensional mapping or catheter manipulation to record from multiple sites to identify origin of tachycardia*

In May 2001 the CPT Editorial Panel clarified this service to be an add-on code, from a 000 day global. The RUC will review 93609 at the September 2001 RUC meeting.

93619 *Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters, without induction or attempted induction of arrhythmia (Do not report 93619 in conjunction with 93600, 93602, 93610, 93612, 93618 or 93620-93622)*

The RUC recommends the current work RVU of 7.32 for CPT code 93619 as the CPT change was editorial and did not change the work of the service.

93620 *Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, his bundle recording, including insertion and repositioning of multiple electrode catheters, with induction or attempted induction of arrhythmia; (Do not report 93620 in conjunction with 93600, 93602, 93610, 93612, 93618 or 93619)*

The RUC recommends the current work RVU of 11.59 for CPT code 93620 as the CPT change was editorial and did not change the work of the service.

93621 *Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, his bundle recording, including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left atrial pacing and recording from coronary sinus or left atrium (List separately in addition to code for primary procedure) (Use 93621 in conjunction with 93620)*

The RUC compared the survey results of code 93621 to add-on code 47550 *Biliary endoscopy, intraoperative (choledochoscopy) (List separately in addition to code for primary procedure)* (work RVU = 3.02), and to the base code 93620 *Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, his bundle recording, including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; (Do not report 93620 in conjunction with 93600, 93602, 93610, 93612, 93618 or 93619)* (work RVU = 11.59). The RUC believed that code 93621 and 47550 had the similar work time of 30 minutes, but an intensity of code 93620. The RUC wanted to maintain the intensity associated with the type of procedure involved, yet maintain some relativity across specialties. The RUC believed code 93621 was less work than code 47550 and had the intensity of the base code 93620 with an intra-operative work intensity of 0.07 (calculated from RUC survey data). The RUC recommended a value below the specialty society's recommended value and survey median, and used an intra-operative work intensity of 0.07 multiplied by 30 minutes of intra-service time to support its recommendation. In addition, the RUC wanted to maintain rank order between other codes such as 92973 *Percutaneous transluminal coronary thrombectomy (List separately in addition to code for primary procedure) (Use 92973 in conjunction with 92980, 92982)* (RUC recommended work value = 3.28) containing 40 minutes of intra-service time and an IWP/UT = 0.08. **The RUC recommends a relative work value of 2.10 for CPT code 93621.**

Practice Expense

The RUC recommends no practice expense inputs for this ZZZ global period code.

93622 *Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, his bundle recording, including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left ventricular pacing and recording (List separately in addition to code for primary procedure) (Use 93622 in conjunction with 93620)*

The RUC compared the survey results of code 93622 to code 93620 *Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, his bundle recording, including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; (Do not report 93620 in conjunction with 93600, 93602, 93610, 93612, 93618 or 93619)* (work RVU = 11.59). The RUC believed that CPT code 93622 had the similar work intensity of code 93620 and the RUC wanted to maintain the intensity associated with the type of procedure, recognizing its surveyed 45 minutes of intra-service time. With this in mind, the RUC used an intra-operative work intensity of 0.07 (calculated from RUC survey data of code 93620), and multiplied by 45 minutes of intra-service time to support its recommended value. The RUC recommended a work relative value below the 25th percentile of the specialty society's survey. **The RUC recommends a relative work value of 3.10 for CPT code 93622.**

Practice Expense

The RUC recommends no practice expense inputs for this ZZZ global period code.

93613 *Intracardiac electrophysiologic 3-dimensional mapping*

The RUC recommends this new code to be referred back to CPT for clarification, and that it remain carrier priced at this time. The CPT Editorial Panel clarified this service to be an add-on code. The RUC will review 93613 during its September 2001 meeting.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
93607		Left ventricular recording <u>(93607 has been deleted. To report, use 93622)</u>	000	N/A
▲93609		Intraventricular and/or intra-atrial mapping of tachycardia site(s) with 3 dimensional mapping or catheter manipulation to record from multiple sites to identify origin of trachycardia (<u>List separately in addition to code for primary procedure</u>) <u>(Use 93609 inconjunction with codes 93620, 93651, 93652)</u>	ZZZ* * Change in the global period	No Recommendation The RUC will review in Sept. 2001
93612		Intraventricular pacing <u>(Do not report 93612 in conjunction with codes 93620-93622)</u>	000	3.02 (No change)
▲93619		Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters, without induction or attempted induction of arrhythmia (This code is to be used when 93600 is combined with 93602, 93610, 93612) <u>(Do not report 93619 in conjunction with 93600, 93602, 93610, or 93612, 93618, or 93620-93622)</u>	000	7.32 (No change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲93620		Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters, with induction or attempted induction of arrhythmia; (This code is to be used when 93618 is combined with 93619) <u>(Do not report 93620 in conjunction with 93600, 93602, 93610, 93612, 93618 or 93619)</u>	000	11.59 (No change)
▲93621	VV1	with left atrial pacing and recordings from coronary sinus or left atrium, with or without pacing, with induction or attempted induction of arrhythmia <u>(List separately in addition to code for primary procedure)</u> <u>(Use 93621 in conjunction with 93620)</u>	ZZZ* *change in global	2.10
▲93622	VV2	with left ventricular pacing and recordings, with or without pacing with induction or attempted induction of arrhythmia <u>(List separately in addition to code for primary procedure)</u> <u>(Use 93622 in conjunction with 93620)</u>	ZZZ* *change in global	3.10
●93613	VV3	Intracardiac electrophysiologic 3-dimensional mapping <u>(List separately in addition to code for primary procedure)</u>	XXX	Carrier Priced

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		(Use 93613 in conjunction with codes 93620, 93651, 93652)		
CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
93737		<p>Other Vascular Studies</p> <p>Electronic analysis of single or dual chamber pacing cardioverter defibrillator only (interrogation, evaluation of pulse generator status); without reprogramming</p> <p><u>(93737 has been deleted. To report, use 93741 or 93743)</u></p>	XXX	N/A
93738		<p>—with reprogramming</p> <p><u>(93738 has been deleted. To report, use 93742 or 93744)</u></p>	XXX	N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: + 93621 Tracking Number: VV1 Global Period: ZZZ ~~Recommended RVW: 3.0~~
RUC Recommended RVW: 2.10

CPT Descriptor: CPT descriptor is being amended for CPT 2002 to make 93621 an add-on code to 93620)

93620 Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia;

(Do not report 93620 in conjunction with 93600, 93602, 93610, 93612, 93618 or 93619)

+93621 with left atrial pacing and recording from coronary sinus or left atrium (List separately in addition to code for primary procedure)

(Use 93621 in conjunction with 93620)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Typical patient: During the course of an electrophysiology procedure (93620), an electrode catheter is placed in the coronary sinus via internal jugular, subclavian, or femoral venous access. The coronary sinus catheter is manipulated to obtain optimum electrogram recordings from the left atrium and left ventricle. The catheter can be used for recording without attempted induction of arrhythmia, or to record, pace, and attempt induction of arrhythmia. Catheter repositioning is often required to optimize recordings and pacing. The catheter is removed at the conclusion of the study, hemostasis obtained, and a description of the catheter use and associated findings are entered into the procedure report.

Description of Intra-Service Work:

The patient is undergoing an electrophysiology procedure (93620, billed separately), and it is necessary to place a catheter in the coronary sinus to record left atrial activity. The venous access site is prepped and draped (this work is in addition to the work of 93620), and a sheath is placed either in the internal jugular vein or subclavian vein using standard percutaneous techniques. The catheter is then introduced into the sheath and advanced into the right atrium where the ostium of the coronary sinus is engaged and the catheter advanced into the coronary sinus. The multi-electrode catheter is used to record electrical activity from the left atrium and, at times, pace the left atrium to attempt arrhythmia induction. Catheter repositioning may occur throughout the course of the electrophysiology study (93620) to optimize recordings and pacing thresholds. At the conclusion of the procedure, the catheter is removed, hemostasis obtained, and a description of the catheter use and associated findings are entered into the procedure report.

SURVEY DATA:

Presenter(s) James Maloney, M.D., and Stephen Hammill, M.D.

Specialty(s): Cardiology/Electrophysiology

Sample Size: 75 Response Rate: (%) 33 (44%) Median RVW: 3.0

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

Survey was sent to a random sample of members of the ACC subspecialty, the North American Society of Pacing and Electrophysiology.

25th Percentile RVW: 2.7 75th Percentile RVW: 4 Low: 2.12 High: 15

Median Pre-Service Time: N/A Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 20 75th Percentile Intra-Svc Time: 60 Low: 0 High: 210

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

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	
93623	Programmed stimulation and pacing after intravenous drug infusion List separately in addition to code for primary procedure)	2.85	ZZZ global

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

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

<u>TIME ESTIMATES (Median)</u>	<u>New/Revis. CPT Code:</u>	<u>Key Reference CPT Code:</u>
Median Pre-Time	N/A	N/A
Median Intra-Time	30	Not available per database
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	3.73	3.09
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.48	2.82
Urgency of medical decision making	3.27	3.18

Technical Skill/Physical Effort (Mean)

Technical skill required	4.09	2.82
Physical effort required	3.39	2.36

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.27	2.82
Outcome depends on the skill and judgement of physician	3.85	3.36
Estimated risk of malpractice suit with poor outcome	3.36	3.18

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	N/A	N/A
Intra-Service intensity/complexity	3.48	2.73
Post-Service intensity/complexity	N/A	N/A

ADDITIONAL RATIONALE

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

The American College of Cardiology has a Cardiovascular RUC Committee, representing cardiology and the cardiology subspecialties, who met by phone conference to discuss the recommended work RVU. The committee determined that the median RVU of 3.0 was an appropriate RVU and puts the value of this code in proper rank order to the reference procedure code 93623, with 2.85 RVUs.

FREQUENCY INFORMATION

How was this service previously reported? As 93621 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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 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 21,336

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 7,112

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

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

CPT Code: + 93622 Tracking Number: VV2 Global Period: ZZZ Recommended RVW: 3.10

CPT Descriptor: (CPT descriptor is being amended for CPT 2002 to make 93622 an add-on code to 93620)

93620 Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia;

(Do not report 93620 in conjunction with 93600, 93602, 93610, 93612, 93618 or 93619)

+93622 with left ventricular pacing and recording (List separately in addition to code for primary procedure)

(Use 93622 in conjunction with 93620)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Typical patient: During the course of electrophysiology procedure (93620), an electrode catheter is placed in the left ventricle via femoral artery access. The catheter is manipulated to obtain optimum electrogram recordings from the left ventricle. The catheter can be used for recording without attempted induction of arrhythmia, or to record, pace, and attempt induction of arrhythmia. Catheter repositioning is often required to optimize the recordings and pacing. The catheter is removed at the conclusion of the study, hemostasis obtained, and a description of the catheter use and associated findings are entered into the procedure report.

Description of Intra-Service Work:

The patient is under going an electrophysiology procedure (93620, billed separately), and it is necessary to place a catheter in the left ventricle to record left ventricular activity. A sheath is placed in the femoral artery using standard percutaneous techniques. The preparation and draping of the site is included as part of the baseline procedure work (93620). A catheter is placed through the sheath and advanced retrograde through the aorta, across the aortic valve, and into the left ventricle. The multi-electrode catheter is used for recording electrical activity from the left ventricle and, at times, pace the left ventricle to attempt arrhythmia induction.. Catheter repositioning may occur throughout the course of the electrophysiology study (93620) to optimize recordings and pacing thresholds. The catheter is removed at the conclusion of the study, hemostasis obtained, and a description of the catheter use and associated findings are entered into the procedure report.

SURVEY DATA:

Presenter(s) James Maloney, M.D., and Stephen Hammill, M.D.

Specialty(s): Cardiology/Electrophysiology

Sample Size: 80 Response Rate: (%): 28 (35%) Median RVW: 4.20

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

Survey was sent to a random sample of members of the ACC subspecialty, the North American Society of Pacing and Electrophysiology.

25th Percentile RVW: 3.4 75th Percentile RVW: 5.3 Low: 2.2 High: 12

Median Pre-Service Time: N/A Median Intra-Service Time: 45

25th Percentile Intra-Svc Time: 30 75th Percentile Intra-Svc Time: 60 Low: 10 High: 215

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

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
93607	Left ventricular recording	3.26 000 global

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

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

<u>TIME ESTIMATES (Median)</u>	<u>New/Revis. CPT Code:</u>	<u>Key Reference CPT Code:</u>
Median Pre-Time	N/A	N/A
Median Intra-Time	45	26 Harvard
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	4.04	3.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.86	3.20
Urgency of medical decision making	4.11	3.40

Technical Skill/Physical Effort (Mean)

Technical skill required	4.32	3.40
--------------------------	------	------

Physical effort required	3.82	2.87
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Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.36	3.60
-------------------------------------------------------------------	------	------

Outcome depends on the skill and judgement of physician	4.50	3.67
---------------------------------------------------------	------	------

Estimated risk of malpractice suit with poor outcome	4.11	3.47
------------------------------------------------------	------	------

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	N/A	N/A
----------------------------------	-----	-----

Intra-Service intensity/complexity	4.15	3.27
------------------------------------	------	------

Post-Service intensity/complexity	N/A	N/A
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ADDITIONAL RATIONALE

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

The American College of Cardiology has a Cardiovascular RUC Committee, representing cardiology and the cardiology subspecialties, who met by phone conference to discuss the recommended work RVU. The committee determined that the 25% of 3.4 was slightly high for this procedure. The procedure is similar in terms of work to the reference procedure minus some time due to the reference procedure being a 000 global and 93622 is being changed to a ZZZ global period. Therefore, the committee determined that an RVU of 3.1 was more appropriate.

FREQUENCY INFORMATION

How was this service previously reported? 93622 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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 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 1,179

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 393

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

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

April 2001

Thoracic Electrical Bioimpedance

A new CPT code was developed to record the use of a new device that monitors cardiac output. The physician's use this device is to obtain a diagnostic cardiac assessment of the patient.

The RUC reviewed the history of this code and agreed that the physician work of reviewing this computer generated print out is included in the E/M code service as directed in the CPT note following this code. **The RUC recommends a relative work value of 0.00 for code 93701.**

Practice Expense

The RUC modified the practice expense inputs to reflect the standard clinical labor staff type and times. The details of the direct practice expense for this code are attached.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 93701	Z1	Bioimpedance, thoracic, electrical <u>(For interpretation and analysis of results, see Evaluation and Management service codes)</u>	XXX	0.00

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

HCPCS Descriptor:

Bioimpedance, thoracic, electrical
Global period XXX

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

The ACC made its recommendations using a consensus panel through its CV RUC Committee and Economics of Health Care Delivery Committee. Most of the cardiology subspecialties are represented on these committees.

Please describe the clinical activities of your staff:

Service Period Clinical Labor Activities:

Patient is greeted in the office, placed in examination room and instructed to put on patient exam gown and lie down on exam table. Vital signs are obtained and patient's neck and thorax are prepped with alcohol wipes for attachment of the 4 sets of dual sensors. Sensors are applied, the Cardiac Output Monitor is turned on and key data is entered into the monitor by the staff before the procedure/monitoring session can commence. The nurse assists the physician during the monitoring session by ensuring proper sensor placement and assisting the patient through positional changes. The monitoring session is completed once the physician has assessed the patient and recommended medication or other changes. The nursing staff disconnects the patient from the monitor, removes the sensors, cleans the patient's skin, and spends further time educating the patient about diet and exercise as well as medication compliance in the home setting. The patient leaves the exam room and the exam table paper and pillow cases are changed, the used sensors are disposed, and the patient cables cleaned for the next patient use.

Total Staff Time In Office: 23 minutes

Visits in Global Period: N/A

HCFA's Staff Type Code*	Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
1130	RN/LPN/MA		20 min	N/A	

- From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
11107	Patient Gown	1		
11111	Exam Table Paper	1		
11112	Pillow Case	1		
31101	Alcohol Swab	4		
None available	Dual Sensors (pack of 4)	1		\$9.95

- From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Procedure Specific Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
E55018	Cardiac Output Monitor	1	10 min.		\$26,225

HCFA's Equipment Code*	Overhead Medical Equipment	No. of units in practice	Cost Estimate and Source (if applicable)
E11001	Exam table	1	

- * From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

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

**SITE OF SERVICE: In-Office
 Clinical Services**

Minutes

**Staff Type – Circle
All RN**

Service Period

Start: Patient arrival at office for service

Greet patient/provide gowning	0	RN, LPN, MA, Other _____
Obtain vital signs	0	RN, LPN, MA, Other _____
Position electrodes on patient	5	RN/LPN/MA
Retrieve and prepare equipment	5	RN/LPN/MA
Performance of test	5	RN/LPN/MA
Education/instruction/ counseling	0	RN, LPN, MA, Other _____
Coordinate home or outpatient care	0	RN, LPN, MA, Other _____
Replacing equipment	5	RN/LPN/MA

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

February 2001

Allergy Immunotherapy (Definition of Dose)

The definitions for these codes have been extensively discussed by the CPT Editorial Panel, the PEAC, and the RUC. The RUC agrees that the CPT modification are consistent with the description and work related to this service. The RUC recommends that these changes are editorial and did not involve a change in the service.

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲95144	H1	Professional services for the supervision <u>of preparation</u> and provision of antigens for allergen immunotherapy; single dose vial(s) (specify number of vials) <u>(Single dose vials contain a single dose of antigen administered in one injection)</u>	000	.06 (no change)
▲95145	H2	Professional services for the supervision <u>of preparation</u> and provision of antigens for allergen immunotherapy (specify number of vials); single stinging insect venom	000	.06 (no change)
▲95165	H3	Professional services for the supervision <u>of preparation</u> and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)	000	.06 (no change)
▲95170	H4	whole body extract of biting insect or other arthropod (specify number of doses) <u>(For allergy immunotherapy reporting, a dose is the amount of antigen(s) administered in a single injection from a multiple dose vial)</u>	000	.06 (no change)



Joint Council
of Allergy,
Asthma and
Immunology

January 3, 2001

50 N. Brockway St.
Suite 3-3
Palatine, IL 60067
847/934-1918
FAX 847/934-1820

James G. Hoehn, M.D.
Chair of the AMA/Specialty Society RVS Update Committee
American Medical Association
515 North State Street
Chicago, IL 60610

VIA FACSIMILE: 312-464-5849

Dear Dr. Hoehn:

The Joint Council of Allergy, Asthma and Immunology (JCAAI), on behalf of the American Academy of Allergy, Asthma and Immunology and the American College of Allergy, Asthma and Immunology, would like to formally request that the issue of the definition of CPT Code 95165 relative to a dose of allergy immunotherapy, be removed from the RUC's February meeting agenda. JCAAI, along with the American Academy of Otolaryngic Allergy, the American Academy of Otolaryngology-Head and Neck Surgeons Otolaryngologic Allergy Section have recently had extensive discussions with Paul Rudolf, M.D., J.D., of HCFA, relative to this definition and we have agreed on how to proceed. I believe the results of this discussion make it unnecessary for the RUC to consider this issue at this time. If RUC review becomes necessary in the future, we would appreciate the opportunity to seek review at that time.

Sincerely,

Donald W. Aaronson, M.D.
Donald W. Aaronson, M.D. *DW*
Acting Executive Director

- cc: M. Jennifer Derebery, M.D., President
American Academy of Otolaryngic Allergy
- Todd Klemp, M.D., Policy Associate
American Medical Association
- Sherry Smith, Committee Secretary
AMA/Specialty Society
RVS Update Committee

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Consultant
Donald W. Aaronson, M.D.
Acting Executive Director

**AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS**

April 2001

Neurology Procedures

95875 Ischemic limb exercise test with serial specimen(s) acquisition for muscle metabolite(s)

CPT code 95875 was revised to more accurately describe the ischemic limb exercise test. The RUC evaluated the physician work required to perform the test and the level of physician decision making. Normally the test is performed when there is suspicion of muscle disease and the test is used to measure the capability of the body's enzymes to convert pyruvate to lactate in the venous circulation of an exercising muscle. This code was examined in comparison to evaluation and management codes such as 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family. (work RVU = 1.10)* and 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family (work RVU = 1.40).* The RUC agreed that the procedure requires a level of physician judgment necessary to prevent complications and to obtain valid test results that is comparable to the work of a level four established patient office visit. Although the Specialty Society recommended the median survey value, the RUC concluded that this overstated the work involved in relation to the E/M codes and therefore decided that the 25% value of 1.10, more accurately described the physician work and was equivalent to the work involved in code 99214. **The RUC recommends a work relative value of 1.10 for CPT code 95875.**

Practice Expense

The RUC accepted the specialty society recommended inputs in the office setting with a change to the clinical staff mix to reflect a mix of RN/LPN/MA. The RUC recommends no direct practice expense when performed in the facility setting.

95965 Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization).

The RUC concluded that the median survey value of 8 work RVUs was appropriate for code 95965. Although the specialty society recommended a higher value, the RUC concluded that time and intensity data only supported the median survey value when compared to the reference code 95951 *Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and video recording and interpretation (eg, for presurgical localization), each 24 hours* (work RVU = 6.00). **The RUC recommends a work relative value of 8.00 for CPT code 95965.**

Practice Expense

The RUC agreed with the specialty society that the code is only performed in the facility setting and therefore has no practice expense direct inputs.

95966 Magnetoencephalography (MEG), recording and analysis for evoked magnetic fields, single modality (eg, sensory, motor, language, or visual cortex localization)

The RUC compared code 95966 to reference code 95961 *Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; initial hour of physician attendance* (work RVU = 2.97). Given the new code has greater physician time of 15 minute pre-service, 75 minutes intra-service, and 30 minutes post-service, as compared to 65 minutes of Harvard time for the reference code, the RUC felt that a value of 4 work RVUs would be appropriate and result in a proper rank order for this code family. **The RUC recommends a work relative value of 4.00 for CPT code 95966.**

Practice Expense

The RUC agreed with the specialty society that the code is only performed in the facility setting and therefore has no practice expense direct inputs.

95967 Magnetoencephalography (MEG), recording and analysis for evoked magnetic fields, each additional modality (eg, sensory, motor, language, or visual cortex localization) (List separately in addition to code for primary procedure)

The RUC compared CPT Code 95967 *Magnetoencephalography (MEG), recording and analysis for evoked magnetic fields, each additional modality (eg, sensory, motor, language, or visual cortex localization) (List separately in addition to code for primary procedure)* to the reference code 95962 *Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; each additional hour of physician attendance (List separately in addition to code for primary procedure)* (work RVU = 3.21). Given the new code has an intra-service time of 75 minutes, compared to the reference code with a time of 70 minutes, the RUC concluded that the value of this new procedure should be slightly higher than the reference procedure and agreed that the survey

median value of 3.50 accurately represented the work involved with this code. **The RUC recommends a work relative value of 3.50 for CPT code 95967.**

Practice Expense

The RUC agreed with the specialty society that the code is only performed in the facility setting and therefore has no practice expense direct inputs.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲95875	WW1	Ischemic limb exercise test with serial specimen(s) acquisition for muscle metabolite(s) with needle electromyography, with lactic acid determination	XXX	1.10
●95965	WW2	Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization)	XXX	8.00
●95966	WW3	for evoked magnetic fields, single modality (eg, sensory, motor, language, or visual cortex localization)	XXX	4.00

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 95967	WW4	<p>for evoked magnetic fields, each additional modality (eg, sensory, motor, language, or visual cortex localization) (List separately in addition to code for primary procedure)</p> <p><u>(Use 95967 in conjunction with 95966)</u></p> <p><u>(For electroencephalography performed in addition to magnetoencephalography, see 95812-95827)</u></p> <p><u>(For somatosensory evoked potentials, auditory evoked potentials, and visual evoked potentials performed in addition to magnetic evoked field responses, see 92585, 95925, 95926, and/or 95930)</u></p> <p><u>(For computerized tomography performed in addition to magnetocephalography, see 70450-70470, 70496)</u></p> <p><u>(For magnetic resonance imaging performed in addition to magnetoencephalography, see 70551- 70553)</u></p>	ZZZ	3.50

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
American Academy of Neurology, American Association of Electrodiagnostic Medicine
SUMMARY OF RECOMMENDATION

CPT Code: 95875 Tracking Number: _____ Global Period: XXX **Recommended RVW: ~~1.50~~**
RUC Recommendation = 1.10

CPT Descriptor: Ischemic limb exercise test with specimen(s) acquisition for muscle metabolite(s)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Case Presentation: A 16-year-old boy consults his physician for weakness and excessive cramps. He states that since the age of 10 he has developed fatigue whenever he has tried to keep up with his peers. Several years ago, he began to experience painful cramps in his arms and legs whenever he participated in heavy exercise lasting more than 10 or 15 minutes. The cramps are severe, painful, and may last several hours. During the spells his heart rate and respiratory rate rise significantly. During several severe bouts, he has noted a change in color of his urine to a burgundy color. Family history is significant for at least two other male relatives with similar problems. Physical examination is unremarkable except for mild weakness in shoulder abductors and hip flexors. Muscle bulk is normal.

Ischemic Exercise Test: The ischemic exercise test is used to measure the capability of the body's enzymes to convert pyruvate to lactate in the venous circulation of an exercising muscle. For convenience, the forearm muscles are exercised. Blood samples in the same arm are taken prior to and following exercise. The test is typically performed using a blood pressure cuff inflated above systolic in order to temporarily cut off circulation and to create ischemia in the muscle.

Before the test begins, a catheter is placed in a superficial vein in the hand or distal forearm. A blood pressure cuff is placed around the upper arm and inflated to a level above systolic blood pressure. The patient is thereafter asked to grip a dynamometer and to repetitively grip and release the dynamometer each second for 60 seconds. The subject is asked to squeeze on the dynamometer with as much force as possible. In addition to a tube of blood drawn prior to exercise, venous blood is collected at set intervals after cessation of the hand exercise and relaxation of the blood pressure cuff.

Description of Pre-Service Work:

- Review previous office notes
- If patient is referred, review records from referring physician

Description of Intra-Service Work:

- Explaining test to patient
- Placement of catheter in a superficial vein in the hand or distal forearm
- Drawing blood sample before test
- Placement of blood pressure cuff around the upper arm and inflation to a level above systolic blood pressure
- Instruction of patient to repetitively grip and release a dynamometer at set intervals
- Drawing blood samples after test
- Removal of catheter from superficial vein
- Application of pressure and subsequent observation of the venipuncture site for recurrent bleeding
- Instruction of patient regarding when to call for results
- Instruction of patient regarding potential complications such as bleeding or infection

Description of Post-Service Work:

- Analysis of data
- Dictation of procedure note

SURVEY DATA:

Presenter(s) **Benjamin R. Brooks, MD; Baldwin Smith, MD**

Specialty(s): **Neurology**

Sample Size: **74**

Response Rate: (%) **47% (35/74)**

Median RVW: **1.50**

Type of Sample (Circle One): random, **panel**, convenience. Explanation of sample size: **AAN and AAEM staff identified physicians who had performed this test in the past year, by sending an e-mail request to the entire AAEM membership, and to the AAN Neuromuscular Section. Seventy-four physicians indicated that they had performed the test, and thirty-five completed the physician work survey.**

25th Percentile RVW: **1.10**

75th Percentile RVW: **1.71**

Low: **0.08**

High: **3.0**

Median Pre-Service Time: **10**

Median Intra-Service Time: **30**

25th Percentile Intra-Svc Time: **22**

75th Percentile Intra-Svc Time: **45**

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:

10

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
95858	Tensilon test for myasthenia gravis; with electromyographic recording	1.56

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

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

TIME ESTIMATES (Median)

Revised
Code 95875

HCFA Phys. Work Time for
95858 = 52 Minutes Total

Median Pre-Time	10
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Median Intra-Time	30
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Median Immediate Post-service Time	10
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INTENSITY/COMPLEXITY MEASURES (Mean)

Revised CPT Code
95875

CPT Reference Code
95858

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.74	3.17
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.83	3.50
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Urgency of medical decision making	2.50	3.39
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.31	3.33
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Physical effort required	3.11	2.61
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Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.43	3.11
Outcome depends on the skill and judgement of physician	3.43	3.78
Estimated risk of malpractice suit with poor outcome	2.26	2.61

INTENSITY/COMPLEXITY MEASURES

Revised CPT Code
 95875

CPT Reference Code
 95858

Time Segments (Mean)

Pre-Service intensity/complexity	2.77	2.72
Intra-Service intensity/complexity	3.83	3.67
Post-Service intensity/complexity	3.00	2.67

ADDITIONAL RATIONALE

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

A consensus panel of AAN and AAEM physicians reviewed the survey results and agreed that the minutes of physician work reflected current typical practice and supported the recommendation of the median Physician Work RVU of 1.50.

FREQUENCY INFORMATION

How was this service previously reported? **95875** (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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 ___ 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 **Neurology** Frequency **897**

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 **15**

Do many physicians perform this service across the United States? ___ Yes **X** No

AMA/Specialty Society Update Process - Summary of Practice Expense Recommendations XXX Global Period- In Office Direct Inputs

CPT Code 95875: Ischemic limb exercise test with specimen(s) acquisition for muscle metabolite(s)

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

Specialty society staff and expert physicians developed lists of supplies, equipment, and clinical staff labor based on CPEP data for this code. AAN and AAEM convened a consensus panel via e-mail list serve to refine the practice expenses, based on typical practice. The consensus panel was composed of sixty-five physicians who indicated that they had performed this test in the past year. The panel discussed the practice expenses via e-mail for ten days, at which point a conference call was held to finalize the data.

Clinical Labor:

HCFA's Staff Type Code*	Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
1129	RN/LPN/MA		43 minutes		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

Description of clinical labor activities:9

Pre-service: Prepare room and equipment. Greet patient, escort to room, gown patient, notify physician that patient is ready

Intra-Service: Assist physician with processing of blood. Stamp and apply labels. Complete blood requisition forms.

Post-service: Send or transport tubes to lab. Clean room.

Supplies:

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	<u>Multi-specialty visit supply package</u>			
11106	Drape, sheet	1		
44407	Patient gown, disposable	4 item		
44111	Exam table paper	4 item		
44302	Gloves, non-sterile	4 item		
31101	Alcohol pads	4 items		
31505	Gauze, sterile 4x4	1 item		
53008	Heparin lock	1 item		
91407	Syringe, 10cc.	7 items		
91402	Needles 21 gauge	7 items		
31514	Tape (6 inches)	4 items 24 inches		
92022	Test tubes	14 items		
75016	Labels	14 items		
91106	Angiocatheter, 20 to 25g	1 item		
91111	Stop cock, 3 way	1 item		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

Equipment

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
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E11001	Exam table				
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**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

_____ 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/escort pt to room

 3 RN, LPN, MA, Other _____

Obtain vital signs

_____ RN, LPN, MA, Other _____

Prep and position patient

_____ RN, LPN, MA, Other _____

Prepare room, equipment, supplies

 3 RN, LPN, MA, Other _____

Assist physician with processing of blood stamp and apply labels to tubes-complete blood registration forms

 30 RN, LPN, MA, Other _____

Education/instruction/ counseling

_____ RN, LPN, MA, Other _____

Coordinate home or outpatient care

_____ RN, LPN, MA, Other _____

Clean room/equipment

 3 RN, LPN, MA, Other _____

Other Clinical Activity (please specify)

_send or transport tubes to lab

 4 RN, LPN, MA, Other _____

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)

_____ RN, LPN, MA, Other _____

End: When appointment for next office visit is made

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

American Academy of Neurology, American College of Radiology, American Society of Neuroradiology

CPT Code: 9596x1Tracking Number: WW2Global Period: XXX~~Recommended RVW: 9.5~~RUC recommendation: 8.0

CPT Descriptor:

Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (e.g., epileptic cerebral cortex localization)

(Report any CT, EEG, or MRI procedures separately).

(For electroencephalography performed in addition to magnetoencephalography, see 95812-95827)

(For computerized tomography performed in addition to magnetoencephalography, see 70450-70470, 70496)

(For magnetic resonance imaging performed in addition to magnetoencephalography, see 70551-70553)

(For somatosensory evoked potentials, auditory evoked potentials, and visual evoked potentials performed in addition to magnetic evoked field responses, see 92585, 95925, 95926, and/or 95930)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Epilepsy Surgery Evaluation: A 23 year-old male with a history of encephalitis and bilateral mesial temporal sclerosis documented by MRI has had seizures recalcitrant to medical therapy since age 14. Extensive work-up including ictal video EEG monitoring with surface recording, has failed to lateralize the onset of his seizures. Epilepsy surgery is contemplated, and an MEG is ordered to identify a predominant focality and direct placement of intracranial electrodes for subsequent ictal recording.

Description of Pre-Service Work:

- Describe procedure to patient
- Review prior functional and anatomic studies
- Supervise patient demagnetization, head measurements and positioning

Description of Intra-Service Work:

- Supervise data acquisition
- Review source data for adequacy with attention to the number of uncontaminated interictal epileptic spikes, and identify true spikes on the whole head or large array Magnetoencephalography tracings, taking into consideration the simultaneous EEG tracing, eye-electrodes and EKG to exclude artifacts.
- Supervise creation of models using a variety of software algorithms to localize the epileptic events within the frame of the detector array
- Use additional software algorithms to superimpose the location of the patient's epileptic events with the patient's MRI data
- Interpret the source and post-processed data
- Interpret the data maps
- Compare with any relevant prior studies

Description of Post-Service Work:

- Prepare, review and sign report of the procedure
- Discuss findings with referring physician
- Meet in conference with the epilepsy team (neurosurgeon, neurologist, electrophysiologist, clinical psychologist, radiologists/ PhD) to discuss clinical and diagnostic findings, and formulate treatment plan.

Urgency of medical decision making	3.25	3.84
Technical Skill/Physical Effort (Mean)	New Code 9596x1	Reference Code 95951
Technical skill required	4.92	4.53
Physical effort required	2.63	2.46
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3	3.92
Outcome depends on the skill and judgement of physician	4.83	4.61
Estimated risk of malpractice suit with poor outcome	3.79	4.23
INTENSITY/COMPLEXITY MEASURES	New Code 9596x1	Reference Code 95951
Time Segments (Mean)		
Pre-Service intensity/complexity	2.88	2.46
Intra-Service intensity/complexity	4.75	4.38
Post-Service intensity/complexity	3.79	3.38

ADDITIONAL RATIONALE

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

A consensus panel reviewed the survey results to develop recommendations to the RUC. The consensus panel included the RUC Committees of AAN, ACR, and ASNR as well as neurologist and radiologist MEG experts. The consensus panel thought that the respondents had misvalued the code and that the RVU recommended by the survey respondents did not reflect the time and intensity of physician work involved in this code. The consensus panel thought that many respondents included in physician work, work sometimes done by clinical staff, and that 180 minutes of intra-service physician work is more realistic.

~~Even allowing for such a reduction of physician work time, the new code requires twice as many minutes of intra-service physician work as the reference code (for which physician work RVU = 6.0). The physician work involved in the new code is at least equally intensive as the work involved in the reference code, and requires twice as much time, the consensus panel concluded that the 8.0 RVUs recommended by survey participants did not reflect the actual physician work involved in the procedure, and recommends that the RUC assign 9.5 RVUs to new code 9596x1.~~

FREQUENCY INFORMATION

How was this service previously reported? 95999 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

999 UNLISTED NEUROLOGIC/NEUROMUSC DX PROC 419

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 Sometimes Rarely

Specialty Radiology 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 Neurology Frequency 435 provided by survey participants in past year; 1000 expected in next year

Specialty Radiology Frequency 565 provided by survey participants in past year; 1000 expected in next year

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 60

Specialty Radiology Frequency 75

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

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

American Academy of Neurology, American College of Radiology, American Society of Neuroradiology

CPT Code: **9596x2** Tracking Number: **WW3** Global Period: **XXX** ~~Recommended RVW: 5.0~~

RUC Recommendation RVW: 4.00

CPT Descriptor:

Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, single modality (eg, sensory, motor, language, or visual cortex localization)

(Report any CT, EEG, or MRI procedures separately).

(For electroencephalography performed in addition to magnetoencephalography, see 95812-95827)

(For computerized tomography performed in addition to magnetoencephalography, see 70450-70470, 70496)

(For magnetic resonance imaging performed in addition to magnetoencephalography, see 70551-70553)

(For somatosensory evoked potentials, auditory evoked potentials, and visual evoked potentials performed in addition to magnetic evoked field responses, see 92585, 95925, 95926, and/or 95930)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Pre-Surgical Functional Procedure: A 54 year old female who has had focal left frontal headaches for three months developed right hand weakness and numbness. An intraxial mass was demonstrated along the left perirolandic region. To facilitate surgical planning, an MEG was requested to map the somatosensory cortex and determine the relationship of the tumor to the primary somatosensory and motor cortex.

Description of Pre-Service Work:

- Describe procedure to patient
- Review prior functional and anatomic studies
- Supervise patient demagnetization , head measurements and positioning

Description of Intra-Service Work:

- Supervise application of somatosensory stimuli
- Supervise data acquisition of somatosensory evoked responses
- Review source data for adequacy with attention to the quality of the sensory evoked responses.
- Supervise creation of models using a variety of software algorithms to localize the sensory evoked responses within the frame of the detector array
- Supervise the calculation of source locations for each major peak in the evoked response waveform
- Use additional software algorithms to superimpose the location of the patient's sensory evoked responses with the patient's MRI data
- Interpret the source and post-processed data
- Interpret the data maps
- Compare with any relevant prior studies

Description of Post-Service Work:

- Prepare, review and sign report of the procedure
- Discuss findings with referring physician

SURVEY DATA:

Presenter(s) Baldwin Smith, MD (AAN); Gregory Barkley, MD (AAN); Arliss Pollock, MD (ASNR)

Specialty(s): Neurology, Radiology

Sample Size: 36 Response Rate: (%): 69% (25/36) Median RVW: 5.0

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: Surveys were sent to thirty-six physicians (neurologists and radiologists) who perform MEGs.

25th Percentile RVW: 3.0 75th Percentile RVW: 6.0 Low: 0.54 High: 6.2

Median Pre-Service Time: 15 Median Intra-Service Time: 75

25th Percentile Intra-Svc Time: 40 75th Percentile Intra-Svc Time: 120 Low: 5 High: 240

Median Post-Service Time: 30

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
95961	Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or depth electrodes, to provoke seizures or identify vital brain structures; initial hour of physician work	2.97

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 comparing to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

TIME ESTIMATES (Median)

New Code 9596x2

Median Pre-Time	15
Median Intra-Time	75
Median Immediate Post-service Time	30

HCFA TIME FOR 95961: 65 Minutes

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

	<u>New Code 9596x2</u>	<u>Reference Code 95961</u>
The number of possible diagnosis and/or the number of management options that must be considered	3.84	4.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.16	4.66
Quality of medical decision making	3.92	4.88

Technical Skill/Physical Effort (Mean)

	New Code 9596x2	Reference Code 95961
Technical skill required	4.60	5
Physical effort required	2.32	2.44

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.60	4.88
Outcome depends on the skill and judgement of physician	4.68	4.88
Estimated risk of malpractice suit with poor outcome	4.28	4.88

INTENSITY/COMPLEXITY MEASURES

	New Code 9596x2	Reference Code 95961
Time Segments (Mean)		
Pre-Service intensity/complexity	3.20	3.33
Intra-Service intensity/complexity	4.12	5
Post-Service intensity/complexity	3.96	4

ADDITIONAL RATIONALE

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

Consensus panel reviewed the survey results to develop recommendations to the RUC. The consensus panel included the RUC Committees of AAN, ACR, and ASNR as well as neurologist and radiologist MEG experts. The consensus panel thought that many respondents included in physician work, work sometimes done by clinical staff, and that 75 minutes of intra-service physician work was more realistic.

FREQUENCY INFORMATION

How was this service previously reported? 95999 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

1999 Medicare Frequency Data:

95999 UNLISTED NEUROLOGIC/NEUROMUSC DX PROC 419

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 ___ Sometimes x 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.

Specialty **Neurology** Frequency 240 reported by survey participants in past year; 550 expected in next year

Specialty **Radiology** Frequency 1003 reported by survey participants in past year; 2000 expected in next year

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 25

Specialty **Radiology** Frequency 100

Do any physicians perform this service across the United States? ___ Yes X No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

American Academy of Neurology, American College of Radiology, American Society of Neuroradiology

T Code: 9596x3 Tracking Number: WW4 Global Period: ZZZ ~~Recommended RVW: 4.5~~
RUC Recommended RVW: 3.50

CPT Descriptor:

Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, each additional modality (eg, sensory, motor language, or visual cortex localization) (List separately in addition to code for primary procedure)

(Report any CT, EEG, or MRI procedures separately).

(For electroencephalography performed in addition to magnetoencephalography, see 95812-95827)

(For computerized tomography performed in addition to magnetoencephalography, see 70450-70470, 70496)

(For magnetic resonance imaging performed in addition to magnetoencephalography, see 70551-70553)

(For somatosensory evoked potentials, auditory evoked potentials, and visual evoked potentials performed in addition to magnetic evoked field responses, see 92585, 95925, 95926, and/or 95930)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Pre-Surgical Functional Procedure: A 54 year old female who has had focal left frontal headaches for three months developed right hand numbness and weakness. An intraxial mass was demonstrated along the left central rolandic cortex. Although she did not have visual symptoms, the mass extended posteriorly toward to the left occipital lobe. To facilitate surgical planning, an MEG was requested to map the somatosensory cortex and determine the relationship of the tumor to the somatosensory and primary motor cortex (reported as 9596X2). Additional mapping of the visual cortex was requested to determine the relationship of the tumor to the visual cortex to aid surgical planning.

Description of Physician Work:

Intra-Service

- Supervise application of somatosensory stimuli of the additional anatomic area
- Supervise data acquisition of somatosensory evoked responses of the additional anatomic area
- Review source data for adequacy with attention to the quality of the sensory evoked responses
- Supervise creation of models using a variety of software algorithms to localize the sensory evoked responses within the frame of the detector array
- Supervise the calculation of source locations for each major peak in the evoked response waveform
- Use additional software algorithms to superimpose the location of the patient's sensory evoked responses with the patient's MRI data
- Interpret the source and post-processed data
- Interpret the data maps
- Compare with any relevant prior studies

Post-Service

- Prepare, review and sign report findings for the additional anatomic site
- Discuss findings at the additional anatomic site with referring physician

SURVEY DATA:

Presenter(s) Baldwin Smith, MD (AAN); Gregory Barkley, MD (AAN); Arliss Pollock, MD (ASNR)

Specialty(s): Neurology, Radiology

Sample Size: 36

Response Rate: (%): 69% (25/36)

Median RVW: 3.50

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: Surveys were sent to thirty-six physicians (neurologists and radiologists) who perform MEGs.

25th Percentile RVW: 2.25

75th Percentile RVW: 5.0

Low: 0.50

High: 7.1

Median Intra-Service Time: 60

th Percentile Intra-Svc Time: 30

75th Percentile Intra-Svc Time: 150

Low: 10

High: 180

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
95962	Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or depth electrodes, to provoke seizures or identify vital brain structures; each additional hour of physician attendance	3.21

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

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

TIME ESTIMATES (Median)

New Code 9596x3

Median Intra-Time	75

HCFA TIME FOR 95962: 70 Minutes

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

New Code 9596x3

Reference Code 95962

The number of possible diagnosis and/or the number of management options that must be considered	4	4.36
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.24	4.54
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Urgency of medical decision making	4.16	4.81
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Technical Skill/Physical Effort (Mean)

New Code 9596x3

Reference Code 95962

Technical skill required	4.60	5
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Physical effort required	2.28	2.18
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.64	4.90
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Outcome depends on the skill and judgement of physician	4.71	4.90
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Estimated risk of malpractice suit with poor outcome	4.04	4.80
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TENSITY/COMPLEXITY MEASURES

New Code
9596x3

Reference
Code
95962

Time Segments (Mean)

Intra-Service intensity/complexity	4.36	4.63
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ADDITIONAL RATIONALE

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

A consensus panel including the RUC Committees of AAN, ACR, and ASNR as well as neurologist and radiologist MEG experts, reviewed the survey results to develop recommendations to the RUC. The consensus panel thought that survey did not adequately capture the physician work involved in this procedure, and therefore the RVU recommended by survey respondents was not an accurate reflection of the physician work. In part this was due to an error in the survey sent to respondents, who were asked to evaluate only intra-service work although this procedure does require a significant amount of post service work.

The physician work required for code 9596x3 is very similar to the physician work required for 9596x2, which respondents (to a more accurate survey, including pre- and post-service time) indicated took 90 minutes of intra-service work and 40 minutes of post-service, and valued at 5.0 RVUs.

Unlike the reference service chosen and other typical ZZZ global period codes, economies of scale in doing a second modality evoked magnetic field test are negligible versus doing an additional hour of functional cortical mapping. A more appropriate comparison would be the physician work involved in doing a visual evoked potential subsequent to a somatosensory evoked potential test. The visual evoked potential test takes nearly the same amount of physician work and time whether it's done as a stand-alone test or subsequent to a somatosensory EP.

The the consensus panel concluded that the 3.5 RVUs recommended by survey participants did not reflect the actual physician work involved in the procedure because respondents were instructed not to include any work done after the patient left the office. The consensus panel agreed that the minutes of intra-service physician work required for this procedure are equal to the minutes required for 9596x2, which survey participants had rated at 90 and the consensus panel revised to 75. Additionally, the consensus panel concluded that new code 9596x3 does include the same amount of post-service physician work as does 9596x2 (30 minutes).

For the reasons detailed above, the consensus panel recommends that the RUC assign 4.5 RVUs to new code 9596x3, based on 75 minutes of intra-service work and 30 minutes of post-service work.

FREQUENCY INFORMATION

How was this service previously reported? 95999 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

Medicare Frequency Data:

95999 UNLISTED NEUROLOGIC/NEUROMUSC DX PROC 419

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 ___ Sometimes ___ x ___ 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.

Specialty Neurology Frequency 100 performed by survey respondents in past year; 225 expected in next year

Specialty Radiology Frequency 725 performed by survey respondents in past year; 1500 expected in next year

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 20

Specialty Radiology Frequency 75

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

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE AND
RUC HCPAC REVIEW BOARD
SUMMARY OF RECOMMENDATIONS

April 2001

Gait and Motion Analysis

The RUC HCPAC Review Board will review codes 96000-96003 at their September 2001 meeting. The physical therapists had indicated that significant issues needed to be clarified regarding the vignettes for these services prior to conducting a survey. These issues will be discussed over the next few months and data will be presented in September. In the event that HCFA is unable to utilize this information in time for the Final Rule, the HCPAC Review Board recommends that these services be carrier priced in 2002.

The RUC discussed new CPT code 96004 and concluded that the vignette needed to be re-written to exclude physician work that would be captured in a separately reportable evaluation and management service and to specify the typical number of tests to be interpreted. The RUC also recommended that the specialty re-survey this service and work with the American Physical Therapy Association as they also prepare recommendations for the September 2001 meeting. The CPT Editorial Panel has also re-visited these codes at their May 2001 meeting and changed the introductory notes to clarify the use of the physician review and interpretation code 96004 so that the code is reported only once, regardless of the number of gait and motion tests performed. The RUC will place this issue on its September 2001 meeting agenda. In the event that HCFA is unable to utilize this information in time for the Final Rule, the RUC recommends that this service be carrier priced in 2002.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p>Medicine Neurology and Neuromuscular Procedures Sleep Testing</p> <p><u>(Do not report codes 95860-95875 in addition to 9600X1-9600X5)</u></p> <p>95860 <i>Needle electromyography, one extremity with or without related paraspinal areas</i></p> <p>95861 <i>Needle electromyography, two extremities with or without related paraspinal areas</i></p> <p><u>(For dynamic electromyography performed during motion analysis studies, see 9600X3-9600X4)</u></p> <p>Medicine Neurology and Neuromuscular Procedures Motion Analysis</p> <p><u>Codes 9600X1-9600X4 describe services performed as part of a major therapeutic or diagnostic decision making process. Motion analysis is performed in a dedicated motion analysis laboratory (ie, a facility capable of performing videotaping from the front, back and both sides, computerized 3-D kinematics, 3-D kinetics, and dynamic electromyography). Code 9600X1 may include 3-D kinetics and stride characteristics. Codes 9600X3-9600X4 describe dynamic electromyography. Do not report codes 95860-95875 in addition to the motion analysis codes.</u></p> <p><u>Code 9600X5 should only be reported once regardless of the number of study(ies) reviewed/interpreted.</u></p> <p><u>(For performance of needle electromyography procedures, see 96860-95875)</u></p> <p><u>(For gait training, use 97116)</u></p>				
●96000	XX1	Comprehensive computer-based motion analysis by video-taping and 3-D kinematics;	XXX	Carrier Price
●96001	XX2	with dynamic plantar pressure measurements during walking	XXX	Carrier Price
●96002	XX3	Dynamic surface electromyography, during walking or other functional activities, 1-12 muscles	XXX	Carrier Price

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●96003	XX4	Dynamic fine wire electromyography, during walking or other functional activities, 1 muscle <u>(Do not report codes 95860-95875 in addition to 96002, 96003)</u>	XXX	Carrier Price
●96004	XX5	Physician review and interpretation of comprehensive computer based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report	XXX	Carrier Price
<p>Medicine Physical Medicine and Rehabilitation Therapeutic Procedures</p> <p><i>97110 Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility</i></p> <p><i>97116 gait training (include stair climbing)</i></p> <p><u>(Use 96000-96003 to report comprehensive gait and motion analysis procedures)</u></p>				

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

April 2001

Photodynamic Therapy Destruction of Malignant/Non-Malignant Skin Lesions

Code 96567 *Photodynamic therapy by external application of light to destroy premalignant and/or malignant lesions of the skin and adjacent mucosa (eg, lip) by activation of photosensitive drugs(s), each phototherapy exposure session*, was created to describe a photodynamic therapy treatment, a new technology recently approved by the FDA. The procedure involves application of a photo-sensitizing agent followed by exposure to special ultra-violet light. A survey of 39 dermatologists using this new technology indicated that there was some physician work for this XXX global period procedure (96567). However, upon review of the survey responses, the specialty society concluded that the respondents did not accurately assess the time required by the physician for this procedure using the new technology and included a written recommendation that for the typical patient receiving this procedure, there is no physician work. The RUC agreed that the procedure, using this new technology, does not involve physician work but does involve practice expense direct inputs.

The RUC recommends a work relative value of 0 for CPT code 96567.

Practice Expense

The typical patient undergoing this procedure typically requires two encounters and the direct inputs have been adjusted to reflect this. Since the first treatment is usually performed on the same day as an E/M visit, the inputs were adjusted to prevent double counting with the inputs already included in the E/M services. For example, the minimum supply package was reduced to one to reflect only the second treatment. Also, the clinical staff times were reduced to reflect an E/M visit on the day of the first treatment. These are inputs for the office setting only. If the procedure is performed in the facility, there would be no direct inputs for this code.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●96567	YY1	Photodynamic therapy by external application of light to destroy premalignant and/or malignant lesions of the skin and adjacent mucosa (eg, lip) by activation of photosensitive drugs(s), each phototherapy exposure session	XXX	0

**AMA/Specialty Society Update Process
RUC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

Sample Size: 120 Response Rate: (%): 32% Global Period: XXX

Tracking Number: YY1 Reference Code 1 96910 Reference Code 2 96912

Geographic Practice Setting %: Rural 3 Suburban 54 Urban 43

Type of Practice %: 54 Solo Practice
40 Single Specialty Group
6 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:

All currently identified users of the new methodology were surveyed directly, with a 32% response rate. The American Academy of Dermatology's RB/RVS Task Force members reviewed the summarized survey data as well as RUC data as well as adoption of PEAC approved standard time and/or supply packages.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Encounter 1: Review of pertinent test results. Education on treatment requirements, risks and scheduling.

Encounter 2: Review treatment requirements, any reactions or complaints regarding photosensitizing agent

Intra-Service Clinical Labor Activities:

Encounter 1: Patient is gowned and positioned. Assist physician during assessment of lesions for size, location, functional risks, depth. Preparation of aminolevulinic acid HCl for Topical Solution, 20%. Application of prepared photo-sensitizing agent in topical solution form directly to individual lesions.

Encounter 2: Patient returns within strict 14 to 18 hour treatment parameter for photodynamic agent treatment. Patient is gowned and positioned. The patient receives irradiation of the affected area with the BLU-U Photodynamic Therapy Illuminator for approximately 17 minutes. Patient must be observed and this process must be monitored by a healthcare professional to provide intervention to any adverse reaction. The time period for light exposure remains the same regardless of the number of lesions. Exposure to the BLU-U light generates a photodynamic reaction with the topical agent. The reaction is a cytotoxic process, preventing further reproduction and growth of the keratotic cells while destroying the existing cells of the lesion.

Post-Service Clinical Labor Activities:

Encounter 1: Instruct patient regarding continued duration of photosensitivity, functional risks, and mandatory follow-up period and care. Communicate with patient and family on intra-procedural care.

Encounter 2: Instruct patient regarding continued duration of photosensitivity, functional risks, follow-up period and care. Communicate with patient and family on post-procedural care.

HCFA's Staff Type Code*	Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
1130	RN/LPN/MA <i>Encounters 1&2</i>	62	71-58	84	

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	M/S Minimum Supply Pkg	21		1.31
11106	Drape, sheet	2		0.26
11304	Gown, staff	2		1.38
11115	Patient Brochure	1		0.92
11118	Paper Towels	40		0.06
D1002 DUSA	Protective Eyewear	3		6.00/\$24 pkg of 4
11524	Skin Marking Pen	1		1.65
31101	Alcohol Swabs	4		0.017
31103	Cotton Applicators	4		0.01
31506	Gauze 4x4 10 pk	1		1.47
Berlix	Levulinic Acid HCl 20%	1		106.25/ea
53070	Ice	1		0.05
11130	Ice Bag	1		1.50

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
E11003	Power Table	1			0.015/ 6939.00
E11011	Exam Chair, reclining	1			0.048/ 4495.00
E30006	Exam Lamp	1			0.003/ 1850.00
DUSA	400+MW light (BLU-U)	1			\$15,759.00*
					* for 1,000 treatments

**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

6 0 RN, LPN, MA, Other _____

Other Clinical Activity (please specify)

examine chart for 2nd encounter

2 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 3 RN, LPN, MA, Other _____

Obtain vital signs 3 vital taken in 2nd encounter

4 3 RN, LPN, MA, Other _____

Prep and position patient

4 3 RN, LPN, MA, Other _____

Prepare room, equipment, supplies

6 4 RN, LPN, MA, Other _____

Assist physician during exam Encounter 1 only

10 12 RN, LPN, MA, Other _____

Application of cream

Education/instruction/ counseling 4 minutes X 2 visits

8 RN, LPN, MA, Other _____

Coordinate home or outpatient care

6 0 RN, LPN, MA, Other _____

Clean room/equipment 3 minutes X 2 visits

4 6 RN, LPN, MA, Other _____

Other Clinical Activity (please specify)

Light application and monitoring Encounter 2 only
and assessment of compliance

17 19 RN, LPN, MA, Other _____

End: Patient leaves office

Post-Service Period

Start: Patient leaves office

Phone calls between visits with patient, family pharmacy

8 4 RN, LPN, MA, Other _____

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 2001

Analysis of Computer Transmitted Data

The CPT Editorial Panel created a new code 99091 *Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, requiring a minimum of 30 minutes of time* to specifically describe the review of data sent to the physician electronically from a patient and/or caregiver for their analysis and interpretation. This service may be reported only once per month and may not be reported in conjunction with an Evaluation and Management service on the same day. This service may also not be reported in conjunction with a care plan oversight code (99374-99380).

The RUC carefully reviewed the survey results from 58 internists and endocrinologists. The survey median reflected a work relative value of 1.20, however, the specialty recommended that the code be valued similar to the care plan oversight services at 1.73. The RUC reviewed the time involved and did not agree that this was an appropriate comparison. The RUC reviewed the time data of 5 minutes pre-time, 20 minutes intra-time, and 5 minutes post-time and compared this to the physician time and intensity involved in CPT code 99214 *Level 4 Established Office Visit* (work RVU = 1.10) with intra-time of 25 minutes, and a total time of 38 minutes, and determined that 99091 should be valued at this level. The RUC also agreed that the intra-service time for this code should be modified to be 30 minutes as the CPT descriptor clearly states that the physician must spend a minimum of 30 minutes to report this service. **The RUC recommends a work relative value of 1.10 for code 99091.**

Practice Expense:

There are no direct practice expense inputs related to this service.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
99090		Analysis of information clinical data stored in computers (eg, ECGs, blood pressures, hematologic data) (For physician/health care professional collection and interpretation of physiologic data stored/transmitted by patient/caregiver, see 99091)	XXX	N/A HCFA considers this a bundled service and provides no separate payment	N/A

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Source of Current Work RVU*	Work RVU Recommendation
		<p><u>(Do not report 99090 if other more specific CPT codes exist, e.g., 93014, 93227, 93233, 93272 for cardiographic services; 95250 for continuous glucose monitoring, 97750 for musculoskeletal function testing)</u></p>			
<p>Medicine Special Services, Procedures and Reports</p> <p><u>Code 99091 should be reported no more than once in a 30 day period to include the physician or health care provider time involved with data accession and review, data interpretation, modification of care plan as necessary (including communication to patient and/or caregiver) and associated documentation.</u></p> <p><u>If the services described by code 99091 are provided on the same day the patient presents for an E/M service, these services should be considered part of the E/M service and not separately reported.</u></p> <p><u>Do not report 99091 if it occurs within 30 days of care plan oversight services 99374-99380. Do not report 99091 if other more specific CPT codes exist, (eg, 93014, 93227, 93233, 93272 for cardiographic services; 95250 for continuous glucose monitoring). Do not report 99091 for transfer and interpretation of data from hospital or clinical laboratory computers.</u></p>					
● 99091	AA1	Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, requiring a minimum of 30 minutes of time	XXX	N/A	1.10

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 990XX Tracking Number: AA1 Global Period: XXX Recommended RVW: ~~1.73~~
RUC Rec: 1.10

CPT Descriptor: Collection and interpretation of physiologic data (e.g. ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, requiring a minimum of 30 minutes of time.

CPT Instructions:

Code 990XX should be reported no more than once in a 30 day period to include the physician or health care provider time involved with data accession and review, data interpretation, modification of care plan as necessary (including communication to patient and/or caregiver) and associated documentation.

If the services described by code 990XX are provided on the same day the patient presents for an E/M service, these services should be considered part of the E/M service and not separately reported.

Do not report 990XX if it occurs within 30 days of care plan oversight services 99374-99380. Do not report 990XX if other more specific CPT codes exist, (eg, 93014, 93227, 93233, 93272 for cardiographic services; 926X1 for continuous glucose monitoring). Do not report 990XX for transfer and interpretation of data from hospital or clinical laboratory computers.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 67-year old male with labile diabetes is utilizing a home glucose-monitoring device to capture multiple glucose readings during the course of a month in association with diary data of symptoms, medication, exercise, and diet. The data is transmitted from home computer to physician's office by email, downloaded by physician and data reviewed. Pre-service work includes chart review concerning prior glucose control methods. Intra-service work involves the physician spending 35 minutes during a 30-day period for the review, interpretation and report based on the physiologic data and diary. Separate time spent typically involves at least one contact with patient (e.g. telephone call or e-mail exchange) with further advice about medical management and monitoring recommendations. Post-service work includes associated chart documentation.

Description of Pre-Service Work: The pre-service period includes chart review regarding patient condition and prior treatment.

Description of Intra-Service Work: The intra-service period includes your review, interpretation, and report of the data digitally stored and/or transmitted by the patient. The intra-service period involves at least one communication (e.g. phone call or e-mail exchange) with the patient to provide medical management and monitoring recommendations.

Description of Post-Service Work: The post-service period includes documenting the service in the patient's medical record and arranging for further services.

SURVEY DATA:

Presenter(s): ACP-ASIM and AACE

Specialty(s): Internal Medicine, Endocrinology, (This service will be provided by most physician specialties).

Sample Size: 58/170 Response Rate: (%): 34.1% Median RVW: 1.2

Type of Sample (Bold One): random, panel, **convenience**.

Explanation of sample size: Survey mailed to 170 AACE and ACP-ASIM members who indicated they were interested in participating in such surveys.

25th Percentile RVW: 0.9 75th Percentile RVW: 1.6 Low: 0.38 High: 3.60

Median Pre-Service Time: 5 minutes Median Intra-Service Time: 30 minutes

25th Percentile Intra-Svc Time: 15 minutes 75th Percentile Intra-Svc Time: 35 minutes

Intra-Svc Time Low: 6 minutes High: 46 minutes

Median Post-Service Time: 5 minutes

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
99375	Care Plan Oversight, 30 minutes or more, home health patient	1.73
99378	Care Plan Oversight, 30 minutes or more, hospice patient	1.73

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

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

TIME ESTIMATES (Median)

<u>TIME ESTIMATES (Median)</u>	<u>New/Revis. CPT Code:</u>	<u>Key Reference* CPT Code:</u>
Median Pre-Time	5	10
Median Intra-Time	30	38
Median Immediate Post-service Time	5	10
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	3.13	3.17
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.47	3.33
Urgency of medical decision making	3.20	3.17

Technical Skill/Physical Effort (Mean)

Technical skill required	3.09	3.17
Physical effort required	2.27	2.33
<u>Psychological Stress (Mean)</u>		
The risk of significant complications, morbidity and/or mortality	3.36	3.33

Outcome depends on the skill and judgement of physician	3.75	3.22
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Estimated risk of malpractice suit with poor outcome	3.25	2.78
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INTENSITY/COMPLEXITY MEASURES

CPT Code

Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.69	2.89
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Intra-Service intensity/complexity	3.5	2.56
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Post-Service intensity/complexity	2.74	2.78
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ADDITIONAL RATIONALE

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

ACP-ASIM and AACE recommend that the RUC approve a RVW of 1.73, which is the same RVW as care plan oversight (99375 and 99378). Please note that intensity and complexity measures of the surveyed code (990XX) and the care plan oversight reference codes are almost identical, with a few exceptions demonstrating greater complexity for the surveyed code (990XX). Most notable is that the intra-service intensity/complexity is significantly higher for the surveyed code (990XX), 3.5 versus 2.56. Both the surveyed code (990XX) and the reference codes are by definition a minimum of 30 minutes a month. Therefore following the CPT definition and the complexity/intensity measures, the surveyed code (990XX) should have the same RVW as care plan oversight or higher.

In addition, the ACP-ASIM and AACE Committees reviewing the survey data believe that the physicians who completed the survey understated the amount of time involved with providing service 990XX because the survey vignette mentions "at least one contact with patient (e.g. telephone call or e-mail exchange) with further advice about medical management and monitoring recommendations." ACP-ASIM and AACE believe this statement encouraged survey respondents to describe the minimum amount of time involved with this service (one physician-patient electronic encounter), rather than the typical time, which may include multiple physician-patient electronic encounters.

FREQUENCY INFORMATION

How was this service previously reported? As care plan oversight in limited settings or as pre- and post- service work in conjunction with an office visit. However, this code was created for circumstances in which physician review of data pertaining to a previous visit exceeds the review involved with typical pre- and post- service E/M service work and /or for on-going monitoring of patient data not in conjunction with an office visit.

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

Specialty Internal Medicine X Commonly Sometimes Rarely

Specialty Endocrinology 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: Internal Medicine (including endocrinology) Frequency: 570,000

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: Internal Medicine (including endocrinology) Frequency: 350,000

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

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

April 2001

Patient Transport

The CPT Editorial Panel created two new codes 99289 *Physician constant attention of the critically ill or injured patient during an interfacility transport; first 30-74 minutes* and 99290 *Physician constant attention of the critically ill or injured patient during an interfacility transport; each additional 30 minutes (List separately in addition to code for primary service)* to describe these interfacility transports involving physicians. The face-to-face time begins when the physician assumes primary responsibility of the patient at the referring hospital/facility, and ends when the receiving hospital/facility accepts responsibility for the patient's care. Only the time the physician spends in direct face-to-face contact with the patient during the transport should be reported.

The RUC reviewed survey data from 56 critical care, neonatology, and burn care physicians. This data indicated a survey median of 4.80 and a 75th percentile of 6.00. The specialty chose to recommend the 75th percentile as they argued that this was more reflective of the intense service that is provided. The specialty also presented information regarding the risk to the physician of such emergency travel, indicating that 2 out of every 1,000 helicopter flights results in a crash involving fatalities and/or injuries. The specialty also indicated that the level of intensity for this service is greater than critical care services as the physician is not working within their own facility and must assist in stabilizing the patient in a different facility or location. The survey respondents also confirmed that they believed these services to be more intense than the critical care services, codes 99291 and 99292. Although, the RUC agreed that these services were certainly more intense than the critical care services, the committee did not agree that they should be valued at the level of 6.00 and 3.00. The RUC agreed that the survey was well conducted and understood by the respondents, and recommends that the survey median of 4.80 for 99289 is appropriate. A work relative value of 2.40 (1/2 of 4.80) would be appropriate for 99290. **The RUC recommends a work relative value of 4.80 for 99289 and 2.40 for 99290.**

Practice Expense

There are no direct practice expense inputs associated with this service.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p><u>The following codes 99289, 99290 are used to report the physical attendance and direct face to face care of a physician during the interfacility transport of a critically ill or injured patient. For the purpose of reporting codes 99289 and 99290, face-to-face care begins when the physician assumes primary responsibility of the patient at the referring hospital/facility, and ends when the receiving hospital/facility accepts responsibility for the patient's care. Only the time the physician spends in direct face-to-face contact with the patient during the transport should be reported. Patient transport services involving less than 30 minutes of face-to-face physician care should not be reported using codes 99289, 99290. Procedure(s) or service(s) performed by other members of the transporting team may not be reported by the supervising physician. Any procedure(s) or service(s) performed by the physician that are identified in CPT may be reported separately with the exception of routine monitoring evaluations (eg, heart rate, respiratory rate, blood pressure, and pulse oximetry) and the initiation of mechanical ventilation. Routine monitoring evaluations and initiation of mechanical ventilation performed by the physician are to be included in the face-to-face time reported by codes 99289, 99290. The time spent by the physician performing separately reportable services or procedures should not be included in the face-to-face time reported by codes 99289, 99290.</u></p> <p><u>The direction of emergency care to transporting staff by a physician located in a hospital or other interfacility by two-way communication is not considered direct face to face care and should not be reported with codes 99289, 99290. Physician directed emergency care through outside voice communication to transporting staff personell is reported with code 99288.</u></p> <p><u>The emergency department services codes (99281-99285), initial hospital care codes (99221-25), hourly critical care codes (99291, 99292), or initial date neonatal intensive care code (99295) are only reported after the patient has been admitted to the emergency department, the inpatient floor or the critical care unit.</u></p> <p><u>Code 99289 is used to report the first 30-74 minutes of direct face-to-face time with the transport patient and should be reported only once on a given date. Code 99290 is used to report each additional 30 minutes provided on a given date. Face to face services less than 30 minutes should not be reported with these codes.</u></p>				
●99289	CC1	Physician constant attention of the critically ill or injured patient during an interfacility transport; first 30-74 minutes	XXX	4.80

●99290	CC2	<p>each additional 30 minutes (List separately in addition to code for primary service)</p> <p><u>(Use 99290 in conjunction with 99289)</u></p> <p><u>(Code 99289, 99290 may be reported separately from any other procedure/service provided on the date of the transfer)</u></p>	ZZZ	2.40
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Critical Care Services

Critical care is the direct delivery by a physician(s) of medical care for a critically ill or critically injured patient. A critical illness or injury

Providing medical care to a critically ill, . . .

Critical care services provided to infants . . .

Services for a patient who is not critically ill

Critical care and other E/M services may be provided to the same patient

The following services are included in reporting critical care when performed during the critical period by the physician(s) providing critical care; the interpretation of cardiac output measurements (93561, 93562), chest x-rays (71010, 71015, 71020), Any services performed which are not listed above should be reported separately.

Codes 99291-99292 should not be reported for the physician's attendance during the transport of critically ill or injured patients to or from a tertiary facility or hospital. Physician transport services of critically ill or injured patients are separately reportable, see 99289, 99290.

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

CPT Code: **99XX3** Tracking Number: **CC1** Global Period: **XXX** Recommended RVW: ~~6.00~~
RUC Rec. Work RVU: **4.80**

CPT Descriptor: Physician constant attention of the critically ill or injured patient during an interfacility transport; first 30-74 minutes

The following codes 99XX3, 99XX4 are used to report the physical attendance and direct face to face care by a physician during the interfacility transport of a critically ill or injured patient. For the purpose of reporting codes 99XX3 and 99XX4, face-to-face care begins when the physician assumes primary responsibility of the patient at the referring hospital/facility, and ends when the receiving hospital/facility accepts responsibility for the patient's care. Only the time the physician spends in direct face-to-face contact with the patient during the transport should be reported. Patient transport services involving less than 30 minutes of face to face physician care should not be reported using codes 99XX3, 99XX4. Any procedure(s) or service(s) performed by the physician that are identified in CPT may be reported separately with the exception of routine monitoring evaluations (eg, heart rate, respiratory rate, blood pressure, and pulse oximetry) and the initiation of mechanical ventilation. Routine monitoring evaluations and initiation of mechanical ventilation performed by the physician are to be included in the face to face time reported by codes 99XX3, 99XX4. The time spent by the physician performing separately reportable services or procedures should not be included in the face to face time reported by codes 99XX3, 99XX4.

The direction of emergency care to transporting staff by a physician located in a hospital or other interfacility by two-way communication is not considered direct face to face care and should not be reported with codes 99XX3, 99XX4. Physician directed emergency care through outside voice communication to transporting staff personell is reported with code 99288.

The emergency department services codes (99281-99285) initial hospital care codes (99221-25), hourly critical care codes (99291, 99292), or initial date neonatal intensive care code (99295) are only reported after the patient has been admitted to the emergency department, the inpatient floor or the critical care unit.

Code 99XX3 is used to report the first 30-74 minutes of direct face to face time with the transport patient and should be reported only once on a given date. Code 99XX4 is used to report each additional 30 minutes provided on a given date. Face to face services less than 30 minutes should not be reported with these codes.

CC1 XXX ●99XX3 Physician constant attention of the critically ill or injured patient during an interfacility transport; first 30-74 minutes

CC2 ZZZ ●99XX4 each additional 30 minutes (List separately in addition to code for primary service)
(Use 99XX4 in conjunction with 99XX3)

(Codes 99XX3, 99XX4 may be reported separately from any other procedure/service provided on the date of the transfer)

Critical Care Services

Critical care is the direct delivery by a physician(s) of medical care for a critically ill or critically injured patient. A critical illness or injury.....

Providing medical care to a critically ill, ...

Critical care services provided to infants ...

Services for a patient who is not critically ill.....

Critical care and other E/M services may be provided to the same patient....

The following services are included in reporting critical care when performed during the critical period by the physician(s) providing critical care: the interpretation of cardiac output measurements (93561, 93562), chest x-rays (71010, 71015, 71020), Any services performed which are not listed above should be reported separately.

Codes 99291-99292 should not be reported for the physician's attendance during the transport of critically ill or injured patients to or from a facility or hospital. Physician transport services of critically ill or injured patients are separately reportable, see 99XX3, 99XX4.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A previously healthy patient is struck by a vehicle while crossing a busy street. The patient is not run over, but is thrown and impacts the road 15 feet from the point of the accident. The patient is taken by EMS to the nearest hospital, a non-trauma facility. During initial stabilization, the ED physician finds significant injuries to the head, chest, and abdomen requiring trauma specialty care that is unavailable at her facility. After consultation with the receiving trauma center, a specialized transport team consisting of a physician, nurse, respiratory therapist, and paramedic is dispatched to the local hospital.

At the local hospital, with the ED physician, the transport physician reviews the patient's history, clinical progress, labs and radiographs, and assists in further stabilization of the patient, including endotracheal intubation (following rapid sequence induction), and the placement of central lines and a chest tube. The patient has unstable vital signs, but requires the trauma center's services. The patient is moved to the transport unit where he is placed on continuous heart, respiratory, blood pressure, pulse oximetry and end-tidal CO₂ monitors. All IVs and medications are on electronic monitoring pumps. The patient is placed on a transport ventilator. The physician remains at the patient's side in continuous attendance providing direct care and directing the activities of the team. The transport unit has limited space and resources. Bedside blood tests are used to adjust respiratory and medical treatment. The vehicle is in constant motion and patient observation and intervention is challenging.

Upon arrival at the trauma center, there has been no further deterioration in the patient's condition. Care is transferred to the trauma service after review of the patient's records from the transferring facility and events that occurred and care that was provided during the transport.

Description of Pre-Service Work: Receive phone call from referring hospital to discuss the patient's diagnosis and present status to determine the most appropriate mode of transport; contact the transport communication center to arrange for the team and vehicle; travel in the transport vehicle to the referring hospital; discuss patient's status with the treating team; review patient records and lab results

Description of Intra-Service Work: Care of critically ill patient during transport

Description of Post-Service Work: Communicate patient information to receiving hospital; complete transport forms; communicate with referring hospital, providing an update on patient's condition

SURVEY DATA:

Presenter(s): Dr. Steve Krug (AAP) & Dr. Bill Peruzzi (SCCM)

Specialty(s): American Academy of Pediatrics, Society of Critical Care Medicine, American Burn Association

Sample Size: 56

Response Rate: (%): 54% (N=30)

Median RVW: 4.80

Type of Sample (Circle One): random panel convenience Explanation of sample size: Each specialty society sent surveys out to those physician members most experienced with the service of patient transport. The results of those surveys were compiled and discussed both within each society's expert panel and then again among representatives from each specialty society's expert panel until consensus was reached.

25th Percentile RVW: 4.00

75th Percentile RVW: 6.00

Low: 2.50

High: 12.00

CPT Code 99XX3

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.37	4.50
Urgency of medical decision making	4.97	4.70

Technical Skill/Physical Effort (Mean)

Technical skill required	4.80	4.66
Physical effort required	4.73	4.20

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.93	4.57
Outcome depends on the skill and judgement of physician	4.87	4.73
Estimated risk of malpractice suit with poor outcome	4.63	4.33

<u>INTENSITY/COMPLEXITY MEASURES</u>	<u>CPT Code</u>	<u>Reference Service 1</u>
---------------------------------------------	------------------------	-----------------------------------

Time Segments (Mean)

Pre-Service intensity/complexity	3.71	3.57
Intra-Service intensity/complexity	4.93	4.77
Post-Service intensity/complexity	3.33	3.74

ADDITIONAL RATIONALE

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

The codes being surveyed require a physician to provide care to a critically ill or injured patient while in a moving vehicle. Based on the additional instability and uncertainty brought about by the actual act of transport itself, the expert panel concluded that the transport code is approximately one and one half times more intense than the reference service codes (critical care codes 99291 and 99292). Given that the reference service codes' RVUs are 4.00 and 2.00, respectively, the recommended values of 6.00 and 3.00 were established. It was noted that these values are also the 75th percentiles of the survey data.

FREQUENCY INFORMATION

How was this service previously reported? 99288 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

CPT Code 99XX3

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

Specialty: Pediatrics _____ Commonly Sometimes _____ Rarely _____

Specialty: Critical Care _____ 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: Pediatrics _____ Frequency: While there is not a national database for pediatric services, one is able to extrapolate some estimates based on the fact that there are currently 116 children's hospitals in this country and approximately 4 million births per year, with between $\frac{1}{2}$ and one percent of those newborns requiring transport.

Specialty: Critical Care _____ Frequency: $\geq 1,000$

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: Pediatrics _____ Frequency: Approximately 0

Specialty: Critical Care _____ Frequency: ≥ 600

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

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

CPT Code: **99XX4** Tracking Number: **CC2** Global Period: **ZZZ** Recommended RVW: ~~3.00~~
RUC Rec. Work RVU: **2.40**

CPT Descriptor: Physician constant attention of the critically ill or injured patient during an interfacility transport; each additional 30 minutes
(Use 99XX4 in conjunction with 99XX3)

The following codes 99XX3, 99XX4 are used to report the physical attendance and direct face to face care by a physician during the interfacility transport of a critically ill or injured patient. For the purpose of reporting codes 99XX3 and 99XX4, face-to-face care begins when the physician assumes primary responsibility of the patient at the referring hospital/facility, and ends when the receiving hospital/facility accepts responsibility for the patient's care. Only the time the physician spends in direct face-to-face contact with the patient during the transport should be reported. Patient transport services involving less than 30 minutes of face to face physician care should not be reported using codes 99XX3, 99XX4. Any procedure(s) or service(s) performed by the physician that are identified in CPT may be reported separately with the exception of routine monitoring evaluations (eg, heart rate, respiratory rate, blood pressure, and pulse oximetry) and the initiation of mechanical ventilation. Routine monitoring evaluations and initiation of mechanical ventilation performed by the physician are to be included in the face to face time reported by codes 99XX3, 99XX4. The time spent by the physician performing separately reportable services or procedures should not be included in the face to face time reported by codes 99XX3, 99XX4.

The direction of emergency care to transporting staff by a physician located in a hospital or other interfacility by two-way communication is not considered direct face to face care and should not be reported with codes 99XX3, 99XX4. Physician directed emergency care through outside voice communication to transporting staff personell is reported with code 99288.

The emergency department services codes (99281-99285) initial hospital care codes (99221-25), hourly critical care codes (99291, 99292), or initial date neonatal intensive care code (99295) are only reported after the patient has been admitted to the emergency department, the inpatient floor or the critical care unit.

Code 99XX3 is used to report the first 30-74 minutes of direct face to face time with the transport patient and should be reported only once on a given date. Code 99XX4 is used to report each additional 30 minutes provided on a given date. Face to face services less than 30 minutes should not be reported with these codes.

CC1 XXX ●99XX3 Physician constant attention of the critically ill or injured patient during an interfacility transport; first 30-74 minutes

CC2 ZZZ ●99XX4 each additional 30 minutes (List separately in addition to code for primary service)
(Use 99XX4 in conjunction with 99XX3)

(Codes 99XX3, 99XX4 may be reported separately from any other procedure/service provided on the date of the transfer)

Critical Care Services

Critical care is the direct delivery by a physician(s) of medical care for a critically ill or critically injured patient. A critical illness or injury.....

Providing medical care to a critically ill, ...

Critical care services provided to infants ...

Services for a patient who is not critically ill.....

Critical care and other E/M services may be provided to the same patient ...

The following services are included in reporting critical care when performed during the critical period by the physician(s) providing critical care; the interpretation of cardiac output measurements (93561, 93562), chest x-rays (71010, 71015, 71020),..... Any services performed which are not listed above should be reported separately.

Codes 99291-99292 should not be reported for the physician's attendance during the transport of critically ill or injured patients to or from a facility or hospital. Physician transport services of critically ill or injured patients are separately reportable, see 99XX3, 99XX4.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A previously healthy patient is struck by a vehicle while crossing a busy street. The patient is not run over, but is thrown and impacts the road 15 feet from the point of the accident. The patient is taken by EMS to the nearest hospital, a non-trauma facility. During initial stabilization, the ED physician finds significant injuries to the head, chest, and abdomen requiring trauma specialty care that is unavailable at her facility. After consultation with the receiving trauma center, a specialized transport team consisting of a physician, nurse, respiratory therapist, and paramedic is dispatched to the local hospital.

At the local hospital, with the ED physician, the transport physician reviews the patient's history, clinical progress, labs and radiographs, and assists in further stabilization of the patient, including endotracheal intubation (following rapid sequence induction), and the placement of central lines and a chest tube. The patient has unstable vital signs, but requires the trauma center's services. The patient is moved to the transport unit where he is placed on continuous heart, respiratory, blood pressure, pulse oximetry and end-tidal CO₂ monitors. All IVs and medications are on electronic monitoring pumps. The patient is placed on a transport ventilator. The physician remains at the patient's side in continuous attendance providing direct care and directing the activities of the team. The transport unit has limited space and resources. Bedside blood tests are used to adjust respiratory and medical treatment. The vehicle is in constant motion and patient observation and intervention is challenging.

Upon arrival at the trauma center, there has been no further deterioration in the patient's condition. Care is transferred to the trauma service after review of the patient's records from the transferring facility and events that occurred and care that was provided during the transport.

Description of Pre-Service Work: N/A

Description of Intra-Service Work: Care of critically ill patient during transport

Description of Post-Service Work: N/A

SURVEY DATA:

Presenter(s): Dr. Steve Krug (AAP) & Dr. Bill Peruzzi (SCCM)

Specialty(s): American Academy of Pediatrics, Society of Critical Care Medicine, American Burn Association

Sample Size: 56 Response Rate: (%): 54% (N=30) Median RVW: 2.50

Type of Sample (Circle One): random panel convenience Explanation of sample size: Each specialty society sent surveys out to those physician members most experienced with the service of patient transport. The results of those surveys were compiled and discussed both within each society's expert panel and then again among representatives from each specialty society's expert panel until consensus was reached.

25th Percentile RVW: 2.00 75th Percentile RVW: 3.00 Low: 1.50 High: 6.00

Median Pre-Service Time: N/A Median Intra-Service Time: 30 minutes

25th Percentile Intra-Svc Time: 30 minutes 75th Percentile Intra-Svc Time: 30 minutes

Low: 30 minutes High: 150 minutes

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:	0
Other Hospital Visits:	0
Discharge Day Mgmt.:	0
Office Visits:	0

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
99292	Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes	2.00

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

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

TIME ESTIMATES (Median)

New/Revis. CPT Code: **99XX3**
Key Reference CPT Code: **99292**

Median Pre-Time	0	0
Median Intra-Time	30	30
Median Immediate Post-service Time	0	0
Median of Aggregate Critical Care Times	0	0
Median of Aggregate Other Hospital Visit Times	0	0
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	4.67	4.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.20	4.27
Urgency of medical decision making	4.93	4.60

Technical Skill/Physical Effort (Mean)

Technical skill required	4.70	4.40
--------------------------	------	------

Physical effort required	4.67	4.20
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.83	4.43
-------------------------------------------------------------------	------	------

Outcome depends on the skill and judgement of physician	4.83	4.63
---------------------------------------------------------	------	------

Estimated risk of malpractice suit with poor outcome	4.50	4.23
------------------------------------------------------	------	------

INTENSITY/COMPLEXITY MEASURES

CPT Code

Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	N/A	N/A
----------------------------------	-----	-----

Intra-Service intensity/complexity	4.77	4.53
------------------------------------	------	------

Post-Service intensity/complexity	N/A	N/A
-----------------------------------	-----	-----

ADDITIONAL RATIONALE

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

The codes being surveyed require a physician to provide care to a critically ill or injured patient while in a moving vehicle. Based on the additional instability and uncertainty brought about by the actual act of transport itself, the expert panel concluded that the transport code is approximately one and one half times more intense than the reference service codes (critical care codes 99291 and 99292). Given that the reference service codes' RVUs are 4.00 and 2.00, respectively, the recommended values of 6.00 and 3.00 were established. It was noted that these values are also the 75th percentiles of the survey data.

FREQUENCY INFORMATION

How was this service previously reported? 99288 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty: Pediatrics _____ Commonly X Sometimes _____ Rarely

Specialty: Critical Care _____ 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: Pediatrics Frequency: While there is not a national database for pediatric services, one is able to extrapolate some estimates based on the fact that there are currently 116 children's hospitals in this country and approximately 4 million births per year, with between $\frac{1}{2}$ and one percent of those newborns requiring transport.

Specialty: Critical Care Frequency: $\geq 1,000$

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: Pediatrics Frequency: Approximately 0

Specialty: Critical Care Frequency: ≥ 600

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



HCPAC Recommendations

For CPT 2002

RUC Meetings:

February 2001 and April 2001

American Medical Association

Physicians dedicated to the health of America



AMA/Specialty Society RVS Update Process 515 North State Street 312 464-4736
Chicago, Illinois 60610 312 464-5849 Fax

May 24, 2001

Terry Kay
Center for Health Plans and Providers
Health Care Financing Administration
7500 Security Boulevard, C4-01-15
Baltimore, Maryland 21244

Dear Mr. Kay:

It is with pleasure that I submit to the Health Care Financing Administration (HCFA), on behalf of the RUC Health Care Professionals Advisory Committee (HCPAC) Review Board, work relative value and direct practice expense inputs for new and revised codes for CPT 2002.

A summary table of our recommendations is included for your review. These recommendations address new codes for gait and motion analysis, health behavior and assessment/intervention services, and editorial changes to the physical medicine and rehabilitation section of CPT. The Review Board has decided that it will not submit recommendations related to the new CPT codes for athletic training.

Also included in the attached material are practice expense refinement recommendations for existing codes, which were first reviewed by the Practice Expense Advisory Committee (PEAC). Work relative value recommendations and direct practice expense inputs for a few remaining interim values for CPT 2001, specifically related to active wound management, are also included for your consideration.

The RUC HCPAC Review Board looks forward to continued HCFA representation at our meetings and your effort to ensure a fair review of the enclosed recommendations.

Sincerely,

Handwritten signature of Richard Whitten in black ink.

Richard Whitten, MD

Handwritten signature of Don Williamson in black ink.

Don Williamson, OD

cc: Paul Rudolf, MD
Ken Simon, MD
Carolyn Mullen
Rick Ensor
Sherry Smith
Patrick Gallagher

CP1 2002 RUC HCPAC Review Board Recommendations

<i>CPT Code</i>	<i>Global Coding</i>	<i>CPT Main</i>	<i>Change</i>	<i>Date</i>	<i>Tab</i>	<i>Issue</i>	<i>Tracking RUC Number</i>	<i>RUC Date</i>	<i>Specialty Tab</i>	<i>RUC Rec</i>	<i>Specialty Rec</i>	<i>RUC RVU as last yr?</i>	<i>Same MFS?</i>	<i>Comments</i>
96000	XXX	N	Feb01	E1		Gait and Motion Studies	XX1	Apr01	HCPAC				Yes	Carrier Price - RUC to Review in Sept. 2001
96001	XXX	N	Feb01	E1		Gait and Motion Studies	XX2	Apr01	HCPAC				Yes	Carrier Price - RUC to Review in Sept. 2001
96002	XXX	N	Feb01	E1		Gait and Motion Studies	XX3	Apr01	HCPAC				Yes	Carrier Price - RUC to Review in Sept. 2001
96003	XXX	N	Feb01	E1		Gait and Motion Studies	XX4	Apr01	HCPAC				Yes	Carrier Price - RUC to Review in Sept. 2001
96150	XXX	N	Aug00	J		Health Behavior Assessment/Intervention	G1	Apr01	HCPAC	0.50	0.50		Yes	
96151	XXX	N	Aug00	J		Health Behavior Assessment/Intervention	G2	Apr01	HCPAC	0.48	0.48		Yes	
96152	XXX	N	Aug00	J		Health Behavior Assessment/Intervention	G3	Apr01	HCPAC	0.46	0.46		Yes	
96153	XXX	N	Aug00	J		Health Behavior Assessment/Intervention	G4	Apr01	HCPAC	0.14	0.10		Yes	
96154	XXX	N	Aug00	J		Health Behavior Assessment/Intervention	G5	Apr01	HCPAC	0.45	0.45		Yes	
96155	XXX	N	Aug00	J		Health Behavior Assessment/Intervention	G6	Apr01	HCPAC	0.44	0.44		Yes	
97005	XXX	N	May00	W		Athletic training	D1	Feb01	HCPAC				Yes	No Recommendation from HCPAC
97006	XXX	N	May00	W		Athletic training	D2	Feb01	HCPAC				Yes	No Recommendation from HCPAC
97112	XXX	R	Nov00	15		Physical Medicine		Editorial	HCPAC	0.45	0.45	Yes	Yes	
97504	XXX	R	Nov00	15		Physical Medicine		Editorial	HCPAC	0.45	0.45	Yes	Yes	
97535	XXX	R	Nov00	15		Physical Medicine		Editorial	HCPAC	0.45	0.45	Yes	Yes	

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE AND
RUC HCPAC REVIEW BOARD
SUMMARY OF RECOMMENDATIONS

April 2001

Gait and Motion Analysis

The RUC HCPAC Review Board will review codes 96000-96003 at their September 2001 meeting. The physical therapists had indicated that significant issues needed to be clarified regarding the vignettes for these services prior to conducting a survey. These issues will be discussed over the next few months and data will be presented in September. In the event that HCFA is unable to utilize this information in time for the Final Rule, the HCPAC Review Board recommends that these services be carrier priced in 2002.

The RUC discussed new CPT code 96004 and concluded that the vignette needed to be re-written to exclude physician work that would be captured in a separately reportable evaluation and management service and to specify the typical number of tests to be interpreted. The RUC also recommended that the specialty re-survey this service and work with the American Physical Therapy Association as they also prepare recommendations for the September 2001 meeting. The CPT Editorial Panel has also re-visited these codes at their May 2001 meeting and changed the introductory notes to clarify the use of the physician review and interpretation code 96004 so that the code is reported only once, regardless of the number of gait and motion tests performed. The RUC will place this issue on its September 2001 meeting agenda. In the event that HCFA is unable to utilize this information in time for the Final Rule, the RUC recommends that this service be carrier priced in 2002.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Medicine Neurology and Neuromuscular Procedures Sleep Testing				
<u>(Do not report codes 95860-95875 in addition to 9600X1-9600X5)</u>				
95860		<i>Needle electromyography, one extremity with or without related paraspinal areas</i>		
95861		<i>Needle electromyography, two extremities with or without related paraspinal areas</i>		
<u>(For dynamic electromyography performed during motion analysis studies, see 9600X3-9600X4)</u>				
Medicine Neurology and Neuromuscular Procedures <u>Motion Analysis</u>				
<u>Codes 9600X1-9600X4 describe services performed as part of a major therapeutic or diagnostic decision making process. Motion analysis is performed in a dedicated motion analysis laboratory (ie, a facility capable of performing videotaping from the front, back and both sides, computerized 3-D kinematics, 3-D kinetics, and dynamic electromyography). Code 9600X1 may include 3-D kinetics and stride characteristics. Codes 9600X3-9600X4 describe dynamic electromyography. Do not report codes 95860-95875 in addition to the motion analysis codes.</u>				
<u>Code 9600X5 should only be reported once regardless of the number of study(ies) reviewed/interpreted.</u>				
<u>(For performance of needle electromyography procedures, see 96860-95875)</u>				
<u>(For gait training, use 97116)</u>				
●96000	XX1	Comprehensive computer-based motion analysis by video-taping and 3-D kinematics;	XXX	Carrier Price
●96001	XX2	with dynamic plantar pressure measurements during walking	XXX	Carrier Price
●96002	XX3	Dynamic surface electromyography, during walking or other functional activities, 1-12 muscles	XXX	Carrier Price

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

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●96003	XX4	Dynamic fine wire electromyography, during walking or other functional activities, 1 muscle <u>(Do not report codes 95860-95875 in addition to 96002, 96003)</u>	XXX	Carrier Price
●96004	XX5	Physician review and interpretation of comprehensive computer based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report	XXX	Carrier Price
<p>Medicine Physical Medicine and Rehabilitation Therapeutic Procedures</p> <p><i>97110 Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility</i></p> <p><i>97116 gait training (include stair climbing)</i></p> <p><u>(Use 96000-96003 to report comprehensive gait and motion analysis procedures)</u></p>				

RUC HEALTH CARE PROFESSIONALS ADVISORY COMMITTEE
SUMMARY OF RECOMMENDATIONS
February 2001 and April 2001

HEALTH BEHAVIOR ASSESSMENT & INTERVENTION

The RUC HCPAC Review Board reviewed the work relative values for the health behavior assessment and intervention new CPT codes at their February 2001 Review Board Meeting. These services are all reported in increments of 15 minutes. The typical number of units reported will be 4 (one hour). The Review Board agreed that the work RVUs for the assessment codes (96150 and 96151) are appropriate relative to the psychiatric interview codes 90801 (2.80) and 90802 (3.01) which are typically one hour in length of service. **The Review Board recommends 0.50 for 96150 and 0.48 for 96152.**

The Review Board also agreed that the intervention codes (96152, 96154, and 96155) are valued appropriately in relation to the psychotherapy codes. The recommended values also compare to the work relative values assigned to the physical medicine codes, which are also based on 15 minutes increments and are primarily valued at 0.45 per 15 minutes. **The Review Board recommends 0.48 for 96152, 0.46 for 96154, and 0.45 for 96155.**

The specialty society recommendation for the group intervention code (96153) was not accepted. The Review Board reviewed the typical number of patients per session (6-8 patients), and agreed that this service should be valued between 99141 *Preventive medicine group counseling, 30 minutes* (work rvu = 0.15; 0.08 per 15 minutes) and 90853 *Group psychotherapy* (work rvu = 0.59, 0.15 per 15 minutes). **The Review Board recommends 0.10 for code 96153.**

The Review Board agreed that these services do not require any clinical staff or medical equipment. The Review Board agreed to a medical supply package (when performed in-office), totaling \$0.37 was accepted. This cost estimate included such supplies as therapeutic toys and games, interactive materials, and assessment and monitoring instruments.

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
• 96150	G1	Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment	XXX	0.50

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

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
• 96151	G2	re-assessment	XXX	0.48
• 96152	G3	Health and behavior intervention, each 15 minutes, face-to-face; individual	XXX	0.46
• 96153	G4	group (2 or more patients)	XXX	0.10
• 96154	G5	family (with the patient present)	XXX	0.45
• 96155	G6	family (without the patient present) <u>(For health and behavior assessment and/or intervention performed by a physician, see Evaluation and Management or Preventive Medicine service codes)</u>	XXX	0.44

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: 909X1 Tracking Number: Global Period: XXX Recommended RVW: .50

CPT Descriptor: Health and behavior assessment (eg, health focused clinical interview, behavioral observations, psychophysiological monitoring, health –oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 5 –year –old boy undergoing treatment for acute lymphoblastic leukemia is referred for assessment of pain, severe behavioral distress and combativeness associated with repeated lumbar punctures and intrathecal chemotherapy administration. Previously unsuccessful approaches had included pharmacologic treatment of anxiety (Ativan), conscious sedation using Versid and finally, chlorohydrate, which only exacerbated the child’s distress as a result of partial sedation. General anesthesia was ruled out because the child’s asthma increased anesthesia respiratory risk to unacceptable levels.

The patient was assessed using standardized questionnaires (e.g., the Information – Seeking scale, Pediatric Pain Questionnaire, Coping Strategies Inventory) which, in view of the child’s age, were administered in a structured format. The medical staff and child’s parents were also interviewed. On the day of a scheduled medical procedure, the child completed a self-report distress questionnaire. Behavioral observations were also made during the procedure using the CAMPIS-R, a structured observation scale that quantifies child, parent, and medical staff behavior.

Description of Pre-Service Work: Review of records, review results of health and assessment instruments, selection and preparation of behavioral health instruments and selection and preparation of equipment.

Description of Intra-Service Work: Assessment of patient’s condition. Administration of health and behavior assessment instruments.

Description of Post-Service Work: Narrative of patient’s condition, description of services provided, results and interpretation of health and behavior assessment instruments and tests.

SURVEY DATA:

Presenter(s) APA James M. Georgoulakis, Ph.D., MBA, / NASW Mirean Coleman , MSW, Nelda Spyres , MSW

Specialty(s): American Psychological Association (APA) and the National Association of Social Workers (NASW).

Sample Size: 119 Response Rate: (%): 21 Median RVW: 1.05 (weighted median)

Type of Sample (Circle One): **random**, panel, convenience. The American Psychological Association utilized a random stratified sample. Sample stratified by surveying psychologists that predominately provide the service. Explanation of sample size: 500 surveys were provided via e-mail (250) and mail (250) to clinical psychologists who listed their speciality as Behavioral Health. A total of 83 surveys were returned. However, errors were noted (incomplete responses) in six surveys resulting in 77 usable surveys. The National Association of Social Workers utilized a panel consisting of interested NASW Private Practice Members and Clinical Social Work Federation Members. The providers who were unable to attend the panel meeting were mailed the surveys. The

members participating in the survey consisted primary of practitioners residing in the Eastern and Midwestern States.

25th Percentile RVW: .63 75th Percentile RVW: 1.08 Low: .35 High: 4.00

Median Pre-Service Time: 3 minutes Median Intra-Service Time: 15 minutes

25th Percentile Intra-Svc Time: 45 minutes 75th Percentile Intra-Svc Time: 60 minutes Low: 15 minutes High: 210 minutes

Median Post-Service Time: 5 minutes

Total Time Level of Service by CPT Code
(List CPT Code & # of Visits)

Critical Care: NA _____

Other Hospital Visits: NA _____

Discharge Day Mgmt.: NA _____

Office Visits: NA _____



KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
90801	Diagnostic Interview	2.80 (.70 per 15 minutes)
90802	Interactive medical psychiatric diagnostic interview examination	3.01 (.75 per 15 minutes)

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.**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u>	<u>Reference Service 1 CPT</u>
Median Pre-Time	18 minutes	18 minutes
Median Intra-Time	72 minutes	78 minutes
Median Immediate Post-service Time	35 minutes	43 minutes
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	5	5
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	5	4
Urgency of medical decision making	5	5

Technical Skill/Physical Effort (Mean)

Technical skill required	5	5
Physical effort required	4.3	4.3

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	5	5
Outcome depends on the skill and judgement of physician	5	5
Estimated risk of malpractice suit with poor outcome	3.4	3.8

INTENSITY/COMPLEXITY MEASURES

CPT Code

Reference

909X1

Service 1

90801

Time Segments (Mean)

Pre-Service intensity/complexity	5	5
Intra-Service intensity/complexity	5	4.4
Post-Service intensity/complexity	5	5

ADDITIONAL RATIONALE

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

1. Graphs (plots) of surveys indicated that the 25th Percentile contained the largest clustering of individual scores (mode) and the individuals comprising this cluster were the most experienced in terms of providing both the service and the reference service.
2. Regression analysis clearly indicated a strong correlation between the amount of clinical experience and length of time required to complete the service. The more clinical experience of the individual the less time required to complete the service.
3. Survey results were reviewed by an expert panel of providers who had extensive experience, (more than 10 years) in providing both the service and the reference service. Based on their review and clinical expertise they believe a work value of .50 which is more consistent with the 25th percentile represents the most appropriate work value for the service.
4. The expert panels of both the American Psychological Association (APA) and the National Association of Social Workers (NASW) independently arrived at the same .50 work value for the service.
5. The work value of .50 is a consensus recommendation, is appropriate to the work value of the reference service and is consistent with the work values for the services within this family of services.
6. This work value also maintains the relationship between the reference service which senior clinicians believe is more intense and complex.

FREQUENCY INFORMATION

How was this service previously reported? New Code - Utilized the reference service

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

Specialty American Psychological Association Commonly X Sometimes _____ Rarely

Specialty National Association of Social Workers 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 American Psychological Association

Frequency Unknown - No Data Available

Specialty National Association of Social Workers

Frequency Three Million

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 American Psychological Association Frequency Unknown - No Data Available

Specialty National Association of Social Workers Frequency 803,000

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

**AMA/Specialty Society Update Process
RUC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

Sample Size: 119 Response Rate: (%): 21 Global Period: XXX

Tracking Number: 909X1 Reference Code 90801 Reference Code 2 90802

Geographic Practice Setting %: Rural 5 Suburban 15 Urban 80

Type of Practice %: 26 Solo Practice
6 Single Specialty Group
18 Multispecialty Group
50 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:

Both the American Psychological Association (APA) and the National Association of Social Workers (NASW) utilized a combination of surveys and panels to develop the Practice Expense Recommendations. The members of both panels (APA) and (NASW) consisted of providers who had extensive experience in providing both the new service and the reference service.

Please describe the clinical activities of your staff: N/A

Pre-Service Clinical Labor Activities: N/A

Intra-Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

HCFA's Staff Type Code*	Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
	RN	N/A	N/A	N/A	N/A
	LPN	N/A	N/A	N/A	N/A
	MA	N/A	N/A	N/A	N/A

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	Assortment of therapeutic toys and games, e.g., sandboxes, puppets, playhouse, dolls etc.			.20
	Interactive materials, e.g., crayons, chalk, poster paper, clay.			.04
	Assessment and monitoring instruments (children, adolescents and adults).			.13
	Supply costs are based on 50% usage.			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Procedure Specific Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)

CPT Code: 909X1
 Specialty Society('s) APA / NASW

HCFA's Equipment Code*	Overhead Medical Equipment	No. of units in practice	Cost Estimate and Source (if applicable)

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

**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

N/A

Start: When appointment for service is made

Review/read X-ray, lab, and pathology reports

_____ RN, LPN, MA, Other _____

Other Clinical Activity (please specify)

_____ RN, LPN, MA, Other _____

End: Patient arrival at office for service

Service Period

N/A

Start: Patient arrival at office for service

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

_____ RN, LPN, MA, Other _____

Other Clinical Activity (please specify)

_____ RN, LPN, MA, Other _____

End: Patient leaves office

Post-Service Period

N/A

Start: Patient leaves office

Phone calls between visits with patient, family pharmacy

_____ RN, LPN, MA, Other _____

Other Activity (please specify)

_____ RN, LPN, MA, Other _____

End: When appointment for next office visit is made.

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

CPT Code: 909X2 Tracking Number: Global Period: XXX Recommended RVW: .48

CPT Descriptor: Health and behavior reassessment (eg, health focused clinical interview, behavioral observations, psychophysiological monitoring, health –oriented questionnaires), each 15 minutes face-to-face with the patient; reassessment.

CLINICAL DESCRIPTION OF SERVICE:

American Psychological Association Vignette Used In Survey:

A 35 year old female, diagnosed with chronic asthma, hypertension and panic attacks was originally seen ten months ago for assessment and follow-up treatment. Original assessment included extensive interview regarding patient's emotional, social and medical history, including her ability to manage problems related to the chronic asthma, hospitalizations, and treatments. Test results from original assessment provided information for treatment planning which included health and behavior interventions involving a combination of behavioral cognitive therapy, relaxation response training and visualization. After four months of treatment interventions, the patient's hypertension and anxiety were significantly reduced and thus the patient was discharged. Now six months following discharge, the patient has injured her knee and has undergone arthroscopic surgery with follow-up physical therapy.

Patient was seen to reassess and evaluate psychophysiological responses to these new health stressors. A review of the records from the initial assessment, testing and treatment intervention, as well as current medical records was made. Patient's affective and physiological status, compliance disposition, and perceptions of efficacy of relaxation and visualization practices utilized during previous treatment intervention are examined. Administration of anxiety inventory/ questionnaire (e.g., Burns Anxiety Inventory) is used to quantify patient's current level of response to present health stressors and compared to original assessment levels. Need for further treatment is evaluated.

Description of Pre-Service Work: Review of records, review results of health and assessment instruments, selection and preparation of behavioral health instruments and selection of equipment.

Description of Intra-Service Work: Reassessment of patient's condition via interview and behavioral health instruments. Administration of behavior health instruments.

Description of Post-Service Work: Narrative of patient's condition, description of services provided, results and interpretation of behavioral health instruments.

National Association of Social Workers Vignette Used In Survey:

A five-year old male has returned for treatment of acute lymphoblastic leukemia. He is being referred for a reassessment of behavioral distress and combativeness associated with repeated lumbar punctures and intrathecal chemotherapy administration. He was initially seen for several sessions and improved with effective management strategies used by his parents and medical staff. His distress and combativeness have suddenly deteriorated to the extent that treatment is difficult.

Description of Pre-Service Work: Preparation for interview. Review of medical records. Consultation with staff.

Description of Intra-Service Work: Play interview and reassessment of patient. Observation of staff working with patient. Family reassessment. Counseling and exploration of behavior modification options.

Description of Post-Service Work: Written report, collaboration with medical staff, family, community, resources, etc.

SURVEY DATA:

Presenter(s) APA James M. Georgoulakis, Ph.D., MBA, NASW Mirean Coleman, MSW, Nelda Spryes, MSW

Specialty(s): American Psychological Association, National Association of Social Workers

Sample Size: 120 Response Rate: (%): 21 Median RVW: .81

Type of Sample (Circle One): **random**, panel, convenience. Random stratified sample. Sample stratified by surveying psychologists that predominately provide the service. Explanation of sample size: 500 surveys were provided via e-mail (250) and mail (250) to clinical psychologists who listed their speciality as Behavioral Health. A total of 83 surveys were returned. However, errors were noted (incomplete responses) in 5 resulting in 78 usable surveys. The National Association of Social Workers utilized a panel consisting of interested NASW Private Practice Members and Clinical Social Work Federation Members. The clinicians who were unable to attend the panel meeting were mailed the surveys. The members participating in the survey consisted primarily of practitioners residing in the Eastern and Midwestern States.

25th Percentile RVW: .61 75th Percentile RVW: .74 Low: .30 High: 5.60

Median Pre-Service Time 4 minutes Median Intra-Service Time: 15 minutes

25th Percentile Intra-Svc Time: 47 minutes 75th Percentile Intra-Svc Time: 81minutes Low: 45 High: 150

Median Post-Service Time: 5 minutes

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

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
90801	Diagnostic Interview	2.80 (.70 per 15 minutes)
90802	Interactive medical psychiatric diagnostic interview examination	3.01 (.60 per 15 minutes)

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)

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u>	<u>Reference Service 1 CPT</u>
Median Pre-Time	17 minutes	17 minutes
Median Intra-Time	70 minutes	81 minutes
Median Immediate Post-service Time	30 minutes	55 minutes
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	4.6	5
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.8	3.7
Urgency of medical decision making	5	4.8

Technical Skill/Physical Effort (Mean)

Technical skill required	4.6	4.4
Physical effort required	4.3	4.3

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	5	4.3
Outcome depends on the skill and judgement of physician	5	4.3

Estimated risk of malpractice suit with poor outcome

3.3

3.7

INTENSITY/COMPLEXITY MEASURES

CPT Code

Reference

Service 1

909X2

90801

Time Segments (Mean)

Pre-Service intensity/complexity

4.6

4.6

Intra-Service intensity/complexity

5

4.3

Post-Service intensity/complexity

4.6

5

ADDITIONAL RATIONALE

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

1. Graphs (plots) of surveys indicated that the 25th Percentile contained the largest clustering of individual scores (mode) and individuals in this cluster were the most experienced in terms of providing the service and the reference service.
2. Regression analysis clearly indicated a strong correlation between the amount of clinical experience and length of time required to complete the service. The more clinical experience possessed by the individual the less time required to complete the service.
3. Survey results were reviewed by an expert panel of providers who had extensive experience, (more than 10 years) in providing both the service and the reference service. Based on their review and their clinical expertise they believe a work value of .48 which is more consistent with the 25th percentile represents the most appropriate work value for this service.
4. The expert panels of both the American Psychological Association (APA) and the National Association of Social Workers (NASW) independently arrived at the same recommended work value .48 for the service.
5. The work value of .48 is a consensus recommendation, is appropriate to the work value of the reference service and is consistent with the work values for the services within this family of codes.
6. This work value also maintains the relationship between the reference service which senior clinicians is more intense and complex.

FREQUENCY INFORMATION

How was this service previously reported? New Code - Utilized the reference service

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

Specialty American Psychological Association Commonly X Sometimes _____ Rarely

Specialty National Association of Social Workers 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 American Psychological Association Frequency Unknown - No data available

Specialty National Association of Social Workers Frequency 300,000

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 American Psychological Association Frequency Unknown - No data available

Specialty National Association of Social Workers Frequency 80,000

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

**AMA/Specialty Society Update Process
RUC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

Sample Size: 120 Response Rate: (%): 21 Global Period: XXX

Tracking Number: 909X2 Reference Code 1 90801 Reference Code 2 90802

Geographic Practice Setting %: Rural 4 Suburban 15 Urban 81

Type of Practice %: 25 Solo Practice
 6 Single Specialty Group
 17 Multispecialty Group
 52 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:

Both the American Psychological Association (APA) and the National Association of Social Workers (NASW) utilized a combination of panels and surveys to develop the Practice Expense Recommendation. The members of both panels (APA) and (NASW) consisted of providers who had extensive experience in providing both the new service and the reference service.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Intra-Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

HCFA's Staff Type Code*	Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
	RN	N/A	N/A	N/A	N/A
	LPN	N/A	N/A	N/A	N/A
	MA	N/A	N/A	N/A	N/A

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	Assortment of therapeutic toys and games, e.g. sandboxes, puppets, playhouse, dolls.			.20
	Interactive materials, e.g. crayons, chalk, poster paper, clay			.04
	Assessment and monitoring instruments (children, adolescents and adults)			.13
	Note: All supply costs are based on 50% usage rates.			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Procedure Specific Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)

CPT Code: 909X2

Specialty Society('s) APA, NASW

HCFA's Equipment Code*	Overhead Medical Equipment	No. of units in practice	Cost Estimate and Source (if applicable)

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

**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

_____ 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

_____ 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

_____ RN, LPN, MA, Other _____

Other Clinical Activity (please specify)

_____ RN, LPN, MA, Other _____

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)

_____ RN, LPN, MA, Other _____

End: When appointment for next office visit is made.

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

CPT Code: 909X3 Tracking Number: Global Period: XXX Recommended RVW: .46

CPT Descriptor: Health and behavior intervention, each 15 minutes, face-to-face; individual

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year-old executive has a history of cardiac arrest, high blood pressure and cholesterol, and a family history of cardiac problems. He is 30 lbs. Overweight, travels extensively for work, and reports to be a moderate social drinker. He currently smokes approximately one-half pack of cigarettes a day, although he has periodically attempted to quit smoking for up to 5 weeks at a time. The patient is considered by his physician to be a "Type A" personality and at high risk for cardiac complications. He experiences angina pains one or two times per month.

Results from the health and behavior assessment are used to develop a treatment plan, taking into account the patient's coping skills and lifestyle. Subsequently, weekly intervention sessions focus on psychoeducational factors impacting his awareness and knowledge about his disease process, and the use of relaxation and guided imagery techniques that directly impact his blood pressure and heart rate. Cognitive and behavioral approaches for cessation of smoking and initiation of an appropriate physician-prescribed diet and exercise regimen are also employed.

Description of Pre-Service Work: Review of records, review results of health and assessment instruments, preparation and selection of health and behavior assessment instruments and equipment.

Description of Intra-Service Work: Cognitive and behavioral intervention treatment approaches for the health risk factors of the patient. Administration of health and behavior instruments.

Description of Post-Service Work: Narrative description of the patient's condition, progress notes, description of services provided and results and interpretation of health and behavior assessment instruments.

SURVEY DATA:

Presenter(s) APA James M. Georgoulakis, Ph.D., MBA / NASW Mirean Coleman, MSW, Nelda Spyres, MSW

Specialty(s): American Psychological Association (APA) and the National Association of Social Workers (NASW)

Sample Size: 115 Response Rate: (%) 20 Median RVW: .56

Type of Sample (Circle One): **random**, panel, convenience. Random stratified sample. Sample stratified by surveying psychologists that predominately provide the service. Explanation of sample size: 500 surveys were provided via mail (250) and e-mail (250) to clinical psychologists who listed their speciality as Behavioral Health. A total of 83 surveys were returned. However, errors were noted (incomplete response) in 10 surveys resulting in 73 usable surveys. The National Association of Social Workers utilized a panel consisting of interested NASW Private Practice Members and Clinical Social Work Federation Members. Those individuals who were unable to attend the panel meeting were mailed the surveys. The members participating in the survey consisted primarily of practitioners residing in the Eastern and Midwestern States.

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
90806	Individual psychotherapy, insight-oriented, behavior modifying and /or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient.	.62 per 15 minutes (1.86)

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.**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u>	<u>Reference Service 1 CPT</u>
Median Pre-Time	17 minutes	13 minutes
Median Intra-Time	54 minutes	49 minutes
Median Immediate Post-service Time	17 minutes	15 minutes
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	50 minutes	50 minutes

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	3.4
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4	3.4
Urgency of medical decision making	3.4	3.4

Technical Skill/Physical Effort (Mean)

Technical skill required	4.6	4
Physical effort required	3.6	3.4

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.4	3.5
Outcome depends on the skill and judgement of physician	4.6	4.4

Estimated risk of malpractice suit with poor outcome	3.4	3.5
------------------------------------------------------	-----	-----

<u>INTENSITY/COMPLEXITY MEASURES</u>	<u>CPT Code</u>	<u>Reference Service 1</u>
	909X3	90806

Time Segments (Mean)

Pre-Service intensity/complexity	3.6	3
Intra-Service intensity/complexity	4.6	3.7
Post-Service intensity/complexity	4	3.8

ADDITIONAL RATIONALE

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

1. Graphs (plots) of surveys indicated that the 25th Percentile contained the largest clustering of individual scores (mode) and individuals in this cluster were the most experienced in terms of providing both the service and the reference service.
2. Regression analysis clearly indicated a strong correlation between the amount of clinical experience and the length of time required to complete the service. The more clinical experience of the provider the less time required to complete the service.
3. Survey results were reviewed with an expert panel of providers who had extensive experience, (more than 10 years) in providing both the service and the reference service. Based on their review and the clinical expertise, they believe a work value of .46 which is more consistent with the 25th percentile, represents the most appropriate work value for the service.
4. The expert panels of both the American Psychological Association (APA) and the National Association of Social Workers (NASW) independently arrived at the same work value of .46 for the service.
5. A work value of .46 is a consensus recommendation, is appropriate to the work value of the reference service and is consistent with the work values for the services within this family of services.
6. This work value also maintains the relationship between the reference service which senior clinicians believe is more intense and complex.

FREQUENCY INFORMATION

How was this service previously reported? New Code / Reference 90806

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

Specialty American Psychological Association Commonly Sometimes Rarely

Specialty National Association of Social Workers 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 American Psychological Association Frequency Unknown - No Data Available

Specialty National Association of Social Workers Frequency 3 million

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 American Psychological Association Frequency Unknown - No Data Available

Specialty National Association of Social Workers Frequency 803,000

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

**AMA/Specialty Society Update Process
RUC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

Sample Size: 115 Response Rate: (%): 20 Global Period: XXX

Tracking Number: 909X3 Reference Code 1 90806 Reference Code 2 _____

Geographic Practice Setting %: Rural 4 Suburban 15 Urban 81

Type of Practice %: 25 Solo Practice
6 Single Specialty Group
17 Multispecialty Group
52 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:

Both the American Psychological Association (APA) and the National Association of Social Workers (NASW) utilized a combination of panels and surveys to develop the Practice Expense Recommendation. The members of both panels (APA) and (NASW) consisted of providers who had extensive experience in providing both the new service and the reference service.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Intra-Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

HCFA's Staff Type Code*	Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
	RN	N/A	N/A	N/A	N/A
	LPN	N/A	N/A	N/A	N/A
	MA	N/A	N/A	N/A	N/A

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	Assortment of therapeutic toys and games, e.g., sandboxes, puppets, playhouse, dolls etc.			.20
	Interactive materials, e.g., crayons, chalk, poster paper, clay.			.04
	Assessment and monitoring instruments (children, adolescents, and adults)			.13
	All supply costs are based on 50% usage.			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Procedure Specific Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)

HCFA's Equipment Code*	Overhead Medical Equipment	No. of units in practice	Cost Estimate and Source (if applicable)

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

**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

Other Clinical Activity (please specify)

_____ RN, LPN, MA, Other _____

_____ RN, LPN, MA, Other _____

End: Patient arrival at office for service

Service Period

Start: Patient arrival at office for service

Greet patient/provide gowning

Obtain vital signs

Prep and position patient

Prepare room, equipment, supplies

Assist physician during exam

Education/instruction/ counseling

Coordinate home or outpatient care

Clean room/equipment

Other Clinical Activity (please specify)

_____ RN, LPN, MA, Other _____

End: Patient leaves office

Post-Service Period

Start: Patient leaves office

Phone calls between visits with patient, family pharmacy

Other Activity (please specify)

_____ RN, LPN, MA, Other _____

_____ RN, LPN, MA, Other _____

End: When appointment for next office visit is made.

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

CPT Code: 909X4 Tracking Number: Global Period: XXX Recommended RVW: ~~.14~~
HCPAC Rec: **0.10**

CPT Descriptor: Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45 year -old female is referred for smoking cessation secondary to chronic bronchitis, with a strong family history of emphysema. She smokes two packs per day. The health and behavior assessment reveals that the patient uses smoking as a primary way of coping with stress. Social influences contributing to her continued smoking include several friends and family members who also smoke. The patient has made multiple previous attempts to quit "on her own." When treatment options are reviewed, she is receptive to the recommendation of an eight-session group cessation program. The program components include educational information (e.g., health risks, nicotine addiction), cognitive-behavioral treatment (e.g., self-monitoring, relaxation training, and behavioral substitution), and social support (e.g., group discussion, social skills training).

Description of Pre-Service Work: Review of records, review results of health and assessment instruments, preparation and selection of health and assessment instruments and equipment.

Description of Intra-Service Work: Cognitive and behavioral intervention treatment approaches for the health risk factors of the patient. Administration of health and behavior assessment instruments.

Description of Post-Service Work: Narrative description of the patient's condition, progress notes, description of services provided and results and interpretation of health and behavior assessment instruments.

SURVEY DATA:

Presenter(s) APA James M. Georgoulakis, Ph.D., MBA / NASW Mirean Coleman, MSW, Nelda Spryes,
MSW

Speciality (s) American Psychological Association (APA) and the National Association of Social Workers
NASW

Sample Size: 118 Response Rate: (%): 20 Median RVW: .48

Type of Sample (Circle One): **random**, panel, convenience. Random stratified sample. Sample stratified by surveying psychologists that predominately provide the service. Explanation of sample size: 500 surveys were provided via mail (250) and e-mail (250) to clinical psychologists who identified their speciality as Behavioral Health. A total of 83 surveys were returned. However, errors were noted (incomplete response) in 7 surveys resulting in 76 usable surveys. The National Association of Social Workers utilized a panel consisting of interested NASW Private Practice Members and Clinical Social Work Federation Members. Those individuals who were unable to attend the panel meeting were mailed the surveys. The members participating in the survey consisted primarily of practitioners residing in the Eastern and Midwestern States.

25th Percentile RVW: .21 75th Percentile RVW: .70 Low: .10 High: 4.50

Median Pre-Service Time: 4 minutes Median Intra-Service Time: 15 minutes

25th Percentile Intra-Svc Time: 50 minutes 75th Percentile Intra-Svc Time: 80 minutes Low: 15 minutes High: 450 minutes

Median Post-Service Time: 5 minutes

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

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
90853	Group Psychotherapy	.59

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.**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u>	<u>Reference Service 1 CPT</u>
Median Pre-Time	14 minutes	17 minutes
Median Intra-Time	65 minutes	65 minutes
Median Immediate Post-service Time	20 minutes	20 minutes
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	60 minutes	60 minutes

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	3.4
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3	3.4
Urgency of medical decision making	2.5	3.4

Technical Skill/Physical Effort (Mean)

Technical skill required	4	4
Physical effort required	3	3

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4	3.4
Outcome depends on the skill and judgement of physician	4.6	4
Estimated risk of malpractice suit with poor outcome	3	3

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference**
Service 1
909X4 90853

Time Segments (Mean)

Pre-Service intensity/complexity	3	3
Intra-Service intensity/complexity	3.4	3.4
Post-Service intensity/complexity	3	3

ADDITIONAL RATIONALE

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

1. Initial recommendation to the RUC did not take into account that the individuals completing the survey did not adjust the work values for the 15 minute increment. When the data is adjusted for a 15 minute increment the work value of .14 is in line with the work value of .59 for Group Psychotherapy for Psychiatric patients. Additionally this value maintains the relationship between the other codes in the family of codes as well as maintaining the relationship between the psychiatric codes.
2. Graphs (plots) of surveys indicated that the 25th percentile contained the largest clustering of individual scores (mode) and the individuals comprising this cluster were the most experienced in terms of providing both the service and the reference service.
3. Regression analysis clearly indicated a strong correlation between the amount of clinical experience and length of time required to complete the service. The more clinical experience possessed by the provider the less time required to complete the service.
4. Survey results were reviewed by an expert expert panel of providers who had extensive experience (more than 10 years) in providing both the service and the reference service. Based on their review and clinical expertise they believe the work value of .14 which is more consistent with the 25th percentile represents the most appropriate work value for the service.
5. The expert panels of both the American Psychological Association (APA) and the National Association of Social Workers (NASW) independently arrived at the same .14 work value for the service.
6. The work value of .14 is a consensus recommendation, is appropriate to the work value of the reference service and is consistent with the work values for the services within this family of services.
7. This work value also maintains the relationship between the reference service which senior clinicians believe is more complex.

FREQUENCY INFORMATION

How was this service previously reported? New Code – Reference Service 90853

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

Specialty American Psychological Association Commonly Sometimes Rarely

Specialty National Association of Social Workers 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 American Psychological Association Frequency Unknown - No Data Available

Specialty National Association of Social Workers Frequency 1.5 million

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: American Psychological Association Frequency: Unknown - No Data Available

Specialty : National Association of Social Workers Frequency: 200,000

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

**AMA/Specialty Society Update Process
RUC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

Sample Size: 118 Response Rate: (%): 20 Global Period: XXX

Tracking Number: 909X4 Reference Code 1 90853 Reference Code 2

Geographic Practice Setting %: Rural 4 Suburban 15 Urban 81

Type of Practice %: 25 Solo Practice
 6 Single Specialty Group
 17 Multispecialty Group
 52 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:

Both the American Psychological Association (APA) and the National Association of Social Workers (NASW) utilized a combination of panels and surveys to develop the Practice Expense Recommendation. The members of both panels (APA) and (NASW) consisted of providers who had extensive experience in providing both the new service and the reference service.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Intra-Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

HCFA's Staff Type Code*	Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
	RN	N/A	N/A	N/A	N/A
	LPN	N/A	N/A	N/A	N/A
	MA	N/A	N/A	N/A	N/A

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	Assessment and monitoring instruments (children, adolescents and adults)			.13

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Procedure Specific Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)

HCFA's Equipment Code*	Overhead Medical Equipment	No. of units in practice	Cost Estimate and Source (if applicable)

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

**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

_____ 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

_____ 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

_____ RN, LPN, MA, Other _____

Other Clinical Activity (please specify)

_____ RN, LPN, MA, Other _____

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)

_____ RN, LPN, MA, Other _____

End: When appointment for next office visit is made.

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

CPT Code: 909X5 Tracking Number: Global Period: XXX Recommended RVW: .45

CPT Descriptor: Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Tara is a 9 year old girl, diagnosed with insulin dependent diabetes two years ago. Her mother reports great difficulty with morning and evening insulin injections and blood glucose testing. Tara whines and cries, delaying the procedures for 30 minutes or more. She refuses to give her own injections or conduct her own blood glucose tests, claiming the "hurt." Her mother spends many minutes pleading for her cooperation. Tara's father refuses to participate, saying he is "afraid" of needles. Both parents have not been able to go to a movie alone, because they know of no one who can care for Tara. Tara's 10 year old-sister claims she never has any time with her mother, since her mother is always occupied with Tara's illness. Tara and her sister have a very poor relationship and are always quarreling. Tara's parents frequently argue; her mother complains that she gets no help from her husband. Tara's father complains that his wife has no time for anyone except Tara.

A family based approach is used to address the multiple components of Tara's problem behaviors. Relaxation and exposure techniques are used to address Tara's father's fear of injections, which he has inadvertently modeling for his daughter. Tara is taught relaxation and distraction techniques to reduce the tension she experiences with finger sticks and injections. Both parents are taught to shape Tara's behavior, praising and rewarding successful diabetes management behaviors, and ignoring delay tactics. Her parents are also taught judicious use of time-out and response cost procedures. Family roles and responsibilities are clarified. Clear communication, conflict resolution, and problem -solving skills are taught. Family members practice applying these skills to a variety of problems so they will know how to successfully address new problems that may arise in the future.

Description of Pre-Service Work: Review of records, review results of health and assessment instruments, preparation and selection of health and behavior assessment instruments and equipment.

Description of Intra-Service Work: Cognitive and behavioral intervention treatment approaches for the health risk factors of the patient. Administration of health and behavior assessment instruments. Use of health and behavior equipment.

Description of Post-Service Work: Narrative description of the patient's condition, progress notes, description of services provided and results and interpretation of health and behavior assessment instruments.

SURVEY DATA:

Presenter(s) APA James M. Georgoulakis, Ph.D., MBA / NASW Mirean Coleman, MSW, Nelda Spryes, MSW

Specialty(s): American Psychological Association (APA) and the National Association of Social Workers (NASW)

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
90847	Family psychotherapy (conjoint psychotherapy) with patient present.	2.21 (.55 per 15 minutes)

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.**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u>	<u>Reference Service 1 CPT</u>
Median Pre-Time	17 minutes	15 minutes
Median Intra-Time	65 minutes	65 minutes
Median Immediate Post-service Time	23 minutes	23 minutes
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	60 minutes	60 minutes

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
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4	3.3
Urgency of medical decision making	4	3.3

Technical Skill/Physical Effort (Mean)

Technical skill required	4	4
Physical effort required	3	3

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.7	3.5
Outcome depends on the skill and judgement of physician	4	4
Estimated risk of malpractice suit with poor outcome	3.3	3.3

INTENSITY/COMPLEXITY MEASURES

CPT Code

Reference

909X5

Service 1

90847

Time Segments (Mean)

Pre-Service intensity/complexity	3.3	3.3
Intra-Service intensity/complexity	3.7	3.3
Post-Service intensity/complexity	3.3	3

ADDITIONAL RATIONALE

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

1. Graph (plots) of surveys indicated that the 25th percentile contained the largest clustering of clustering of individual scores (mode) and the individuals in this cluster were the most experienced in terms of providing both the service and the reference service.
2. Regression analysis clearly indicated a strong correlation between the amount of clinical experience and length of time required to complete the service. The more clinical experience of the provider the less time required to complete the service.
3. Survey results were reviewed by an expert panel of providers, who had extensive experience (more than 10 years) in providing both the service and the reference service. Based on their review and clinical expertise they believe a work value of .45 which is more consistent with the 25th percentile represents the most appropriate work value for the service.
4. The expert panels of both the American Psychological Association (APA) and the National Association of Social Workers (NASW) independently arrived at the same .45 work value for the service.
5. The work value of .45 is a consensus recommendation, is appropriate to the work value of the reference code and is consistent with the work values for the services within this family of services.
6. This work value also maintains the relationship between the reference service which senior clinicians believe is more intense and complex.

FREQUENCY INFORMATION

How was this service previously reported? New Code - Reference Service 90847

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

Specialty American Psychological Association X Commonly ___ Sometimes ___ Rarely

Specialty National Association of Social Workers 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 American Psychological Association Frequency Unknown - No Data Available

Specialty National Association of Social Workers Frequency 2 million

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 American Psychological Association Frequency Unknown - No Data Available

Specialty National Association of Social Workers Frequency 200,000

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

**AMA/Specialty Society Update Process
RUC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

Sample Size: 117 Response Rate: (%): 20 Global Period: XXX

Tracking Number: 909X5 Reference Code 1 90853 Reference Code 2

Geographic Practice Setting %: Rural 4 Suburban 15 Urban 81

Type of Practice %: 25 Solo Practice
6 Single Specialty Group
17 Multispecialty Group
52 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:

Both the American Psychological Association (APA) and the National Association of Social Workers (NASW) utilized a combination of panels and surveys to develop the Practice Expense Recommendation. The members of both panels (APA) and (NASW) consisted of providers who had extensive experience in providing both the new service and the reference service.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Intra-Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

HCFA's Staff Type Code*	Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
	RN	N/A	N/A	N/A	N/A
	LPN	N/A	N/A	N/A	N/A
	MA	N/A	N/A	N/A	N/A

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	Assortment of therapeutic toys and games, e.g., sandboxes, puppets, playhouse, dolls, etc.			.20
	Interactive materials, e.g., crayons, chalk, poster paper, Clay.			.04
	Assessment and monitoring instruments (children, adolescents and adults)			.13
	Supply costs are based on 50% usage.			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Procedure Specific Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)

CPT Code: 909X5

Specialty Society('s) APA, NASW

HCFA's Equipment Code*	Overhead Medical Equipment	No. of units in practice	Cost Estimate and Source (if applicable)

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

**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

_____ 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

_____ 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

_____ RN, LPN, MA, Other _____

Other Clinical Activity (please specify)

_____ RN, LPN, MA, Other _____

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)

_____ RN, LPN, MA, Other _____

End: When appointment for next office visit is made.

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

CPT Code: 909X6 Tracking Number: Global Period: XXX Recommended RVW: .44

CPT Descriptor: Health and behavior intervention, each 15 minutes, face-to-face; family (without the patient present)

CLINICAL DESCRIPTION OF SERVICE:

American Psychological Association Vignette Used in Survey:

Greg is a 42 year -old male diagnosed with cancer of the pancreas. He is currently undergoing both aggressive chemotherapy and radiation treatment. However, his prognosis is guarded. At present, he is not in the endstage disease process and therefore does not qualify for Hospice care. The patient is seen initially to address issues of pain management via imagery, breathing exercises, and other therapeutic interventions to address quality of life issues, treatment options, and death and dying issues.

Due to the medical protocol and the patient's inability to travel to additional sessions between hospitalizations, a plan is developed for extending treatment at home via the patient's wife, who is the primary home caregiver. The patient's wife is seen by the healthcare provider to train the wife in how to assist the patient in objectively monitoring his pain and in applying exercises learned via his treatment sessions to manage pain. Issues of the patient's quality of life, as well as death and dying concerns, are also addressed with assistance given to the wife as to how to make appropriate home interventions between sessions. Effective communication techniques with her husband's physician and other members of his treatment team regarding his treatment protocols are facilitated.

Description of Pre-Service Work: Review of records, review results of health and assessment instruments, preparation and selection of health and behavior assessment instruments and equipment.

Description of Intra-Service Work: Cognitive and behavioral intervention treatment approaches for the health risk factors of the patient. Administration of health and behavior assessment instruments.

Description of Post-Service Work: Narrative description of the patient's condition, progress notes, description of services provided and results and interpretation of health and behavior assessment instruments.

National Association of Social Workers Vignette Used In Survey:

A 16 year-old newly diagnosed asthmatic male has been recently discharged from the hospital to home. Patient is refusing his Albuterol treatment and inhaler. Parents are in disagreement about how the patient should be managed and by whom. Consider family session without the patient to include psychoeducational sessions, conflict resolution, and role clarification. Assess outside resources.

Description of Pre-Service Work: Contact parents for interview. Consult with medical personnel involved. Prepare for interview.

Description of Intra-Service Work: Face-to-face interview with parents without patient. Counseling , conflict resolution, role clarification. Exploration of feelings towards patient and illness. Assessment of resources.

Description of Post-Service Work: Written report. Collaboration with medical personnel involved.

SURVEY DATA:

Presenter(s) APA James M. Georgoulakis, Ph.D., MBA / NASW Mirean Coleman, MSW, Nelda Spryes, MSW

Specialty(s): American Psychological Association (APA) and the National Association of Social Workers (NASW)

Sample Size: 121 Response Rate: (%): 21 Median RVW: .57

Type of Sample (Circle One): **random**, panel, convenience. Random stratified sample. Sample stratified by surveying psychologists that predominately provide the service. Explanation of sample size: 500 surveys were provided via mail (250) and e-mail (250) to clinical psychologists who identified their speciality as Behavioral Health. A total of 83 surveys were returned. However, errors were noted (incomplete response) in 4 surveys resulting in 79 usable surveys. The National Association of Social Workers utilized a panel consisting of interested NASW Private Practice Members and Clinical Social Work Federation Members. Those individuals who were unable to attend the panel meeting were mailed the surveys. The members participating in the survey consisted primarily of practitioners residing in the Eastern and Midwestern States.

25th Percentile RVW: .45 75th Percentile RVW: .72 Low: .10 High: 4.70

Median Pre-Service Time: 4 minutes Median Intra-Service Time: 15 minutes

25th Percentile Intra-Svc Time: 50 minutes 75th Percentile Intra-Svc Time: 80 minutes Low: 10 minutes High: 360 minutes

Median Post-Service Time: 5 minutes

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

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
90847	Family psychotherapy (conjoint Psychotherapy) without patient present	1.83(.46 per 15 minute)

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.**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u>	<u>Reference Service 1 CPT</u>
Median Pre-Time	17 minutes	17 minutes
Median Intra-Time	65 minutes	60 minutes
Median Immediate Post-service Time	23 minutes	23 minutes
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	60 minutes	60 minutes

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	3.6	3
Urgency of medical decision making	4.6	4

Technical Skill/Physical Effort (Mean)

Technical skill required	4.6	4
Physical effort required	3	3

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.6	3.3
Outcome depends on the skill and judgement of physician	4.6	4

Estimated risk of malpractice suit with poor outcome	3.3	3.3
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INTENSITY/COMPLEXITY MEASURES

<u>CPT Code</u>	<u>Reference Service 1</u>
909X6	90847

Time Segments (Mean)

Pre-Service intensity/complexity	3	3
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Intra-Service intensity/complexity	3.3	3.3
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Post-Service intensity/complexity	3	3.3
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ADDITIONAL RATIONALE

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

1. Graph (plots) of surveys indicated that the 25th percentile contained the largest clustering of individual scores (mode) and the individuals comprising this cluster were the most experienced in terms of providing both the service and the reference service.
2. Regression analysis clearly indicated a strong correlation between the amount of clinical experience and length of time required to complete the service. The more clinical experience of the provider the less time required to complete the service.
3. Survey results were reviewed by an expert panel of providers who had extensive experience, (more than 10 years) in providing both the service and the reference service. Based on their review and clinical expertise they believe a work value of .44 which is more consistent with the 25th percentile, represents the most appropriate work value for the service.
4. The expert panels of both the American Psychological Association (APA) and the National Association of Social Workers (NASW) independently arrived at the same .44 work value for the service.
5. The work value of .44 is a consensus recommendation, is appropriate to the work value of the reference service and is consistent with the work values for the services within this family of services.
6. This work value also maintains the relationship between the reference service which senior clinicians believe is more intense and complex.

FREQUENCY INFORMATION

How was this service previously reported? New Code - Reference Service 90846

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

Specialty American Psychological Association Commonly Sometimes Rarely

Specialty National Association of Social Workers 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 American Psychological Association Frequency Unknown - No Data Available

Specialty National Association of Social Workers Frequency 2 Million

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 American Psychological Association Frequency Unknown - No Data Available

Specialty National Association of Social Workers Frequency 200,000

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

**AMA/Specialty Society Update Process
RUC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

Sample Size: 121 Response Rate: (%): 21 Global Period: XXX

Tracking Number: 909X6 Reference Code 1 90853 Reference Code 2 _____

Geographic Practice Setting %: Rural 4 Suburban 15 Urban 81

Type of Practice %: 25 Solo Practice
6 Single Specialty Group
17 Multispecialty Group
52 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:

Both the American Psychological Association (APA) and the National Association of Social Workers (NASW) utilized a combination of panels and surveys to develop the Practice Expense Recommendation. The members of both panels (APA) and (NASW) consisted of providers who had extensive experience in providing both the new service and the reference service.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Intra-Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

HCFA's Staff Type Code*	Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
	RN	N/A	N/A	N/A	N/A
	LPN	N/A	N/A	N/A	N/A
	MA	N/A	N/A	N/A	N/A

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	Assessment and monitoring instruments (children, adolescents and adults)			.13
	Supply costs are based on 50% usage.			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Procedure Specific Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)

CPT Code: 909X6

Specialty Society('s) APA, NASW

HCFA's Equipment Code*	Overhead Medical Equipment	No. of units in practice	Cost Estimate and Source (if applicable)

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

**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

_____ 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

_____ 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

_____ RN, LPN, MA, Other _____

Other Clinical Activity (please specify)

_____ RN, LPN, MA, Other _____

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)

_____ RN, LPN, MA, Other _____

End: When appointment for next office visit is made.

RUC HEALTH CARE PROFESSIONALS ADVISORY COMMITTEE
SUMMARY OF RECOMMENDATIONS
February 2001

ACTIVE WOUND MANAGEMENT

The RUC HCPAC Review Board reviewed the work relative values for codes 97601 *Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg, high pressure interject, sharp debridement with scissors, scalpel and tweezers), including topical application(s), wound assessment, and instructions(s) for ongoing care, per session* and 97602 *Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic abrasion) including topical application(s), wound assessment, and instruction(s) for ongoing care, per session* at their February 2001 meeting. The HCPAC Reviewed Survey data from more than 50 physical and occupational therapists and determined that the survey median work relative values were too high. The committee agreed that 97601 described the same service as CPT code 11040 *Debridement; skin, partial thickness* (work RVU = 0.50) and recommends that it be valued the same. The physical therapists indicated that 20-30% of their cases involve debridement; skin, full thickness. The Review Board suggested that the physical therapists develop a coding proposal to describe this more complex service. **The Review Board recommends 0.50 work relative values for CPT code 97601.**

The survey respondents had indicated that 97602 was approximately 63% of the work of 9701. The Review Board utilized the same relativity of the survey medians for 97601 and 97602 to **recommend a work RVU of 0.32 for 97602.** The survey respondents indicated a median intra-service time of 20 minutes for this service.

Practice Expense:

The Review Board considered revised direct practice expenses submitted by the specialty that were reviewed after the Practice Expense Advisory Committee had considered all of the physical medicine and rehabilitation codes in February and March 2001. The Review Board made additional adjustments to the clinical staff and significant changes to the medical supplies and equipment. The revised direct practice expense inputs are attached to the recommendation.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommen- dation
• 97601	Removal of devitalized tissue from wound(s); selective debridement, without anesthesia (eg. High pressure waterjet, sharp selective debridement with scissors, scalpel and tweezers), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session.	XXX	0.50
• 97602	Removal of devitalized tissue from wound(s); non-selective debridement, without anesthesia (eg., wet-to-moist dressings, enzymatic abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session.	XXX	0.32

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

CPT Code: 97601X Tracking Number: Global Period: XXX Recommended RVW: 0.80

HCPAC Recommendation: 0.50

CPT Descriptor: Removal of devitalized tissue from wound; selective debridement, without anesthesia (eg. High pressure waterjet, sharp selective debridement with scissors, scalpel and tweezers), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is a 68-year old woman, who has developed pressure ulcers on the sacrum and reports pain from the ulcerated area. Examination reveals that the wound is covered with blackeschar and is surrounded by chronic inflammation with dark pigmentation and is tender to palpation. It is determined that the patient is not a candidate for surgery, due to the report of several comorbidities, but would benefit from sharp debridement of the necrotic tissue.

Description of Pre-Service Work: The patient is positioned in a sidelying position with the head of the plinth elevated to 10-20 degrees, both lower extremities are flexed at the hip and knee with a foam positioner between the knees for pressure relief. The dressings on the sacrum are removed.

Description of Intra-Service Work: Wound is lightly cleansed and then measured. The sacrum wound is measured 6.5 cm x 2.0 cm x unknown depth, with 100% black wound bed and no obvious drainage. The surrounding tissue is palpated with the wound margins observed as being inflamed and indurated. A more thorough cleansing is performed utilizing pulsed lavage with suction, in order to facilitate loosening of the tissue. The wound is then wiped with an anti-microbial solution, followed by mechanical debridement in the form of sharp selective debridement using scissors, scalpel and tweezers to remove the devitalized tissue and facilitate subsequent wound healing. The last component related to this intervention and work involves placing an enzyme, a saline gauze and a composite dressing directly on the wound bed.

Description of Post-Service Work: A protective dressing is then applied to the area. The maintenance of proper positions when in bed and in the wheelchair are reviewed with the patient or caregiver. The intervention is documented including the components of the care provided, any changes in the patient's status and future plan of care. Contact is made with physician on patient's progress, as well as with any other health care professionals and /or family. Patient is discharged with instructions to inspect the bandage daily for break through drainage.

SURVEY DATA:

Presenter(s) Sam Brown, PT; Mary Foto, OT

Specialty(s): APTA

Sample Size: 200 Response Rate: (%): 26.5% Median RVW: 0.80

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

25th Percentile RVW: 0.60 75th Percentile RVW: 1.2 Low: 0.44 High: 2.60

Median Pre-Service Time: 10 min Median Intra-Service Time: 35 min

25th Percentile Intra-Svc Time: 30 min 75th Percentile Intra-Svc Time: 45 min Low: 13.5 min High: 92

Median Post-Service Time: 10 min

<u>Total Time</u>	<u>Level of Service by CPT Code</u> <u>(List CPT Code & # of Visits)</u>
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Immediate Post Service Time:

Critical Care:

Other Hospital Visits: _____

Discharge Day Mgmt.: _____

Office Visits: _____

CPT Code: 97601

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
97002	physical therapy re-evaluation	0.60

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)

	<u>CPT Code</u>	<u>Reference Service 1 CPT</u>
Median Pre-Time	10	10
Median Intra-Time	40	22.5
Median Immediate Post-service Time	10	10
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	4.33	3.80
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.33	4.06
Urgency of medical decision making	4.26	3.27

Technical Skill/Physical Effort (Mean)

Technical skill required	4.80	4.27
Physical effort required	3.73	3.53

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality 4.73 3.20

Outcome depends on the skill and judgement of physician 4.60 4.13

Estimated risk of malpractice suit with poor outcome 4.53 3.53

INTENSITY/COMPLEXITY MEASURES

CPT Code

Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity 3.20 3.47

Intra-Service intensity/complexity 4.27 4.13

Post-Service intensity/complexity 4.20 3.27

ADDITIONAL RATIONALE

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

Advisory member consultants accepted survey's median work value.

FREQUENCY INFORMATION

How was this service previously reported? G0169

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

Specialty APTA ___ x ___ Commonly ___ Sometimes ___ Rarely

Specialty APTA ___ 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 APTA Frequency 1000's ___

Specialty APTA Frequency 1000's ___

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 APTA _____ Frequency 1000's _____

Specialty APTA _____ Frequency 1000's _____

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

AMA/Specialty Society Update Process

HCPAC Summary of Recommendation XXX Global Period In Office Direct Inputs

CPT Long Descriptor: Removal of devitalized tissue from wound; selective debridement, without anesthesia (eg, high pressure waterjet, sharp selective debridement with scissors, scalpel and tweezers), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session

Sample Size: N/A Response Rate: (%): Global Period:

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:

An Advisory Panel of physical therapists was convened to review the codes in the 97000 series. The Advisory Panel represented multiple levels of care where CPT coding is used. The Panel was trained in the practice expense process. The results of the Panel's efforts were further reviewed by additional clinical consultants. The data were drafted, routed to the Advisory Panel for additional comments and finalized.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Pre service includes the review of the documentation, plan of care and treatment goals and the effect of previous treatment. An aide will also verify the availability of resources, materials and equipment.

Intra-Service Clinical Labor Activities:

Intra-Service includes greeting and preparing the patient, preparing the room, obtaining relevant measurements and vital signs, assisting the physical therapist during the intervention, demonstration and performance verification, post treatment assistance of the patient and cleaning the room/exercise area.

Post-Service Clinical Labor Activities:

Post-Service includes recording data and results and communication with patient, family and other providers.

Total Staff Time In Office:

Visits in Global Period:

HCFA's Staff Type Code*	Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
	PTA		24-14	4 strike to 0	
	Aide		25-27 24		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
14004	Sterile towel.	1		.31
11107	gown	1		.57
11112	pillowcase	1		.32
11111	Table paper	1		.015
14005	Gloves, sterile	1pr		.89
	Sharp debridement kit	1		11.95(Sammons, 2000,pg 408)
31526	Kling, sterile	1		1.00
31514	tape	1		.015
	Chlorazeen	1		2.50
32014	Ace bandage	1		.45
11306	Face mask	1		.30
52304	Silver nitrate sticks	1		.049
	Hi pressure water jet gun (pulsatile lavage unit disposable jet)	1		41.82 (Davol (800-562-0027)
	disposable water jet tip	1		69.20 (Davol)
92034	Culturette	1		.74
92035	Culture media	1		.15
31508	Gauze,sterile	1		1.47
	Biohazard waste bag	1		
	1000 ml bag, Saline	1		1.80
	Biohazard Cannister and Tubing	1		
	Chux	1		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
E92005	Whirlpool	1			3700.
	Low mat table	1	25		6995. 5,000 Sammons 2000, p 226
	Suction Machine				

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

SITE OF SERVICE: In-Office
Clinical Services

	<u>Minutes</u>	<u>Staff Type – Circle</u>
Pre-Service Period		
<i>Start: When appointment for service is made</i>		
Review/read X-ray, lab, and pathology reports documentation, plan of care, treatment goals	<u>new 3</u>	RN, LPN, MA, Other _____ PTA _____
Other Clinical Activity (please specify)		
Verify/Coordinate availability of resources/ equip	<u>new 3</u>	RN, LPN, MA, Other _____ Aide _____
<i>End: Patient arrival at office for service</i>		
Service Period		
<i>Start: Patient arrival at office for service</i>		
Greet patient/provide gowning	<u>1 3</u>	RN, LPN, MA, Other _____ Aide _____
Obtain vital signs	<u>5 2</u>	RN, LPN, MA, Other _____ PTA _____
Obtain wound measurements, eg, ROM/strength/edema	<u>5 3</u>	RN, LPN, MA, Other _____ PTA _____
Prep and position patient	<u>5 3</u>	RN, LPN, MA, Other _____ Aide _____
Prepare room, equipment, supplies	<u>8 6</u>	RN, LPN, MA, Other _____ Aide _____
Assist physician therapist during treatment	<u>5</u>	RN, LPN, MA, Other _____ PTA _____
Education/instruction/ counseling/coord home care	<u>4 2</u>	RN, LPN, MA, Other _____ PTA _____
Coordinate home or outpatient care		RN, LPN, MA, Other _____
Clean room/equipment	<u>15 10</u>	RN, LPN, MA, Other _____ Aide _____
Other Clinical Activity (please specify)		
Post treatment patient assistance	<u>4 2</u>	RN, LPN, MA, Other _____ Aide _____
<i>End: Patient leaves office</i>		
Post-Service Period		
<i>Start: Patient leaves office</i>		
Phone calls between visits with patient, family	<u>4 2</u>	RN, LPN, MA, Other _____ PTA _____
Other Activity (please specify)		
Record data and results/complete record		RN, LPN, MA, Other _____ PTA _____
<i>End: When appointment for next office visit is made.</i>		

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

CPT Code: 97602X Tracking Number: ___ Global Period: XXX Recommended RVW: 0.50
HCPAC Rec.: **0.32**

CPT Descriptor: Removal of devitalized tissue from wound; non-selective debridement, without anesthesia (eg., wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 70-year old male who has developed lower extremity ulcers as a result of venous insufficiency. Examination reveals yellow necrotic tissue adherent to the base of the wound. The wound margin is indurated and inflamed. There is minimal clear serous drainage noted. It is determined that the patient would benefit from autolytic debridement.

Description of Pre Service Work: The wound is measured at 4.8 cm X 3.1 cm, depth is undeterminable. The surrounding area is examined and palpated.

Intra-Service Work: Loose tissue is debrided from the wound using non-toxic cleanser. An occlusive dressing (hydrocolloid/hydrogel) is then applied carefully to areas of the wound bed.

Description of Post-Service Work: . The dressing is secured with a secondary bulk dressing. Patient is discharged with instructions to inspect the bandage daily for break through drainage.

SURVEY DATA:

Presenter(s) Sam Brown, PT; Mary Foto. OT _____

Specialty(s): APTA _____

Sample Size: 200 Response Rate: (%): 24.5% Median RVW: 0.50

Type of Sample (Circle One): **panel**. Explanation of sample size: _____

25th Percentile RVW: 0.395 75th Percentile RVW: 0.62 Low: .17 High: 1.80

Median Pre-Service Time: 5.5 Median Intra-Service Time: 20 min

25th Percentile Intra-Svc Time: 15 min 75th Percentile Intra-Svc Time: 30 min Low: 0.50 High: 60

Median Post-Service Time: 10

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

KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	0.45

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.**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code</u>	<u>Reference Service 1 CPT</u>
Median Pre-Time	10	5
Median Intra-Time	20	15
Median Immediate Post-service Time	10	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	3.7	3.78
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.9	3.67
Urgency of medical decision making	4.0	3.34

Technical Skill/Physical Effort (Mean)

Technical skill required	4.1	3.67
Physical effort required	2.6	3.56

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.9	3.34
Outcome depends on the skill and judgement of physician	3.8	3.78

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.

Advisory member consultants accepted survey median work value.

FREQUENCY INFORMATION

How was this service previously reported? G0169

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

Specialty APTA Commonly Sometimes Rarely

Specialty APTA 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 APTA Frequency 1000's

Specialty APTA Frequency 1000's

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 APTA Frequency 1000's

Specialty APTA Frequency 1000's

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

**AMA/Specialty Society Update Process
HCPAC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

CPT Long Descriptor: Removal of devitalized tissue from wound; non-selective debridement, with out anesthesia (eg, wet to moist dressings, enzymatic, abrasion), including topical applications(s), wound assissment, and instruction(s) for ongoing care, per session

Sample Size: __N/A__ Response Rate: (%): _____ Global Period: _____

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:

An Advisory Panel of physical therapists was convened to review the codes in the 97000 series. The Advisory Panel represented multiple levels of care where CPT coding is used. The Panel was trained in the practice expense process. The results of the Panel's efforts were further reviewed by additional clinical consultants. The data were drafted, routed to the Advisory Panel for additional comments and finalized.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Pre service includes the review of the documentation, plan of care and treatment goals and the effect of previous treatment. An aide will also verify the availability of resources, materials and equipment.

Intra-Service Clinical Labor Activities:

Intra-Service includes greeting and preparing the patient, preparing the room, obtaining relevant measurements and vital signs, assisting the physical therapist during the intervention, demonstration and performance verification, post treatment assistance of the patient and cleaning the room/exercise area.

Post-Service Clinical Labor Activities:

Post-Service includes recording data and results and communication with patient, family and other providers.

Total Staff Time In Office:

Visits in Global Period:

HCFA's Staff Type Code*	Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
	PTA		24-14	4 strike to 0	
	Aide		25 14-13		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
14004	Sterile towel.	1		.31
11107	gown	1		.57
11112	pillowcase	1		.32
11111	Table paper	1		.015
14005	Gloves, sterile	1pr		.89
31526	Kling, sterile	1		1.00
31514	tape	1		.015
	Chlorazeen	1		2.50
32014	Ace bandage	1		.45
	Chux	1		
11306	Face mask	1		.30
52304	Silver nitrate sticks	1		.049
	1000 ml bag, Saline	1		1.80
92034	Culturette	1		.74
92035	Culture media	1		.15
31508	Gauze, sterile	1		1.47
	Biohazard waste bag	1		
	Hi pressure water jet gun (pulsatile lavage unit disposable jet)	1		41.82 (Daval (800-562-0027))
	disposable water jet tip	1		69.20 (Daval)

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
E92005	Whirlpool	1	6		3700.
	Low mat table	1	10		6995. 5000 Sammons 2000, p 226
	"Pulsatile Lavage" water jet		4		

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

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~~
 documentation, plan of care, treatment goals

new 1

RN, LPN, MA, Other _____ PTA _____

Other Clinical Activity (please specify)

Verify/Coordinate availability of resources/ equip

new 1

RN, LPN, MA, Other _____ Aide _____

End: Patient arrival at office for service

Service Period

Start: Patient arrival at office for service

Greet patient/provide gowning

1

RN, LPN, MA, Other _____ Aide _____

Obtain vital signs

5 2

RN, LPN, MA, Other _____ PTA _____

Obtain measurements, eg, ROM/strength/edema

5 3

RN, LPN, MA, Other _____ PTA _____

Prep and position patient

5 1

RN, LPN, MA, Other _____ Aide _____

Prepare room, equipment, supplies

8 5

RN, LPN, MA, Other _____ Aide _____

Assist ~~physician~~ therapist during treatment

5

RN, LPN, MA, Other _____ PTA _____

Education/instruction/ counseling/coord home care

1

RN, LPN, MA, Other _____ PTA _____

~~Coordinate home or outpatient care~~

RN, LPN, MA, Other _____

Clean room/equipment

15 5

RN, LPN, MA, Other _____ Aide _____

Other Clinical Activity (please specify)

Post treatment patient assistance

4 1

RN, LPN, MA, Other _____ Aide _____

End: Patient leaves office

Post-Service Period

Start: Patient leaves office

Phone calls between visits with patient, family

4 2

RN, LPN, MA, Other _____ PTA _____

Other Activity (please specify)

Record data and results/complete record

RN, LPN, MA, Other _____ PTA _____

End: When appointment for next office visit is made.

**RUC HCPAC Review Board
Practice Expense Refinement Recommendations from
February and March 2001 Practice Expense Advisory Committee**

CPT Code	Specialty Society Interest	Action by PEAC in February or March 2001	Month Reviewed
11040	APMA	Passed	March
11041	APMA	Passed	March
11042	APMA	Passed	March
11305	APMA	Passed	March
11306	APMA	Passed	March
11307	APMA	Passed	March
11308	APMA	Passed	March
11719	APMA	In Office Inputs Only Passed	March
11720	APMA	In Office Inputs Only Passed	March
11721	APMA	In Office Inputs Only Passed	March
97001	APTA	Passed	March
97002	APTA	Passed	March
97003	AOTA	Passed	March
97004	AOTA	Passed	March
97010	APTA	Passed	March
97012	APTA	Passed	March
97014	APTA	Passed	March
97016	APTA	Passed	March
97018	AOTA	Passed	March
97020	APTA	Passed	March
97022	APTA	Passed	March
97024	APTA	Passed	March
97026	APTA	Passed	March
97028	APTA	Passed	March
97032	APTA	Passed	March
97033	APTA	Passed	March
97034	APTA	Passed	March
97035	APTA	Passed	March
97036	APTA	Passed	March
97039	APTA	Passed	March
97110	APTA	Passed	February
97112	APTA	Passed	February
97113	APTA	Passed	February
97116	APTA	Passed	February
97124	APTA	Passed	February
97139	APTA	Passed	February
97140	APTA	Passed	February
97504	AOTA	Passed	March
97520	APTA	Passed	March
97530	AOTA	Passed	March

97535	AOTA	Passed	March
97537	AOTA	Passed	March
97542	AOTA	Passed	March
97703	AOTA	Passed	March
97750	AOTA	Passed	March
G0127	APMA	Passed	March

LOCATION	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	FAMILY 1					
		11040		11041		11042	
		Debridement; skin, partial thickness		Debridement; skin, full thickness		Debridement; skin, and subcutaneous tissue	
		In Office	Out Office	In Office	Out Office	In Office	Out Office
GLOBAL PERIOD		0		0		0	
TOTAL CLINICAL LABOR TIME	N/LPN/MA 1013	32	3	33	3	39	5
PRE-SERVICE							
Start: Following visit when decision for surgery or procedure made							
Complete pre-service diagnostic & referral forms							
Coordinate pre-surgery services							
Office visit before surgery/procedure Review test and exam results							
Provide pre-service education/obtain consent							
Follow-up phone calls & prescriptions							
Other Clinical Activity (please specify)							
End: When patient enters office for surgery/procedure							
SERVICE PERIOD							
Start: When patient enters office for surgery/procedure							
Pre-service services							
Review charts		2		2		2	
Greet patient and provide gowning		2		2		2	
Obtain vital signs		3		3		3	3
Provide pre-service education/obtain consent		3		3		3	3
Prepare room, equipment, supplies		5		5		5	
Prepare and position patient/ monitor patient/ set up IV		2		2		2	
Sedate/apply anesthesia							
Intra-service							
Assist physician in performing procedure		3		4		7	
Post-Service							
Monitor pt following service/check tubes, monitors, drains							
Clean room/equipment by physician staff		3		3		4	
Complete diagnostic forms, lab & X-ray requisitions		2		2		3	
Review/read X-ray, lab, and pathology reports							
Check dressings & wound/ home care instructions /coordinate office visits /prescriptions		7	3	7	3	8	5
Other Clinical Activity (please specify)							
End: Patient leaves office							
POST-SERVICE Period							
Start: Patient leaves office							
Conduct phone calls/call in prescriptions							
Office visits: Greet patient, escort to room, provide gowning, interval history & vital signs and 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							
List Total Number of Office Visits							
Total Office Visit Time			0	0	0	0	0
Conduct phone calls between office visits							
Other Activity (please specify)							
End: with last office visit before end of global period							

		11040		11041		11042	
	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Debridement; skin, partial thickness		Debridement; skin, full thickness		Debridement; skin; and subcutaneous tissue	
LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office
MEDICAL SUPPLIES							
Slippers, disposable	11105	1 pair		1 pair		1 pair	
Patient gown, disposable	11107						
Gown, staff, impervious, disposable	11304						
Exam table paper	11111	7 feet		7 feet		7 feet	
Gloves, non-sterile	11302	2 pair		2 pair		2 pair	
Mask, surgical	11306						
Cotton tipped applicators	31103	2 items		2 items		2 items	
Gauze, sterile 3 x 3	31507	2 items		2 items		2 items	
Gauze, non-sterile, 4 x 4	31518	2 items		2 items		2 items	
Betadine swab, 3 pack	52305	1 item		1 item		1 item	
Emesis basin	11506	1 item		1 item		1 item	
Gloves, sterile	14005	1 pair		1 pair		1 pair	
Sterile drape 22 in x 25 in	14001	1 item		1 item		1 item	
Drape, sterile, fenestrated, 16" x 29"	14007	1 item		1 item		1 item	
Swab, alcohol	31101	2 items		2 items		2 items	
Gauze, sterile 4 x 4 (10 pack)	31508					1 item	
Culturette	92034					2 items	
Pad, sterile, telfa	31512					1 item	
Kling roller bandage 3"	31527	1 item		1 item		1 item	
Fabco Gauzetex 1"	31534	1 roll		1 roll		1 roll	
Spray pre-tape 9 oz can	31535	1 ounce		1 ounce		1 ounce	
Silver nitrate stick	52304	2 items		2 items		2 items	
Hydrogen peroxide	52303	10 ml		10 ml		10 ml	
Syringe, 10 cc	91407	1 item		1 item		1 item	
Water, sterile	91414	30 ml		30 ml		50 ml	
Bard-Parker Sterile Blades /62/each p 49 - Gill	NEW	2 items		2 items		2 items	
PROCEDURE SPECIFIC EQUIPMENT							
Power table	E11003	32 min		33 min		39 min	
Exam lamp	E30006	32 min		33 min		39 min	
Soft Tissue Procedure Pack	New	23 min		24 min		30 min	
Foot & Ankle surgery instrument pack							

	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	FAMILY 2		11306		11307		11308	
		11305							
		Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5cm or less		Lesion diameter 0.6 to 1.0 cm		Lesion diameter 1.1 to 2.0 cm		Lesion diameter over 2.0 cm	
LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office
GLOBAL PERIOD		0		0		0		0	
TOTAL CLINICAL LABOR TIME	N/LPN/MA 1013	26	2	31	0	34	0	37	0
PRE-SERVICE									
Start: Following visit when decision for surgery or procedure made									
Complete pre-service diagnostic & referral forms									
Coordinate pre-surgery services									
Office visit before surgery/procedure: Review test and exam results									
Provide pre-service education/obtain consent									
Follow-up phone calls & prescriptions									
Other Clinical Activity (please specify)									
End: When patient enters office for surgery/procedure									
SERVICE PERIOD									
Start: When patient enters office for surgery/procedure									
Pre-service services									
Review charts									
Greet patient and provide gowning		3		3		3		3	
Obtain vital signs		3		3		3		3	
Provide pre-service education/obtain consent		4		4		4		4	
Prepare room, equipment, supplies		2		2		2		2	
Prepare and position patient/ monitor patient/ set up IV		3		3		3		3	
Sedate/apply anesthesia									
Intra-service									
Assist physician in performing procedure		4		6		9		11	
Post-Service									
Monitor pt following service/check tubes, monitors, drains									
Clean room/equipment by physician staff		3		3		3		3	
Complete diagnostic forms, lab & X-ray requisitions		2		2		2		2	
Review/read X-ray, lab, and pathology reports									
Check dressings & wound/ home care instructions /coordinate office visits /prescriptions		2	2	5		5		6	
Other Clinical Activity (please specify)									
End: Patient leaves office									
POST-SERVICE Period									
Start: Patient leaves office									
Conduct phone calls/call in prescriptions									
Office visits: Greet patient, escort to room, provide gowning, interval history & vital signs and 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									
List Total Number of Office Visits									
Total Office Visit Time		0	0	0	0	0	0	0	0
Conduct phone calls between office visits									
Other Activity (please specify)									
End: with last office visit before end of global period									

	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	FAMILY 3		11720		11721		G0127	
		11719							
		Trimming of nondystrophic nails, any number		Debridement of nail(s) by any method(s) one to five		Debridement of nails by any method(s) six or more		Trimming of dystrophic nails, any number	
LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office
GLOBAL PERIOD		0		0		0		0	
TOTAL CLINICAL LABOR TIME	N/LPN/MA 1013	17	3	21	3	23	3	17	3
PRE-SERVICE									
Start: Following visit when decision for surgery or procedure made									
Complete pre-service diagnostic & referral forms									
Coordinate pre-surgery services									
Office visit before surgery/procedure: Review test and exam results									
Provide pre-service education/obtain consent									
Follow-up phone calls & prescriptions									
Other Clinical Activity (please specify)									
End: When patient enters office for surgery/procedure									
SERVICE PERIOD									
Start: When patient enters office for surgery/procedure									
Pre-service services									
Review charts		2		2		2		2	
Greet patient and provide gowning		2		2		2		2	
Obtain vital signs		3		3		3		3	
Provide pre-service education/obtain consent		2		2		2		2	
Prepare room, equipment, supplies		2		2		2		2	
Prepare and position patient/ monitor patient/ set up IV		2		2		2		2	
Sedate/apply anesthesia									
Intra-service									
Assist physician in performing procedure		1		5		7		1	
Post-Service									
Monitor pt following service/check tubes, monitors, drains									
Clean room/equipment by physician staff		3		3		3		3	
Complete diagnostic forms, lab & X-ray requisitions									
Review/read X-ray, lab, and pathology reports									
Check dressings & wound/ home care instructions /coordinate office visits /prescriptions									
Other Clinical Activity (please specify)									
End: Patient leaves office									
POST-SERVICE Period									
Start: Patient leaves office									
Conduct phone calls/call in prescriptions									
Office visits: Greet patient, escort to room; provide gowning; interval history & vital signs and 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									
List Total Number of Office Visits									
Total Office Visit Time		0	0	0	0	0	0	0	0
Conduct phone calls between office visits									
Other Activity (please specify)									
End: with last office visit before end of global period									

		11719		11720		11721		G0127	
	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Trimming of nondystrophic nails, any number		Debridement of nail(s) by any method(s): one to five		Debridement of nails by any method(s): six or more		Trimming of dystrophic nails, any number	
LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office
MEDICAL SUPPLIES									
Slippers, disposable	11105	1 pair		1 pair		1 pair		1 pair	
Exam table paper	11111	7 feet		7 feet		7 feet		7 feet	
Gloves, non-sterile	11302	2 pair		2 pair		2 pair		2 pair	
Mask, surgical	11306			1 item		1 item		1 item	
Cotton tipped applicators	31103	2 items		2 items		2 items		2 items	
Gauze, non-sterile, 4 x 4	31518	2 items		2 items		2 items		2 items	
Betadine swab, 3 pack	52305	1 item		1 item		1 item		1 item	
Swab, alcohol	31101	2 items		2 items		2 items		2 items	
Hydrogen peroxide	52303	10 ml		10 ml		10 ml		10 ml	
Silver nitrate stick	52304			2 items		2 items		2 items	
Bard-Parker Sterile Blades .62/each p 49 - Gill	NEW	2 items		2 items		2 items		2 items	
Beaver Chisel Blades - p 52/Gill - \$13.25/five	NEW	1 item		1 item		1 item		1 item	
PROCEDURE SPECIFIC EQUIPMENT									
Power table	E11003	23 min		29 min		31 min		23 min	
Exam lamp	E30006	23 min		29 min		31 min		23 min	

APTA Methodology

The presenter provided an explanation of the methodology involved in developing the recommendations, which is based on creating a typical scenario of a patient visit. This is necessary since during a typical visit several codes are utilized. Therefore, to prevent double counting the presenter provided the following explanation. Although many of the physical therapy codes are listed as 15 minute codes, it would be unusual that only one 15 minute code would be delivered in a visit. Similarly, the modality codes such as unattended electrical electric stimulation or the superficial heat modalities are not typically delivered without other services also being performed. APTA has a policy that discourages the exclusive use of modalities without additional therapeutic procedures being delivered at the visit.

Because these codes are typically not used in a vacuum, the APTA attempted to construct the "typical" patient visit. A HCFA Carrier Medical Director subcommittee has argued that the "usual treatment session" for physical therapy is 30 to 45 minutes. The APTA contends that the usual visit is 45 to 60 minutes. Since both sides have some reference to 45 minutes, that time was chosen as the starting point in developing the typical visit.

The APTA further elected to divide the "typical" visit into two procedures and a modality. While several of the modalities are untimed (the "supervised" modalities), others are 15 minute services. We believe that dividing the 45 minutes as two procedures and a modality is the most accurate way to describe the "typical" visit.

For developing the practice expense for these codes, there are two primary implications to this concept of a 45 minute "typical" visit. The first is that the clinical labor that is required to provide two 15 minute units of a procedure must be halved when allocated to a single 15 minute code. Second, because the modality services are being delivered in conjunction with the procedures, it would be duplicative to include the "greet and gowning" times that are already being assigned to the procedure codes. Again, while it is true that there will be occasions where the modalities are delivered without procedures, these occasions should be exceptions rather than typical patients.

The APTA began their presentation with code 97110, therapeutic exercise because this code contains a basic set of practice expense costs that was then applied, with slight modifications, to additional codes. This code was used as a base and crosswalked to 97112, 97116, 97124, 97139, 97140, and 97113 (with an incremental difference of 7 minutes). Additionally, the modality codes were based on the anchor code of 97014. These inputs were crosswalked as follows: 97010, 97032, and 97039 were all crosswalked at 7 minutes. 97012 had two additional minutes for assisting with procedure, 97020, 97024, 97026, 97028, and 97035 (all are 1 minute less than 97014). 97016 has additional time due to increased complexity, 97033 (3 additional minutes), 97034 had 9 additional minutes due to two contrast baths that involved more time for the cleaning and preparation. 97022 and 97036 were considered together in relation to the anchor code and had significantly different inputs.

For the following codes the PEAC approved clinical staff time supplies, and equipment (pending further HCFA review of time attributed to the equipment use) 97110, 97112, 97113, 97116, 97124, 97139, and 97140.

The PEAC approved only the clinical staff time for the following codes: 97010, 97012, 97014, 97016, 97020, 97022, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, and 97039.

AOTA Workforce Survey

Date of Survey: November, 2000

Estimated number of OTRs in workforce: 70,000¹

<u>Work Settings</u>	<u>%</u>	<u>Estimated No. of OTRs</u>
OUTPATIENT SETTINGS		
Outpatient hospital	7.6	5,320
CORF	1.7	1,190
SNF	9.8	6,860
Rehab Agency/Clinic	2.8	1,960
Physician Office	.8	560
OTHER SETTINGS (are not reimbursed based on RBRVS)		
School System	24.9	17,430
Inpatient Hosp (acute/rehab)	15.4	10,780
Home Health	5.5	3,850
Mental Health	4.6	3,220
Other ²	25	17,500
PRIVATE PRACTICE		
Private Practice/Medicare Certified	2	1,270
Solo Practice	(68.6)	864
Group Practice(OT only)	(13.7)	174
Multi-specialty	(17.8)	226

¹ Based on NBCOT certification data.

² Includes academic, volunteer agency, public health agency, hospice, group home, transitional home, other community programs.

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

CPT Long Descriptor: Physical therapy evaluation

Sample Size: __N/A__ Response Rate: (%): _____ Global Period: _____

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:

An Advisory Panel of physical therapists was convened to review the codes in the 97000 series. The Advisory Panel represented multiple levels of care where CPT coding is used. The Panel was trained in the practice expense process. The results of the Panel's efforts were further reviewed by additional clinical consultants. The data were drafted, routed to the Advisory Panel for additional comments and finalized.

A "typical visit" was defined by the Advisory Panel as a 45 minute visit during which the patient receives two 15 minute procedures and a modality. Consequently clinical labor is calculated for two 15 minute units and then halved for the summary. Additionally, as they are not "typically" delivered by themselves, modalities tend not to have "greet and gowning" labor expenses. These expenses are already with the procedure codes.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Pre service includes the review of the documentation, plan of care and treatment goals and the effect of previous treatment. An aide will also verify the availability of resources, materials and equipment.

Intra-Service Clinical Labor Activities:

Intra-Service includes greeting and preparing the patient, preparing the room, obtaining relevant measurements and vital signs, assisting the physical therapist during the intervention, demonstration and performance verification, post treatment assistance of the patient and cleaning the room/exercise area.

Post-Service Clinical Labor Activities:

Post-Service includes recording data and results and communication with patient, family and other providers.

Total Staff Time In Office:

Visits in Global Period:

HCFA's Staff Type Code*	Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
	RN				
	LPN				
	MA				
	PTA		21		
	Aide		13		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	Multispecialty Visit Package			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Low mat table		20		5000. (Sammons 2000, p226).
E92011	Parallel bars		5		1755.
	Exercise stairs		5		870. (Sammons 2000, pg 257)
	Hand dexterity/sensory kit/strength		10		1407 (Sammons 2000, pg 303,309-313, 320-322)
	Isokinetic Testing Equipment		10		45820. (BTE)

Equipment used simultaneously.

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

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
 documentation, plan of care, treatment goals 1 RN, LPN, MA, Other PTA

Other Clinical Activity (please specify)

Verify/Coordinate availability of resources/ equip 3 RN, LPN, MA, Other Aide

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 Aide

Obtain vital signs 3 RN, LPN, MA, Other PTA

Obtain measurements, eg, ROM/strength/edema 8 RN, LPN, MA, Other PTA

Prep and position patient 2 RN, LPN, MA, Other Aide

Prepare room, equipment, supplies 2 RN, LPN, MA, Other Aide

Assist physician therapist during exam 5 RN, LPN, MA, Other PTA

Education/instruction/ counseling/coord home care 2 RN, LPN, MA, Other PTA

Coordinate home or outpatient care RN, LPN, MA, Other

Clean room/equipment 3 RN, LPN, MA, Other Aide

Other Clinical Activity (please specify)

Post treatment patient assistance RN, LPN, MA, Other Aide

End: Patient leaves office

Post-Service Period

Start: Patient leaves office

Phone calls between visits with patient, family 2 RN, LPN, MA, Other PTA

Other Activity (please specify)

Record data and results/complete record RN, LPN, MA, Other PTA

End: When appointment for next office visit is made.

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

CPT Long Descriptor: Physical Therapy re-evaluation

Sample Size: __N/A__ Response Rate: (%): _____ Global Period: _____

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:

An Advisory Panel of physical therapists was convened to review the codes in the 97000 series. The Advisory Panel represented multiple levels of care where CPT coding is used. The Panel was trained in the practice expense process. The results of the Panel's efforts were further reviewed by additional clinical consultants. The data were drafted, routed to the Advisory Panel for additional comments and finalized.

A "typical visit" was defined by the Advisory Panel as a 45 minute visit during which the patient receives two 15 minute procedures and a modality. Consequently clinical labor is calculated for two 15 minute units and then halved for the summary. Additionally, as they are not "typically" delivered by themselves, modalities tend not to have "greet and gowning" labor expenses. These expenses are already with the procedure codes.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Pre service includes the review of the documentation, plan of care and treatment goals and the effect of previous treatment. An aide will also verify the availability of resources, materials and equipment.

Intra-Service Clinical Labor Activities:

Intra-Service includes greeting and preparing the patient, preparing the room, obtaining relevant measurements and vital signs, assisting the physical therapist during the intervention, demonstration and performance verification, post treatment assistance of the patient and cleaning the room/exercise area.

Post-Service Clinical Labor Activities:

Post-Service includes recording data and results and communication with patient, family and other providers.

Total Staff Time In Office:

Visits in Global Period:

HCFA's Staff Type Code*	Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
	RN				
	LPN				
	MA				
	PTA		14		
	Aide		13		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	1 Multispecialty Visit Package			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Low mat table		10		5000. (Sammons 2000, p226)
E92011	Parallel bars		5		1755
	Exercise stairs		5		870. (Sammons 2000, pg 257
	Hand dexterity/sensory kit/strength		5		1407 (Sammons 2000, pg.303, 309-313, 320-322.)
	Isokinetic Exercise Equipment		5		45820 (BTE)

Equipment used simultaneously.

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

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
 documentation, plan of care, treatment goals 1 RN, LPN, MA, Other PTA

Other Clinical Activity (please specify)

Verify/Coordinate availability of resources/ equip 3 RN, LPN, MA, Other Aide

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 Aide

Obtain vital signs 3 RN, LPN, MA, Other PTA

Obtain measurements, eg, ROM/strength/edema 3 RN, LPN, MA, Other PTA

Prep and position patient 2 RN, LPN, MA, Other Aide

Prepare room, equipment, supplies 2 RN, LPN, MA, Other Aide

Assist physician therapist during exam 3 RN, LPN, MA, Other PTA

Education/instruction/ counseling/coord home care 2 RN, LPN, MA, Other PTA

~~Coordinate home or outpatient care~~ _____ RN, LPN, MA, Other _____

Clean room/equipment 3 RN, LPN, MA, Other Aide

Other Clinical Activity (please specify)

 Post treatment patient assistance _____ RN, LPN, MA, Other Aide

End: Patient leaves office

Post-Service Period

Start: Patient leaves office

Phone calls between visits with patient, family 2 RN, LPN, MA, Other PTA

Other Activity (please specify)

 Record data and results/complete record _____ RN, LPN, MA, Other PTA

End: When appointment for next office visit is made.

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

CPT Long Descriptor: Occupational therapy evaluation

Sample Size: N/A Response Rate: (%): Global Period:

Vignette: Initial visit with a 42 year old female with diagnosis of multiple sclerosis. Patient is employed as a librarian. She shares in caregiver responsibilities of her two teenage children and in home maintenance tasks. Her chief complaints are lack of strength and endurance and sensory problems. The therapist designs an activity which parallels the physical requirements of the activities in which the patient has identified deficits. In addition to observing the patient's completion of the activity, the therapist engages the patient in a discussion of other issues that the patient believes are interfering with her ability to function in her home and career. Based on the patient's self report and actual performance, the patient's deficits in the following **performance components** (see Uniform Terminology for Occupational Therapy, 3rd edition) are evaluated:

- activities of daily living
- work and productive activities
- sensory awareness
- sensory processing
- neuro-musculoskeletal (e.g., range of motion, muscle tone, endurance, strength)
- motor (e.g., gross coordination, bilateral integration, fine coordination, visual-motor integration)

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:

AOTA data were developed by a consensus panel of occupational therapists, who are either in private practice or have significant experience as rehabilitation managers of large outpatient therapy departments. This group consulted with additional therapists and administrative personnel within their respective practice settings. The panel was trained in the practice expense process and developed data during an intensive 2 day face to face meeting. Additional telephone conferences were held to refine the data and include comments from additional clinical consultants. The data presented are consistent with the cross-walk approved at the February 2001 PEAC for procedures and modalities in the 97XXX family of codes.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: Pre service includes the review of the documentation, plan of care and treatment goals and the effect of previous treatment. An aide will also verify the availability of resources, materials and equipment.

Intra-Service Clinical Labor Activities: Intra-Service includes greeting and preparing the patient, preparing the room, obtaining relevant measurements and vital signs, assisting the occupational therapist during the

intervention, demonstration and performance verification, post treatment assistance of the patient and cleaning the room/clinic area.

Post-Service Clinical Labor Activities: Post-Service includes communication with patient, family, other providers, and payers.

Total Staff Time In Office:

Visits in Global Period:

HCFA's Staff Type Code*	Clinical Labor (for all of the activities performed on the day of service)	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
	Assistant	1	18	2	
	Aide	3	10		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Price	Source of Supply	Cost Estimate
31103	Q-tips	1			.16
31102	Cotton balls	3			.02
11118	Paper towels	4			.04
	Antibacterial lotion	.25 oz	3.59/8oz	drugstore	.11
	SaniZene Disinfectant	2oz	29.95/1gal	NC(70455)	.46

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	% of use ¹ per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Adjustable height treatment table (used with Greenleaf system; sensory/motor kits)	1	50%		2,905 Hausmann Industries
	Adjustable treatment stool (used with Greenleaf system)	1	50%		370 (AliMed 95-209))
	Greenleaf eval systems for UE/hand	1	30%		16,500 Preston-Sammons catalogue (1999) p.16
	Environmental modules – Kitchen	1	17%		50,000 (Guynes Design, Inc.)
	Environ. modules-Bathroom	1	17%		40,000 (Guynes)
	Environ. modules – Bedroom	1	16%		20,000 (Guynes)
	Sensory Kit	1	10%		677.35 NC(21000)
	Motor coordination Kit	1	10%		643.75 NC(21000-1)
	ADL Kit (used with kitchen and bath modules)	1	34%		586.50 NC(21000-2)

¹During the typical treatment for the patient described in the vignette, the therapist would treat half the session while the patient is seated on the stool at the table and half the session in the environmental modules. While on the stool and at the table, the therapist would be using the Greenleaf system and the sensory and motor coordination kits. While in the modules, the therapist would be using the ADL kit (30% cost in kitchen module, 70% in bathroom).

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

CPT Long Descriptor: Occupational therapy re-evaluation

Sample Size: N/A Response Rate: (%): Global Period:

Vignette: Patient is 49 year old female who sustained a forearm fracture (distal end of the radius) in an automobile accident. She received treatment during and after casting to prevent edema, maintain range of motion, muscle strength and sensation, and assure safe return to daily activities. She was discharged to home 3 months ago with a maintenance program of exercises and gradual increase in daily home activities. She returned to work 6 weeks ago. During a recent physician visit, she complained that her ability to grasp and hold objects had not returned to normal and there was pain and a lack of strength associated with these activities. She was referred back to therapy, as these problems are interfering with her ability to get dressed, prepare meals and perform her job as a manicurist. The therapist re-assesses her ability to perform tasks with the affected arm and re-tests muscle strength, using discharge data as a baseline, and explores compensatory methods which help to ameliorate the pain. Based on the patient's self report and actual performance, the patient's deficits in the following **performance components** (see Uniform Terminology for Occupational Therapy, 3rd edition) are re-evaluated:

- activities of daily living
- work and productive activities
- neuro-musculoskeletal
- motor

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:

AOTA data were developed by a consensus panel of occupational therapists, who are either in private practice or have significant experience as rehabilitation managers of large outpatient therapy departments. This group consulted with additional therapists and administrative personnel within their respective practice settings. The panel was trained in the practice expense process and developed data during an intensive 2 day face to face meeting. Additional telephone conferences were held to refine the data and include comments from additional clinical consultants. The data presented are consistent with the cross-walk approved at the February 2001 PEAC for procedures and modalities in the 97XXX family of codes.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: Pre service includes the review of the documentation, plan of care and treatment goals and the effect of previous treatment. An aide will also verify the availability of resources, materials and equipment.

Intra-Service Clinical Labor Activities: Intra-Service includes greeting and preparing the patient, preparing the room, obtaining relevant measurements and vital signs, assisting the occupational therapist

during the intervention, demonstration and performance verification, post treatment assistance of the patient and cleaning the room/clinic area.

Post-Service Clinical Labor Activities: Post-Service includes communication with patient, family, other providers, and payers.

Total Staff Time In Office:

Visits in Global Period:

HCFA's Staff Type Code*	Clinical Labor (for all of the activities performed on the day of service)	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
	RN				
	LPN				
	MA				
	Assistant	1	12	2	
	Aide	3	9		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Price	Source of Supply	Cost Estimate
31103	Q-tips	1			.16
11111	Saniwipe	1			.13
	Soap	.5 oz	1.99/7.59 oz	drugstore	.13
	Nail polish	1	2.99	drugstore	2.99
	Nail polish remover towelettes	2	2.99/6	drugstore	1.00
	Emery boards	1	.99/10	drugstore	.09

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	% of use ¹ per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Adjustable height treatment table	1	67%		2,905 (Hausmann Industries (#4380))
	Greenleaf Systems for UE/Hand	1	33%		16,500 (Preston-Samons)
	BTE Primus	1	33%		45,820 (BTE)

¹ During the typical treatment for the patient described in the vignette, the patient would be seated on the stool at the table for two-thirds of the session. While at the table, the therapist would evaluate the patient using the Greenleaf system and assess her ability to perform the requirements of her profession as a manicurist. The therapist would evaluate the patient on the BTE during one-third of the session.

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

CPT Long Descriptor: Application of a modality to one or more areas; hot or cold packs

Sample Size: __N/A__ Response Rate: (%): _____ Global Period: _____

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:

An Advisory Panel of physical therapists was convened to review the codes in the 97000 series. The Advisory Panel represented multiple levels of care where CPT coding is used. The Panel was trained in the practice expense process. The results of the Panel's efforts were further reviewed by additional clinical consultants. The data were drafted, routed to the Advisory Panel for additional comments and finalized.

A "typical visit" was defined by the Advisory Panel as a 45 minute visit during which the patient receives two 15 minute procedures and a modality. Consequently clinical labor is calculated for two 15 minute units and then halved for the summary. Additionally, as they are not "typically" delivered by themselves, modalities tend not to have "greet and gowning" labor expenses. These expenses are already with the procedure codes.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Pre service includes the review of the documentation, plan of care and treatment goals and the effect of previous treatment. An aide will also verify the availability of resources, materials and equipment.

Intra-Service Clinical Labor Activities:

Intra-Service includes greeting and preparing the patient, preparing the room, obtaining relevant measurements and vital signs, assisting the physical therapist during the intervention, demonstration and performance verification, post treatment assistance of the patient and cleaning the room/exercise area.

Post-Service Clinical Labor Activities:

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Equipment is included in the procedures that are typically delivered with this modality				

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

SITE OF SERVICE: In-Office
Clinical Services

Minutes Staff Type – Circle

Pre-Service Period

PEAC
 APPROVED
 02/2001

Start: When appointment for service is made

Review/read X-ray, lab, and pathology reports
 documentation, plan of care, treatment goals

_____ RN, LPN, MA, Other _____ PTA _____

Other Clinical Activity (please specify)

Verify/Coordinate availability of resources/ equip

_____ RN, LPN, MA, Other _____ Aide _____

End: Patient arrival at office for service

Service Period

Start: Patient arrival at office for service

Greet patient/provide gowning

_____ RN, LPN, MA, Other _____ Aide _____

Obtain vital signs

_____ RN, LPN, MA, Other _____ PTA _____

Obtain measurements, eg, ROM/strength/edema

_____ RN, LPN, MA, Other _____ PTA _____

Prep and position patient

_____ RN, LPN, MA, Other _____ Aide _____

Prepare room, equipment, supplies

_____ RN, LPN, MA, Other _____ Aide _____

Assist physician therapist during exam

_____ 3 _____ RN, LPN, MA, Other _____ Aide _____

Education/instruction/ counseling/coord home care

_____ 1 _____ RN, LPN, MA, Other _____ PTA _____

~~Coordinate home or outpatient care~~

_____ RN, LPN, MA, Other _____

Clean room/equipment

_____ 2 _____ RN, LPN, MA, Other _____ Aide _____

Other Clinical Activity (please specify)

Post treatment patient assistance

_____ 1 _____ RN, LPN, MA, Other _____ Aide _____

End: Patient leaves office

Post-Service Period

Start: Patient leaves office

Phone calls between visits with patient, family

_____ RN, LPN, MA, Other _____ PTA _____

Other Activity (please specify)

Record data and results/complete record

_____ RN, LPN, MA, Other _____ PTA _____

End: When appointment for next office visit is made.

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

CPT Long Descriptor: Application of a modality to one or more areas; traction, mechanical

Sample Size: __N/A__ Response Rate: (%): _____ Global Period: _____

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:

An Advisory Panel of physical therapists was convened to review the codes in the 97000 series. The Advisory Panel represented multiple levels of care where CPT coding is used. The Panel was trained in the practice expense process. The results of the Panel's efforts were further reviewed by additional clinical consultants. The data were drafted, routed to the Advisory Panel for additional comments and finalized.

A "typical visit" was defined by the Advisory Panel as a 45 minute visit during which the patient receives two 15 minute procedures and a modality. Consequently clinical labor is calculated for two 15 minute units and then halved for the summary. Additionally, as they are not "typically" delivered by themselves, modalities tend not to have "greet and gowning" labor expenses. These expenses are already with the procedure codes.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Pre service includes the review of the documentation, plan of care and treatment goals and the effect of previous treatment. An aide will also verify the availability of resources, materials and equipment.

Intra-Service Clinical Labor Activities:

Intra-Service includes greeting and preparing the patient, preparing the room, obtaining relevant measurements and vital signs, assisting the physical therapist during the intervention, demonstration and performance verification, post treatment assistance of the patient and cleaning the room/exercise area.

Post-Service Clinical Labor Activities:

Post-Service includes recording data and results and communication with patient, family and other providers.

Total Staff Time In Office:

Visits in Global Period:

HCFA's Staff Type Code*	Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
	RN				
	LPN				
	MA				
	PTA		6		
	Aide		3		
	PEAC APPROVED 02/2001				

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
31501	Guaze-chin strap protector	1		0.24
	Other supplies are included in the procedures that are typically delivered with this modality			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
E92010	Mechanical traction		15		2090
	Traction table and leg rest		15		3770. (Sammons 2000, pg 238)
	Saunders strap and support (cervical, lumbar, thoracic, one of which is used)		15 for one of 3 supports		950
	The above equipment is used together				
	Other equipment is included in the procedures that are typically delivered with this modality				

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

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
 documentation, plan of care, treatment goals

_____ RN, LPN, MA, Other _____ PTA _____

Other Clinical Activity (please specify)

Verify/Coordinate availability of resources/ equip

_____ RN, LPN, MA, Other _____ Aide _____

End: Patient arrival at office for service

Service Period

Start: Patient arrival at office for service

Greet patient/provide gowning

_____ RN, LPN, MA, Other _____ Aide _____

Obtain vital signs

_____ RN, LPN, MA, Other _____ PTA _____

Obtain measurements, eg, ROM/strength/edema

_____ RN, LPN, MA, Other _____ PTA _____

Prep and position patient

_____ RN, LPN, MA, Other _____ Aide _____

Prepare room, equipment, supplies

_____ RN, LPN, MA, Other _____ Aide _____

Assist physician therapist during exam

_____ 5 _____ RN, LPN, MA, Other _____ PTA _____

Education/instruction/ counseling/coord home care

_____ 1 _____ RN, LPN, MA, Other _____ PTA _____

~~Coordinate home or outpatient care~~

_____ RN, LPN, MA, Other _____

Clean room/equipment

_____ 2 _____ RN, LPN, MA, Other _____ Aide _____

Other Clinical Activity (please specify)

Post treatment patient assistance

_____ 1 _____ RN, LPN, MA, Other _____ Aide _____

End: Patient leaves office

Post-Service Period

Start: Patient leaves office

Phone calls between visits with patient, family

_____ RN, LPN, MA, Other _____ PTA _____

Other Activity (please specify)

Record data and results/complete record

_____ RN, LPN, MA, Other _____ PTA _____

End: When appointment for next office visit is made.

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

CPT Long Descriptor: Application of a modality to one or more areas; electrical stimulation (unattended)

Sample Size: N/A Response Rate: (%): Global Period:

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:

An Advisory Panel of physical therapists was convened to review the codes in the 97000 series. The Advisory Panel represented multiple levels of care where CPT coding is used. The Panel was trained in the practice expense process. The results of the Panel's efforts were further reviewed by additional clinical consultants. The data were drafted, routed to the Advisory Panel for additional comments and finalized.

A "typical visit" was defined by the Advisory Panel as a 45 minute visit during which the patient receives two 15 minute procedures and a modality. Consequently clinical labor is calculated for two 15 minute units and then halved for the summary. Additionally, as they are not "typically" delivered by themselves, modalities tend not to have "greet and gowning" labor expenses. These expenses are already with the procedure codes.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Pre service includes the review of the documentation, plan of care and treatment goals and the effect of previous treatment. An aide will also verify the availability of resources, materials and equipment.

Intra-Service Clinical Labor Activities:

Intra-Service includes greeting and preparing the patient, preparing the room, obtaining relevant measurements and vital signs, assisting the physical therapist during the intervention, demonstration and performance verification, post treatment assistance of the patient and cleaning the room/exercise area.

Post-Service Clinical Labor Activities:

Post-Service includes recording data and results and communication with patient, family and other providers.

Total Staff Time In Office:

Visits in Global Period:

HCFA's Staff Type Code*	Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
	RN				
	LPN				
	MA				
	PTA		4		
	Aide		3		
	PEAC Approved 02/2001				

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
11522	Gel	1oz		.168
	Disposable electrodes	2		6.35 Smith & Nephew(1999) pg.159
31514	tape	6"		.015
31101	Alcohol swabx2	1		.017
11104	razor	1		.31
11302	gloves, non sterile	1		.12
	Other supplies are included in the procedures that are typically delivered with this modality			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

CPT Code: 97014 _____

Specialty Society('s)_APTA _____

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
E92009	Hi volt electrical stimulator		15		1395.
	Low mat table		15		5000. Sammons,2000, pg226
	Equipment used simultaneously				

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

SITE OF SERVICE: In-Office
Clinical Services

Minutes **Staff Type – Circle**

Pre-Service Period

PEAC
Approved
02/2001

Start: When appointment for service is made

Review/read X-ray, lab, and pathology reports
documentation, plan of care, treatment goals

_____ RN, LPN, MA, Other _____ PTA _____

Other Clinical Activity (please specify)

Verify/Coordinate availability of resources/ equip

_____ RN, LPN, MA, Other _____ Aide _____

End: Patient arrival at office for service

Service Period

Start: Patient arrival at office for service

Greet patient/provide gowning

_____ RN, LPN, MA, Other _____ Aide _____

Obtain vital signs

_____ RN, LPN, MA, Other _____ PTA _____

Obtain measurements, eg, ROM/strength/edema

_____ RN, LPN, MA, Other _____ PTA _____

Prep and position patient

_____ RN, LPN, MA, Other _____ Aide _____

Prepare room, equipment, supplies

_____ RN, LPN, MA, Other _____ Aide _____

Assist ~~physician~~ therapist during exam

_____ 3 _____ RN, LPN, MA, Other _____ PTA _____

Education/instruction/ counseling/coord home care

_____ 1 _____ RN, LPN, MA, Other _____ PTA _____

~~Coordinate home or outpatient care~~

_____ RN, LPN, MA, Other _____

Clean room/equipment

_____ 2 _____ RN, LPN, MA, Other _____ Aide _____

Other Clinical Activity (please specify)

Post treatment patient assistance

_____ 1 _____ RN, LPN, MA, Other _____ Aide _____

End: Patient leaves office

Post-Service Period

Start: Patient leaves office

Phone calls between visits with patient, family

_____ RN, LPN, MA, Other _____ PTA _____

Other Activity (please specify)

Record data and results/complete record

_____ RN, LPN, MA, Other _____ PTA _____

End: When appointment for next office visit is made.

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

CPT Long Descriptor: Application of a modality to one or more areas; vasopneumatic devices

Sample Size: __N/A__ Response Rate: (%): _____ Global Period: _____

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:

An Advisory Panel of physical therapists was convened to review the codes in the 97000 series. The Advisory Panel represented multiple levels of care where CPT coding is used. The Panel was trained in the practice expense process. The results of the Panel's efforts were further reviewed by additional clinical consultants. The data were drafted, routed to the Advisory Panel for additional comments and finalized.

A "typical visit" was defined by the Advisory Panel as a 45 minute visit during which the patient receives two 15 minute procedures and a modality. Consequently clinical labor is calculated for two 15 minute units and then halved for the summary. Additionally, as they are not "typically" delivered by themselves, modalities tend not to have "greet and gowning" labor expenses. These expenses are already with the procedure codes.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Pre service includes the review of the documentation, plan of care and treatment goals and the effect of previous treatment. An aide will also verify the availability of resources, materials and equipment.

Intra-Service Clinical Labor Activities:

Intra-Service includes greeting and preparing the patient, preparing the room, obtaining relevant measurements and vital signs, assisting the physical therapist during the intervention, demonstration and performance verification, post treatment assistance of the patient and cleaning the room/exercise area.

Post-Service Clinical Labor Activities:

Post-Service includes recording data and results and communication with patient, family and other providers.

Total Staff Time In Office:

Visits in Global Period:

HCFA's Staff Type Code*	Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
	RN				
	LPN				
	MA				
	PTA		17		
	Aide		4		
	PEAC Approved 02/2001				

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
32014	stockinette	3ft		.45
	Other supplies are included in the procedures that are typically delivered with this modality			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Low mat table		20		5000. Sammons 2000, pg 226
E92015	Vasopneumatic device		20		795.

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

SITE OF SERVICE: In-Office
Clinical Services

	<u>Minutes</u>	<u>Staff Type – Circle</u>
Pre-Service Period	PEAC	
<i>Start: When appointment for service is made</i>	Approved	
	02/2001	
Review/read X-ray, lab, and pathology reports documentation, plan of care, treatment goals	_____	RN, LPN, MA, Other _____ PTA _____
Other Clinical Activity (please specify)		
Verify/Coordinate availability of resources/ equip	_____	RN, LPN, MA, Other _____ Aide _____
<i>End: Patient arrival at office for service</i>		
Service Period		
<i>Start: Patient arrival at office for service</i>		
Greet patient/provide gowning	_____	RN, LPN, MA, Other _____ Aide _____
Obtain vital signs	2	RN, LPN, MA, Other _____ PTA _____
Obtain measurements, eg, ROM/strength/edema	_____	RN, LPN, MA, Other _____ PTA _____
Prep and position patient	_____	RN, LPN, MA, Other _____ Aide _____
Prepare room, equipment, supplies	_____	RN, LPN, MA, Other _____ Aide _____
Assist physician therapist during exam	10	RN, LPN, MA, Other _____ PTA _____
Education/instruction/ counseling/coord home care	5	RN, LPN, MA, Other _____ PTA _____
Coordinate home or outpatient care	_____	RN, LPN, MA, Other _____
Clean room/equipment	2	RN, LPN, MA, Other _____ Aide _____
Other Clinical Activity (please specify)		
Post treatment patient assistance	2	RN, LPN, MA, Other _____ Aide _____
<i>End: Patient leaves office</i>		
Post-Service Period		
<i>Start: Patient leaves office</i>		
Phone calls between visits with patient, family	_____	RN, LPN, MA, Other _____ PTA _____
Other Activity (please specify)		
Record data and results/complete record	_____	RN, LPN, MA, Other _____ PTA _____
<i>End: When appointment for next office visit is made.</i>		

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

CPT Long Descriptor: Application of a modality to one or more areas; paraffin bath

Vignette: Patient is a 32 year old male with fracture dislocation of the PIP joints, radial digits. K-wires have been removed and ROM initiated to increase flexion. The hand is heated in paraffin bath to increase collagen extensibility prior to exercises. The provider enhances effect by taping the PIP's in flexion, under slight tension. Patient is instructed in the techniques of paraffin dip (6-10 times). Paraffin is left in place on the hand for 15-20 minutes.

Sample Size: N/A Response Rate: (%): Global Period:

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:

AOTA data were developed by a consensus panel of occupational therapists, who are either in private practice or have significant experience as rehabilitation managers of large outpatient therapy departments. This group consulted with additional therapists and administrative personnel within their respective practice settings. The panel was trained in the practice expense process and developed data during an intensive 2 day face to face meeting. Additional telephone conferences were held to refine the data and include comments from additional clinical consultants. The data presented are consistent with the cross walk approved at the February 2001 PEAC for procedures and modalities in the 97XXX family of codes.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: Pre service includes the review of the documentation, plan of care and treatment goals and the effect of previous treatment. An aide will also verify the availability of resources, materials and equipment.

Intra-Service Clinical Labor Activities: Intra-Service includes greeting and preparing the patient, preparing the room, obtaining relevant measurements and vital signs, assisting the occupational therapist during the intervention, demonstration and performance verification, post treatment assistance of the patient and cleaning the room/clinic area.

Post-Service Clinical Labor Activities: Post-Service includes communication with patient, family, other providers, and payers.

Total Staff Time In Office:

Visits in Global Period:

HCFA's Staff Type Code*	Clinical Labor (for all of the activities performed on the day of service)	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
	RN				
	LPN				
	MA				
	Assistant		6		
	Aide		9		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	Paraffin	4 oz	22.75/6 1lb bars	.95 Smith & Nephew (1999)
	Multispecialty package			
	Plastic wrap	18"	2.89 per 100 sq. ft.	.48 (supermarket)

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	% of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Institutional paraffin bath (arm, hand, foot)	1	100%		3,349.95 (S&N #819-002)

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

CPT Long Descriptor: Application of a modality to one or more areas; microwave

Sample Size: __N/A__ Response Rate: (%): _____ Global Period: _____

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:

An Advisory Panel of physical therapists was convened to review the codes in the 97000 series. The Advisory Panel represented multiple levels of care where CPT coding is used. The Panel was trained in the practice expense process. The results of the Panel's efforts were further reviewed by additional clinical consultants. The data were drafted, routed to the Advisory Panel for additional comments and finalized.

A "typical visit" was defined by the Advisory Panel as a 45 minute visit during which the patient receives two 15 minute procedures and a modality. Consequently clinical labor is calculated for two 15 minute units and then halved for the summary. Additionally, as they are not "typically" delivered by themselves, modalities tend not to have "greet and gowning" labor expenses. These expenses are already with the procedure codes.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Pre service includes the review of the documentation, plan of care and treatment goals and the effect of previous treatment. An aide will also verify the availability of resources, materials and equipment.

Intra-Service Clinical Labor Activities:

Intra-Service includes greeting and preparing the patient, preparing the room, obtaining relevant measurements and vital signs, assisting the physical therapist during the intervention, demonstration and performance verification, post treatment assistance of the patient and cleaning the room/exercise area.

Post-Service Clinical Labor Activities:

Post-Service includes recording data and results and communication with patient, family and other providers.

Total Staff Time In Office:

Visits in Global Period:

HCFA's Staff Type Code*	Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
	RN				
	LPN				
	MA				
	PTA		4		
	Aide		2		
	PEAC Approved 02/2001				

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	Supplies are included in the procedures that are typically delivered with this modality.			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Low mat table		15		5000., Sammons 2000, pg 226
	Microwave		10		

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

SITE OF SERVICE: In-Office
Clinical Services

	<u>Minutes</u>	<u>Staff Type – Circle</u>
Pre-Service Period		
<i>Start: When appointment for service is made</i>		
Review/read X-ray, lab, and pathology reports documentation, plan of care, treatment goals	_____	RN, LPN, MA, Other _____ PTA_____
Other Clinical Activity (please specify)		
Verify/Coordinate availability of resources/ equip	_____	RN, LPN, MA, Other _____ Aide_____
<i>End: Patient arrival at office for service</i>		
Service Period		
<i>Start: Patient arrival at office for service</i>		
Greet patient/provide gowning	_____	RN, LPN, MA, Other _____ Aide_____
Obtain vital signs	_____	RN, LPN, MA, Other _____ PTA_____
Obtain measurements, eg, ROM/strength/edema	_____	RN, LPN, MA, Other _____ PTA_____
Prep and position patient	_____	RN, LPN, MA, Other _____ Aide_____
Prepare room, equipment, supplies	_____	RN, LPN, MA, Other _____ Aide_____
Assist physician therapist during exam	_____ 3 _____	RN, LPN, MA, Other _____ PTA_____
Education/instruction/ counseling/coord home care	_____ 1 _____	RN, LPN, MA, Other _____ PTA_____
Coordinate home or outpatient care	_____	RN, LPN, MA, Other _____
Clean room/equipment	_____ 1 _____	RN, LPN, MA, Other _____ Aide_____
Other Clinical Activity (please specify)		
Post treatment patient assistance	_____ 1 _____	RN, LPN, MA, Other _____ Aide_____
<i>End: Patient leaves office</i>		
Post-Service Period		
<i>Start: Patient leaves office</i>		
Phone calls between visits with patient, family	_____	RN, LPN, MA, Other _____ PTA_____
Other Activity (please specify)		
Record data and results/complete record	_____	RN, LPN, MA, Other _____ PTA_____
<i>End: When appointment for next office visit is made.</i>		

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

CPT Long Descriptor: Application of a modality to one or more areas; whirlpool

Sample Size: __N/A__ Response Rate: (%): _____ Global Period: _____

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:

An Advisory Panel of physical therapists was convened to review the codes in the 97000 series. The Advisory Panel represented multiple levels of care where CPT coding is used. The Panel was trained in the practice expense process. The results of the Panel's efforts were further reviewed by additional clinical consultants. The data were drafted, routed to the Advisory Panel for additional comments and finalized.

A "typical visit" was defined by the Advisory Panel as a 45 minute visit during which the patient receives two 15 minute procedures and a modality. Consequently clinical labor is calculated for two 15 minute units and then halved for the summary. Additionally, as they are not "typically" delivered by themselves, modalities tend not to have "greet and gowning" labor expenses. These expenses are already with the procedure codes.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Pre service includes the review of the documentation, plan of care and treatment goals and the effect of previous treatment. An aide will also verify the availability of resources, materials and equipment.

Intra-Service Clinical Labor Activities:

Intra-Service includes greeting and preparing the patient, preparing the room, obtaining relevant measurements and vital signs, assisting the physical therapist during the intervention, demonstration and performance verification, post treatment assistance of the patient and cleaning the room/exercise area.

Post-Service Clinical Labor Activities:

Post-Service includes recording data and results and communication with patient, family and other providers.

Total Staff Time In Office:

Visits in Global Period:

HCFA's Staff Type Code*	Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
	PTA		6		
	Aide		18		
	PEAC Approved 02/2001				

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
11107	gown	1		.57
	Chlorozene, germicidal	1 packet	24 packets	2.50 Smith & Nephew (1999) pg. 149
92034	Culturette	1		.74
92035	Culture media	1		.15
31508	Gauze 4x4	5		.72
31514	Tape/hypoallergenic	12"		.03
31509	Kling wrap	1		.38
32014	Ace bandages	1		.45
11124	Eye shield	1		.52
11306	Face mask	1		.03
	Biohazard waste bags	1		
31703	Suture removal kit	1		1.95
14005	Sterile gloves	1pr		.89
52304	Silver nitrate sticks	1		.049

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
E92005	Whirlpool		20		3700.
	Hydrolic chair lift		4		4730. (Sammons 2000, pg. 267)

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

**SITE OF SERVICE: In-Office
 Clinical Services**

	<u>Minutes</u>	<u>Staff Type – Circle</u>
Pre-Service Period <i>Start: When appointment for service is made</i>	PEAC Approved 02/2001	
Review/read X-ray, lab, and pathology reports documentation, plan of care, treatment goals	_____	RN, LPN, MA, Other _____ PTA _____
Other Clinical Activity (please specify)		
Verify/Coordinate availability of resources/ equip	_____	RN, LPN, MA, Other _____ Aide _____
<i>End: Patient arrival at office for service</i>		
Service Period <i>Start: Patient arrival at office for service</i>		
Greet patient/provide gowning	_____	RN, LPN, MA, Other _____ Aide _____
Obtain vital signs	_____	RN, LPN, MA, Other _____ PTA _____
Obtain measurements, eg, ROM/strength/edema	_____	RN, LPN, MA, Other _____ PTA _____
Prep and position patient	___ 3 ___	RN, LPN, MA, Other _____ Aide _____
Prepare room, equipment, supplies	___ 4 ___	RN, LPN, MA, Other _____ Aide _____
Assist physician therapist during exam	___ 5 ___	RN, LPN, MA, Other _____ PTA _____
Education/instruction/ counseling/coord home care	___ 1 ___	RN, LPN, MA, Other _____ PTA _____
Coordinate home or outpatient care	_____	RN, LPN, MA, Other _____
Clean room/equipment	___ 8 ___	RN, LPN, MA, Other _____ Aide _____
Other Clinical Activity (please specify)		
Post treatment patient assistance	___ 3 ___	RN, LPN, MA, Other _____ Aide _____
<i>End: Patient leaves office</i>		
Post-Service Period <i>Start: Patient leaves office</i>		
Phone calls between visits with patient, family	___ 1 ___	RN, LPN, MA, Other _____ PTA _____
Other Activity (please specify) Record data and results/complete record	_____	RN, LPN, MA, Other _____ PTA _____
<i>End: When appointment for next office visit is made.</i>		

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

CPT Long Descriptor: Application of a modality to one or more areas; diathermy

Sample Size: __N/A__ Response Rate: (%): _____ Global Period: _____

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:

An Advisory Panel of physical therapists was convened to review the codes in the 97000 series. The Advisory Panel represented multiple levels of care where CPT coding is used. The Panel was trained in the practice expense process. The results of the Panel's efforts were further reviewed by additional clinical consultants. The data were drafted, routed to the Advisory Panel for additional comments and finalized.

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Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Pre service includes the review of the documentation, plan of care and treatment goals and the effect of previous treatment. An aide will also verify the availability of resources, materials and equipment.

Intra-Service Clinical Labor Activities:

Intra-Service includes greeting and preparing the patient, preparing the room, obtaining relevant measurements and vital signs, assisting the physical therapist during the intervention, demonstration and performance verification, post treatment assistance of the patient and cleaning the room/exercise area.

Post-Service Clinical Labor Activities:

CPT Code: 97024_____

Specialty Society('s)_APTA_____

E71015	Diathermy		15		3120

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

SITE OF SERVICE: In-Office
Clinical Services

	<u>Minutes</u>	<u>Staff Type – Circle</u>
Pre-Service Period		
<i>Start: When appointment for service is made</i>		
Review/read X-ray, lab, and pathology reports documentation, plan of care, treatment goals	_____	RN, LPN, MA, Other _____ PTA _____
Other Clinical Activity (please specify)		
Verify/Coordinate availability of resources/ equip	_____	RN, LPN, MA, Other _____ Aide _____
<i>End: Patient arrival at office for service</i>		
Service Period		
<i>Start: Patient arrival at office for service</i>		
Greet patient/provide gowning	_____	RN, LPN, MA, Other _____ Aide _____
Obtain vital signs	_____	RN, LPN, MA, Other _____ PTA _____
Obtain measurements, eg, ROM/strength/edema	_____	RN, LPN, MA, Other _____ PTA _____
Prep and position patient	_____	RN, LPN, MA, Other _____ Aide _____
Prepare room, equipment, supplies	_____	RN, LPN, MA, Other _____ Aide _____
Assist physician therapist during exam	_____ 3 _____	RN, LPN, MA, Other _____ PTA _____
Education/instruction/ counseling/coord home care	_____ 1 _____	RN, LPN, MA, Other _____ PTA _____
Coordinate home or outpatient care	_____	RN, LPN, MA, Other _____
Clean room/equipment	_____ 1 _____	RN, LPN, MA, Other _____ Aide _____
Other Clinical Activity (please specify)		
Post treatment patient assistance	_____ 1 _____	RN, LPN, MA, Other _____ Aide _____
<i>End: Patient leaves office</i>		
Post-Service Period		
<i>Start: Patient leaves office</i>		
Phone calls between visits with patient, family	_____	RN, LPN, MA, Other _____ PTA _____
Other Activity (please specify)		
Record data and results/complete record	_____	RN, LPN, MA, Other _____ PTA _____
<i>End: When appointment for next office visit is made.</i>		

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

CPT Long Descriptor: Application of a modality to one or more areas; infrared

Sample Size: N/A Response Rate: (%): Global Period:

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:

An Advisory Panel of physical therapists was convened to review the codes in the 97000 series. The Advisory Panel represented multiple levels of care where CPT coding is used. The Panel was trained in the practice expense process. The results of the Panel's efforts were further reviewed by additional clinical consultants. The data were drafted, routed to the Advisory Panel for additional comments and finalized.

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Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Pre service includes the review of the documentation, plan of care and treatment goals and the effect of previous treatment. An aide will also verify the availability of resources, materials and equipment.

Intra-Service Clinical Labor Activities:

Intra-Service includes greeting and preparing the patient, preparing the room, obtaining relevant measurements and vital signs, assisting the physical therapist during the intervention, demonstration and performance verification, post treatment assistance of the patient and cleaning the room/exercise area.

Post-Service Clinical Labor Activities:

CPT Code: 97026 _____

Specialty Society('s)_APTA _____

					226

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

SITE OF SERVICE: In-Office

Clinical Services

Minutes

Staff Type – Circle

Pre-Service Period

Start: When appointment for service is made

PEAC
Approved
02/2001

Review/read X-ray, lab, and pathology reports
documentation, plan of care, treatment goals

_____ RN, LPN, MA, Other _____ PTA _____

Other Clinical Activity (please specify)

Verify/Coordinate availability of resources/ equip

_____ RN, LPN, MA, Other _____ Aide _____

End: Patient arrival at office for service

Service Period

Start: Patient arrival at office for service

Greet patient/provide gowning

_____ RN, LPN, MA, Other _____ Aide _____

Obtain vital signs

_____ RN, LPN, MA, Other _____ PTA _____

Obtain measurements, eg, ROM/strength/edema

_____ RN, LPN, MA, Other _____ PTA _____

Prep and position patient

_____ RN, LPN, MA, Other _____ Aide _____

Prepare room, equipment, supplies

_____ RN, LPN, MA, Other _____ Aide _____

Assist physician therapist during exam

_____ 3 _____ RN, LPN, MA, Other _____ PTA _____

Education/instruction/ counseling/coord home care

_____ 1 _____ RN, LPN, MA, Other _____ PTA _____

~~Coordinate home or outpatient care~~

_____ RN, LPN, MA, Other _____

Clean room/equipment

_____ 1 _____ RN, LPN, MA, Other _____ Aide _____

Other Clinical Activity (please specify)

Post treatment patient assistance

_____ 1 _____ RN, LPN, MA, Other _____ Aide _____

End: Patient leaves office

Post-Service Period

Start: Patient leaves office

Phone calls between visits with patient, family

_____ RN, LPN, MA, Other _____ PTA _____

Other Activity (please specify)

Record data and results/complete record

_____ RN, LPN, MA, Other _____ PTA _____

End: When appointment for next office visit is made.

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

CPT Long Descriptor: Application of a modality to one or more areas; ultraviolet

Sample Size: __N/A__ Response Rate: (%): _____ Global Period: _____

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:

An Advisory Panel of physical therapists was convened to review the codes in the 97000 series. The Advisory Panel represented multiple levels of care where CPT coding is used. The Panel was trained in the practice expense process. The results of the Panel's efforts were further reviewed by additional clinical consultants. The data were drafted, routed to the Advisory Panel for additional comments and finalized.

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Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Pre service includes the review of the documentation, plan of care and treatment goals and the effect of previous treatment. An aide will also verify the availability of resources, materials and equipment.

Intra-Service Clinical Labor Activities:

Intra-Service includes greeting and preparing the patient, preparing the room, obtaining relevant measurements and vital signs, assisting the physical therapist during the intervention, demonstration and performance verification, post treatment assistance of the patient and cleaning the room/exercise area.

Post-Service Clinical Labor Activities:

CPT Code: 97028 _____
Specialty Society('s)_APTA _____

					2000, pg 226

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

SITE OF SERVICE: In-Office

Clinical Services

Minutes

Staff Type – Circle

Pre-Service Period

Start: When appointment for service is made

PEAC
 Approved
 02/2001

Review/read X-ray, lab, and pathology reports
 documentation, plan of care, treatment goals

_____ RN, LPN, MA, Other _____ PTA _____

Other Clinical Activity (please specify)

Verify/Coordinate availability of resources/ equip

_____ RN, LPN, MA, Other _____ Aide _____

End: Patient arrival at office for service

Service Period

Start: Patient arrival at office for service

Greet patient/provide gowning

_____ RN, LPN, MA, Other _____ Aide _____

Obtain vital signs

_____ RN, LPN, MA, Other _____ PTA _____

Obtain measurements, eg, ROM/strength/edema

_____ RN, LPN, MA, Other _____ PTA _____

Prep and position patient

_____ RN, LPN, MA, Other _____ Aide _____

Prepare room, equipment, supplies

_____ RN, LPN, MA, Other _____ Aide _____

Assist ~~physician~~ therapist during exam

_____ 3 _____ RN, LPN, MA, Other _____ PTA _____

Education/instruction/ counseling/coord home care

_____ 1 _____ RN, LPN, MA, Other _____ PTA _____

~~Coordinate home or outpatient care~~

_____ RN, LPN, MA, Other _____

Clean room/equipment

_____ 1 _____ RN, LPN, MA, Other _____ Aide _____

Other Clinical Activity (please specify)

Post treatment patient assistance

_____ 1 _____ RN, LPN, MA, Other _____ Aide _____

End: Patient leaves office

Post-Service Period

Start: Patient leaves office

Phone calls between visits with patient, family

_____ RN, LPN, MA, Other _____ PTA _____

Other Activity (please specify)

Record data and results/complete record

_____ RN, LPN, MA, Other _____ PTA _____

End: When appointment for next office visit is made.

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

CPT Long Descriptor: Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes

Sample Size: __N/A__ Response Rate: (%): _____ Global Period: _____

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:

An Advisory Panel of physical therapists was convened to review the codes in the 97000 series. The Advisory Panel represented multiple levels of care where CPT coding is used. The Panel was trained in the practice expense process. The results of the Panel's efforts were further reviewed by additional clinical consultants. The data were drafted, routed to the Advisory Panel for additional comments and finalized.

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Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

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Intra-Service Clinical Labor Activities:

Intra-Service includes greeting and preparing the patient, preparing the room, obtaining relevant measurements and vital signs, assisting the physical therapist during the intervention, demonstration and performance verification, post treatment assistance of the patient and cleaning the room/exercise area.

Post-Service Clinical Labor Activities:

Post-Service includes recording data and results and communication with patient, family and other providers.

Total Staff Time In Office:

Visits in Global Period:

HCFA's Staff Type Code*	Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
	RN				
	LPN				
	MA				
	PTA per single unit of 15 min		4		
	Aide per single unit of 15 min		3		
	PEAC Approved 02/2001				

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
31101	Alcohol swab	2		.034
	Disposable electrodes	2		6.35 Smith & Nephew (1999) p159
11104	razor	1		.31
31514	tape	6"		.015
11522	Conducting gel	1		.168
31505	gauze	1		.22
	Other supplies are included in the procedures that are typically delivered with this modality			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

CPT Code: 97032 _____

Specialty Society('s)_APTA _____

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
E92009	Hi Volt Electrical Stimulator		15		1395.
	Low mat table		15		5000., Sammons 2000, pg 226

Type of Service: Evaluation/Management Services or Diagnostic Tests
XXX Global Period
Per single 15 minute unit

SITE OF SERVICE: In-Office

Clinical Services

Minutes

Staff Type – Circle

Pre-Service Period

Start: When appointment for service is made

PEAC
 Approved
 02/2001

Review/read X-ray, lab, and pathology reports
 documentation, plan of care, treatment goals

_____ RN, LPN, MA, Other _____ PTA _____

Other Clinical Activity (please specify)

Verify/Coordinate availability of resources/ equip

_____ RN, LPN, MA, Other _____ Aide _____

End: Patient arrival at office for service

Service Period

Start: Patient arrival at office for service

Greet patient/provide gowning

_____ RN, LPN, MA, Other _____ Aide _____

Obtain vital signs

_____ RN, LPN, MA, Other _____ PTA _____

Obtain measurements, eg, ROM/strength/edema

_____ RN, LPN, MA, Other _____ PTA _____

Prep and position patient

_____ RN, LPN, MA, Other _____ Aide _____

Prepare room, equipment, supplies

_____ RN, LPN, MA, Other _____ Aide _____

Assist physician therapist during exam

_____ 3 _____ RN, LPN, MA, Other _____ PTA _____

Education/instruction/ counseling/coord home care

_____ 1 _____ RN, LPN, MA, Other _____ PTA _____

~~Coordinate home or outpatient care~~

_____ RN, LPN, MA, Other _____

Clean room/equipment

_____ 2 _____ RN, LPN, MA, Other _____ Aide _____

Other Clinical Activity (please specify)

Post treatment patient assistance

_____ 1 _____ RN, LPN, MA, Other _____ Aide _____

End: Patient leaves office

Post-Service Period

Start: Patient leaves office

Phone calls between visits with patient, family

_____ RN, LPN, MA, Other _____ PTA _____

Other Activity (please specify)

Record data and results/complete record

_____ RN, LPN, MA, Other _____ PTA _____

End: When appointment for next office visit is made.

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

CPT Long Descriptor: Application of a modality to one or more areas; iontophoresis, each 15 minutes

Sample Size: N/A Response Rate: (%): Global Period:

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:

An Advisory Panel of physical therapists was convened to review the codes in the 97000 series. The Advisory Panel represented multiple levels of care where CPT coding is used. The Panel was trained in the practice expense process. The results of the Panel's efforts were further reviewed by additional clinical consultants. The data were drafted, routed to the Advisory Panel for additional comments and finalized.

A "typical visit" was defined by the Advisory Panel as a 45 minute visit during which the patient receives two 15 minute procedures and a modality. Consequently clinical labor is calculated for two 15 minute units and then halved for the summary. Additionally, as they are not "typically" delivered by themselves, modalities tend not to have "greet and gowning" labor expenses. These expenses are already with the procedure codes.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Pre service includes the review of the documentation, plan of care and treatment goals and the effect of previous treatment. An aide will also verify the availability of resources, materials and equipment.

Intra-Service Clinical Labor Activities:

Intra-Service includes greeting and preparing the patient, preparing the room, obtaining relevant measurements and vital signs, assisting the physical therapist during the intervention, demonstration and performance verification, post treatment assistance of the patient and cleaning the room/exercise area.

Post-Service Clinical Labor Activities:

CPT Code: 97033 _____
 Specialty Society('s)_APTA _____

Post-Service includes recording data and results and communication with patient, family and other providers.

Total Staff Time In Office:

Visits in Global Period:

HCFA's Staff Type Code*	Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
	RN				
	LPN				
	MA				
	PTA per single unit of 15 min		1		
	Aide per single unit of 15 min		9		
	PEAC Approved 02/2001				

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
31101	Alcohol swab	1		.017
	Disposable electrode with medication vesicle	2		\$16/IOMED price quote \$8 per electrode
11104	razor	1		.31
31514	tape	6in		.015
31505	Gauze4x4	1		.22
91408	syringe	2		.50
	Other supplies are included in the procedures that are typically delivered with this modality			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Low mat table		15		5000., Sammons 2000, pg 226
	Phoresor		15		1000. (IOMED quote)

Type of Service: Evaluation/Management Services or Diagnostic Tests
XXX Global Period
Per single 15 minute unit

SITE OF SERVICE: In-Office

Clinical Services

Minutes

Staff Type – Circle

Pre-Service Period

Start: When appointment for service is made

PEAC
Approved
02/2001

Review/read X-ray, lab, and pathology reports
documentation, plan of care, treatment goals

_____ RN, LPN, MA, Other _____ PTA _____

Other Clinical Activity (please specify)

Verify/Coordinate availability of resources/ equip

_____ RN, LPN, MA, Other _____ Aide _____

End: Patient arrival at office for service

Service Period

Start: Patient arrival at office for service

Greet patient/provide gowning

_____ RN, LPN, MA, Other _____ Aide _____

Obtain vital signs

_____ RN, LPN, MA, Other _____ PTA _____

Obtain measurements, eg, ROM/strength/edema

_____ 1 _____ RN, LPN, MA, Other _____ PTA _____

Prep and position patient

_____ 1 _____ RN, LPN, MA, Other _____ Aide _____

Prepare room, equipment, supplies

_____ 3 _____ RN, LPN, MA, Other _____ Aide _____

Assist ~~physician~~ therapist during exam

_____ RN, LPN, MA, Other _____ PTA _____

Education/instruction/ counseling/coord home care

_____ 1 _____ RN, LPN, MA, Other _____ PTA _____

~~Coordinate home or outpatient care~~

_____ RN, LPN, MA, Other _____

Clean room/equipment

_____ 3 _____ RN, LPN, MA, Other _____ Aide _____

Other Clinical Activity (please specify)

Post treatment patient assistance

_____ 1 _____ RN, LPN, MA, Other _____ Aide _____

End: Patient leaves office

Post-Service Period

Start: Patient leaves office

Phone calls between visits with patient, family

_____ RN, LPN, MA, Other _____ PTA _____

Other Activity (please specify)

Record data and results/complete record

_____ RN, LPN, MA, Other _____ PTA _____

End: When appointment for next office visit is made.

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

CPT Long Descriptor: Application of a modality to one or more areas; contrast baths, each 15 minutes

Sample Size: __N/A__ Response Rate: (%): _____ Global Period: _____

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:

An Advisory Panel of physical therapists was convened to review the codes in the 97000 series. The Advisory Panel represented multiple levels of care where CPT coding is used. The Panel was trained in the practice expense process. The results of the Panel's efforts were further reviewed by additional clinical consultants. The data were drafted, routed to the Advisory Panel for additional comments and finalized.

A "typical visit" was defined by the Advisory Panel as a 45 minute visit during which the patient receives two 15 minute procedures and a modality. Consequently clinical labor is calculated for two 15 minute units and then halved for the summary. Additionally, as they are not "typically" delivered by themselves, modalities tend not to have "greet and gowning" labor expenses. These expenses are already with the procedure codes.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Pre service includes the review of the documentation, plan of care and treatment goals and the effect of previous treatment. An aide will also verify the availability of resources, materials and equipment.

Intra-Service Clinical Labor Activities:

Intra-Service includes greeting and preparing the patient, preparing the room, obtaining relevant measurements and vital signs, assisting the physical therapist during the intervention, demonstration and performance verification, post treatment assistance of the patient and cleaning the room/exercise area.

Post-Service Clinical Labor Activities:

CPT Code: 97034 _____

Specialty Society('s)_APTA _____

Type of Service: Evaluation/Management Services or Diagnostic Tests
XXX Global Period
Per single 15 minute unit

SITE OF SERVICE: In-Office

Clinical Services

Minutes

Staff Type – Circle

Pre-Service Period

PEAC
Approved
02/2001

Start: When appointment for service is made

Review/read X-ray, lab, and pathology reports
documentation, plan of care, treatment goals

_____ RN, LPN, MA, Other _____ PTA _____

Other Clinical Activity (please specify)

Verify/Coordinate availability of resources/ equip

_____ RN, LPN, MA, Other _____ Aide _____

End: Patient arrival at office for service

Service Period

Start: Patient arrival at office for service

Greet patient/provide gowning

_____ RN, LPN, MA, Other _____ Aide _____

Obtain vital signs

_____ RN, LPN, MA, Other _____ PTA _____

Obtain measurements, eg, ROM/strength/edema

_____ RN, LPN, MA, Other _____ PTA _____

Prep and position patient

_____ 2 _____ RN, LPN, MA, Other _____ Aide _____

Prepare room, equipment, supplies

_____ 3 _____ RN, LPN, MA, Other _____ Aide _____

Assist physician therapist during exam

_____ 3 _____ RN, LPN, MA, Other _____ PTA _____

Education/instruction/ counseling/coord home care

_____ 3 _____ RN, LPN, MA, Other _____ PTA _____

~~Coordinate home or outpatient care~~

_____ RN, LPN, MA, Other _____

Clean room/equipment

_____ 5 _____ RN, LPN, MA, Other _____ Aide _____

Other Clinical Activity (please specify)

Post treatment patient assistance

_____ RN, LPN, MA, Other _____ Aide _____

End: Patient leaves office

Post-Service Period

Start: Patient leaves office

Phone calls between visits with patient, family

_____ 1 _____ RN, LPN, MA, Other _____ PTA _____

Other Activity (please specify)

Record data and results/complete record

_____ RN, LPN, MA, Other _____ PTA _____

End: When appointment for next office visit is made.

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

CPT Long Descriptor: Application of a modality to one or more areas; ultrasound, each 15 minutes

Sample Size: __N/A__ Response Rate: (%): _____ Global Period: _____

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:

An Advisory Panel of physical therapists was convened to review the codes in the 97000 series. The Advisory Panel represented multiple levels of care where CPT coding is used. The Panel was trained in the practice expense process. The results of the Panel's efforts were further reviewed by additional clinical consultants. The data were drafted, routed to the Advisory Panel for additional comments and finalized.

A "typical visit" was defined by the Advisory Panel as a 45 minute visit during which the patient receives two 15 minute procedures and a modality. Consequently clinical labor is calculated for two 15 minute units and then halved for the summary. Additionally, as they are not "typically" delivered by themselves, modalities tend not to have "greet and gowning" labor expenses. These expenses are already with the procedure codes.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Pre service includes the review of the documentation, plan of care and treatment goals and the effect of previous treatment. An aide will also verify the availability of resources, materials and equipment.

Intra-Service Clinical Labor Activities:

Intra-Service includes greeting and preparing the patient, preparing the room, obtaining relevant measurements and vital signs, assisting the physical therapist during the intervention, demonstration and performance verification, post treatment assistance of the patient and cleaning the room/exercise area.

Post-Service Clinical Labor Activities:

CPT Code: 97035 _____
Specialty Society('s)_APTA _____

E92001	Therapeutic ultrasound unit		8		1995.

Type of Service: Evaluation/Management Services or Diagnostic Tests
XXX Global Period
Per single 15 minute unit

SITE OF SERVICE: In-Office

Clinical Services

Minutes

Staff Type – Circle

Pre-Service Period

Start: When appointment for service is made

PEAC
Approved
02/2001

Review/read X-ray, lab, and pathology reports
documentation, plan of care, treatment goals

_____ RN, LPN, MA, Other _____ PTA _____

Other Clinical Activity (please specify)

Verify/Coordinate availability of resources/ equip

_____ RN, LPN, MA, Other _____ Aide _____

End: Patient arrival at office for service

Service Period

Start: Patient arrival at office for service

Greet patient/provide gowning

_____ RN, LPN, MA, Other _____ Aide _____

Obtain vital signs

_____ RN, LPN, MA, Other _____ PTA _____

Obtain measurements, eg, ROM/strength/edema

_____ RN, LPN, MA, Other _____ PTA _____

Prep and position patient

_____ RN, LPN, MA, Other _____ Aide _____

Prepare room, equipment, supplies

_____ RN, LPN, MA, Other _____ Aide _____

Assist physician therapist during exam

_____ 3 _____ RN, LPN, MA, Other _____ PTA _____

Education/instruction/ counseling/coord home care

_____ 1 _____ RN, LPN, MA, Other _____ PTA _____

~~Coordinate home or outpatient care~~

_____ RN, LPN, MA, Other _____

Clean room/equipment

_____ 1 _____ RN, LPN, MA, Other _____ Aide _____

Other Clinical Activity (please specify)

Post treatment patient assistance

_____ 1 _____ RN, LPN, MA, Other _____ Aide _____

End: Patient leaves office

Post-Service Period

Start: Patient leaves office

Phone calls between visits with patient, family

_____ RN, LPN, MA, Other _____ PTA _____

Other Activity (please specify)

Record data and results/complete record

_____ RN, LPN, MA, Other _____ PTA _____

End: When appointment for next office visit is made.

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

CPT Long Descriptor: Application of a modality to one or more areas; Hubbard tank, each 15 minutes

Sample Size: __N/A____ Response Rate: (%):_____ Global Period: _____

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:

An Advisory Panel of physical therapists was convened to review the codes in the 97000 series. The Advisory Panel represented multiple levels of care where CPT coding is used. The Panel was trained in the practice expense process. The results of the Panel's efforts were further reviewed by additional clinical consultants. The data were drafted, routed to the Advisory Panel for additional comments and finalized.

A "typical visit" was defined by the Advisory Panel as a 45 minute visit during which the patient receives two 15 minute procedures and a modality. Consequently clinical labor is calculated for two 15 minute units and then halved for the summary. Additionally, as they are not "typically" delivered by themselves, modalities tend not to have "greet and gowning" labor expenses. These expenses are already with the procedure codes.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Pre service includes the review of the documentation, plan of care and treatment goals and the effect of previous treatment. An aide will also verify the availability of resources, materials and equipment.

Intra-Service Clinical Labor Activities:

Intra-Service includes greeting and preparing the patient, preparing the room, obtaining relevant measurements and vital signs, assisting the physical therapist during the intervention, demonstration and performance verification, post treatment assistance of the patient and cleaning the room/exercise area.

Post-Service Clinical Labor Activities:

Post-Service includes recording data and results and communication with patient, family and other providers.

Total Staff Time In Office:

Visits in Global Period:

HCFA's Staff Type Code*	Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
	RN				
	LPN				
	MA				
	PTA per single unit of 15 min		16		
	Aide per single unit of 15 min		24		
	PEAC Approved 02/2001				

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	Chlorazine	1packet	24 packets	2.95Smith & Nephew (1999) pg. 149
14004	Gloves, sterile	1pr		.89
92034	culturette	1		.74
92035	Culture media	10ml		.15
	Other supplies are included in the procedures that are typically delivered with this modality			

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
E92016	Hubbard Tank		15		17000.
	Hydraulic lift		6		4945. (Sammons 2000, pg. 267)

Type of Service: Evaluation/Management Services or Diagnostic Tests
XXX Global Period
Per single 15 minute unit

SITE OF SERVICE: In-Office
Clinical Services

	<u>Minutes</u>	<u>Staff Type – Circle</u>
Pre-Service Period		
<i>Start: When appointment for service is made</i>		
Review/read X-ray, lab, and pathology reports documentation, plan of care, treatment goals	_____	RN, LPN, MA, Other _____ PTA _____
Other Clinical Activity (please specify)		
Verify/Coordinate availability of resources/ equip	_____	RN, LPN, MA, Other _____ Aide _____
<i>End: Patient arrival at office for service</i>		
Service Period		
<i>Start: Patient arrival at office for service</i>		
Greet patient/provide gowning	_____	RN, LPN, MA, Other _____ Aide _____
Obtain vital signs	_____	RN, LPN, MA, Other _____ PTA _____
Obtain measurements, eg, ROM/strength/edema	_____	RN, LPN, MA, Other _____ PTA _____
Prep and position patient	5	RN, LPN, MA, Other _____ Aide _____
Prepare room, equipment, supplies	6	RN, LPN, MA, Other _____ Aide _____
Assist physician therapist during exam	15	RN, LPN, MA, Other _____ PTA _____
Education/instruction/ counseling/coord home care	1	RN, LPN, MA, Other _____ PTA _____
Coordinate home or outpatient care	_____	RN, LPN, MA, Other _____
Clean room/equipment	8	RN, LPN, MA, Other _____ Aide _____
Other Clinical Activity (please specify)		
Post treatment patient assistance	5	RN, LPN, MA, Other _____ Aide _____
<i>End: Patient leaves office</i>		
Post-Service Period		
<i>Start: Patient leaves office</i>		
Phone calls between visits with patient, family	_____	RN, LPN, MA, Other _____ PTA _____
Other Activity (please specify)		
Record data and results/complete record	_____	RN, LPN, MA, Other _____ PTA _____
<i>End: When appointment for next office visit is made.</i>		

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

CPT Long Descriptor: Application of a modality to one or more areas; unlisted modality (specify type and time if constant attendance)

Sample Size: N/A Response Rate: (%): Global Period:

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:

An Advisory Panel of physical therapists was convened to review the codes in the 97000 series. The Advisory Panel represented multiple levels of care where CPT coding is used. The Panel was trained in the practice expense process. The results of the Panel's efforts were further reviewed by additional clinical consultants. The data were drafted, routed to the Advisory Panel for additional comments and finalized.

A "typical visit" was defined by the Advisory Panel as a 45 minute visit during which the patient receives two 15 minute procedures and a modality. Consequently clinical labor is calculated for two 15 minute units and then halved for the summary. Additionally, as they are not "typically" delivered by themselves, modalities tend not to have "greet and gowning" labor expenses. These expenses are already with the procedure codes.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Pre service includes the review of the documentation, plan of care and treatment goals and the effect of previous treatment. An aide will also verify the availability of resources, materials and equipment.

Intra-Service Clinical Labor Activities:

Intra-Service includes greeting and preparing the patient, preparing the room, obtaining relevant measurements and vital signs, assisting the physical therapist during the intervention, demonstration and performance verification, post treatment assistance of the patient and cleaning the room/exercise area.

CPT Code: 97039 _____
Specialty Society('s)_APTA _____

					2000, pg 226

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

SITE OF SERVICE: In-Office
Clinical Services

	<u>Minutes</u>	<u>Staff Type – Circle</u>
Pre-Service Period		
<i>Start: When appointment for service is made</i>		
Review/read X-ray, lab, and pathology reports documentation, plan of care, treatment goals	_____	RN, LPN, MA, Other _____ PTA _____
Other Clinical Activity (please specify)		
Verify/Coordinate availability of resources/ equip	_____	RN, LPN, MA, Other _____ Aide _____
<i>End: Patient arrival at office for service</i>		
Service Period		
<i>Start: Patient arrival at office for service</i>		
Greet patient/provide gowning	_____	RN, LPN, MA, Other _____ Aide _____
Obtain vital signs	_____	RN, LPN, MA, Other _____ PTA _____
Obtain measurements, eg, ROM/strength/edema	_____	RN, LPN, MA, Other _____ PTA _____
Prep and position patient	_____	RN, LPN, MA, Other _____ Aide _____
Prepare room, equipment, supplies	_____	RN, LPN, MA, Other _____ Aide _____
Assist physician therapist during exam	_____ 3 _____	RN, LPN, MA, Other _____ Aide _____
Education/instruction/ counseling/coord home care	_____ 1 _____	RN, LPN, MA, Other _____ PTA _____
Coordinate home or outpatient care	_____	RN, LPN, MA, Other _____
Clean room/equipment	_____ 2 _____	RN, LPN, MA, Other _____ Aide _____
Other Clinical Activity (please specify)		
Post treatment patient assistance	_____ 1 _____	RN, LPN, MA, Other _____ Aide _____
<i>End: Patient leaves office</i>		
Post-Service Period		
<i>Start: Patient leaves office</i>		
Phone calls between visits with patient, family	_____	RN, LPN, MA, Other _____ PTA _____
Other Activity (please specify)		
Record data and results/complete record	_____	RN, LPN, MA, Other _____ PTA _____
<i>End: When appointment for next office visit is made.</i>		

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

CPT Long Descriptor: Orthotics fitting and training, upper and/or lower extremities; each 15 minutes

Vignette: Patient with 6 week old median & ulnar nerve injury is referred to splinting to improve hand use. Through a combination of gross impairment assessment and clinical reasoning, the therapist designs a splint that stabilizes the thumb for 3 jaw chuck prehension and facilitates the finger extension required to place the hand around large objects. During the fitting process, the patient is instructed in splint application, uses and frequency of wear, how to check for pressure areas and care of the splint.

Sample Size: ___N/A___ Response Rate: (%): _____ Global Period: _____

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:

AOTA data were developed by a consensus panel of occupational therapists, who are either in private practice or have significant experience as rehabilitation managers of large outpatient therapy departments. This group consulted with additional therapists and administrative personnel within their respective practice settings. The panel was trained in the practice expense process and developed data during an intensive 2 day face to face meeting. Additional telephone conferences were held to refine the data and include comments from additional clinical consultants. The data presented are consistent with the cross-walk approved at the February 2001 PEAC for procedures and modalities in the 97XXX family of codes.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: Pre service includes the review of the documentation, plan of care and treatment goals and the effect of previous treatment. An aide will also verify the availability of resources, materials and equipment.

Intra-Service Clinical Labor Activities: Intra-Service includes greeting and preparing the patient, preparing the room, obtaining relevant measurements and vital signs, assisting the occupational therapist during the intervention, demonstration and performance verification, post treatment assistance of the patient and cleaning the room/clinic area.

Post-Service Clinical Labor Activities: Post-Service includes communication with patient, family, other providers, and payers.

Total Staff Time In Office:

Visits in Global Period:

HCFA's Staff Type Code*	Clinical Labor (for all of the activities performed on the day of service)	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
	RN				
	LPN				
	MA				
	Assistant	1.5	12.5	1	
	Aide	1.5	3.5		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Price	Source of Supply	Cost Estimate
	1 Multispecialty package				
	Orthotic bonder	.5 oz	21.95/3 2 oz	NC(12561)	.34
	Cold Spray	.24 oz		NC(12720)	.23
	Distilled Water	1 gallon	1.30/gal	drugstore	1.30

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	% time of use per procedure ¹	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Adjustable height work table	1	67%		2,905 (Hausmann)
	Splint-Form 2000/ cart heating pan	1	67%		790 (NC 76290)
	BTE	1	33%		45,820 (BTE)
	Mobile orthotics work bench	1	67%		750 (NC76290)

¹ During the typical treatment described in the vignette, the patient would spend two-thirds of the session seated on the chair at the treatment table. The work bench and the heating pan are accessed by the therapist during this time. One- third of the session is spent assessing the patient's progress using the BTE.

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

CPT Long Descriptor: PROSTHETIC TRAINING, UPPER AND/OR LOWER EXTREMITIES, EACH 15 MINUTES

Sample Size: __N/A__ Response Rate: (%): _____ Global Period: _____

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:

An Advisory Panel of physical therapists was convened to review the codes in the 97000 series. The Advisory Panel represented multiple levels of care where CPT coding is used. The Panel was trained in the practice expense process. The results of the Panel's efforts were further reviewed by additional clinical consultants. The data were drafted, routed to the Advisory Panel for additional comments and finalized.

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Pre-Service Clinical Labor Activities:

Pre service includes the review of the documentation, plan of care and treatment goals and the effect of previous treatment. An aide will also verify the availability of resources, materials and equipment.

Intra-Service Clinical Labor Activities:

Intra-Service includes greeting and preparing the patient, preparing the room, obtaining relevant measurements and vital signs, assisting the physical therapist during the intervention, demonstration and performance verification, post treatment assistance of the patient and cleaning the room/exercise area.

Post-Service Clinical Labor Activities:

Post-Service includes recording data and results and communication with patient, family and other providers.

Total Staff Time In Office:

Visits in Global Period:

HCFA's Staff Type Code*	Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
	RN				
	LPN				
	MA				
	PTA per single unit of 15 min		15		
	Aide per single unit of 15 min		5		
	\				

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	0.5 Multispecialty Visit Package			
32014	stockinette	1yd.		.45
	moleskin	4"	4yd	1.40 Sammons (2000) pg. 342

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Low mat table		5		5000., Sammons 200, pg 226
E92011	Parallel bars		4		1755.
	Exercise stair case		3		870. (Sammons 2000, pg 257)
	Balance board		4		600 (Sammons 2000, pg. 185)
	Treadmill		3		4700 (Sammons 2000, pg 194)

Type of Service: Evaluation/Management Services or Diagnostic Tests
XXX Global Period
Per two 15 minute units

SITE OF SERVICE: In-Office
Clinical Services

Minutes **Staff Type – Circle**

Pre-Service Period

PEAC
 Approved
 02/2001

Start: When appointment for service is made

Review/read X-ray, lab, and pathology reports
 documentation, plan of care, treatment goals

_____ 3 _____ RN, LPN, MA, Other _____ PTA _____

Other Clinical Activity (please specify)

Verify/Coordinate availability of resources/ equip

_____ 3 _____ RN, LPN, MA, Other _____ Aide _____

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 _____ Aide _____

Obtain vital signs

_____ 2 _____ RN, LPN, MA, Other _____ PTA _____

Obtain measurements, eg, ROM/strength/edema

_____ 3 _____ RN, LPN, MA, Other _____ PTA _____

Prep and position patient

_____ RN, LPN, MA, Other _____ Aide _____

Prepare room, equipment, supplies

_____ RN, LPN, MA, Other _____ Aide _____

Assist ~~physician~~ therapist during exam

_____ 15 _____ RN, LPN, MA, Other _____ PTA _____

Education/instruction/ counseling/coord home care

_____ 5 _____ RN, LPN, MA, Other _____ PTA _____

~~Coordinate home or outpatient care~~

_____ RN, LPN, MA, Other _____

Clean room/equipment

_____ 2 _____ RN, LPN, MA, Other _____ Aide _____

Other Clinical Activity (please specify)

Post treatment patient assistance

_____ 2 _____ RN, LPN, MA, Other _____ Aide _____

End: Patient leaves office

Post-Service Period

Start: Patient leaves office

Phone calls between visits with patient, family

_____ 2 _____ RN, LPN, MA, Other _____ PTA _____

Other Activity (please specify)

Record data and results/complete record

_____ RN, LPN, MA, Other _____ PTA _____

End: When appointment for next office visit is made.

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

CPT Long Descriptor: Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

Vignette: A carpenter who sustained multiple trauma from an automobile accident experiences decreased strength and coordination of both upper extremities and poor standing tolerance. The provider designs a woodworking project requiring the patient to make a series of items which require standing for periods of time and use of upper extremity coordination. The difficulty of each project requires progressively increased strength, coordination, endurance and standing tolerance.

Sample Size: N/A Response Rate: (%): Global Period:

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:

AOTA data were developed by a consensus panel of occupational therapists, who are either in private practice or have significant experience as rehabilitation managers of large outpatient therapy departments. This group consulted with additional therapists and administrative personnel within their respective practice settings. The panel was trained in the practice expense process and developed data during an intensive 2 day face to face meeting. Additional telephone conferences were held to refine the data and include comments from additional clinical consultants. The data presented are consistent with the cross-walk approved at the February 2001 PEAC for procedures and modalities in the 97XXX family of codes.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: Pre service includes the review of the documentation, plan of care and treatment goals and the effect of previous treatment. An aide will also verify the availability of resources, materials and equipment.

Intra-Service Clinical Labor Activities: Intra-Service includes greeting and preparing the patient, preparing the room, obtaining relevant measurements and vital signs, assisting the occupational therapist during the intervention, demonstration and performance verification, post treatment assistance of the patient and cleaning the room/clinic area.

Post-Service Clinical Labor Activities: Post-Service includes communication with patient, family, other providers, and payers.

Total Staff Time In Office:

Visits in Global Period:

HCFA's Staff Type Code*	Clinical Labor (for all of the activities performed on the day of service)	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
	RN				
	LPN				
	MA				
	Assistant	1.5	11	1	
	Aide	1.5	5		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Price	Source of Supply	Cost Estimate
	Woodworking Kit	1 kit	12.99	S&S	12.99

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	% time of use per procedure ¹	Hours per week in use for all services	Cost Estimate and Source (if applicable)

The PEAC did not develop a recommendation on the equipment for this code and is deferring to HCFA and the AOTA to develop an appropriate assignment of equipment.

¹ During the typical treatment for the patient described in the vignette, the therapist would be treating the patient for three-quarters of the session in the environmental module, using the woodworking kit and Valpar. The other quarter of the session would be spent assessing the patient's progress using the BTE.

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

CPT Long Descriptor: Self care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment), direct one on one contact by provider, each 15 minutes

Vignette: The patient is a 65-year old woman recently discharged from the hospital with a diagnosis of CVA resulting in a right hemiparesis. the patient lives alone and wants to be able to remain in her home. The initial evaluation has revealed performance deficits in bathroom activities and meal preparation. At the home site, the therapist recommends and sets up proper adaptive equipment in the bathroom, so that the patient can safely transfer to toilet and bathtub using contemporary techniques. In the kitchen, the therapist teaches and observes meal preparation using one-handed techniques and special adaptive equipment. Therapist must assure that patient's functional level is sufficient to perform necessary self care and home management activities within safe limits (e.g. picking items off floor, lifting pots from stove, reaching items in cupboards, opening drawers.)

Sample Size: N/A Response Rate: (%): Global Period:

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:

AOTA data were developed by a consensus panel of occupational therapists, who are either in private practice or have significant experience as rehabilitation managers of large outpatient therapy departments. This group consulted with additional therapists and administrative personnel within their respective practice settings. The panel was trained in the practice expense process and developed data during an intensive 2 day face to face meeting. Additional telephone conferences were held to refine the data and include comments from additional clinical consultants. The data presented are consistent with the cross-walk approved at the February 2001 PEAC for procedures and modalities in the 97XXX family of codes.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: Pre service includes the review of the documentation, plan of care and treatment goals and the effect of previous treatment. An aide will also verify the availability of resources, materials and equipment.

Intra-Service Clinical Labor Activities: Intra-Service includes greeting and preparing the patient, preparing the room, obtaining relevant measurements and vital signs, assisting the occupational therapist during the intervention, demonstration and performance verification, post treatment assistance of the patient and cleaning the room/clinic area.

Post-Service Clinical Labor Activities: Post-Service includes communication with patient, family, other providers, and payers.

Total Staff Time In Office:

Visits in Global Period:

HCFA's Staff Type Code*	Clinical Labor (for all of the activities performed on the day of service)	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
	RN				
	LPN				
	MA				
	Assistant	1.5	11	1	
	Aide	1.5	5		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Price	Source of Supply	Cost Estimate
	Soap	.5 oz	1.99/7.59 oz	drugstore	.13
	Cooking activity (mac and cheese)	1 pkg 1 c. milk	.89 1.79/.5 gal	Grocery store	.89 .22
	Toothpaste	.25 oz	3.29/6 oz	Grocery store	.14
	Toothbrush	1	3.99	Grocery store	
	SaniZene Disinfectant	2 oz.	29.95/1 gal	NC (70455)	.46

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	% time of use per procedure ¹	Hours per week in use for all services	Cost Estimate and Source (if applicable)

The PEAC did not develop a recommendation on the equipment for this code and is deferring to HCFA and the AOTA to develop an appropriate assignment of equipment.

¹ During the typical treatment for the patient described in the vignette, the therapist would be treating the patient in the kitchen and bathroom modules. Approximately 30% of cost of the ADL kit would be used in the kitchen, and 70% in the bathroom.

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

CPT Long Descriptor: Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis), direct one on one contact by provider, each 15 minutes

Vignette: A 35 year old computer programmer with a diagnosis of Guillain-Barre syndrome is being treated in an outpatient department for residual weakness which is limiting his ability to return to community and work activities. After evaluation, the therapist identifies transportation and work environment as two barriers to his ability to return to former functional level. The therapist determines the type of driving adaptation needed, trains him in the use of the equipment (including on-road practice), and trains on car transfer techniques. With the patient, the therapist analyzes the essential job functions. At the work site the therapist analyzes the work environment to identify any factors with potential negative impact on balance/stability, posture and safe extremity function. The therapist reports all findings to the patient and, if necessary, the employer recommends necessary changes in routine (e.g.stretching periods) or assertive technology (e.g ergonomic seating, computer access) and provides equipment purchasing information to the patient and/or employer.

Sample Size: N/A Response Rate: (%): Global Period:

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:

AOTA data were developed by a consensus panel of occupational therapists, who are either in private practice or have significant experience as rehabilitation managers of large outpatient therapy departments. This group consulted with additional therapists and administrative personnel within their respective practice settings. The panel was trained in the practice expense process and developed data during an intensive 2 day face to face meeting. Additional telephone conferences were held to refine the data and include comments from additional clinical consultants. The data presented are consistent with the cross-walk approved at the February 2001 PEAC for procedures and modalities in the 97XXX family of codes.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: Pre service includes the review of the documentation, plan of care and treatment goals and the effect of previous treatment. An aide will also verify the availability of resources, materials and equipment.

Intra-Service Clinical Labor Activities: Intra-Service includes greeting and preparing the patient, preparing the room, obtaining relevant measurements and vital signs, assisting the occupational therapist during the intervention, demonstration and performance verification, post treatment assistance of the patient and cleaning the room/clinic area.

Post-Service Clinical Labor Activities: Post-Service includes communication with patient, family, other providers, and payers.

Total Staff Time In Office:

Visits in Global Period:

HCFA's Staff Type Code*	Clinical Labor (for all of the activities performed on the day of service)	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
	RN				
	LPN				
	MA				
	Assistant	1.5	11	1	
	Aide	1.5	5		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Price	Source of Supply	Cost Estimate
	<i>None</i>				

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	% time of use per procedure ¹	Hours per week in use for all services	Cost Estimate and Source (if applicable)

The PEAC did not develop a recommendation on the equipment for this code and is deferring to HCFA and the AOTA to develop an appropriate assignment of equipment.

¹ The typical treatment for the patient described in the vignette would consist of the therapist performing transfer training half the time using the car module and training the patient in performing activities relating to functioning in the office. The ergonomic kit would be used in the office module.

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

CPT Long Descriptor: Wheelchair management/propulsion training, each 15 minutes

Vignette: A 29-year old C4 quadrangle with complete right shoulder disarticulation and left above knee amputation has been fitted with powered wheelchair and custom seating system. After an assessment of the seating system in conjunction with his functional goals, the therapist determines that the system must provide stabilization, support and balance as well as pressure management. To achieve these goals, the therapist trains the patient in the safe operation and management of the wheelchair in order to achieve independent mobility in his home and community environment.

Sample Size: N/A Response Rate: (%): Global Period:

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:

AOTA data were developed by a consensus panel of occupational therapists, who are either in private practice or have significant experience as rehabilitation managers of large outpatient therapy departments. This group consulted with additional therapists and administrative personnel within their respective practice settings. The panel was trained in the practice expense process and developed data during an intensive 2 day face to face meeting. Additional telephone conferences were held to refine the data and include comments from additional clinical consultants. The data presented are consistent with the cross-walk approved at the February 2001 PEAC for procedures and modalities in the 97XXX family of codes.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: Pre service includes the review of the documentation, plan of care and treatment goals and the effect of previous treatment. An aide will also verify the availability of resources, materials and equipment.

Intra-Service Clinical Labor Activities: Intra-Service includes greeting and preparing the patient, preparing the room, obtaining relevant measurements and vital signs, assisting the occupational therapist during the intervention, demonstration and performance verification, post treatment assistance of the patient and cleaning the room/clinic area.

Post-Service Clinical Labor Activities: Post-Service includes communication with patient, family, other providers, and payers.

Total Staff Time In Office:

Visits in Global Period:

HCFA's Staff Type Code*	Clinical Labor (for all of the activities performed on the day of service)	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
	RN				
	LPN				
	MA				
	Assistant	1.5	11	1	
	Aide	1.5	5		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Price	Source of Supply	Cost Estimate
	<i>None</i>				

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	% time of use per procedure ¹	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Environmental module - Ambu-trac	1	35%		15,000 (Guynes)
	Environmental module - The Car	1	15%		30,000 (Guynes)
	Environmental module - Kitchen	1	25%		50,000 (Guynes)
	Environmental module - Bathroom	1	25%		40,000 (Guynes)

Note: AOTA will be distributing a supplemental spreadsheet containing the staff time data for all the procedures and modalities in the 97XXX family of codes.

¹ During a typical treatment for the patient described in the vignette, the therapist would work on wheelchair management in each of the environmental modules listed.

**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
 documentation, plan of care, treatment goals

___ 1.5 ___ RN, LPN, MA, Other ___ Assistant ___

Other Clinical Activity (please specify)

Verify/Coordinate availability of resources/ equip

___ 1.5 ___ RN, LPN, MA, Other ___ Aide ___

End: Patient arrival at office for service

Service Period

Start: Patient arrival at office for service

Greet patient/provide gowning

___ 1.5 ___ RN, LPN, MA, Other ___ Aide ___

Obtain vital signs

___ 1 ___ RN, LPN, MA, Other Assistant ___

Obtain measurements, eg, ROM/strength/edema

___ RN, LPN, MA, Other Assistant

Prep and position patient

___ RN, LPN, MA, Other ___ Aide ___

Prepare room, equipment, supplies

___ RN, LPN, MA, Other ___ Aide ___

Assist physician therapist during exam

___ 7.5 ___ RN, LPN, MA, Other ___ Assistant

Education/instruction/ counseling/coord home care

___ 2.5 ___ RN, LPN, MA, Other ___ Assistant

~~Coordinate home or outpatient care~~

___ RN, LPN, MA, Other _____

Clean room/equipment

___ 2.5 ___ RN, LPN, MA, Other ___ Aide ___

Other Clinical Activity (please specify)

 Post treatment patient assistance

___ 1 ___ RN, LPN, MA, Other ___ Aide ___

End: Patient leaves office

Post-Service Period

Start: Patient leaves office

Phone calls between visits with patient, family

___ 1 ___ RN, LPN, MA, Other ___ Assistant

Other Activity (please specify)

 Record data and results/complete record

___ RN, LPN, MA, Other ___ Assistant

End: When appointment for next office visit is made.

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

CPT Long Descriptor: Checkout for orthotics/prosthetics use; established patient, each 15 minutes

Vignette: A 56 year old female with a diagnosis of rheumatoid arthritis is seen for a follow-up checkout subsequent to a metacarpal phalangeal flexible implant arthroplasty. The therapist has previously fitted the patient with a dorsal dynamic orthosis that provides correction of residual deformity and permits metacarpal flexion and extension in desired plane and range. The patients edema has decreased and she complains of pressure on the ulnar styloid. The therapist re-assess the fit and makes adjustments to the orthosis.

Sample Size: __N/A__ Response Rate: (%): _____ Global Period: _____

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:

AOTA data were developed by a consensus panel of occupational therapists, who are either in private practice or have significant experience as rehabilitation managers of large outpatient therapy departments. This group consulted with additional therapists and administrative personnel within their respective practice settings. The panel was trained in the practice expense process and developed data during an intensive 2 day face to face meeting. Additional telephone conferences were held to refine the data and include comments from additional clinical consultants. The data presented are consistent with the cross-walk approved at the February 2001 PEAC for procedures and modalities in the 97XXX family of codes.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: Pre service includes the review of the documentation, plan of care and treatment goals and the effect of previous treatment. An aide will also verify the availability of resources, materials and equipment.

Intra-Service Clinical Labor Activities: Intra-Service includes greeting and preparing the patient, preparing the room, obtaining relevant measurements and vital signs, assisting the occupational therapist during the intervention, demonstration and performance verification, post treatment assistance of the patient and cleaning the room/clinic area.

Post-Service Clinical Labor Activities: Post-Service includes communication with patient, family, other providers, and payers.

Total Staff Time In Office:

Visits in Global Period:

HCFA's Staff Type Code*	Clinical Labor (for all of the activities performed on the day of service)	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
	RN				
	LPN				
	MA				
	Assistant	1.5	11	1	
	Aide	1.5	5		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Price	Source of Supply	Cost Estimate
	Multispecialty package				
32014	Stockinette	18"			.23
	Alpha Splint Straps (2")	2	14.95/10	(NC15277)	3.00
	Alpha Splint Straps (1")	1	12.95/10	(NC15276)	1.30
	Rubber bands	6	5.95 pkg	(NC 12506)	.20
	Cold Spray	.25 oz	10.95/12 oz	(NC 12720)	.23
	Moleskin	9"x11"	51.00/9"x 4yds.	(NC 12913)	3.89
	Braided outrigger line	50"	9.50/100 yds.	(NC 12520)	.13
	Outrigger line connections	4-5	10.95/100	(NC 12495)	.44
	Orthotic bonder	.5 oz	21.95/32 oz	(NC 12561)	.34
	Distilled Water	1 gallon	1.30/gal	drugstore	1.30

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	% time of use per procedure ¹	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Adjustable height work table	1	100%		2,905 (Hausmann)
	Mobile orthotics work bench	1	67%		750 (NC76290)
	Splint-Form 2000/ cart heating pan	1	67%		790 (NC76290)

¹During a typical treatment for the patient described in the vignette, the patient would be seated on the stool at the table the entire session. The therapist would access the heating pan and mobile orthotics work bench throughout the session.

**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
documentation, plan of care, treatment goals

___ 1.5 ___ RN, LPN, MA, Other ___ Assistant ___

Other Clinical Activity (please specify)

Verify/Coordinate availability of resources/ equip

___ 1.5 ___ RN, LPN, MA, Other ___ Aide ___

End: Patient arrival at office for service

Service Period

Start: Patient arrival at office for service

Greet patient/provide gowning

___ 1.5 ___ RN, LPN, MA, Other ___ Aide ___

Obtain vital signs

___ 1 ___ RN, LPN, MA, Other Assistant ___

Obtain measurements, eg, ROM/strength/edema

___ RN, LPN, MA, Other Assistant

Prep and position patient

___ RN, LPN, MA, Other ___ Aide ___

Prepare room, equipment, supplies

___ RN, LPN, MA, Other ___ Aide ___

Assist physician therapist during exam

___ 7.5 ___ RN, LPN, MA, Other ___ Assistant

Education/instruction/ counseling/coord home care

___ 2.5 ___ RN, LPN, MA, Other ___ Assistant

~~Coordinate home or outpatient care~~

___ RN, LPN, MA, Other _____

Clean room/equipment

___ 2.5 ___ RN, LPN, MA, Other ___ Aide ___

Other Clinical Activity (please specify)

Post treatment patient assistance

___ 1 ___ RN, LPN, MA, Other ___ Aide ___

End: Patient leaves office

Post-Service Period

Start: Patient leaves office

Phone calls between visits with patient, family

___ 1 ___ RN, LPN, MA, Other Assistant

Other Activity (please specify)

Record data and results/complete record

___ RN, LPN, MA, Other ___ Assistant

End: When appointment for next office visit is made.

**AMA/Specialty Society Update Process
PEAC Summary of Recommendation
XXX Global Period
In Office Direct Inputs**

CPT Long Descriptor: Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minute

Vignette: The physician refers the patient, a data entry person, for evaluation & treatment of suspected carpal tunnel syndrome. Nerve conduction studies were negative, however patient complains of a numbness in the median nerve distribution and pain in the proximal palm while on the job & often at night. Assessments are made of pinch & grip strengths using computerized instruments which are calibrated before each evaluation. Sensibility tests of touch pressure threshold and vibration are also performed on the patient for their ability to detect early development of carpal tunnel syndrome. Computerized instruments are preferred as hand held instruments are subject to inter-rater reliability. Test results are negative, and work simulation is set-up for patient to perform key board entry for 30 minutes. Upon re-test, vibration detection, touch pressure threshold have decreased from normal to diminished light tough in the dominant hand. Pinch & grip strengths have also diminished because of pain. Conservative treatment is initiated which includes ergonomic changes in equipment and job pacing in conjunction with physician's application of anti-inflammatory medication

Sample Size: __N/A__ Response Rate: (%): _____ Global Period: _____

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:

AOTA data were developed by a consensus panel of occupational therapists, who are either in private practice or have significant experience as rehabilitation managers of large outpatient therapy departments. This group consulted with additional therapists and administrative personnel within their respective practice settings. The panel was trained in the practice expense process and developed data during an intensive 2 day face to face meeting. Additional telephone conferences were held to refine the data and include comments from additional clinical consultants. The data presented are consistent with the cross-walk approved at the February 2001 PEAC for procedures and modalities in the 97XXX family of codes.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: Pre service includes the review of the documentation, plan of care and treatment goals and the effect of previous treatment. An aide will also verify the availability of resources, materials and equipment.

Intra-Service Clinical Labor Activities: Intra-Service includes greeting and preparing the patient, preparing the room, obtaining relevant measurements and vital signs, assisting the occupational therapist

during the intervention, demonstration and performance verification, post treatment assistance of the patient and cleaning the room/clinic area.

Post-Service Clinical Labor Activities: Post-Service includes communication with patient, family, other providers, and payers.

Total Staff Time In Office:

Visits in Global Period:

HCFA's Staff Type Code*	Clinical Labor (for all of the activities performed on the day of service)	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
	RN				
	LPN				
	MA				
	Assistant	.5	12	.5	
	Aide	.5	6.5		

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Price	Source of Supply	Cost Estimate
11302	Gloves, nonsterile	1			.12

* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	% time of use per procedure ¹	Hours per week in use for all services	Cost Estimate and Source (if applicable)
	Adjustable height work table (used with first 2 Valpar modules)	1	33%		2,905 (Hausmann Industries)
	BTE Primus	1	50%		45,820 (BTE)
	Valpar (clerical comprehension)	1	16%		2680 (Valpar)
	Valpar (Fine finger dexterity)	1	17%		725 (Valpar)
	Valpar (Physical capacity and mobility screening evaluation)	1	17%		725 (Valpar)

Note: AOTA will be distributing a supplemental spreadsheet containing the staff time data for all the procedures and modalities in the 97XXX family of codes.

¹ The typical treatment for the patient described in the vignette would consist of the patient spending one-third of the session seated on the stool at the table. The therapist would be using the clerical comprehension and fine finger dexterity Valpar systems. Half the session would be spent evaluating the patient on the BTE and the remaining 17% of the time the therapist would be using the physical capacity and mobility screening evaluation.

	A	B	C	D	E	F	G	H
2			97001	97002	97003	97004	Anchor Code	97018
3			APTA submission Physical Therapy Evaluation	APTA submission Physical Therapy Re- Evaluation	Occupational Therapy Evaluation	Occupational Therapy Re- Evaluation	97014 PEAC 2/01 Approved Anchor Modality Code; electrical stimulation (unattended)	Application of a Modality to one or more areas; paraffin bath
4		STAFF TYPE						
5	TOTAL CLINICAL LABOR		34	27	34	27	7	15
6	Therapy assistant	assistant	21	14	21	15	4	6
7	Therapy aide	aide	13	13	13	12	3	9
8	PRE-SERVICE							
9	Start: When appointment for service is made							
10	Review/read documentation, plan of care, treatment goals	Assistant	1	1	1	1	0	0
11	Verify/Coordinate availability of resources/equipment	Aide	3	3	3	3	0	0
12	End: Patient arrival at office for service							
13	SERVICE PERIOD							
14	Start: When patient enters office for surgery/procedure							
15	Pre-service services							
16	Greet patient and provide gowning	Aide	3	3	3	3	0	0
17	Obtain vital signs	Assistant	3	3	3	3	0	0
18	Obtain Measurements	Assistant	8	3	8	3	0	0
19	Prep and position patient	Aide	2	2	2	2	0	3
20	Prepare room, equipment, supplies	Aide	2	2	2	2	0	3
21	Assist therapist during exam	Assistant	5	3	5	3	3	5
22	Education/instruction/counseling/home care	Assistant	(0) 2	0	2	3	1	1
23	Clean room/equipment	Aide	3	3	3	2	2	2
24	Other: Post treatment assistance	Aide	0	0	0	0	1	1
25	POST SERVICE PERIOD							
26	Conduct phone calls	Assistant	(4) 2	4	2	2	0	0
27	Other/ Record data and results	Assistant	0	0	0	0	0	0

	A	B	I	J	K	L	M	N
2			Anchor Code	97504	97520	97530	97535	97537
3			97110 PEAC 2/01 Approved Anchor Procedure Code; Therapeutic procedure, one or more areas, each 15 minutes; Therapeutic Exercise	Orthotics fitting and training, upper and/or lower extremities, each 15 minutes	APTA Submission Prosthetic training, upper and/or lower extremities, each 15 minutes	Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	Self care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment), direct one on one contact by provider, each 15 minutes	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification on analysis, work task analysis), direct one on one contact, by provider, each 15 minutes
4		STAFF TYPE						
5	TOTAL CLINICAL LABOR		20	20	20	20	20	20
6	Therapy assistant	assistant	15	13.5		13.5	13.5	13.5
7	Therapy aide	aide	5	6.5		6.5	6.5	6.5
8	PRE-SERVICE							
9	Start: When appointment for service is made							
10	Review/read documentation, plan of care, treatment goals	Assistant	1.5	1.5	1.5	1.5	1.5	1.5
11	Verify/Coordinate availability of resources/equipment	Aide	1.5	1.5	1.5	1.5	1.5	1.5
12	End: Patient arrival at office for service							
13	SERVICE PERIOD							
14	Start: When patient enters office for surgery/procedure							
15	Pre-service services							
16	Greet patient and provide gowning	Aide	1.5	1.5	1.5	1.5	1.5	1.5
17	Obtain vital signs	Assistant	1	1	1	1	1	1
18	Obtain Measurements	Assistant	1.5	0	1.5	0	0	0
19	Prep and position patient	Aide	0	0	0	0	0	0
20	Prepare room, equipment, supplies	Aide	0	(0) 1.5	0	1.5	1.5	1.5
21	Assist therapist during exam	Assistant	7.5	7.5	7.5	7.5	7.5	7.5
22	Education/instruction/counseling/home care	Assistant	2.5	2.5	2.5	2.5	2.5	2.5
23	Clean room/equipment	Aide	1	(2.5) 1	1	1	1	1
24	Other: Post treatment assistance	Aide	1	1	1	1	1	1
25	POST SERVICE PERIOD							
26	Conduct phone calls	Assistant	1	1	1	1	1	1
27	Other/ Record data and results	Assistant	0	0	0	0	0	0

	A	B	O	P	Q
2			97542	97703	97750
3			Wheelchair management/propulsion training, each 15 minutes	Checkout for Orthotic/Prosthetic use, established patient, each 15 minutes	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes
4		STAFF TYPE			
5	TOTAL CLINICAL LABOR		20	20	(23) 20
6	Therapy assistant	assistant	13.5	13.5	(16.5) 13
7	Therapy aide	aide	6.5	6.5	(6.5) 7
8	PRE-SERVICE				
9	Start: When appointment for service is made				
10	Review/read documentation, plan of care, treatment goals	Assistant	1.5	1.5	(1.5) 0.5
11	Verify/Coordinate availability of resources/equipment	Aide	1.5	1.5	(1.5) 0.5
12	End: Patient arrival at office for service				
13	SERVICE PERIOD				
14	Start: When patient enters office for surgery/procedure				
15	Pre-service services				
16	Greet patient and provide gowning	Aide	1.5	1.5	(1.5) 0
17	Obtain vital signs	Assistant	1	1	(1) 0
18	Obtain Measurements	Assistant	0	0	3
19	Prep and position patient	Aide	0	0	0
20	Prepare room, equipment, supplies	Aide	(0) 1.5	(0) 1.5	(2.5) 3.5
21	Assist therapist during exam	Assistant	7.5	7.5	(7.5) 8.5
22	Education/instruction/counseling/home care	Assistant	2.5	(2.5) 1	(2.5) 0.5
23	Clean room/equipment	Aide	(2.5) 1	2.5	(1) 3
24	Other: Post treatment assistance	Aide	1	1	0
25	POST-SERVICE PERIOD				
26	Conduct phone calls	Assistant	1	1	(1) 0.5
27	Other/ Record data and results	Assistant	0	0	0