RUC Recommendations

For CPT 2003

RUC Meetings:
February 2002 and April 2002

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
RUC RECOMMENDATION FOR CPT 2003

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American Medical Association

Physicians dedicated to the health of America

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February 26, 2003

Thomas A. Scully
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 443-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Programs; Revision to Payment Policies Under the Physician Fee Schedule for Calendar Year 2003; Final Rule

Dear Administrator Scully:

The American Medical Association (AMA)/ Specialty Society RVS Update Committee (RUC) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Final Rule for Medicare Programs; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2003, published in the December 31, 2002 Federal Register.

The RUC is extremely pleased that CMS has accepted nearly all of the recommendations that this volunteer multi-specialty committee has submitted over the past year. We believe that our success in this year is attributed to a level of mutual respect between CMS and the RUC, which has been developed over the course of the last decade. The RUC looks forward to your visit on April 25, 2003 to share first-hand the experiences of the committee in our attempts to improve the Resource-Based Relative Value Scale (RBRVS).

Although we are pleased about the high level of acceptance of RUC recommendations as published in this *Final Rule*, we are offering comments on certain issues that are of concern to the committee. We urge you to consider modifications to some of your decisions as you refine the CPT 2003 relative values for the 2004 *Final Rule* publication late this year.

Direct Practice Expense Refinements

The challenge of refining the direct practice expense data has been onerous for organized medicine and your staff at CMS. However, the ability to gain confidence in the data via

direct involvement in its refinement is important to physicians and other health care professionals involved in our process. We appreciate CMS response to accept 100% of the practice expense refinements proposed by the RUC's Practice Expense Advisory Committee (PEAC) this year. The efforts made by CMS staff to articulate concerns at the meetings of the PEAC result in effective dialogue that have improved the direct practice expense inputs and enabled the medical community to contribute their expertise about the resources required to perform each procedure or service.

The PEAC reviewed more than 1,200 codes in 2002 and is scheduled to review a large number of codes in 2003. In addition, CMS will be receiving a recommendation to standardize the inputs for most 090-day major surgical procedures. We understand that these revisions will be considered for the 2004 Medicare Payment Schedule update.

CMS decided to not include direct practice expense inputs for CPT codes reported with a –26 modifier in a facility. The PEAC has recommended clinical staff for several services in this category. The RUC believes that the current direct practice expense inputs for these codes are not appropriate. The recommended changes in clinical staff time provide more accurate direct practice expense inputs for these codes. The RUC strongly urges CMS to include these clinical staff times in practice expense determinations for these codes.

Non-Physician Work Pool

We understand that CMS intends to make the zero work pool issue a priority in 2003. The RUC agrees that this methodology should be studied and potentially modified. Accordingly, the RUC has created a Non-Physician Work Pool Workgroup. The workgroup recently received an informative presentation on the current methodology by your staff at their January 30th meeting.

The RUC's Non-Physician Work Pool Workgroup will meet again on Thursday, April 24 to further discuss this issue and any potential recommendations that may be referred on to the RUC and CMS.

Budget Neutrality

During the course of the transition to the resource-based practice expense relative values and the refinement of its methodology, CMS has implemented changes and maintained budget neutrality via a re-scaling of all practice expense relative values. This has been a necessary step in the methodology and refinement as the relativity between CPT codes is still under development.

As the PEAC completes its efforts in the spring of 2004 and CMS finalizes policies related to practice expense, we believe that CMS should consider providing the same stability to the practice expense relative values as is seen in the work relative values. CMS should consider keeping the practice expense relative values stable at the conclusion of the refinement process. Much like what is done with work relative values, any code-level refinements due to annual coding changes that result in a non-budget neutral impact should not result in a reduction of all practice expense relative values. The RUC requests that CMS present an analysis of this issue in an upcoming Proposed Rule.

The RUC is also deeply concerned that CMS continues to impose a behavioral offset to the practice expense relative values beyond the transition to the resource-based relative values. In the November 1, 2001 *Final Rule,* CMS announced that on January 1, 2002, "We are making a 0.18 percent reduction to the conversion factor to account for an anticipated increase in the volume and intensity of services in response to the final year of the implementation of resource-based practice expense RVUs." This offset was applied as many specialties faced significant cuts to their overall Medicare payment as a result of the transition to the resource-based practice expense relative values.

In the December 31, 2002 *Final Rule* CMS announced that it will implement a 0.49 percent reduction to all practice expense relative values in 2003 to "account for an anticipated increase in the volume and intensity of services in response to payment reductions from the refinement of practice expense relative values." The rationale for the 0.49 percent reduction to the practice expense relative values, which translates into a larger volume and intensity adjustment than in 2002, is not explained in this *Final Rule.*

Since the resource-based practice expense relative values are now fully resource-based and any changes are likely a result of PEAC refinement activities, shifts in the practice expense values should largely be within a specialty. The specialty impact table within the *Final Rule* emphasizes this point, as few specialties should anticipate an overall decrease in their Medicare payments due solely to the practice expense refinements. The RUC requests that CMS provide further explanation of this offset, as it appears to be unwarranted and potentially calculated on flawed data or assumptions.

Five-Year Review of Anesthesia Work

Beginning in August, 2000, the RUC worked with the American Society Anesthesiologists in an extended Five-Year Review of physician work values in anesthesiology. Though the RUC was unable to develop a recommendation for new work values for all anesthesia services, in April 2002 we provided the results of more than two years of RUC analysis of nineteen high volume anesthesia codes.

In the December 31, 2002 *Final Rule*, CMS announced an increase to the physician work component of the anesthesia conversion factor by 2.10 percent to reflect a 9.13 percent payment increase in payment applied to 23 percent of anesthesia allowed changes. These changes were the result of considering changes to nineteen codes reviewed by the RUC. CMS announced that this is an interim adjustment that is subject to comment.

I am in receipt of your letter of February 5, 2003 requesting the RUC to continue its review of the anesthesia work relative values, in the expectation of developing a final recommendation as to a change in the Medicare anesthesia conversion factor involving all anesthesia codes. Over the course of the next several weeks, I will review your request with the RUC members and we will respond to you with our planned course of action on this issue.

Definition for ZZZ Global Periods

The RUC appreciates CMS consideration and implementation of the revision to the ZZZ global period definition to read as follows:

ZZZ = Code related to another service and is always included in the global period of the other service (Note: Physician work is associated with intra-service time and in some instances the pre- and post-service time)

The RUC's Research Subcommittee has discussed the process by which any specialty may seek to have codes with a ZZZ re-reviewed and determined that the RUC will ask specialties to identify any ZZZ codes whose physician work may be affected by the definition change. Once the list is compiled and presented to the Research Subcommittee in April, the Research Subcommittee will discuss the issue further and determine if the RUC should review these codes outside of the five-year review process.

Immunization Administration

The RUC joins many others who will comment that CMS should be applauded for addressing the overall payment for immunization administration via a significant increase to the practice expense relative values. We are pleased that the CMS has accepted the RUC's recommendations for the direct practice expense inputs for these codes.

The RUC has commented on the issue of assigning physician work relative values for immunization administration repeatedly over the past few years. The RUC firmly believes that although the nurse may administer the vaccine and often addresses questions posed by the patient/parent, this is in follow-up to the physician's discussion with the patient/parent.

As the RUC has indicated in the past, the physician does discuss with the patient/parent the benefits and risks related to the vaccine(s). These interactions are similar to other services where CMS has acknowledged, through acceptance of RUC recommendations, that a nurse may follow-up or repeat earlier discussions that the patient has had with the physician. The RUC concluded that the physician work involved in immunization administration was comparable to the work involved in 99211 (*see Evaluation & Management, established Patient*) which has a work RVU of 0.17. **We continue to strongly urge you to publish work relative values of 0.17 and 0.15 for CPT codes 90471 and 90472, respectively. The RUC also offers to collect additional data regarding the physician involvement in these services, if CMS indicates that this data may be useful in reconsidering this issue.**

The RUC also urges CMS to eliminate the G codes that are duplicative of the CPT codes that may be used for the administration of Medicare covered vaccines.

Creation of G Codes

The RUC echoes the concern expressed by many specialty societies and the AMA, that CMS has recently over-utilized its ability to create G codes and we urge CMS to take more serious steps to establish a set process and to limit this activity as much as feasible. CMS observes the great deal of effort and expertise that is required by each specialty in developing coding proposals, vignettes, conducting surveys to determine physician time and work, convening consensus panels, and determining appropriate direct practice expense inputs for each new CPT code that is created. The results of these efforts are then validated through multi-specialty groups of physicians, including CPT Advisors, the CPT Editorial Panel, and the RUC. While the creation of a G code, and its resulting relative values, may be expedient, it lacks the credibility and fairness of the CPT codes that have gone through these processes.

In reviewing the G codes that were announced in this *Final Rule*, it appears that many of these issues did not need immediate resolution and could have been processed through the normal channels (eg, G0275 *Renal angiography*). We recommend that CMS determine an internal process for considering such G code issues and communicate it to organized medicine.

The RUC would also offer that CMS consider the RUC's guidance on any G code, or CPT Level III tracking code, for which you are considering the establishment of relative values.

Revisions to Malpractice RVUs for New and Revised CPT Codes for 2002

The RUC is very concerned that updates to the Professional Liability Insurance (PLI) component of the Medicare Fee Schedule have failed to reflect the actual and rapidly rising cost of liability insurance. We are encouraged that the agency is committed to

examining ways to use more accurate and timely data, as evidenced by its engaging a contractor to examine the issue. In addition, the RUC is pleased that CMS acknowledged the need to update PLI data used in the Medicare Fee Schedule at the recent meeting of the Practicing Physicians Advisory Council held at the CMS Headquarters in Baltimore on February 10, 2003. Given the significant impact that this is having on patient access, we urge CMS to work closely with medical specialty societies in the process of an imperative update of the PLI component. The substantial increases in medical liability insurance premiums that for some specialties have more than doubled in the past two years have created a serious crisis for many physicians. The RUC applauds the efforts of President Bush in focusing attention on this serious problem during his address in Scranton on January 16th, as well as in the State of the Union Address. We urge CMS to likewise respond quickly in updating the assigned values to accurately reflect the practice costs incurred.

Relative Value Recommendations for New and Revised 2003 Codes

CMS has announced that it has accepted 96 percent of the RUC's work relative value recommendations and 100 percent of the RUC's practice expense recommendations. We appreciate the confidence that you have displayed in this activity. We also believe that our recommendations are based on quality data and serious deliberations. Therefore, we offer additional comments on RUC recommendations that you have not accepted. We hope that this additional information is helpful to you in refining the relative values for the 2004 *Final Rule*. We also urge you to consider additional information that the specialty societies include in their comments.

Mohs Micrographic Surgery (17304-17310)

In May 2002, the RUC submitted an interim recommendation to maintain the relative values for mohs micrographic surgery codes until the RUC had the opportunity to review this issue further in February 2003. CMS has disagreed with the work relative value for code 17310 and lowered it from its 2002 value. The RUC considered this issue at our most recent meeting and is attaching new recommendations for your consideration during your refinement process.

Excision of Benign Tumor or Mandible/Maxilla (Codes 21030 and 21040)

The RUC submitted new recommendations for CPT codes 21030 and 21040 to CMS on October 14, 2002. We understand that CMS was not able to consider these recommendations prior to finalizing this *Final Rule*. We ask that you consider these recommendations during your 2003 refinement process.

Minimally Invasive Repair of Pectus Excavatum (21740, 21742, and 21743)

The RUC continues to recommend that minimally invasive repair of pectus excavatum services remain carrier priced in 2004 as the specialty has been unable to acquire data for these services and is not expected to do so prior to the April 2003 RUC meeting.

Venipuncture (36415 and 36416)

While the RUC did recommend that there was no physician work associated with either CPT code 36415 or 36416, both describing venipuncture services, the PEAC and RUC did determine that there were direct practice expense inputs. CMS, however, has not published any practice expense relative values for these codes. We understand that currently Medicare's payment for these services is based on statute and included on the Clinical Lab Fee Schedule. The RUC would request that CMS publish practice expense relative values for these services, regardless of your payment policies. For other services,

CMS has published the relative values with a footnote that indicates that the RVUs are not used for Medicare payment.

Therapeutic Apheresis (36511-36516)

In the *Final Rule* CMS notes that it had not yet received recommendations for therapeutic apheresis services. We understand that CMS was not able to consider our October 14 submission in time for the *Final Rule*, but urge you to consider the information during refinement. In this instance, CMS has the same relative value for the first five codes in this family as the RUC's final recommendation. However, for CPT code 36516, the RUC has actually submitted a lower work relative value (1.22) than the value published by CMS of 1.74.

Bone Marrow Procedures (38204 – 38215)

The AMA RUC deliberated throughout 2002 and was satisfied that representatives of the American Society of Hematology (ASH) had clearly described thirteen new bone marrow transplant and stem cell processing codes (CPT codes 38204-38215) that reflect newer techniques used in a transplant laboratory under physician supervision. These new codes replace CPT 38231 *Blood-derived peripheral stem cell harvesting for transplantation, per collection* and CPT 86915 *Bone marrow or peripheral stem cell harvest, modification or treatment to eliminate cell type(s) (e.g., T-cells, metastatic carcinoma).*

In the 2003 Medicare Physician Fee Schedule, the Centers for Medicare and Medicaid Services (CMS), were not able to utilize the RUC's deliberations from the September 2002 meeting that were submitted to CMS on October 14, 2002. The RUC spent a great deal of time deliberating this issue in September and recommended certain changes to CPT and improved interim work relative value recommendations for several codes. CPT will be implementing these coding revisions in 2004 and we urge CMS to review the RUC recommendations that were submitted in October, along with any new information that the RUC provides following our April 2003 meeting. We offer the following comments on the specific codes in this family:

CPT Code 38204, Management of Recipient Hematopoietic Progenitor Cell Donor Search and Cell Acquisition

At the September RUC meeting, CPT code 38204 was assigned a work value of 2.0. In the final rule, however, CMS gave the code a status indicator of "B" meaning that it will not make separate payment for this service. The reasons cited by CMS are that 1) the payment for any physician work associated with this service is part of the payment for other bone marrow transplant codes including CPT codes 38205, 38206, 38240, 38241, and 38242, 2) there is a possibility that beneficiaries would be billed for failed donor searches, 3) there is doubt that beneficiaries would be able to determine that a search had been conducted and would likely never meet the physician conducting the search; and 4) the clinical vignette provided by the specialty does not distinguish between the work of the physician and the clinical and administrative staff. Furthermore, CMS asks in the rule that the RUC determine whether any physician work associated with a cell donor search is already included in the work of the physician performing the harvest or transplant and if it is not included, the RUC should recommend appropriate changes in the work values.

The RUC disagrees with CMS' assessment of CPT code 38204. First, the physician work associated with a donor search is not included in the work of the codes cited by CMS. In fact, three of these CPT codes (38205, 38206 and 38242) were reviewed by the RUC during the same meeting. The vignette and subsequent RUC discussion clearly indicate that management of a donor search is not encompassed in the work value assigned to the harvesting and transplantation codes. Insofar as packaging the work of a bone marrow/stem cell donor search into the harvesting or transplant codes, we simply do not understand the point of such an exercise. While theoretically this could be done, we would note that frequently the physician performing the donor search is not the same as the physician doing the harvest or transplant. Thus, it would not make any sense to assign the work of conducting the donor search to a physician who did not do the work. This would be contrary to the principles of the physician fee schedule.

Second, the intention of ASH representatives before the RUC was to explain that CPT 38204 would be reported only once for the potential transplant for which the donor search was being made. These searches may take anywhere from weeks to months to years, but, again, would only be billed once per potential transplant. In a theoretical sense, then, CMS is technically correct that beneficiaries could be billed for a failed search. However, the RUC would appreciate an elaboration by CMS on how this technicality contributes significantly to the decision not to provide separate payment for the service.

Third, CMS' question about how beneficiaries would "know" that a search was conducted and doubt that a beneficiary would meet the physician conducting the search are both irrelevant. Presumably, a beneficiary undergoing an allogeneic bone marrow/stem cell transplant would understand that a donor search took place. Furthermore, while it is true that beneficiaries will frequently not meet the physician who conducted the donor search, this is also the case with other physician services. Patients
do not meet the pathologist who interpreted their specimen or the radiologist who read their x-ray.

Fourth, regarding CMS' argument that the specialty has not explained in detail the tasks performed by the physician and administrative/clinical staff in a donor search, the RUC heard significant discussion of this issue in April and September and did feel comfortable with the physician work described.

We urge CMS to reconsider its decision concerning CPT 38204 and to assign the RUC recommended work value of 2.00 for this important service.

Codes 38207-38215, Preservation and Preparation of Stem Cells for Transplant

All of these codes involve various physician activities prior to stem cell transplant. At the April meeting, the RUC assigned interim work values to these codes. At the September meeting, a pre-facilitation committee spent over 4 hours discussing just these codes. On the basis of their enhanced understanding of the specific tasks involved, the RUC developed much improved interim values. The RUC did recommended several technical changes to be made to the CPT definitions to more clearly delineate the washing and thawing activities and to make it clear that flow cytometry could not be billed with these services.

Following these changes, the RUC recommended that these codes be resurveyed specifying that a refined reference list be developed and every effort was to be made to assure that survey respondents were better educated regarding the work survey. Moreover the facilitation committee wanted to provide assistance prior to the actual dissemination of the survey instrument.

In the final rule, CMS assigned an indicator of "I" to all of the codes meaning that the codes are not recognized for Medicare purposes. The reasons cited by CMS were a lack of clarity as to whether any physician work was required, concern about the unbundling of an existing code, and questions about the RUC's analysis of the physician work. We understand that CMS did not consider any of the deliberations of the RUC or the facilitation committee during the September meeting in its analysis. Rather, it was based on the April RUC recommendations only. We urge to consider this analysis during the refinement period.

One issue raised by CMS related to concerns with the units of service and questions as to whether multiple services would be billed for each aliquot of the material. To make this clear that this is not the case, ASH has submitted the following language to CPT:

> Codes 38207-38215 describe various steps used to preserve, prepare and purify bone marrow/stem cells prior to transplantation or reinfusion. A code would be reported only once per session regardless of the quantity of bone marrow/stem cells manipulated. For this purpose, a session will be defined as all the activity on a day relating to that specific processing step for a single patient."

The RUC is convinced that there is physician work associated with these services and that a resurvey, with the conditions identified, is needed. However, we are reluctant to urge the specialty to resurvey unless there is some assurance that the effort will lead CMS to value these services. We would hope CMS will meet with ASH to resolve its concerns and advise the RUC as to whether further reexamination of the work of these codes is desired.

Sigmoidoscopy, flexible; with dilation by balloon, each stricture (45340)

In April 2002, the RUC reviewed a series of gastrointestinal endoscopy services that were created with dilation by balloon or endoscopic injections, performed in conjunction with the base procedure. In evaluating these new services, the RUC developed work relative values that included increments that were in proportion to the base codes. In its recommendation, the RUC noted that the increment between the base code for flexible sigmoidoscopy (45330) and the new dilation code (45340) was 1.00, which was slightly higher than the other incremental increases for dilation (0.79 – 0.88). The RUC concluded that since flexible sigmoidoscopy does not inherently include conscious sedation and the new dilation code would, the additional increment of 0.12 - 0.21 was appropriate. The RUC did not state that this range of work relative value (0.12 – 0.21) was the appropriate increment for conscious sedation, but rather the fact that the work of conscious sedation needed to be added to the flex sigmoidoscopy base was rationale for a higher increment.

CMS has responded to this recommendation by stating that "The RUC has been considering the issue of conscious sedation in general for some time and has not been able to conclude that there is any incremental physician work associated with conscious sedation. In absence of a specific RUC recommendation affirmatively stating that specific physician work is associated with conscious sedation, we do not believe it is appropriate to assign a work RVU for CPT code 45340 that is based on the presumption that a portion of the work value is for using conscious sedation."

We believe that CMS has misunderstood the RUC's efforts surrounding the conscious sedation project. The RUC absolutely believes that there is physician work related to the provision of conscious sedation. The question rather is, has there been an incremental increase in the amount of physician work attributable to the provision of conscious sedation over the past five-years? As you may know, this issue was initiated by gastroenterology during the course of the previous Five-Year Review. The RUC has determined that it must first determine the universe of codes where, in today's practice, conscious sedation is an inherent part of the service and is provided by the operating physician. The RUC has not yet concluded its work on determining whether conscious sedation has been appropriately accounted for in the work relative values for these codes.

In light of this further explanation and clarification, we urge CMS to accept the RUC's original recommendation of 1.96 for CPT code 45340.

Urine Capacity Measurement (51798)

The RUC requests that CMS reconsider its decision to assign 0.00 work RVUs to CPT code 51798, *Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, nonimaging*. A survey conducted by the American Urological Association (AUA) indicated that physicians perform this procedure 75 percent of the time. Based on this survey data as well as a comparison of this procedure to CPT code 76857, *Ultrasound, pelvic (nonobstetric), B-scan and/or real time with image documentation; limited or follow-up (eg, for follicles)*, the RUC recommended 0.38 work RVUs for this procedure.

CMS's reasoning for disagreeing with the RUC recommendation is based on a stated belief that there is no physician work involved, not on actual data as presented by the AUA. Therefore, we request that CMS work with the AUA to review this decision or that CMS review the work value for this code as part of its annual multi-specialty validation panel.

Laparoscopic Hysterectomy/Myomectomy Procedures (58545 – 58554)

The RUC submitted interim work relative value recommendations for Laparoscopic Hysterectomy/Myomectomy Procedures in May 2002. The RUC has recently reviewed new

survey data for these services. Attached are new RUC recommendations for these services, which we urge you to review during your refinement process.

Speech, Language, and Hearing Procedures (92613, 92615, and 92617)

New CPT codes 92613, 92615, and 92617 involve the review of videotapes of recorded swallowing and/or sensory reflex by a physician to assess and report findings and recommendations to the primary care giver and/or the patient or caregiver (eg, changes in diet and/or non-oral forms of alimentation). The RUC recommended physician work values for codes 92613 (0.99), 92615 (0.88), and 92617 (1.10) are based on the specialty's survey data and a comparison to Evaluation and Management services and code 93314 *Echo transesophageal* (work RVU = 1.25).
CMS did not accept the RUC recommendations stating the following:

> For these three services that refer only to a separately identified physician review and interpretation of the fiberoptic endoscopic evaluation, we consider the physician interpretation and report bundled into an evaluation and management service. We believe the physician who does not perform the testing should only bill the patient when performing an evaluation and management service, not as the supervisor of another professional performing and reviewing the initial fiberoptic endoscopic evaluation. The interpretation of this test is an integral part of the testing itself. If a nonphysician professional has the credentials and experience to perform this testing, then that professional should also provide the interpretation of the findings.

The RUC would offer the following arguments that CMS is incorrect in its position on these services:

1. The interpretation and report related to this service is not related to an Evaluation and Management Service. The description of intra-service work includes a detailed analysis by the physician, after the procedure has been completed; review the videotaped procedure frame-by-frame to develop the medical diagnosis; and preparation of a written report. This is similar to many other services included in CPT and the Medicare Physicians Payment Schedule where there is a separate interpretation and report performed by the physician, which is separate from any Evaluation and Management service.

2. CMS makes the assertion that "the interpretation of this test is an integral part of the testing itself." The RUC valued the procedure codes and the interpretation/report codes separately and thus separated out the interpretation from the test itself. The work relative

values do not integrate the interpretation into the testing. If CMS maintains that the interpretation must be integral to the test, then the procedure codes must be re-valued.

3. We do not agree with the statement that if a nonphysician has the credentials and experience to perform a test, then they should also provide the interpretation of the findings. In fact, we are certain that CMS, upon re-examination of this statement, would agree that it was made in error.

We urge CMS to reconsider the relative values and payment policies for these services and accept the RUC recommendation during your refinement process.

Ambulatory Blood Pressure Monitoring (92784, 93786, 93788, and 93790)

In this *Final Rule* you note that you had not yet received RUC recommendations on the ambulatory blood pressure monitoring codes and were maintaining the relative values that you established during the National Coverage Decision process for this issue. The RUC submitted work relative values and direct practice expense inputs to you in our October 14 submission. We request that you consider the RUC recommendations during your refinement process for the 2004 MFS *Final Rule.*

Global Period Corrections

The RUC concurs with your decision to accept our recommendation to alter the 90 day global period to a 000 day global period for CPT code 77789 *Surface Application of Radiation Source.* We note that the Final Rule does not include this change in Addendum B. However, we understand that this was in error and will be corrected in the systems on April 1, 2003, retroactive to March 1, 2003.

CMS has also announced its decision to accept the RUC recommendation for CPT code 33224 *Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously placed pacemaker or pacing cardioverter-defibrillator pulse generator (including revision of pocket, removal, insertion and/or replacement of generator)* of 9.00. The RUC had also recommended a global period of 000 for this service. We note that Addendum B includes a global period of 090 for this service. However, we understand that this was in error and will be corrected in the systems on April 1, 2003, retroactive to March 1, 2003.

CMS has also accepted the RUC's interim recommendation for CPT code 58550 *Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 grams or less.* The RUC had recommended a global period change to 090 for this service. However, in Addendum B,

CMS has assigned a global period of 010. We would also request that the global period for this service also be corrected.

Update on the Conscious Sedation Project

As we mentioned above, the RUC has been reviewing the issue of conscious sedation over the course of the past few years. The RUC created a Conscious Sedation Workgroup, chaired by Doctor William Gee. The Workgroup has made significant progress in identifying the CPT codes in which conscious sedation is an inherent part of the service and is provided by the operating physician. The Workgroup hopes to finalize its review of these codes at the April RUC meeting and submit a coding proposal to the CPT Editorial Panel to include this list within CPT. The RUC will also recommend that direct practice expense inputs related to conscious sedation will only be included in those services that are identified on this list.

The RUC also continues to advocate that CMS consider a change in payment policy to allow separate payment for conscious sedation, utilizing the stand-alone CPT codes 99141 and 99142, when this service is provided in conjunction with a procedure where conscious sedation is not an inherent component.

The January 2003 Conscious Sedation Workgroup report is appended for your information. We would request that CMS review the work that has been completed to date and share any suggestions and/or concerns with the Workgroup at its meeting in April. The RUC's efforts in this area are aimed at ensuring that the physician work and practice expenses attributable to the provision of conscious sedation are captured accurately in either the procedure code or stand-alone codes. It is very important that we address any issues that CMS may have regarding this project before concluding our deliberations on this issue.

We appreciate your consideration of these comments. If you have any specific questions regarding our relative value recommendations, please contact Sherry Smith at the AMA at (312) 464-5604 or via e-mail at Sherry_Smith@ama-assn.org.

Sincerely,

James G. Hoehn, M.D.

James G. Hoehn, MD

cc: RUC Participants
Attachments

AMA/Specialty Society RVS Update Committee
Conscious Sedation Workgroup
Thursday, January 30, 2003

The Conscious Sedation Workgroup met on Friday, January 30 to discuss several issues related to the provision of conscious sedation. The following members were in attendance: Doctors William F. Gee (Chair), James Blankenship, Neil Brooks, John Derr, Lanny Garvar, Alexander Hannenberg, Charles Mick, Alan Plummer, J. Baldwin Smith, Richard Tuck, and David Keepnews, RN.

Review of List of CPT Codes Where Conscious Sedation is Inherent

At the April 2002 RUC meeting, the RUC agreed to ask specialty societies to review their services and indicate which CPT codes, in today's practice, inherently include conscious sedation. Twenty-eight medical specialty societies and HCPAC organizations responded to this request. AMA staff compiled the list of more than 250 CPT codes identified by the specialties for review at the September 2002 RUC meeting. At that meeting, the Workgroup agreed that the list of 250+ codes should be re-circulated to all of the specialty societies with additional definition and explanation. For example, the Workgroup agreed that the codes should be included whether IV or oral conscious sedation is inherently provided. In addition, it was clarified that only services where the sedation services are administered by or under the supervision of the operator (physician performing the procedures) should be included. If conscious sedation is an inherent part of the procedure, but is most typically provided by an anesthesiologist or CRNA, the code should not be included in the specialty's list.

Fifty-three specialty societies responded to this second review of the conscious sedation list. These responses were used to create a new list of 226 CPT codes that met the above criteria. However, specialties differed on their recommendations for 27 CPT codes. In general this disagreement was based on the issues surrounding whether the service is more typically provided to an adult or pediatric patient. For one category of these services, the pediatricians have indicated that they typically utilize conscious sedation when performing the procedure, while the society which predominately performs the procedures indicate that they do not typically utilize conscious sedation for adult patients. The workgroup agrees that for this category, the services should not be included on the conscious sedation list. If conscious sedation is utilized then it would be reported separately. The Workgroup, therefore, agreed to remove the following nominated codes from the list:

47000 *Biopsy of liver, needle; percutaneous*
74360 *Intraluminal dilation of strictures and/or obstructions (eg, esophagus), radiological supervision and interpretation*
74363 *Percutaneous transhepatic dilation of biliary duct stricture with or without placement of stent, radiological supervision and interpretation*
75600 *Aortography, thoracic, without serialography, radiological supervision and interpretation*
75605 *Aortography, thoracic, by serialography, radiological supervision and interpretation*
75625 *Aortography, abdominal, by serialography, radiological supervision and interpretation*
75630 *Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation*
75894 *Transcatheter therapy, embolization, any method, radiological supervision and interpretation*
75960 *Transcatheter introduction of intravascular stent(s), (non-coronary vessel), percutaneous and/or open, radiological supervision and interpretation, each vessel*
75984 *Change of percutaneous tube or drainage catheter with contrast monitoring (eg, gastrointestinal system, genitourinary system, abscess), radiological supervision and interpretation*

75989 *Radiological guidance for percutaneous drainage of abscess,, or specimen collection (ie, fluoroscopy, ultrasound, or computed axial tomography), with placement of indwelling catheter, radiological supervision and interpretation*
76003 *Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)*

In addition, the pediatricians had noted that a number of the codes on the proposed list would typically be performed under general anesthesia, rather than conscious sedation, for the pediatric patient. Therefore, the Workgroup reviewed the list to determine which codes were more commonly performed on pediatric patients. This review resulted in the removal of the following codes:

92990 *Percutaneous balloon valvuloplasty; pulmonary valve*
92992 *Atrial septectomy; transvenous method, balloon (eg, Rashkind type) (includes cardiac catheterization)*
92993 *Atrial septectomy or septostomy; blade method (Park septostomy) (includes cardiac catheterization)*
92997 *Percutaneous transluminal pulmonary artery balloon angioplasty; single vessel*
92998 *each additional vessel*
93531 *Combined right heart catheterization and retrograde left heart catheterization, for congenital cardiac anomalies*
93532 *Combined right heart catheterization and transseptal left heart catheterization through intact septum with or without retrograde left heart catheterization, for congenital cardiac anomalies*
93533 *Combined right heart catheterization and transseptal left heart catheterization through existing septal opening, with or without retrograde left heart catheterization, for congenital cardiac anomalies*

Clarification of Vignettes and Descriptions of Work

At the April 2002 Conscious Sedation Workgroup meeting, concern was expressed that some specialties did not respond to the request to identify codes and others may not have identified a complete list of codes that inherently include conscious sedation in today's practice. The Workgroup identified twenty CPT codes (eg, 49021 *Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; percutaneous)*) in which sedation is discussed in the information in the RUC database (pre, intra, or post-service work descriptions). A letter was sent to three specialty societies requesting them to review the issue again and address/clarify the vignettes and descriptions of work for these services.

Two specialties (ophthalmology and otolaryngology) responded that the seven codes (31233, 31235, 31237, 31571, 67207, 67316, and 67900) that were identified from the RUC database either 1) do not typically require conscious sedation or 2) the conscious sedation by an anesthesiologist. The specialties recommended minor editorial revisions to the vignettes. The Workgroup agreed that these clarifications are appropriate and do not effect the past valuation of these services.

The RUC also sent a letter to interventional radiology requesting the specialty to review thirteen specific CPT codes identified through the review of the RUC database of vignettes. The specialty responded that one of the codes identified, 36870 *Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)*, should be added to the conscious sedation list. The specialty also indicated that the vignettes for the percutaneous

abscess drainage codes (44901, 47011, 48511, 49021, 49041, 49061, 50021, and 58823) were designed to reflect local variation in conscious sedation administration between anesthesiologists and the operating physician. The Workgroup was concerned that the physicians responding to the survey for these abscess drainage codes may have considered the work of conscious sedation in their valuation as the vignettes in the RUC data base clearly state that conscious sedation was administered in conjunction with the procedure. In addition, the Workgroup would like the interventional radiologists to address the vignettes related to CPT codes 32201, 35472, 49423, and 49424. The Workgroup recommends that another letter be sent to interventional radiology to re-review these codes, along with other codes in the family, to assess whether conscious sedation is inherent to the procedure. The Workgroup will request that this information be presented at their April meeting.

PEAC Update

The RUC had requested that the PEAC review the direct practice expense inputs for the stand-alone conscious sedation codes (CPT codes 99141 and 99142). The PEAC has recommended that the CPT codes be revised to differentiate between the initial 15 minutes of the procedure and each additional 15 minutes of monitoring time. It was determined that this would provide the only reasonable way to determine resources required to perform conscious sedation related to many disparate procedures with varying intra-service time. The Workgroup agreed with this approach and will recommend that CPT consider these revisions when the CPT proposal is developed for the entire conscious sedation issue.

The PEAC has established standards for conscious sedation which include the following:

- 2 minutes RN time for initiation of sedation
- 100% of intra-service physician time for RN time
- 15 minutes of RN time for each hour of monitoring following the procedure
- medical supplies and equipment related to the provision of conscious sedation

Conclusions

The Workgroup intends to finalize a coding proposal on this issue at the April 2003 meeting, which will include a list of codes where conscious sedation is inherent to the procedure and the suggested revision to the current conscious sedation stand alone code family. This proposal will be reviewed by the RUC in April. It is anticipated that any recommendations to the CPT Editorial Panel would be considered in the CPT 2005 cycle.

The Workgroup also recommends that an update on this project be included in the RUC comment letter to CMS to initiate a dialogue on the issue. In particular, the Workgroup would be interested in learning whether CMS has any questions or concerns regarding the list that will be discussed and finalized in April. The RUC and CPT effort on this issue is to initiate a policy change where CMS will begin separate payment for conscious sedation for those services that do not inherently include conscious sedation. It is important to understand any CMS suggestions or concerns regarding this effort prior to the conclusion of the Workgroup's recommendations.

American Medical Association

Physicians dedicated to the health of America

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February 26, 2003

Thomas A. Scully
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
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200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Programs; Revision to Payment Policies Under the Physician Fee Schedule for Calendar Year 2003; Final Rule

Dear Administrator Scully:

The American Medical Association (AMA)/ Specialty Society RVS Update Committee (RUC) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Final Rule for Medicare Programs; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2003, published in the December 31, 2002 Federal Register.

The RUC is extremely pleased that CMS has accepted nearly all of the recommendations that this volunteer multi-specialty committee has submitted over the past year. We believe that our success in this year is attributed to a level of mutual respect between CMS and the RUC, which has been developed over the course of the last decade. The RUC looks forward to your visit on April 25, 2003 to share first-hand the experiences of the committee in our attempts to improve the Resource-Based Relative Value Scale (RBRVS).

Although we are pleased about the high level of acceptance of RUC recommendations as published in this *Final Rule*, we are offering comments on certain issues that are of concern to the committee. We urge you to consider modifications to some of your decisions as you refine the CPT 2003 relative values for the 2004 *Final Rule* publication late this year.

Direct Practice Expense Refinements

The challenge of refining the direct practice expense data has been onerous for organized medicine and your staff at CMS. However, the ability to gain confidence in the data via

direct involvement in its refinement is important to physicians and other health care professionals involved in our process. We appreciate CMS response to accept 100% of the practice expense refinements proposed by the RUC's Practice Expense Advisory Committee (PEAC) this year. The efforts made by CMS staff to articulate concerns at the meetings of the PEAC result in effective dialogue that have improved the direct practice expense inputs and enabled the medical community to contribute their expertise about the resources required to perform each procedure or service.

The PEAC reviewed more than 1,200 codes in 2002 and is scheduled to review a large number of codes in 2003. In addition, CMS will be receiving a recommendation to standardize the inputs for most 090-day major surgical procedures. We understand that these revisions will be considered for the 2004 Medicare Payment Schedule update.

CMS decided to not include direct practice expense inputs for CPT codes reported with a –26 modifier in a facility. The PEAC has recommended clinical staff for several services in this category. The RUC believes that the current direct practice expense inputs for these codes are not appropriate. The recommended changes in clinical staff time provide more accurate direct practice expense inputs for these codes. The RUC strongly urges CMS to include these clinical staff times in practice expense determinations for these codes.

Non-Physician Work Pool

We understand that CMS intends to make the zero work pool issue a priority in 2003. The RUC agrees that this methodology should be studied and potentially modified. Accordingly, the RUC has created a Non-Physician Work Pool Workgroup. The workgroup recently received an informative presentation on the current methodology by your staff at their January 30th meeting.

The RUC's Non-Physician Work Pool Workgroup will meet again on Thursday, April 24 to further discuss this issue and any potential recommendations that may be referred on to the RUC and CMS.

Budget Neutrality

During the course of the transition to the resource-based practice expense relative values and the refinement of its methodology, CMS has implemented changes and maintained budget neutrality via a re-scaling of all practice expense relative values. This has been a necessary step in the methodology and refinement as the relativity between CPT codes is still under development.

As the PEAC completes its efforts in the spring of 2004 and CMS finalizes policies related to practice expense, we believe that CMS should consider providing the same stability to the practice expense relative values as is seen in the work relative values. CMS should consider keeping the practice expense relative values stable at the conclusion of the refinement process. Much like what is done with work relative values, any code-level refinements due to annual coding changes that result in a non-budget neutral impact should not result in a reduction of all practice expense relative values. The RUC requests that CMS present an analysis of this issue in an upcoming Proposed Rule.

The RUC is also deeply concerned that CMS continues to impose a behavioral offset to the practice expense relative values beyond the transition to the resource-based relative values. In the November 1, 2001 *Final Rule,* CMS announced that on January 1, 2002, "We are making a 0.18 percent reduction to the conversion factor to account for an anticipated increase in the volume and intensity of services in response to the final year of the implementation of resource-based practice expense RVUs." This offset was applied as many specialties faced significant cuts to their overall Medicare payment as a result of the transition to the resource-based practice expense relative values.

In the December 31, 2002 *Final Rule* CMS announced that it will implement a 0.49 percent reduction to all practice expense relative values in 2003 to "account for an anticipated increase in the volume and intensity of services in response to payment reductions from the refinement of practice expense relative values." The rationale for the 0.49 percent reduction to the practice expense relative values, which translates into a larger volume and intensity adjustment than in 2002, is not explained in this *Final Rule.*

Since the resource-based practice expense relative values are now fully resource-based and any changes are likely a result of PEAC refinement activities, shifts in the practice expense values should largely be within a specialty. The specialty impact table within the *Final Rule* emphasizes this point, as few specialties should anticipate an overall decrease in their Medicare payments due solely to the practice expense refinements. The RUC requests that CMS provide further explanation of this offset, as it appears to be unwarranted and potentially calculated on flawed data or assumptions.

Five-Year Review of Anesthesia Work

Beginning in August, 2000, the RUC worked with the American Society Anesthesiologists in an extended Five-Year Review of physician work values in anesthesiology. Though the RUC was unable to develop a recommendation for new work values for all anesthesia services, in April 2002 we provided the results of more than two years of RUC analysis of nineteen high volume anesthesia codes.

In the December 31, 2002 *Final Rule*, CMS announced an increase to the physician work component of the anesthesia conversion factor by 2.10 percent to reflect a 9.13 percent payment increase in payment applied to 23 percent of anesthesia allowed changes. These changes were the result of considering changes to nineteen codes reviewed by the RUC. CMS announced that this is an interim adjustment that is subject to comment.

I am in receipt of your letter of February 5, 2003 requesting the RUC to continue its review of the anesthesia work relative values, in the expectation of developing a final recommendation as to a change in the Medicare anesthesia conversion factor involving all anesthesia codes. Over the course of the next several weeks, I will review your request with the RUC members and we will respond to you with our planned course of action on this issue.

Definition for ZZZ Global Periods

The RUC appreciates CMS consideration and implementation of the revision to the ZZZ global period definition to read as follows:

ZZZ = Code related to another service and is always included in the global period of the other service (Note: Physician work is associated with intra-service time and in some instances the pre- and post-service time)

The RUC's Research Subcommittee has discussed the process by which any specialty may seek to have codes with a ZZZ re-reviewed and determined that the RUC will ask specialties to identify any ZZZ codes whose physician work may be affected by the definition change. Once the list is compiled and presented to the Research Subcommittee in April, the Research Subcommittee will discuss the issue further and determine if the RUC should review these codes outside of the five-year review process.

Immunization Administration

The RUC joins many others who will comment that CMS should be applauded for addressing the overall payment for immunization administration via a significant increase to the practice expense relative values. We are pleased that the CMS has accepted the RUC's recommendations for the direct practice expense inputs for these codes.

The RUC has commented on the issue of assigning physician work relative values for immunization administration repeatedly over the past few years. The RUC firmly believes that although the nurse may administer the vaccine and often addresses questions posed by the patient/parent, this is in follow-up to the physician's discussion with the patient/parent.

As the RUC has indicated in the past, the physician does discuss with the patient/parent the benefits and risks related to the vaccine(s). These interactions are similar to other services where CMS has acknowledged, through acceptance of RUC recommendations, that a nurse may follow-up or repeat earlier discussions that the patient has had with the physician. The RUC concluded that the physician work involved in immunization administration was comparable to the work involved in 99211 (*see Evaluation & Management, established Patient*) which has a work RVU of 0.17. **We continue to strongly urge you to publish work relative values of 0.17 and 0.15 for CPT codes 90471 and 90472, respectively. The RUC also offers to collect additional data regarding the physician involvement in these services, if CMS indicates that this data may be useful in reconsidering this issue.**

The RUC also urges CMS to eliminate the G codes that are duplicative of the CPT codes that may be used for the administration of Medicare covered vaccines.

Creation of G Codes

The RUC echoes the concern expressed by many specialty societies and the AMA, that CMS has recently over-utilized its ability to create G codes and we urge CMS to take more serious steps to establish a set process and to limit this activity as much as feasible. CMS observes the great deal of effort and expertise that is required by each specialty in developing coding proposals, vignettes, conducting surveys to determine physician time and work, convening consensus panels, and determining appropriate direct practice expense inputs for each new CPT code that is created. The results of these efforts are then validated through multi-specialty groups of physicians, including CPT Advisors, the CPT Editorial Panel, and the RUC. While the creation of a G code, and its resulting relative values, may be expedient, it lacks the credibility and fairness of the CPT codes that have gone through these processes.

In reviewing the G codes that were announced in this *Final Rule*, it appears that many of these issues did not need immediate resolution and could have been processed through the normal channels (eg, G0275 *Renal angiography*). We recommend that CMS determine an internal process for considering such G code issues and communicate it to organized medicine.

The RUC would also offer that CMS consider the RUC's guidance on any G code, or CPT Level III tracking code, for which you are considering the establishment of relative values.

Revisions to Malpractice RVUs for New and Revised CPT Codes for 2002

The RUC is very concerned that updates to the Professional Liability Insurance (PLI) component of the Medicare Fee Schedule have failed to reflect the actual and rapidly rising cost of liability insurance. We are encouraged that the agency is committed to

examining ways to use more accurate and timely data, as evidenced by its engaging a contractor to examine the issue. In addition, the RUC is pleased that CMS acknowledged the need to update PLI data used in the Medicare Fee Schedule at the recent meeting of the Practicing Physicians Advisory Council held at the CMS Headquarters in Baltimore on February 10, 2003. Given the significant impact that this is having on patient access, we urge CMS to work closely with medical specialty societies in the process of an imperative update of the PLI component. The substantial increases in medical liability insurance premiums that for some specialties have more than doubled in the past two years have created a serious crisis for many physicians. The RUC applauds the efforts of President Bush in focusing attention on this serious problem during his address in Scranton on January 16th, as well as in the State of the Union Address. We urge CMS to likewise respond quickly in updating the assigned values to accurately reflect the practice costs incurred.

Relative Value Recommendations for New and Revised 2003 Codes

CMS has announced that it has accepted 96 percent of the RUC's work relative value recommendations and 100 percent of the RUC's practice expense recommendations. We appreciate the confidence that you have displayed in this activity. We also believe that our recommendations are based on quality data and serious deliberations. Therefore, we offer additional comments on RUC recommendations that you have not accepted. We hope that this additional information is helpful to you in refining the relative values for the 2004 *Final Rule*. We also urge you to consider additional information that the specialty societies include in their comments.

Mohs Micrographic Surgery (17304-17310)

In May 2002, the RUC submitted an interim recommendation to maintain the relative values for mohs micrographic surgery codes until the RUC had the opportunity to review this issue further in February 2003. CMS has disagreed with the work relative value for code 17310 and lowered it from its 2002 value. The RUC considered this issue at our most recent meeting and is attaching new recommendations for your consideration during your refinement process.

Excision of Benign Tumor or Mandible/Maxilla (Codes 21030 and 21040)

The RUC submitted new recommendations for CPT codes 21030 and 21040 to CMS on October 14, 2002. We understand that CMS was not able to consider these recommendations prior to finalizing this *Final Rule*. We ask that you consider these recommendations during your 2003 refinement process.

Minimally Invasive Repair of Pectus Excavatum (21740, 21742, and 21743)

The RUC continues to recommend that minimally invasive repair of pectus excavatum services remain carrier priced in 2004 as the specialty has been unable to acquire data for these services and is not expected to do so prior to the April 2003 RUC meeting.

Venipuncture (36415 and 36416)

While the RUC did recommend that there was no physician work associated with either CPT code 36415 or 36416, both describing venipuncture services, the PEAC and RUC did determine that there were direct practice expense inputs. CMS, however, has not published any practice expense relative values for these codes. We understand that currently Medicare's payment for these services is based on statute and included on the Clinical Lab Fee Schedule. The RUC would request that CMS publish practice expense relative values for these services, regardless of your payment policies. For other services,

CMS has published the relative values with a footnote that indicates that the RVUs are not used for Medicare payment.

Therapeutic Apheresis (36511-36516)

In the *Final Rule* CMS notes that it had not yet received recommendations for therapeutic apheresis services. We understand that CMS was not able to consider our October 14 submission in time for the *Final Rule*, but urge you to consider the information during refinement. In this instance, CMS has the same relative value for the first five codes in this family as the RUC's final recommendation. However, for CPT code 36516, the RUC has actually submitted a lower work relative value (1.22) than the value published by CMS of 1.74.

Bone Marrow Procedures (38204 – 38215)

The AMA RUC deliberated throughout 2002 and was satisfied that representatives of the American Society of Hematology (ASH) had clearly described thirteen new bone marrow transplant and stem cell processing codes (CPT codes 38204-38215) that reflect newer techniques used in a transplant laboratory under physician supervision. These new codes replace CPT 38231 *Blood-derived peripheral stem cell harvesting for transplantation, per collection* and CPT 86915 *Bone marrow or peripheral stem cell harvest, modification or treatment to eliminate cell type(s) (e.g., T-cells, metastatic carcinoma).*

In the 2003 Medicare Physician Fee Schedule, the Centers for Medicare and Medicaid Services (CMS), were not able to utilize the RUC's deliberations from the September 2002 meeting that were submitted to CMS on October 14, 2002. The RUC spent a great deal of time deliberating this issue in September and recommended certain changes to CPT and improved interim work relative value recommendations for several codes. CPT will be implementing these coding revisions in 2004 and we urge CMS to review the RUC recommendations that were submitted in October, along with any new information that the RUC provides following our April 2003 meeting. We offer the following comments on the specific codes in this family:

CPT Code 38204, Management of Recipient Hematopoietic Progenitor Cell Donor Search and Cell Acquisition

At the September RUC meeting, CPT code 38204 was assigned a work value of 2.0. In the final rule, however, CMS gave the code a status indicator of "B" meaning that it will not make separate payment for this service. The reasons cited by CMS are that 1) the payment for any physician work associated with this service is part of the payment for other bone marrow transplant codes including CPT codes 38205, 38206, 38240, 38241, and 38242, 2) there is a possibility that beneficiaries would be billed for failed donor searches, 3) there is doubt that beneficiaries would be able to determine that a search had been conducted and would likely never meet the physician conducting the search, and 4) the clinical vignette provided by the specialty does not distinguish between the work of the physician and the clinical and administrative staff. Furthermore, CMS asks in the rule that the RUC determine whether any physician work associated with a cell donor search is already included in the work of the physician performing the harvest or transplant and if it is not included, the RUC should recommend appropriate changes in the work values.

The RUC disagrees with CMS' assessment of CPT code 38204. First, the physician work associated with a donor search is not included in the work of the codes cited by CMS. In fact, three of these CPT codes (38205, 38206 and 38242) were reviewed by the RUC during the same meeting. The vignette and subsequent RUC discussion clearly indicate that management of a donor search is not encompassed in the work value assigned to the harvesting and transplantation codes. Insofar as packaging the work of a bone marrow/stem cell donor search into the harvesting or transplant codes, we simply do not understand the point of such an exercise. While theoretically this could be done, we would note that frequently the physician performing the donor search is not the same as the physician doing the harvest or transplant. Thus, it would not make any sense to assign the work of conducting the donor search to a physician who did not do the work. This would be contrary to the principles of the physician fee schedule.

Second, the intention of ASH representatives before the RUC was to explain that CPT 38204 would be reported only once for the potential transplant for which the donor search was being made. These searches may take anywhere from weeks to months to years, but, again, would only be billed once per potential transplant. In a theoretical sense, then, CMS is technically correct that beneficiaries could be billed for a failed search. However, the RUC would appreciate an elaboration by CMS on how this technicality contributes significantly to the decision not to provide separate payment for the service.

Third, CMS' question about how beneficiaries would "know" that a search was conducted and doubt that a beneficiary would meet the physician conducting the search are both irrelevant. Presumably, a beneficiary undergoing an allogeneic bone marrow/stem cell transplant would understand that a donor search took place. Furthermore, while it is true that beneficiaries will frequently not meet the physician who conducted the donor search, this is also the case with other physician services. Patients
do not meet the pathologist who interpreted their specimen or the radiologist who read their x-ray.

Fourth, regarding CMS' argument that the specialty has not explained in detail the tasks performed by the physician and administrative/clinical staff in a donor search, the RUC heard significant discussion of this issue in April and September and did feel comfortable with the physician work described.

We urge CMS to reconsider its decision concerning CPT 38204 and to assign the RUC recommended work value of 2.00 for this important service.

Codes 38207-38215, Preservation and Preparation of Stem Cells for Transplant

All of these codes involve various physician activities prior to stem cell transplant. At the April meeting, the RUC assigned interim work values to these codes. At the September meeting, a pre-facilitation committee spent over 4 hours discussing just these codes. On the basis of their enhanced understanding of the specific tasks involved, the RUC developed much improved interim values. The RUC did recommended several technical changes to be made to the CPT definitions to more clearly delineate the washing and thawing activities and to make it clear that flow cytometry could not be billed with these services.

Following these changes, the RUC recommended that these codes be resurveyed specifying that a refined reference list be developed and every effort was to be made to assure that survey respondents were better educated regarding the work survey. Moreover the facilitation committee wanted to provide assistance prior to the actual dissemination of the survey instrument.

In the final rule, CMS assigned an indicator of "I" to all of the codes meaning that the codes are not recognized for Medicare purposes. The reasons cited by CMS were a lack of clarity as to whether any physician work was required, concern about the unbundling of an existing code, and questions about the RUC's analysis of the physician work. We understand that CMS did not consider any of the deliberations of the RUC or the facilitation committee during the September meeting in its analysis. Rather, it was based on the April RUC recommendations only. We urge to consider this analysis during the refinement period.

One issue raised by CMS related to concerns with the units of service and questions as to whether multiple services would be billed for each aliquot of the material. To make this clear that this is not the case, ASH has submitted the following language to CPT:

> Codes 38207-38215 describe various steps used to preserve, prepare and purify bone marrow/stem cells prior to transplantation or reinfusion. A code would be reported only once per session regardless of the quantity of bone marrow/stem cells manipulated. For this purpose, a session will be defined as all the activity on a day relating to that specific processing step for a single patient."

The RUC is convinced that there is physician work associated with these services and that a resurvey, with the conditions identified, is needed. However, we are reluctant to urge the specialty to resurvey unless there is some assurance that the effort will lead CMS to value these services. We would hope CMS will meet with ASH to resolve its concerns and advise the RUC as to whether further reexamination of the work of these codes is desired.

Sigmoidoscopy, flexible; with dilation by balloon, each stricture (45340)

In April 2002, the RUC reviewed a series of gastrointestinal endoscopy services that were created with dilation by balloon or endoscopic injections, performed in conjunction with the base procedure. In evaluating these new services, the RUC developed work relative values that included increments that were in proportion to the base codes. In its recommendation, the RUC noted that the increment between the base code for flexible sigmoidoscopy (45330) and the new dilation code (45340) was 1.00, which was slightly higher than the other incremental increases for dilation (0.79 – 0.88). The RUC concluded that since flexible sigmoidoscopy does not inherently include conscious sedation and the new dilation code would, the additional increment of 0.12 - 0.21 was appropriate. The RUC did not state that this range of work relative value (0.12 – 0.21) was the appropriate increment for conscious sedation, but rather the fact that the work of conscious sedation needed to be added to the flex sigmoidoscopy base was rationale for a higher increment.

CMS has responded to this recommendation by stating that "The RUC has been considering the issue of conscious sedation in general for some time and has not been able to conclude that there is any incremental physician work associated with conscious sedation. In absence of a specific RUC recommendation affirmatively stating that specific physician work is associated with conscious sedation, we do not believe it is appropriate to assign a work RVU for CPT code 45340 that is based on the presumption that a portion of the work value is for using conscious sedation."

We believe that CMS has misunderstood the RUC's efforts surrounding the conscious sedation project. The RUC absolutely believes that there is physician work related to the provision of conscious sedation. The question rather is, has there been an incremental increase in the amount of physician work attributable to the provision of conscious sedation over the past five-years? As you may know, this issue was initiated by gastroenterology during the course of the previous Five-Year Review. The RUC has determined that it must first determine the universe of codes where, in today's practice, conscious sedation is an inherent part of the service and is provided by the operating physician. The RUC has not yet concluded its work on determining whether conscious sedation has been appropriately accounted for in the work relative values for these codes.

In light of this further explanation and clarification, we urge CMS to accept the RUC's original recommendation of 1.96 for CPT code 45340.

Urine Capacity Measurement (51798)

The RUC requests that CMS reconsider its decision to assign 0.00 work RVUs to CPT code 51798, *Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, nonimaging*. A survey conducted by the American Urological Association (AUA) indicated that physicians perform this procedure 75 percent of the time. Based on this survey data as well as a comparison of this procedure to CPT code 76857, *Ultrasound, pelvic (nonobstetric), B-scan and/or real time with image documentation; limited or follow-up (eg, for follicles)*, the RUC recommended 0.38 work RVUs for this procedure.

CMS's reasoning for disagreeing with the RUC recommendation is based on a stated belief that there is no physician work involved, not on actual data as presented by the AUA. Therefore, we request that CMS work with the AUA to review this decision or that CMS review the work value for this code as part of its annual multi-specialty validation panel.

Laparoscopic Hysterectomy/Myomectomy Procedures (58545 – 58554)

The RUC submitted interim work relative value recommendations for Laparoscopic Hysterectomy/Myomectomy Procedures in May 2002. The RUC has recently reviewed new

survey data for these services. Attached are new RUC recommendations for these services, which we urge you to review during your refinement process.

Speech, Language, and Hearing Procedures (92613, 92615, and 92617)

New CPT codes 92613, 92615, and 92617 involve the review of videotapes of recorded swallowing and/or sensory reflex by a physician to assess and report findings and recommendations to the primary care giver and/or the patient or caregiver (eg, changes in diet and/or non-oral forms of alimentation). The RUC recommended physician work values for codes 92613 (0.99), 92615 (0.88), and 92617 (1.10) are based on the specialty's survey data and a comparison to Evaluation and Management services and code 93314 *Echo transesophageal* (work RVU = 1.25).
CMS did not accept the RUC recommendations stating the following:

> For these three services that refer only to a separately identified physician review and interpretation of the fiberoptic endoscopic evaluation, we consider the physician interpretation and report bundled into an evaluation and management service. We believe the physician who does not perform the testing should only bill the patient when performing an evaluation and management service, not as the supervisor of another professional performing and reviewing the initial fiberoptic endoscopic evaluation. The interpretation of this test is an integral part of the testing itself. If a nonphysician professional has the credentials and experience to perform this testing, then that professional should also provide the interpretation of the findings.

The RUC would offer the following arguments that CMS is incorrect in its position on these services:

1. The interpretation and report related to this service is not related to an Evaluation and Management Service. The description of intra-service work includes a detailed analysis by the physician, after the procedure has been completed; review the videotaped procedure frame-by-frame to develop the medical diagnosis; and preparation of a written report. This is similar to many other services included in CPT and the Medicare Physicians Payment Schedule where there is a separate interpretation and report performed by the physician, which is separate from any Evaluation and Management service.

2. CMS makes the assertion that "the interpretation of this test is an integral part of the testing itself." The RUC valued the procedure codes and the interpretation/report codes separately and thus separated out the interpretation from the test itself. The work relative

values do not integrate the interpretation into the testing. If CMS maintains that the interpretation must be integral to the test, then the procedure codes must be re-valued.

3. We do not agree with the statement that if a nonphysician has the credentials and experience to perform a test, then they should also provide the interpretation of the findings. In fact, we are certain that CMS, upon re-examination of this statement, would agree that it was made in error.

We urge CMS to reconsider the relative values and payment policies for these services and accept the RUC recommendation during your refinement process.

Ambulatory Blood Pressure Monitoring (92784, 93786, 93788, and 93790)

In this *Final Rule* you note that you had not yet received RUC recommendations on the ambulatory blood pressure monitoring codes and were maintaining the relative values that you established during the National Coverage Decision process for this issue. The RUC submitted work relative values and direct practice expense inputs to you in our October 14 submission. We request that you consider the RUC recommendations during your refinement process for the 2004 MFS *Final Rule.*

Global Period Corrections

The RUC concurs with your decision to accept our recommendation to alter the 90 day global period to a 000 day global period for CPT code 77789 *Surface Application of Radiation Source.* We note that the Final Rule does not include this change in Addendum B. However, we understand that this was in error and will be corrected in the systems on April 1, 2003, retroactive to March 1, 2003.

CMS has also announced its decision to accept the RUC recommendation for CPT code 33224 *Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously placed pacemaker or pacing cardioverter-defibrillator pulse generator (including revision of pocket, removal, insertion and/or replacement of generator)* of 9.00. The RUC had also recommended a global period of 000 for this service. We note that Addendum B includes a global period of 090 for this service. However, we understand that this was in error and will be corrected in the systems on April 1, 2003, retroactive to March 1, 2003.

CMS has also accepted the RUC's interim recommendation for CPT code 58550 *Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 grams or less.* The RUC had recommended a global period change to 090 for this service. However, in Addendum B,

CMS has assigned a global period of 010. We would also request that the global period for this service also be corrected.

Update on the Conscious Sedation Project

As we mentioned above, the RUC has been reviewing the issue of conscious sedation over the course of the past few years. The RUC created a Conscious Sedation Workgroup, chaired by Doctor William Gee. The Workgroup has made significant progress in identifying the CPT codes in which conscious sedation is an inherent part of the service and is provided by the operating physician. The Workgroup hopes to finalize its review of these codes at the April RUC meeting and submit a coding proposal to the CPT Editorial Panel to include this list within CPT. The RUC will also recommend that direct practice expense inputs related to conscious sedation will only be included in those services that are identified on this list.

The RUC also continues to advocate that CMS consider a change in payment policy to allow separate payment for conscious sedation, utilizing the stand-alone CPT codes 99141 and 99142, when this service is provided in conjunction with a procedure where conscious sedation is not an inherent component.

The January 2003 Conscious Sedation Workgroup report is appended for your information. We would request that CMS review the work that has been completed to date and share any suggestions and/or concerns with the Workgroup at its meeting in April. The RUC's efforts in this area are aimed at ensuring that the physician work and practice expenses attributable to the provision of conscious sedation are captured accurately in either the procedure code or stand-alone codes. It is very important that we address any issues that CMS may have regarding this project before concluding our deliberations on this issue.

We appreciate your consideration of these comments. If you have any specific questions regarding our relative value recommendations, please contact Sherry Smith at the AMA at (312) 464-5604 or via e-mail at Sherry_Smith@ama-assn.org.

Sincerely,

James G. Hoehn, M.D.

James G. Hoehn, MD

cc: RUC Participants
Attachments

AMA/Specialty Society RVS Update Committee
Conscious Sedation Workgroup
Thursday, January 30, 2003

The Conscious Sedation Workgroup met on Friday, January 30 to discuss several issues related to the provision of conscious sedation. The following members were in attendance: Doctors William F. Gee (Chair), James Blankenship, Neil Brooks, John Derr, Lanny Garvar, Alexander Hannenberg, Charles Mick, Alan Plummer, J. Baldwin Smith, Richard Tuck, and David Keepnews, RN.

Review of List of CPT Codes Where Conscious Sedation is Inherent

At the April 2002 RUC meeting, the RUC agreed to ask specialty societies to review their services and indicate which CPT codes, in today's practice, inherently include conscious sedation. Twenty-eight medical specialty societies and HCPAC organizations responded to this request. AMA staff compiled the list of more than 250 CPT codes identified by the specialties for review at the September 2002 RUC meeting. At that meeting, the Workgroup agreed that the list of 250+ codes should be re-circulated to all of the specialty societies with additional definition and explanation. For example, the Workgroup agreed that the codes should be included whether IV or oral conscious sedation is inherently provided. In addition, it was clarified that only services where the sedation services are administered by or under the supervision of the operator (physician performing the procedures) should be included. If conscious sedation is an inherent part of the procedure, but is most typically provided by an anesthesiologist or CRNA, the code should not be included in the specialty's list.

Fifty-three specialty societies responded to this second review of the conscious sedation list. These responses were used to create a new list of 226 CPT codes that met the above criteria. However, specialties differed on their recommendations for 27 CPT codes. In general this disagreement was based on the issues surrounding whether the service is more typically provided to an adult or pediatric patient. For one category of these services, the pediatricians have indicated that they typically utilize conscious sedation when performing the procedure, while the society which predominately performs the procedures indicate that they do not typically utilize conscious sedation for adult patients. The workgroup agrees that for this category, the services should not be included on the conscious sedation list. If conscious sedation is utilized then it would be reported separately. The Workgroup, therefore, agreed to remove the following nominated codes from the list:

47000 *Biopsy of liver, needle; percutaneous*
74360 *Intraluminal dilation of strictures and/or obstructions (eg, esophagus), radiological supervision and interpretation*
74363 *Percutaneous transhepatic dilation of biliary duct stricture with or without placement of stent, radiological supervision and interpretation*
75600 *Aortography, thoracic, without serialography, radiological supervision and interpretation*
75605 *Aortography, thoracic, by serialography, radiological supervision and interpretation*
75625 *Aortography, abdominal, by serialography, radiological supervision and interpretation*
75630 *Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation*
75894 *Transcatheter therapy, embolization, any method, radiological supervision and interpretation*
75960 *Transcatheter introduction of intravascular stent(s), (non-coronary vessel), percutaneous and/or open, radiological supervision and interpretation, each vessel*
75984 *Change of percutaneous tube or drainage catheter with contrast monitoring (eg, gastrointestinal system, genitourinary system, abscess), radiological supervision and interpretation*

75989 *Radiological guidance for percutaneous drainage of abscess,, or specimen collection (ie, fluoroscopy, ultrasound, or computed axial tomography), with placement of indwelling catheter, radiological supervision and interpretation*

76003 *Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)*

In addition, the pediatricians had noted that a number of the codes on the proposed list would typically be performed under general anesthesia, rather than conscious sedation, for the pediatric patient. Therefore, the Workgroup reviewed the list to determine which codes were more commonly performed on pediatric patients. This review resulted in the removal of the following codes:

92990 *Percutaneous balloon valvuloplasty; pulmonary valve*

92992 *Atrial septectomy; transvenous method, balloon (eg, Rashkind type) (includes cardiac catheterization)*

92993 *Atrial septectomy or septostomy; blade method (Park septostomy) (includes cardiac catheterization)*

92997 *Percutaneous transluminal pulmonary artery balloon angioplasty; single vessel*

92998 *each additional vessel*

93531 *Combined right heart catheterization and retrograde left heart catheterization, for congenital cardiac anomalies*

93532 *Combined right heart catheterization and transseptal left heart catheterization through intact septum with or without retrograde left heart catheterization, for congenital cardiac anomalies*

93533 *Combined right heart catheterization and transseptal left heart catheterization through existing septal opening, with or without retrograde left heart catheterization, for congenital cardiac anomalies*

Clarification of Vignettes and Descriptions of Work

At the April 2002 Conscious Sedation Workgroup meeting, concern was expressed that some specialties did not respond to the request to identify codes and others may not have identified a complete list of codes that inherently include conscious sedation in today's practice. The Workgroup identified twenty CPT codes (eg, 49021 *Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; percutaneous)*) in which sedation is discussed in the information in the RUC database (pre, intra, or post-service work descriptions). A letter was sent to three specialty societies requesting them to review the issue again and address/clarify the vignettes and descriptions of work for these services.

Two specialties (ophthalmology and otolaryngology) responded that the seven codes (31233, 31235, 31237, 31571, 67207, 67316, and 67900) that were identified from the RUC database either 1) do not typically require conscious sedation or 2) the conscious sedation by an anesthesiologist. The specialties recommended minor editorial revisions to the vignettes. The Workgroup agreed that these clarifications are appropriate and do not effect the past valuation of these services.

The RUC also sent a letter to interventional radiology requesting the specialty to review thirteen specific CPT codes identified through the review of the RUC database of vignettes. The specialty responded that one of the codes identified, 36870 *Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)*, should be added to the conscious sedation list. The specialty also indicated that the vignettes for the percutaneous

abscess drainage codes (44901, 47011, 48511, 49021, 49041, 49061, 50021, and 58823) were designed to reflect local variation in conscious sedation administration between anesthesiologists and the operating physician. The Workgroup was concerned that the physicians responding to the survey for these abscess drainage codes may have considered the work of conscious sedation in their valuation as the vignettes in the RUC data base clearly state that conscious sedation was administered in conjunction with the procedure. In addition, the Workgroup would like the interventional radiologists to address the vignettes related to CPT codes 32201, 35472, 49423, and 49424. The Workgroup recommends that another letter be sent to interventional radiology to re-review these codes, along with other codes in the family, to assess whether conscious sedation is inherent to the procedure. The Workgroup will request that this information be presented at their April meeting.

PEAC Update

The RUC had requested that the PEAC review the direct practice expense inputs for the stand-alone conscious sedation codes (CPT codes 99141 and 99142). The PEAC has recommended that the CPT codes be revised to differentiate between the initial 15 minutes of the procedure and each additional 15 minutes of monitoring time. It was determined that this would provide the only reasonable way to determine resources required to perform conscious sedation related to many disparate procedures with varying intra-service time. The Workgroup agreed with this approach and will recommend that CPT consider these revisions when the CPT proposal is developed for the entire conscious sedation issue.

The PEAC has established standards for conscious sedation which include the following:

- 2 minutes RN time for initiation of sedation
- 100% of intra-service physician time for RN time
- 15 minutes of RN time for each hour of monitoring following the procedure
- medical supplies and equipment related to the provision of conscious sedation

Conclusions

The Workgroup intends to finalize a coding proposal on this issue at the April 2003 meeting, which will include a list of codes where conscious sedation is inherent to the procedure and the suggested revision to the current conscious sedation stand alone code family. This proposal will be reviewed by the RUC in April. It is anticipated that any recommendations to the CPT Editorial Panel would be considered in the CPT 2005 cycle.

The Workgroup also recommends that an update on this project be included in the RUC comment letter to CMS to initiate a dialogue on the issue. In particular, the Workgroup would be interested in learning whether CMS has any questions or concerns regarding the list that will be discussed and finalized in April. The RUC and CPT effort on this issue is to initiate a policy change where CMS will begin separate payment for conscious sedation for those services that do not inherently include conscious sedation. It is important to understand any CMS suggestions or concerns regarding this effort prior to the conclusion of the Workgroup's recommendations.

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002 and February 2003

Mohs Micrographic Surgery

RUC Recommendation from April 2002:

For CPT 2003, the American Academy of Dermatology recommended changes that would clarify that a biopsy and frozen pathology could be done on the same day as Mohs surgery. In addition, the specialty proposed changes to special procedures such as decalcification of the bone during Mohs surgery or specialty stains (i.e. immunostaining for melanoma). Finally, modifications to code 17310 were recommended to clarify that each specimen after the first 5 specimens in each layer is separately reimbursable. The Center's for Medicare and Medicaid recommended that the work value for 17310 be changed from 000 to ZZZ. CPT approved these changes.

Modification to codes 17304, 17305, 17306, and 17307 were considered editorial changes, and were not reviewed by the RUC. The specialty survey for code 17310 did not provide calculations that were work neutral. In addition, RUC members were unclear on the historical information regarding whether the code could be billed more than one time on the same day for greater than 5 specimens, as the interpretation from CPT differed from the interpretation put forth by CMS in 1994 letter from a CMS Chief Medical Officer. Therefore, the RUC approved a motion to let the value stand for the CPT 2003 cycle as interim. Between the April 2002 RUC Meeting and the February 2003 RUC Meeting, an ad-hoc committee would further clarify with CPT the intent of code 17310. In addition, the specialty society would revise their survey based on the agreed upon interpretation of the descriptor and the new ZZZ global period.

The RUC recommends an interim work relative value for CPT code 17310 of 0.95.

Practice Expense
The RUC referred practice expense inputs for this family of codes to the September 2002 Practice Expense Advisory Committee.

RUC Recommendation from February 2003:

A workgroup of the RUC reviewed this issue at the February 2003 meeting and concluded that a number of issues should be addressed regarding these services, including:

- The code descriptors for these services remain confusing and open to various interpretations. Although the RUC understands that many in the Mohs community and payors had historically interpreted CPT code 17310 as an add-on code to be reported for each additional specimen beyond the first five specimens, concern was expressed regarding the potential for over-utilization of this code. In addition, the workgroup noted that the nomenclature for these services is not consistent with other integumentary coding conventions in CPT, which are based on the size of the lesion, rather than the number of specimens. The RUC, therefore, recommends that the specialty work with the CPT Editorial Panel to re-define the Mohs Micrographic Surgery section in CPT. After this revision is complete, the RUC believes that these codes can be appropriately re-evaluated.

- In the interim, the RUC recommends that CMS retain the 2002 work relative value of 0.95 for CPT code 17310. In the December 31, 2002 *Final Rule*, CMS had published that it had reduced the RUC's interim recommendation of 0.95 to 0.62. CMS concluded that intent of the code had changed as it will now be described as an add-on code. The RUC believes that CMS should research its past policies regarding this code, as the specialty has provided documentation that CMS had already been under the assumption that this service was an add-on and could be reported once for each additional specimen beyond the first five specimens. Specifically, the specialty has referred to the November 25, 1991 *Final Rule*, which states that "Code 17310, which is described as *Mohs', more than 5 specimens, fixed or fresh tissue, any stage*, should be treated as a single specimen; that is, if more than 5 specimens are necessary at any stage, each additional specimen beyond 5 should be separately paid. The work RVUs have been established according to the above interpretation." The RUC is also concerned that CMS' approach to determining a new value of 0.62 may be flawed. CMS only considered the pathology work and the specialty has presented that the work of the additional excision should also be factored into the work relative value.

- The RUC's Practice Expense Advisory Committee had reviewed the direct practice expense inputs for these services in April 1999. The RUC recommends that these recommendations remain "interim" pending re-definition and re-evaluation of this family of codes.

- The workgroup that extensively examined this issue at the February 2003 meeting will be assigned to review this issue again after the codes are re-defined by CPT.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery **Integumentary System** **Mohs Micrographic Surgery** *Mohs Micrographic surgery, for the removal of complex or ill-defined skin cancer, requires a single physician to act in two integrated, but separate and distinct capacities: surgeon and pathologist. If either of these responsibilities is delegated to another physician who reports his services separately, these codes are not appropriate. If repair is performed, use separate repair, flap, or graft codes.* If a biopsy of a suspected skin cancer is performed on the same day as Mohs surgery because there was no prior pathology confirmation of a diagnosis, then report diagnostic skin biopsy (11100, 11101) and frozen section pathology (88331) with modifier –59 to distinguish from the subsequent definitive surgical procedure of Mohs surgery.				
▲17304	M1	Chemosurgery (Mohs micrographic technique), including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and complete histopathological preparation including the first routine stain (eg, hematoxylin and eosin, toluidine blue); first stage, fresh tissue technique, up to 5 specimens. (If additional special pathology procedures, stains or immunostains are required, use 88311-88314, 88342)	000	7.60 (no change)
▲17305	M2	*second stage, fixed or fresh tissue, up to five specimens*	000	2.85 (no change)
▲17306	M3	*third stage...*	000	2.85 (no change)
▲17307	M4	*additional stage(s),...*	000	2.85 (no change)
+▲17310	M5	each additional specimen, ~~more than~~ after the first 5 specimens, fixed or fresh tissue, any stage (List separately in addition to code for primary procedure) Use 17310 in conjunction with codes 17304-17307)	ZZZ* *Change in global from 000	0.95 (interim)

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002 and February 2003

Laproscopic Hysterectomy/Myomectomy Procedures

Interim Recommendation from April 2002 Meeting:

New codes 58545, 58546, 58550, and 58552-58554 were created to specifically describe vaginal hysterectomy/myomectomy procedures performed on enlarged uteri.

At the April 2002 meeting, the specialty society stated that they would need to re-survey these codes, as the correct global period for these services should be 90 days not 10 days as stated on their survey instrument. The specialty society presented survey data at the February 2003 RUC meeting. In the interim, the RUC recommended that these laproscopic codes be valued equivalent to the recommended relative work values of the open approach hysterectomy codes as follows:

New Code	Tracking Number	Crosswalk to Code	Work RVU (Interim 2003)
58545	BA1	58140	14.60
58546	BA2	58146	19.00
58550	BA3	58550 (old code number 56308)	14.19 (no change)
58552	BA4	58550 (old code number 56308)	14.19
58553	BA5	58290	19.00
58554	BA6	58290	19.00

58550 and 58552 both compared to 58550 *Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)* (RVU = 14.19) because there is no difference in the work of removing the tube or ovaries in the laproscopic approach. The same applies to 58553 and 58554 where both are crosswalked to

58290 *Vaginal hysterectomy, for uteri greater than 250 grams* (recommended RVU 19.00). Therefore, the RUC recommended interim 2003 work relative values of 14.60 for 58545, 19.00 for 58546, 14.19 for 58550 and 58552, 19.00 for 58553 and 58554.

RUC Recommendations from the February 2003 Meeting:

At the February 2003 meeting, the specialty society presented survey data for all 6 codes. For all codes, the specialty society determined that a 090-day global period should be used for the survey. The RUC expressed concern that the pre-service time of 90 minutes for all six of these procedures is too high and suggested that it be reduced to 60 minutes to be consistent with other major surgical procedures. The specialty society agreed to modify its recommendation of pre-service time to 60 minutes for all six codes. The RUC also discussed the issue of work neutrality for these codes, as the new codes are derived from existing services. The RUC agreed with the specialty that the new codes described new techniques that were not previously performed under the existing codes. In addition, these services would not likely be provided to Medicare patients.

New CPT Codes 58545 *Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; excision of 1-4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas* and 58546, *Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams* replace deleted CPT code 58551 *Laparoscopy, surgical; with removal of leiomyomata (single or multiple)* (work value = 14.21). Old CPT code 58551 was previously assigned a global of 010, while the new CPT codes are assigned a 090 day global. The specialty society had presented a median survey result of 14.86 and an IWPUT comparison to reference code 58140 *Myomectomy, excision of leiomyomata of uterus, single or multiple (separate procedure); abdominal approach* (14.60 RVU). However, the RUC did not agree that the work described in 58545 differed than the work described in the existing code, 58551 (14.21). The RUC recommends the 25th percentile of the survey median of 14.21. **The RUC recommends work relative values of 14.21 for code 58545.**

The RUC had previously recommended an interim value of 19.00 for new CPT code 58546, utilizing 58146 *Myomectomy, excision of fibroid tumor(s) of uterus, 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams, abdominal approach* (work value = 19.00) as a crosswalk. The specialty society then conducted a survey, which also resulted in a survey median of 19.00. The specialty society's survey indicated more intra-service time for the laparoscopic approach (180 vs. 150 minutes), but a lower amount of hospital visit time (30 vs. 79 minutes). The RUC agreed that the open approach remained an appropriate crosswalk and recommends 19.00 for 58546. The specialty clarified that the post-surgical office visits should be revised from one 99214 visit and one 99212 visit to two 99213 visits. The RUC's comments on the work neutrality above apply to this service. It was also noted that the

services now described by 58546 had previously been performed as open procedures, under code 58146. **The RUC recommends a work relative value of 19.00 for code 58546.**

Existing CPT code 58550 was modified and three new codes (58552, 58553, and 58554) were created to specifically differentiate between laparoscopic hysterectomies performed with or without removal of tube(s) and/or ovary(s) and to differentiate based on size of the uteri. CPT code 58550 will now specifically states that it is reported for laparoscopic vaginal hysterectomies only, for uteri less than 250 grams. The RUC understands that this is how this code was originally evaluated when it was added to CPT in 2003. At that time, the work value for this code was determined by comparing the code to CPT 58260 *Vaginal hysterectomy* which did not include the removal of tube(s), and/or ovary(s). The specialty surveyed thirty-six physicians and a consensus panel of physicians to determine the final recommendations for code 58550 For code 58550, a work relative value of 14.19 reflected the 25th percentile of survey responses. The validity of the 25th percentile value was tested using IWPUT analysis. The specialty society determined that the resulting IWPUT of .08 was an appropriate value for this procedure since the laparoscopic route for hysterectomies is chosen over the vaginal route due to some factor impeding the vaginal route. The RUC agreed that the work relative value for this service should not change for its current value of 14.19. **The RUC recommends a work relative value of 14.19 for CPT code 58550.**

CPT code 58552 *Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)* now describes the services in which the tube(s) and/or ovary(s) are also removed. The work relative value survey median for this service was 16.00. The validity of the median value was checked using IWPUT analysis that resulted in an IWPUT of .07, which the specialty society concluded was appropriate. In addition, the society used a building block approach to validate the recommendation and to identify the appropriate value for removal of tubes and ovary(s). The increment between the laparoscopic hysterectomy only procedure described by 58550 and the hysterectomy with removal of the tube(s) and/or ovaries, described by 58552, was 1.81 RVUs. In comparison to the traditional procedure codes CPT code 58260, *Vaginal hysterectomy* (RVU = 12.98), and CPT code 58262, *Vaginal hysterectomy; with removal of tube(s), and/or ovary(s)* (RVU =14.77) the increment of 1.79 RVUs, is a very similar increment. In addition, when comparing the surveyed code (58550) with similar codes 58150, *Total abdominal hysterectomy,* and CPT code 58260, *Vaginal hysterectomy*, the specialty felt that the relative value recommendation was consistent with other hysterectomy codes. The RUC agreed that the increment and the overall relativity was correct and recommends the survey median of 16.00. **The RUC recommends a work relative value of 16.00 for CPT code 58552.**

New CPT code 58553, *Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams; without removal of tube(s) and/or ovary(s)*, and code 58554, *Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)*, were created to reflect new techniques allowing surgeons to remove larger uteri laparoscopically. The specialty society stated that there is additional work with the more complex procedures thereby necessitating the new codes. For code 58553, the

specialty society analyzed data received from thirty-one surveys and tested the validity of the median surveyed RVW using IWPUT analysis. The specialty society determined that an IWPUT of 0.08 was an appropriate value for the level of service for these codes. The specialty society also compared the surveyed code 58553 with similar codes 58150, *Total abdominal hysterectomy* and 58290, *Vaginal hysterectomy, for uterus greater than 250 grams*. CPT code 58150 is valued at 15.24 RVW and the RUC approved 19.00 RVW for 58290 at the April 2002 meeting. The RUC agreed with the survey median, which indicated that the median value for code 58553 was 20.00, a value slightly larger than 58290 due to the increased work for removing larger uteri laparoscopically. The specialty modified the post-service visits from one 99214 and one 99212 to two 99213 visits. **The RUC recommends work relative values of 20.00 for CPT code 58553.**

Analysis of the survey results for new CPT code 58554 indicated median of 22.00 RVUs. The specialty society tested the validity of the survey results using IWPUT analysis and found an IWPUT of 0.09. The 0.09 intensity was slightly higher than for 58553. The specialty agreed that complexity and physician skill required of this procedure should result in a greater intensity, and therefore determined it to be appropriate. The specialty compared the difference in similar vaginal procedures CPT code 58260 *Vaginal hysterectomy* (12.98 RVUs) and CPT code 58262, *Vaginal hysterectomy with removal of tubes and ovary(s)* (14.77 RVU). The difference in the work increment between these two codes is 1.79 RVUs. In comparison, the difference in the recommended values for the laparoscopic codes 58553 and 58554 is 2.00 RVUs. The RUC agreed that this increment and the overall relativity for this code was appropriate and recommends the survey median of 22.00. **The RUC recommends work relative values of 22.00 for CPT code 58554.**

Practice Expense

The RUC approved the practice expense inputs for 58545,58546, 58550, and 58552-58554. The RUC understood that the 090- day global period standard should apply for all of these codes. The revised practice expense sheets are attached to this recommendation. **The RUC recommends all the practice expense inputs presented by the specialty society.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●58545	BA1	Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; 1 to 4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas	090	14.21

●58546	BA2	5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams	090	19.00
▲58550 56308 (old code #)	BA3	Laparoscopy surgical~~,~~ ,with vaginal hysterectomy, for uterus 250 grams or less; ~~with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy~~	090	14.19 (no change)
~~58551(D)~~ 56309 (old code #)		~~with removal of leiomyomata (single or multiple)~~ (58551 has been deleted. To report see 58545, 58546)	090	N/A
●58552	BA4	with removal of tube(s) and/or ovary(s)	090	16.00
●58553	BA5	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams;	090	20.00
●58554	BA6	with removal of tube(s) and/or ovary(s)	090	22.00

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 58545 **Tracking Number:** BA1 **Global Period:** 090 **Recommended RVW:** ~~14.88~~
RUC Recommendation: 14.21

CPT Descriptor: Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; excision of 1-4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
A 42-year old multigravida woman has been evaluated for an enlarging symptomatic pelvic mass. The uterus has increased from 6-12 weeks' size over 8 months and is causing urinary frequency, nocturia, and dyspareunia. Ultrasound documented a leiomyomatous uterus with two separate myomas 4X5 and 3X4 cm. Management options are discussed with her. The patient expresses a desire to keep her fertility options open and keep her uterus. The patient elects a myomectomy. A laparoscopic myomectomy is performed. All fibroids are removed and the uterine incisions are closed in multiple layers using laparoscopic suturing technique.

Description of Pre-Service Work:
The preservice work includes performing a comprehensive preoperative medical history, physical exam including a detailed pelvic exam. A physician must then dictate a history and physical, including writing of all admission orders. The patient is identified in the preoperative holding area with the appropriate consents. Patient identification is verified. The patient's family is also spoken to. All preoperative documentation is also reviewed at this time. This includes imaging studies, including ultrasounds and associated laboratory data. The physician reviews with the OR personnel the operative instrumentation necessary for the advanced laparoscopy. This includes ensuring that the video monitors are in proper working order. The patient is taken to the OR and correctly positioned on the operating table. This includes positioning of the lower extremities to avoid any potential injury.

Description of Intra-Service Work:
The patient is prepped and draped in a sterile fashion. A pelvic exam is performed under anesthesia. A Foley catheter is inserted into the bladder. The uterus is sounded. The size and flexion of the uterus is noted and the uterine manipulator is placed. The cervix must be dilated and the uterine manipulator applied. The manipulator allows "hand assistance" of exposing and manipulating the uterus to facilitate surgical removal of myomas. A vertical umbilical incision is then made. A veries needle is carefully inserted into the abdominal cavity. The insufflator is attached and correct pressure readings reflect proper intraabdominal placement. The abdominal cavity is then insufflated. The veries needle is removed and a trochar is carefully inserted into the abdominal cavity. The trochar is then removed from the obturator and a 10 mm laparoscope is inserted. The pelvis and lower abdomen are then grossly inspected. A decision is reached on the placement of the lower quadrant trochars. Using the anatomy of the anterior abdominal wall, the sites are chosen for entry of the right and left lower quadrant trochars, which are placed under direct visualization. The patient is then placed in Trendelenberg position. The small and large bowel are carefully grasped and placed in the upper abdomen. The myomas are inspected and a surgical plan is developed as to which myoma to approach first and how surgery shall proceed. A vasopressant agent such as Pitressin may be injected along the myometrium to minimize blood loss. A harmonic scalpel or similar cutting coagulating instrument is utilized to incise the myometrium overlying the fibroids. The incision is made on the uterus parallel to the course of the vascular supply.

Once the myoma has been exposed, it is grasped with a specially designed myoma forceps. Careful dissection is carried to free the myoma from surrounding myometrium. This would be a combination of sharp as well as blunt dissection. If pedicle is identified, it is isolated and independently coagulated and then transected. Once the myoma has been completely removed, hemostasis from the bed of the myoma is achieved. This most often involves a series of laparoscopic sutures. Once hemostasis is achieved within the bed of the myometrium, the uterus itself must be reconstructed. Care is taken to place several sutures through the myometrium. They are then tied in sequence using extracorporeal knot tying techniques. Depending on size of the myoma itself it is either suture tagged or placed in the cul-de-sac for later retrieval. The second, third and fourth myomas are removed in a similar fashion. Again, care

is taken to suture tag the myomas upon their removal. With each myoma there is suture placement for hemostasis within the bed of the myometrium followed by uterine reconstruction. Upon achieving hemostasis and uterine reconstruction, the myomas are then individually retrieved and morcellated. Then the myomas must individually be fed to the morcellator, which removes 1 cm strips of tissue at a time. This process can take a long period of time, depending on the size and nature of the myomas. Once the myomas have been completely removed, the trochars are then removed within the abdominal wall. The trochar sites are closed using again laparoscopic suturing techniques. The skin incision is closed with a subcuticular closure.

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 is evaluated and stabilized. The family is then counseled regarding the results of the procedure and the anticipated convalescence. Once the patient is alert, she too is counseled regarding the outcome of surgery and the anticipated hospital stay and subsequent convalescence. She is monitored the day of surgery as well as the following day in the hospital. She is discharged in the evening or afternoon of post day #1. She will be followed as an outpatient with approximately two to three office visits during the 90-day global period.

SURVEY DATA

Presenter(s):	George Hill, MD, FACOG and Sandra Reed, MD, FACOG					
Specialty(s):	American College of Obstetricians and Gynecologists (ACOG)					
CPT Code:	58545, Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; excision of 1-4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas					
Sample Size:	70	**Resp n:**	29	**Resp %:**	41%	
Sample Type:	Survey was distributed at the American Association of Gynecological Laparoscopists (AAGL) annual meeting.					
		Low	**25th pctl**	**Median**	**75th pctl**	**High**
Survey RVW:		13.1	14.21	16.00	18.00	28
Pre-Service Time: (day preceding procedure)		5	30	~~45~~ **30**	60	180
Pre-Service Time: (day of procedure)		15	30	~~40~~ **30**	55	60
Intra-Service Time:		50	90	**120**	150	210
Post-Service	**Total Min***	**CPT code / # of visits**				
Immed. Post-time:	**30**					
Critical Care time/visit(s):	**0**					
Other Hospital time/visit(s):	**30**	**99232/1**				
Discharge Day Mgmt:	**36**	**99238/1**				
Office time/visit(s):	**46**	**99213/2**				

*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
58140	Myomectomy, excision of fleiomyomata of uterus, single or multiple (separate procedure); abdominal approach	90	14.60

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 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: 5854X**	**Key Reference CPT Code: 58140**
Median Pre-Service Time	~~90~~ 60	60
Median Intra-Service Time	120	120
Median Immediate Post-service Time	30	30
Median Critical Care Time	0	0
Median Other Hospital Visit Time	30	68
Median Discharge Day Management Time	36	36
Median Office Visit Time	46	46
Median Total Time	~~352~~ 322	**360**

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	3.46	3.31
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.35	3.73
Urgency of medical decision making	3.23	3.38

Technical Skill/Physical Effort (Mean)

Technical skill required	4.48	3.80
Physical effort required	4.33	3.64

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.19	3.71
Outcome depends on the skill and judgement of physician	4.44	3.84
Estimated risk of malpractice suit with poor outcome	4.33	3.92

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.46	3.31
Intra-Service intensity/complexity	4.35	3.73
Post-Service intensity/complexity	3.23	3.38

ADDITIONAL RATIONALE

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

SURVEY METHOD

At the September 2002 RUC meeting, the RUC research subcommittee approved the revised multiple code survey instrument proposed by the American College of Obstetricians and Gynecologists (ACOG).

ACOG in collaboration with the American Association of Gynecological Laparoscopists (AAGL) disseminated the RUC survey at the November 2002 AAGL annual meeting. Twenty-nine surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG and AAGL reviewed the results and drafted the final recommendations.

PANEL DISCUSSION

The panel developed the recommendation in the following manner:

1. Comparing the surveyed code to CPT code 58551
2. Evaluating the recommendation using IWPUT analysis
3. Comparing the surveyed code (58545) with the reference code (58140)
4. Comparing the surveyed code value with other codes

CPT code 58551 –

CPT code 58551, the previous laparoscopic myomectomy code was valued at 14.21. While it could be argued that the more difficult myomectomies will now be coded by 5854X2, the panel agreed that only a handful of physicians across the country would be performing the more complex myomectomy procedure.

A more significant issue is that the laparoscopic myomectomy went from a 10-day to a 90-day global. The committee agreed that 14.21 was a fair value for a 10-day global but adding the value of the 1 additional hospital visit now that it was a 90 day global was appropriate. This results in an addition of 1-99213:

14.21 + 0.65(99231) = 14.86

The panel felt this justified the recommendation of 14.86.

IWPUT Analysis

The panel tested the validity of 14.86using the IWPUT analysis. **Applying the formula to the surveyed code resulted in an IWPUT of .07. The panel concluded that .07 was an appropriate value for this level of service.**

CPT code values: 99232= 1.06; 99238=1.28; 99213= .67

14.86 - {.0224(90min) + .0224(30 min) + 1.06 + .1.28 + .67 + .67} /120 min = .07 IWPUT

The panel agreed that a .07 IWPUT was an appropriate intensity level for a laparoscopic myomectomy. The panel discussed .08 being a generally accepted level of intensity for most abdominal surgical procedures. They felt that certain factors of laparoscopic surgery in general and this procedure in particular could justify an even higher level of intensity.

- Laparoscopic surgery does not have the reduced intensity times during opening and closing, as do abdominal surgeries.
- Laparoscopic surgery requires the development of specialized skills
- Laparoscopic surgery requires the physician to view their surgical environment using cameras and other technology
- Laparoscopic myomectomy specifically is not just clipping and taking out an organ but it requires suturing and organ repair. This can increase hemostasis.

All of these factors result in high levels of intensity during the surgery.

After reviewing the IWPUT analysis the committee agreed that a recommendation of 14.88 was not only fair but also a conservative recommendation.

Reference code 58140 – Next the panel compared the surveyed code (58545) with the reference code (58140). CPT code 58140 is valued at 14.60 RVW. For your reference, a summary of the times is listed below.

CPT CODE	58545	58140
RVW	14.88	14.60
PRE-SERVICE TIME	~~90 min~~ 60 min	60 min
INTRA SERVICE TIME	120 min	120 min
IMMEDIATE POST-SERVICE TIME	30 min	30 min
HOSPITAL VISITS TIME	30 min	68 min
DISCHARGE TIME	36 min	36 min
OFFICE VISIT TIME	46 min	46 min
TOTAL TIME	~~352 min~~ 322 min	360 min

After comparing the data, the recommendation of 14.88 seemed to be an appropriate and fair recommendation.

Other related codes: – The panel compared the surveyed code to other laparoscopic procedures

CPT CODE	Short Descriptor	INTRA SERVICE TIME	RVW	GLOBAL
47564	Laparoscopic cholecystectomy		14.23	90
58545	**Laparoscopic myomectomy**	**~~120 min~~ 90 min**	**14.88**	**90**
44204	Laparoscopic partial colectomy	180 min	25.08	90
50546	Laparoscopic nephrectomy	205 min	20.48	90

After reviewing the survey data to other laparoscopic codes in the RUC database the committee felt that the recommendation of 14.86 was consistent with other laparoscopic codes.

The panel concluded their discussion stating they were very comfortable with the recommendation of 14.86 RVW for 58545. They reviewed the data using a number of factors and all of the factors indicated that 14.88 was a reasonable and fair if not somewhat conservative recommendation.

The panel unanimously supported the recommendation of 14.86 RVW for CPT code 58545.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported?
CPT code 58551, Laparoscopy, surgical; with removal of leiomyomata (single or multiple)

(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 American Association of Gynecological Laparoscopists (AAGL)
_____Commonly
X Sometimes
_____Rarely

Specialty American College of Obstetricians and Gynecologists (ACOG)
_____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.

It is estimated that 10-15% of abdominal myomectomies are now done laparoscopically

Specialty _____ Frequency_____

CPT Code: 58545

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.
It is unlikely that this procedure will be performed on Medicare patients.

Specialty _____ Frequency_____

Specialty _____ Frequency_____

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 58546 **Tracking Number:** BA2 **Global Period:** 090 **Recommended RVW:** 19.00

CPT Descriptor: Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 35-year old nulligravid patient is evaluated for menorrhagia with anemia. She is recently married and anxious to have children. On examination she is found to have a 16-week size fibroid uterus. Ultrasound confirms a 15cm uterus with six distinct intramural myomas distorting the endometrium. Management options are discussed with her. The patient expresses a desire to keep her fertility options open and keep her uterus. The patient elects a myomectomy. A laparoscopic myomectomy is performed. All fibroids are removed and the uterine incisions are closed in multiple layers using a laparoscopic suturing technique.

Description of Pre-Service Work:

The preservice work includes performing a comprehensive preoperative medical history, physical exam including a detailed pelvic exam. A physician must then dictate a history and physical, including writing of all admission orders. The patient is identified in the preoperative holding area with the appropriate consents. Patient identification is verified. The patient's family is also spoken to. All preoperative documentation is also reviewed at this time. This includes imaging studies, including ultrasounds and associated laboratory data. The physician reviews with the OR personnel the operative instrumentation necessary for the advanced laparoscopy. This includes ensuring that the video monitors are in proper working order. The patient is taken to the OR and correctly positioned on the operating table. This includes positioning of the lower extremities to avoid any potential injury.

Description of Intra-Service Work:

The patient is prepped and draped in a sterile fashion. A pelvic exam is performed under anesthesia. A Foley catheter is inserted into the bladder. The uterus is sounded. The size and flexion of the uterus is noted and the uterine manipulator is placed. The cervix must be dilated and the uterine manipulator applied. The manipulator allows "hand assistance" of exposing and manipulating the uterus to facilitate surgical removal of myomas. A vertical umbilical incision is then made. A veries needle is carefully inserted into the abdominal cavity. The insufflator is attached and correct pressure readings reflect proper intraabdominal placement. The abdominal cavity is then insufflated. The veries needle is removed and a trochar is carefully inserted into the abdominal cavity. The trochar is then removed from the obturator and a 10 mm laparoscope is inserted. The pelvis and lower abdomen are then grossly inspected. A decision is reached on the placement of the lower quadrant trochars. Using the anatomy of the anterior abdominal wall, the sites are chosen for entry of the right and left lower quadrant trochars, which are placed under direct visualization. The patient is then placed in Trendelenberg position. The small and large bowel are carefully grasped and placed in the upper abdomen. The myomas are inspected and a surgical plan is developed as to which myoma to approach first and how surgery shall proceed. A vasopressant agent such as Pitressin may be injected along the myometrium to minimize blood loss. A harmonic scalpel or similar cutting coagulating instrument is utilized to incise the myometrium overlying the fibroids. The incision is made on the uterus parallel to the course of the vascular supply.

Once the myoma has been exposed, it is grasped with a specially designed myoma forceps. Careful dissection is carried to free the myoma from surrounding myometrium. This would be a combination of sharp as well as blunt dissection. If pedicle is identified, it is isolated and independently coagulated and then transected. Once the myoma has been completely removed, hemostasis from the bed of the myoma is achieved. This most often involves a series of laparoscopic sutures. Once hemostasis is achieved within the bed of the myometrium, the uterus itself must be reconstructed. Care is taken to place several sutures through the myometrium. They are then tied in sequence using extracorporeal knot tying techniques. Depending on size of the myoma itself it is either suture tagged or placed in the cul-de-sac for later retrieval. Four additional myomas are removed in a similar fashion. Again, care is taken to

suture tag the myomas upon their removal. With each myoma there is suture placement for hemostasis within the bed of the myometrium followed by uterine reconstruction. Upon achieving hemostasis and uterine reconstruction, the myomas are then individually retrieved and morcellated. Then the myomas must individually be fed to the morcellator, which removes 1 cm strips of tissue at a time. This process can take a long period of time, depending on the size and nature of the myomas. Once the myomas have been completely removed, the trochars are then removed within the abdominal wall. The trochar sites are closed using again laparoscopic suturing techniques. The skin incision is closed with a subcuticular closure.

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 is evaluated and stabilized. The family is then counseled regarding the results of the procedure and the anticipated convalescence. Once the patient is alert, she too is counseled regarding the outcome of surgery and the anticipated hospital stay and subsequent convalescence. She is monitored the day of surgery as well as the following day in the hospital. She is discharged in the evening or afternoon of post day #1. She will be followed as an outpatient with approximately two to three office visits during the next 90day global period.

SURVEY DATA

Presenter(s):	George Hill, MD, FACOG and Sandra Reed, MD, FACOG					
Specialty(s):	American College of Obstetricians and Gynecologists (ACOG)					
CPT Code:	58546, Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams					
Sample Size:	70	**Resp n:**	21	**Resp %:**	30%	
Sample Type:	Survey was distributed at the American Association of Gynecological Laparoscopists (AAGL) annual meeting.					
		Low	**25th pctl**	**Median**	**75th pctl**	**High**
Survey RVW:		14.21	17.85	19.00	23.50	28.85
Pre-Service Time: (day preceding procedure)		15	30	~~60~~ **30**	60	90
Pre-Service Time: (day of procedure)		45	30	~~45~~ **30**	60	60
Intra-Service Time:		75	150	**180**	210	290
Post-Service	**Total Min***	**CPT code / # of visits**				
Immed. Post-time:	**30**					
Critical Care time/visit(s):	**0**					
Other Hospital time/visit(s):	**30**	**99232/1**				
Discharge Day Mgmt:	**36**	**99238/1**				
Office time/visit(s):	~~53~~ **46**	~~99214/1 and 99212/1~~ **2 - 99213**				

*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
58140	Myomectomy, excision of leiomyomata of uterus, single or multiple (separate procedure); abdominal approach	90	14.60

CPT Code: 58546

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: 58546	Key Reference CPT Code: 58140
Median Pre-Service Time	~~90~~ 60	60
Median Intra-Service Time	180	120
Median Immediate Post-service Time	30	30
Median Critical Care Time	0	0
Median Other Hospital Visit Time	30	68
Median Discharge Day Management Time	36	36
Median Office Visit Time	~~53~~ 46	46
Median Total Time	~~419~~ **382**	**360**

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	3.94	3.47
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.0	3.73
Urgency of medical decision making	3.72	3.60

Technical Skill/Physical Effort (Mean)

Technical skill required	4.67	3.87
Physical effort required	4.61	3.80

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.56	4.00
Outcome depends on the skill and judgement of physician	4.78	3.87
Estimated risk of malpractice suit with poor outcome	4.39	4.07

CPT Code: 58546

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.72	3.59
Intra-Service intensity/complexity	4.72	4.00
Post-Service intensity/complexity	3.67	3.59

ADDITIONAL RATIONALE

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

SURVEY METHOD

At the September 2002 RUC meeting, the RUC research subcommittee approved the revised multiple code survey instrument proposed by the American College of Obstetricians and Gynecologists (ACOG).

ACOG in collaboration with the American Association of Gynecological Laparoscopists (AAGL) disseminated the RUC survey at the November 2002 AAGL annual meeting. Twenty-one surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG and AAGL reviewed the results and drafted the final recommendations.

PANEL DISCUSSION

The panel developed the recommendation in the following manner:

1. Reviewing the survey data
2. Comparing the surveyed code (58546) with the reference code (58140)
3. Compared the surveyed code with other laparoscopic codes
4. Comparing the surveyed value of the code with the interim value

Survey Data – ACOG received nineteen completed surveys. The median RVW from the data was 19.00. The panel tested the validity of the median surveyed RVW using IWPUT analysis. **Applying the formula to the surveyed code resulted in an IWPUT of .07. The panel concluded that .07 was an appropriate value for this level of service.**
CPT code values: 99232= 1.06; 99238=1.28; 99214= 1.10; 99212= .45

19.00 - {.0224(90min) + .0224(30 min) + 1.06 + .1.28 + .1.10 + .45} /180 min = .07 IWPUT

Many of the same issues regarding laparoscopic procedures as described in the recommendation form for 5854X1 were again discussed. In addition, the panel discussed the difference between this code and the simple laparoscopic myomectomy. The entire panel agreed that very few physicians perform the more complex myomectomy procedure. CPT code 58546 is much more surgically challenging and requires a much higher surgical skill level. While only a few physicians currently will use this code, the panel emphasized the importance in encouraging physicians to expand their surgical skills. As discussed in the CPT proposal, doing this procedure laparoscopically versus abdominally has a variety of benefits for the patient.

Reference code 58140 – Next the panel compared the surveyed code (58546) with the reference code (58140). CPT code 58140 is values at 14.60 RVW. For your reference, a summary of the times is listed below.

CPT CODE	5854X1	58140
RVW	19.00	14.60
PRE-SERVICE TIME	~~90 min~~ **60 min**	60 min
INTRA SERVICE TIME	180 min	120 min
IMMEDIATE POST-SERVICE TIME	30 min	30 min
HOSPITAL VISITS TIME	30 min	36 min
DISCHARGE TIME	36 min	68 min
OFFICE VISIT TIME	~~53 min~~ **46 min**	46 min
TOTAL TIME	~~419 min~~ **389 min**	360 min

The panel concluded that the greater physician time reflected in the data for 58546 justified the higher RVW.

Other laparoscopic procedures
The panel also compared the surveyed code to other laparoscopic codes.

CPT CODE	Short Descriptor	INTRA SERVICE TIME	RVW	GLOBAL
47564	Laparoscopic cholecystectomy		14.23	90
5854X	**Laparoscopic myomectomy**	~~180~~ **120 min**	**19.00**	**90**
44204	Laparoscopic partial colectomy	180 min	25.08	90
50546	Laparoscopic nephrectomy	205 min	20.48	90

After reviewing the survey data to other laparoscopic codes in the RUC database the committee felt that the recommendation of 19.00 was consistent with other laparoscopic codes.

Interim value: – When comparing the surveyed code to the interim value the recommended RVW seemed to be appropriate and fair. 19.00 RVW was also recommended in April 2002 for the interim value.

The panel supports the recommendation of 19.00 RVW for 58546.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each,

summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported?
CPT code 58551, Laparoscopy, surgical; with removal of leiomyomata (single or multiple)

(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 American Association of Gynecological Laparoscopists (AAGL)
_____Commonly
X Sometimes
_____Rarely

Specialty American College of Obstetricians and Gynecologists (ACOG)
_____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.

It is estimated that 10-15% of abdominal myomectomies are now done laparoscopically

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.
It is unlikely that this procedure will be performed on Medicare patients.

Specialty _____ Frequency_____

Specialty _____ Frequency_____

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

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 58550 **Tracking Number:** BA3 **Global Period:** 090 **Recommended RVW:** 14.19

CPT Descriptor: Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 45 year-old G1P1 is evaluated for profound menorrhagia with anemia. Her hematocrit is 25% despite daily iron therapy and treatment with oral contraceptives. On physical examination she has an irregular, mobile 4-6 week size fibroid uterus. Ultrasound confirms multiple uterine fibroids, several of which impinge on the endometrium. After management options are discussed with her, the patient elects a hysterectomy. A laparoscopic assisted vaginal hysterectomy (LAVH) is performed.

Description of Pre-Service Work:

The preservice work includes performing a comprehensive preoperative medical history, physical exam including a detailed pelvic exam. A physician must then dictate a history and physical, including in writing of all admission orders. The patient is identified in the preoperative holding area with the appropriate consents. Patient identification is verified. The patient's family is also spoken to. All preoperative documentation is also reviewed at this time. This includes imaging studies, including ultrasounds and associated laboratory data. The physician reviews with the OR personnel the operative instrumentation necessary for the advanced operative laparoscopy. This includes ensuring that video monitors are in proper working order. The patient is taken to the OR and correctly positioned on the operating table. This includes positioning of the lower extremities to avoid any potential injury. The physician also will position the monitors prior to the beginning of the case.

Description of Intra-Service Work:

After general anesthesia is obtained, an exam under anesthesia is performed and compared to operative finding. The patient is then prepped and draped in the usual sterile fashion. In the dorsal lithotomy position a Foley catheter is then inserted to provide a means of intermittent bladder drainage. A weighted speculum is placed into the patient's vagina and the anterior lip of the cervix is grasped using a single tooth tenaculum. The uterus is then sounded and the cervix is then dilated in order to facilitate the Valchev uterine manipulator. The weighted speculum is then removed.

The laparoscopic portion of the procedure is begun by first placing the veries needle umbilically and achieving and adequate pneumoperit. A 10 mm trochar is then placed at this site and a laparoscope is used to confirm appropriate entrance and no injury to any pelvic or abdominal structures. Next, using laparoscopic guidance, two additional 10 mm trochar ports are then placed in the right and left lower quadrant. A careful inspection of the abdomen and pelvis are made and findings documented. The ureters are then carefully identified bilaterally. The procedure is then begun by using either the seitzinger (tripolar) forceps or using the harmonic scalpel. The round ligaments are identified bilaterally, clamped, cauterized and transected. The uteroovarian vasculature is clamped, cauterized and suture ligated until freed from the fundal region of the uterus bilaterally.

Next, attention is turned to the vaginal portion of the procedure. The Valchev uterine manipulator is removed and the single tooth tenaculum is repositioned to provide a means of traction on the uterus. Using the Bovie, a circumferential incision is made at the cervicovaginal junction. Using careful sharp dissection, the anterior and posterior cul-de-sacs are entered sharply. The posterior peritoneum is identified and a figure-of-eight stay sutures then placed for hemostasis and securement of the posterior peritoneum.

A narrow weighted speculum is then placed in the posterior cul-de-sac and using Haney clamps the uterosacral ligaments, cardinal and broad ligament are bilaterally clamped, cut and suture ligated. Hemostasis is assured. Once completely freed, the uterus is then delivered. Both ovaries are identified and all pedicles are assured for hemostasis. The hysterectomy portion of the procedure is complete. The peritoneum and vaginal cuff are closed in the usual fashion. Attention is then turned to the abdominal incisions where the trochars are removed and the abdominal incisions are closed in the usual fashion.

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 is evaluated and stabilized. The family is then counseled regarding the results of the procedure and the anticipated convalescence. Once the patient is alert, she too is counseled regarding the outcome of the surgery and the subsequent convalescence. She is monitored the day of surgery as well as the following hospital day in the hospital. She is discharged in the evening or afternoon of post op day #1. She will be followed as an outpatient with approximately two to three office visits during the 90-day global period.

SURVEY DATA

Presenter(s):	George Hill, MD, FACOG and Sandra Reed, MD, FACOG		
Specialty(s):	American College of Obstetricians and Gynecologists (ACOG)		
CPT Code:	58550, Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less		
Sample Size: 70	**Resp n:** 36	**Resp %:** 51%	
Sample Type:	Survey was distributed at the American Association of Gynecological Laparoscopists (AAGL) annual meeting.		

	Low	25th pctl	Median	75th pctl	High
Survey RVW:	13.25	14.19	15.00	18.00	28.14
Pre-Service Time: (day preceding procedure)	0	30	~~40~~ **30**	60	90
Pre-Service Time: (day of procedure)	15	30	~~45~~ **30**	50	60
Intra-Service Time:	15	80	**100**	120	180

Post-Service	**Total Min***	**CPT code / # of visits**
Immed. Post-time:	**30**	
Critical Care time/visit(s):	**0**	
Other Hospital time/visit(s):	**38**	**99231/2**
Discharge Day Mgmt:	**36**	**99238/1**
Office time/visit(s):	**61**	**99213/2 and 99212/1**

*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
58550	Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)	10	14.19

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: 58550**	**Key Reference CPT Code: 58550**
Median Pre-Service Time	~~90~~ 60	
Median Intra-Service Time	100	
Median Immediate Post-service Time	30	
Median Critical Care Time	0	
Median Other Hospital Visit Time	38	
Median Discharge Day Management Time	36	
Median Office Visit Time	61	
Median Total Time	~~355~~ 325	

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	3.68	3.55
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.56	3.48
Urgency of medical decision making	3.28	3.23

Technical Skill/Physical Effort (Mean)

Technical skill required	4.24	3.76
Physical effort required	3.94	3.58

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.03	3.79

Outcome depends on the skill and judgement of physician	4.26	3.94
Estimated risk of malpractice suit with poor outcome	4.21	4.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.06	3.67
Intra-Service intensity/complexity	3.82	3.18
Post-Service intensity/complexity	3.68	3.55

ADDITIONAL RATIONALE

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

SURVEY METHOD

At the September 2002 RUC meeting, the RUC research subcommittee approved the revised multiple code survey instrument proposed by the American College of Obstetricians and Gynecologists (ACOG).

ACOG in collaboration with the American Association of Gynecological Laparoscopists (AAGL) disseminated the RUC survey at the November 2002 AAGL annual meeting. Thirty-six surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG and AAGL reviewed the results and drafted the final recommendations.

PANEL DISCUSSION

The panel developed the recommendation in the following manner:

1. Reviewing the survey data
2. Comparing the surveyed code (58550) with similar codes
3. Comparing the surveyed value with the interim value

Survey Data – ACOG received thirty-four completed surveys. The 25th percentile RVW from the data was 14.19. The panel tested the validity of the 25th percentile value using IWPUT analysis. **Applying the formula to the surveyed code resulted in an IWPUT of .08. The panel concluded that .08 was an appropriate value for this procedure.** In their experience the panel agreed that generally laparoscopic hysterectomies are a little more difficult than vaginal hysterectomies because the laparoscopic route is chosen over the vaginal route due to some factor impeding the vaginal route.

CPT code values: 99231= .64; 99238=1.28; 99213= 0.65; 99212= 0.43

14.19 - {.0224(60min) + .0224(30 min) + .64 + .1.28 + .67 + .67 + .45} /100 min = .08 IWPUT

Similar code s – Next the panel compared the surveyed code (5854X2) with similar codes 58150, Total abdominal hysterectomy and CPT code 58260, Vaginal hysterectomy. For your reference, a summary of the times for both codes is listed below.

CPT CODE	58550	58260	58150
RVW	14.19	12.98	15.24
PRE-SERVICE TIME	~~90 min~~ **60 min**	60 min	60 min
INTRA SERVICE TIME	100 min	60 min	120 min
IMMEDIATE POST-SERVICE TIME	30 min	30 min	40 min
HOSPITAL VISITS TIME	38 min	49 min	87 min
DISCHARGE TIME	36 min	36 min	36 min
OFFICE VISIT TIME	61 min	61 min	46 min
TOTAL TIME	~~355 min~~ **325 min**	296 min	389 min

After reviewing this data the panel felt that the recommendation was consistent with other hysterectomy codes.

Interim value – The panel also compared the survey value of the code with the interim value. It was the same. The panel agreed that the survey results validated the interim values.

The panel supports the recommendation of 14.19 RVW for 58550.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported?

CPT Code: 58550

CPT code 58550, Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)

(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 American Association of Gynecological Laparoscopists (AAGL)
_____Commonly
X Sometimes
_____Rarely

Specialty American College of Obstetricians and Gynecologists (ACOG)
_____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.

It is estimated that 10-15% of abdominal hysterectomies are now done laparoscopically

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.
It is unlikely that this procedure will be performed on Medicare patients.

Specialty _____ Frequency_____

Specialty _____ Frequency_____

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 58552 **Tracking Number:** BA4 **Global Period:** 090 **Recommended RVW:** 16.00

CPT Descriptor: Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 45 year-old G1P1 is evaluated for profound menorrhagia with anemia. Her hematocrit is 25% despite daily iron therapy and treatment with oral contraceptives. On physical examination she has an irregular, mobile 4-6 week size fibroid uterus. Ultrasound confirms multiple uterine fibroids, several of which impinge on the endometrium. After management options are discussed with her, the patient elects a hysterectomy. A laparoscopic assisted vaginal hysterectomy (LAVH) is performed. The patient has a strong history of ovarian cancer in her family and does not desire any more children therefore her tube(s) and ovary(s) removed.

Description of Pre-Service Work:

The preservice work includes performing a comprehensive preoperative medical history, physical exam including a detailed pelvic exam. A physician must then dictate a history and physical, including in writing of all admission orders. The patient is identified in the preoperative holding area with the appropriate consents. Patient identification is verified. The patient's family is also spoken to. All preoperative documentation is also reviewed at this time. This includes imaging studies, including ultrasounds and associated laboratory data. The physician reviews with the OR personnel the operative instrumentation necessary for the advanced operative laparoscopy. This includes ensuring that the video monitors are in proper working order. The patient is taken to the OR and correctly positioned on the operating table. This includes positioning of the lower extremities to avoid any potential injury. The physician also will position the monitors prior to the beginning of the case.

Description of Intra-Service Work:

After general anesthesia is obtained and the patient is prepped and draped in the usual sterile fashion, an exam under anesthesia is to be performed and compared to preoperative findings.

The procedure begins with placing a weighted speculum into the patient's vagina. The anterior lip of the cervix is grasped using a single tooth tenaculum and the uterus is then sounded. Next, the cervix is then dilated beginning with a #9 French and progressing to an #18 French dilator. This facilitates the placement of a Valchev uterine manipulator, which is then placed into the cervix and connected with a single tooth tenaculum to provide means of manipulating the uterus. At that time the weighted speculum is removed and a Foley catheter is placed to provide intermittent bladder drainage. The laparoscopic portion of the procedure then ensues by first elevating the abdomen and placing the veries needle into the abdominal cavity and insufflating the abdomen until an adequate pneumoperitoneum is achieved. Once an adequate pneumoperitoneum is achieved, a 10 mm trochar is placed umbilically. A laparoscope is then used to confirm adequate placement and to also verify no injury to any adjacent structures intrabdominally. Next, two additional 10 mm trochar ports are placed in the right lower quadrant and left lower quadrant using laparoscopic guidance so to avoid any vascular guidance. Next, using either the seitzinger (tripolar) forceps or the harmonic scalpel, the infundibular pelvic ligaments bilaterally are clamped, cauterized and transected. Next, the round ligaments bilaterally are identified, clamped, cauterized and transected. Both ureters are identified bilaterally. At that time the abdominal portion of the procedure is completed. The laparoscope is removed from the patient's abdomen and all gas is allowed to exsufflate from the patient's abdomen. At that time a weighted speculum is placed in the patient's vagina and the Valchev uterine manipulator is removed. The single tooth tenaculum is then used to grasp the cervix for traction purposes. A circumferential incision is then made around the cervix. Next, using sharp dissection, the cervicovesical space is entered anteriorly. Next, in a similar fashion the posterior cul-de-sac is entered using careful sharp dissection. The peritneum is identified. A figure-of-eight stay suture is placed for hemostasis and securement of the posterior peritoneum. A long narrow weighted speculum is placed in the posterior cul-de-sac. Haney clamps are placed at the uterosacral ligaments which are then incised and suture ligated. This is carried bilaterally in an ascending fashion. Haney clamps are intermittently

placed on the immediate paracervical tissue, which is then incised and suture ligated individually. This is carried out along the length of the uterus. Uterine artery vasculature is carefully identified, clamped, incised and suture ligated. The anterior peritoneal fold is identified and incised. The anterior cul-de-sac is entered and the bladder is then retracted anteriorly. Continued intermittent clamping, incising and suture ligation of the paramaterial tissue is carried out along the length of the uterus. Uterine artery vasculature is carefully identified, clamped, incised and suture ligated. The anterior peritoneal field is identified and incised. The anterior cul-de-sac is entered and the bladder is then retracted anteriorly. Continued intermittent clamping, incising and suture ligation of the paramaterial tissue is carried out along the broad ligament until finally the cornual region of the uterus is reached. The uterus, tubes and ovaries are then removed and handed off the field. All pedicles are carefully inspected and hemostasis is assured. The peritoneum and vaginal cuff is closed in the usual fashion.

Next, attention is then redirected to the abdominal incisions which are closed in subcuticular fashion after careful inspection using a laparoscope. The pedicles are yet again identified and inspected and hemostasis is assured. The laparoscope and all trochars are removed and the abdominal incisions are closed in the usual fashion.

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 is evaluated and stabilized. The family is counseled regarding the results of the procedure and the anticipated convalescence. Once the patient is alert, she too is counseled regarding the outcome of the surgery and the anticipated hospital stay and subsequent convalescence. She is monitored the day of the surgery as well as the following day in the hospital. She is discharged in the evening or afternoon of post day #1. She will be followed as an outpatient with approximately two to three office visits during the 90-day global period.

SURVEY DATA

Presenter(s):	George Hill, MD, FACOG and Sandra Reed, MD, FACOG					
Specialty(s):	American College of Obstetricians and Gynecologists (ACOG)					
CPT Code:	58552, Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)					
Sample Size:	70	**Resp n:**	35	**Resp %:**	50%	
Sample Type:	Survey was distributed at the American Association of Gynecological Laparoscopists (AAGL) annual meeting.					
		Low	**25th pctl**	**Median**	**75th pctl**	**High**
Survey RVW:		13.5	14.64	16	19.5	30.19
Pre-Service Time: (day preceding procedure)		0	30	45 **30**	60	90
Pre-Service Time: (day of procedure)		15	30	45 **30**	50	60
Intra-Service Time:		15	90	**120**	140	200

Post-Service	**Total Min***	**CPT code / # of visits**
Immed. Post-time:	**30**	
Critical Care time/visit(s):	**0**	
Other Hospital time/visit(s):	**38**	**99231/2**
Discharge Day Mgmt:	**36**	**99238/1**
Office time/visit(s):	**61**	**99213/2 and 99212/1**

*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU

58550	Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)	10	14.19

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: 58552**	**Key Reference CPT Code: 58550**
Median Pre-Service Time	~~90~~ 60	
Median Intra-Service Time	120	
Median Immediate Post-service Time	30	
Median Critical Care Time	0	
Median Other Hospital Visit Time	38	
Median Discharge Day Management Time	36	
Median Office Visit Time	61	
Median Total Time	~~375~~ 345	

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.75	3.52
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.57	3.42
Urgency of medical decision making	3.82	3.20

Technical Skill/Physical Effort (Mean)

Technical skill required	4.41	3.82
Physical effort required	4.24	3.64

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.18	3.82
Outcome depends on the skill and judgement of physician	4.38	4.00

Estimated risk of malpractice suit with poor outcome	4.32	4.03

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.54	3.32
Intra-Service intensity/complexity	4.19	3.76
Post-Service intensity/complexity	3.54	3.32

ADDITIONAL RATIONALE

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

SURVEY METHOD

At the September 2002 RUC meeting, the RUC research subcommittee approved the revised multiple code survey instrument proposed by the American College of Obstetricians and Gynecologists (ACOG).

ACOG in collaboration with the American Association of Gynecological Laparoscopists (AAGL) disseminated the RUC survey at the November 2002 AAGL annual meeting. Thirty-five surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG and AAGL reviewed the results and drafted the final recommendations.

PANEL DISCUSSION

The panel developed the recommendation in the following manner:

1. Reviewing the survey data using IWPUT analysis
2. Reviewing the survey data using the building block approach

IWPUT analysis – ACOG received thirty-three completed surveys. The median RVW from the data was 16.00. The panel tested the validity of the median surveyed RVW using IWPUT analysis. **Applying the formula to the surveyed code resulted in an IWPUT of .07. The panel concluded that .07 was an appropriate value for this level of service.**
CPT code values: 99231= .64; 99238=1.28; 99213= .67; 99212= .45

16.00 - {.0224(60min) + .0224(30 min) + .64 + .64 + .1.28 + .67 + .67 + .45} /120 min = .07 IWPUT

Building block approach – The panel used the building block approach to validate the recommendation and to identify the appropriate value for removal of tubes and ovary(s).
CPT code 58550, Laparoscopic hysterectomy less than 250 grams = 14.19 RVUs
CPT code 58661, Laparoscopic removal of tubes and ovary(s) = 11.05

14.19 + .50(11.05) = 19.72

Another method is to compare the difference in similar vaginal.
CPT code 58260 Vaginal hysterectomy = 12.98
CPT code 58262, Vaginal hysterectomy with removal of tubes and ovary(s) = 14.77
14.77 – 12.98 = 1.79

The difference between these two codes is 1.79 RVUs. Similarly the difference in the recommended laparoscopic codes is 1.81.
CPT code 58550, Laparoscopic hysterectomy = 14.19
CPT code 5854X1, Laparoscopic hysterectomy with removal of tubes and ovary(s) = 16.00
16.00 – 14.19 = 1.81

The panel agreed that both methods validate the survey median of 16.00 RVW for this code.

The panel concluded discussion of this code by unanimously supporting the recommendation of 16.00 RVW for 58552.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported?
CPT code 58550, Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)

(if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

CPT Code: 58552

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 Association of Gynecological Laparoscopists (AAGL)
_____Commonly
X Sometimes
_____Rarely

Specialty American College of Obstetricians and Gynecologists (ACOG)
_____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.

It is estimated that 10-15% of abdominal hysterectomies are now done laparoscopically

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.
It is unlikely that this procedure will be performed on Medicare patients.

Specialty _____ Frequency_____

Specialty _____ Frequency_____

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 58553 **Tracking Number**: B5 **Global Period**: 090 **Recommended RVW:** 20.00

CPT Descriptor: Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 45 year-old G1P1 is evaluated for profound menorrhagia with anemia. Her hematocrit is 25% despite daily iron therapy and treatment with oral contraceptives. On physical examination she has an irregular, mobile 12-14 week size fibroid uterus. Ultrasound confirms multiple uterine fibroids, several of which impinge on the endometrium. After management options are discussed with her, the patient elects a hysterectomy. A laparoscopic assisted vaginal hysterectomy (LAVH) is performed.

Description of Pre-Service Work:

The preservice work includes performing a comprehensive preoperative medical history, physical exam including a detailed pelvic exam. A physician must then dictate a history and physical, including in writing of all admission orders. The patient is identified in the preoperative holding area with the appropriate consents. Patient identification is verified. The patient's family is also spoken to. All preoperative documentation is also reviewed at this time. This includes imaging studies, including ultrasounds and associated laboratory data. The physician reviews with the OR personnel the operative instrumentation necessary for the advanced operative laparoscopy. This includes ensuring that the video monitors are in proper working order. The patient is taken to the OR and correctly positioned on the operating table. This includes positioning of the lower extremities to avoid any potential injury. The physician also will position the monitors prior to the beginning of the case.

Description of Intra-Service Work:

After being placed on the operating room table, general anesthesia is obtained and an exam under anesthesia is performed and compared to preoperative findings. The patient is prepped and draped in the usual sterile fashion. A Foley catheter is then placed to provide a means for intermittent bladder drainage. Next, attention is then turned to the placement of a weighted speculum. The anterior lip of the cervix is grasped using a single tooth tenaculum and the Valchev uterine manipulator is placed and attached to the single tooth tenaculum. Attention is then directed to the abdominal portion of the procedure where the abdomen is tented and the veries needle is placed through the umbilicus. An adequate pneumoperitoneum is achieved. The veries needle is then removed and a 10 mm trochar is placed. Using the laparoscope, confirmation of no abdominal or pelvic injuries. Next, using the laparoscopic assisted guidance, a right and left lower quadrant 10 mm trochar port is placed ensuring that there is no injury to the abdominal wall vasculature. At this time, decompression of the uterus is performed by performing multiple myomectomies. Multiple large myomas are noted and injected with a solution of dilute Pitressin. Using the harmonic scalpel, the surface of the myomas are incised along their length, and using a combination of blunt and sharp dissection, the myomas are grasped and removed by a means of sharp and blunt dissection. These myomas are then sutured, tagged and placed into the posterior cul-de-sac to be removed at the time of the vaginal portion of the procedure. After adequate decompression is performed, the fibroid beds are then cauterized to achieve adequate hemostasis. Next, attention is then turned to the round ligaments which are then clamped, cauterized and transected bilaterally. Next, the uteroovarian vasculature is again clamped, cauterized and transected bilaterally. Hemostasis is assured.

Next, attention is then turned to the vaginal portion of the procedure. All air is allowed to be exsufflated from the patient's abdomen and the laparoscope is removed. The Valchev uterine manipulator is then removed and the single tooth tenaculum is repositioned for means of traction of the uterus. Using the Bovie, the cervix is then incised circumferentially at the cervicovaginal junction. The anterior and posterior cul-de-sacs are entered carefully using sharp dissection. The peritoneum is identified posteriorly and a figure-of-eight stay suture is placed for hemostasis and securement of the posterior peritoneum. Next, a narrow weighted speculum is placed in the posterior cul-de-sac. Using Haney clamps, the uterosacral, cardinal and broad ligaments are bilaterally clamped, cut and ligated. This is continued until the fundal region is reached. At that time the uterine specimen is delivered and handed off field.

General traction and palpation of the ovaries is done at this time and the pedicles are inspected for excellent hemostasis. After all pedicles are carefully inspected to ensure hemostasis, the peritoneum and vaginal cuff are closed in the usual fashion. Attention is then directed toward the abdomen where, after trochar removal, these abdominal incisions are also closed in the usual fashion.

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 is evaluated and stabilized. The family is then counseled regarding the results of the procedure and the anticipated convalescence. Once the patient is alert, she too is counseled regarding the outcome of the surgery and the anticipated hospital stay and subsequent convalescence. She is monitored the day of surgery as well as the following day in the hospital. She is discharged in the evening or afternoon of post day #1. She will be followed as an outpatient with approximately two or three office visits during the next 90-day global period.

SURVEY DATA

Presenter(s):	George Hill, MD, FACOG and Sandra Reed, MD, FACOG					
Specialty(s):	American College of Obstetricians and Gynecologists (ACOG)					
CPT Code:	58553, Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams					
Sample Size:	70	**Resp n:**	33	**Resp %:**	47%	
Sample Type:	Survey was distributed at the American Association of Gynecological Laparoscopists (AAGL) annual meeting.					
		Low	**25th pctl**	**Median**	**75th pctl**	**High**
Survey RVW:		14.19	17.75	20	23.13	32.14
Pre-Service Time: (day preceding procedure)		5	27.5	~~42.5~~ **30**	60	120
Pre-Service Time: (day of procedure)		0	30	~~45~~ **30**	50	60
Intra-Service Time:		30	120	**150**	180	240
Post-Service	**Total Min***	**CPT code / # of visits**				
Immed. Post-time:	**37.5**					
Critical Care time/visit(s):	**0**					
Other Hospital time/visit(s):	**49**	**99232/1 and 99231/1**				
Discharge Day Mgmt:	**36**	**99238/1**				
Office time/visit(s):	~~53~~ **46**	~~99214/1 and 99212/1~~ **2x 99213**				

*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
58550	Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)	10	14.19

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: 58553**	**Key Reference CPT Code: 58550**
Median Pre-Service Time	~~90~~ 60	
Median Intra-Service Time	150	
Median Immediate Post-service Time	37.5	
Median Critical Care Time	0	
Median Other Hospital Visit Time	49	
Median Discharge Day Management Time	36	
Median Office Visit Time	~~53~~ **46**	
Median Total Time	~~415.5~~ **378.5**	

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	4.08	3.77
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.08	3.77
Urgency of medical decision making	3.67	3.6

Technical Skill/Physical Effort (Mean)

Technical skill required	4.88	4.17
Physical effort required	4.72	3.93

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.59	4.00
Outcome depends on the skill and judgement of physician	4.88	4.17
Estimated risk of malpractice suit with poor outcome	4.63	4.13

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.73	3.48

Intra-Service intensity/complexity	4.70	4.06
Post-Service intensity/complexity	3.80	3.58

ADDITIONAL RATIONALE

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

SURVEY METHOD

At the September 2002 RUC meeting, the RUC research subcommittee approved the revised multiple code survey instrument proposed by the American College of Obstetricians and Gynecologists (ACOG).

ACOG in collaboration with the American Association of Gynecological Laparoscopists (AAGL) disseminated the RUC survey at the November 2002 AAGL annual meeting. Thirty-three surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG and AAGL reviewed the results and drafted the final recommendations.

PANEL DISCUSSION

The panel developed the recommendation in the following manner:

1. Reviewing the survey data
2. Comparing the surveyed code (58553) with similar codes
3. Comparing the surveyed value with the interim value

Survey Data – ACOG received thirty-one completed surveys. The panel recommended 20.00 RVW, the survey median. The panel tested the validity of the median surveyed RVW using IWPUT analysis. **Applying the formula to the surveyed code resulted in an IWPUT of .08. The panel concluded that .08 was an appropriate value for this level of service.**
CPT code values: 99232= 1.06; 99231= .64; 99238=1.28; 99213x2= 1.30

20.00 - {.0224(60min) + .0224(37.5 min) + 1.06 + .64 + .1.28 + .1.30} /150 min = .08 IWPUT

Similar codes – Next the panel compared the surveyed code (5854X2) with similar codes 58150, Total Abdominal Hysterectomy and 58290, Vaginal hysterectomy, for uterus greater than 250 grams. CPT code 58150 is valued at 15.24 RVW and the RUC approved 19.00 RVW for 58290 at the April 2002 meeting. For your reference, a summary of the times for all three codes is listed below.

CPT CODE	58553	58290	58150
RVW	20.00	19.00	15.24
PRE-SERVICE TIME	~~90~~ **60**	75	60
INTRA SERVICE TIME	150	120	120
IMMEDIATE POST-SERVICE TIME	37.5	30	40
HOSPITAL VISITS TIME	49	60	87
DISCHARGE TIME	36	36	36
OFFICE VISIT TIME	~~53~~ **46**	46	46
TOTAL TIME	~~415.5~~ **378.5**	367	389

The panel agreed that the consistently higher times for 58553 supported the recommendation of 20.00 RVW. These higher times were a reflection of the intensity and complexity of this procedure.

Interim value –The interim value recommended by the RUC in April 2002 was 19.00. The interim data, a fair estimation of physician work was in the end an estimation. The panel agreed that survey data provided strong evidence that 20.00, the survey median, is a fair and reasonable recommendation for physician work for this code.

The panel unanimously supports the recommendation of 20.00 RVW for 58553.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported?
CPT code 58550, Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)

(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 American Association of Gynecological Laparoscopists (AAGL)
_____Commonly
X Sometimes
_____Rarely

Specialty American College of Obstetricians and Gynecologists (ACOG)
_____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.

It is estimated that 10-15% of abdominal hysterectomies are now done laparoscopically

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.
It is unlikely that this procedure will be performed on Medicare patients.

Specialty _____ Frequency_____

Specialty _____ Frequency_____

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 58554 **Tracking Number:** B6 **Global Period:** 090 **Recommended RVW:** 22

CPT Descriptor: 58554, Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 45 year-old G1P1 is evaluated for profound menorrhagia with anemia. Her hematocrit is 25% despite daily iron therapy and treatment with oral contraceptives. On physical examination she has an irregular, mobile 12-14 week size fibroid uterus. Ultrasound confirms multiple uterine fibroids, several of which impinge on the endometrium. After management options are discussed with her, the patient elects a hysterectomy. A laparoscopic assisted vaginal hysterectomy (LAVH) is performed. The patient has a strong history of ovarian cancer in her family and does not desire any more children therefore her tube(s) and ovary(s) are removed.

Description of Pre-Service Work:

The preservice work includes performing a comprehensive preoperative medical history, physical exam including a detailed pelvic exam. A physician must dictate a history and physical, including all admission orders. The patient is identified in the preoperative holding area with the appropriate consents. Patient identification is verified. The patient's family is also spoken to. All preoperative documentation is also reviewed at this time. This includes imaging studies, including ultrasounds and associated laboratory data. The physician reviews with the OR personnel the operative instrumentation necessary for the advanced operative laparoscopy. This includes ensuring that the video monitors are in proper working order. The patient is taken to the OR and correctly positioned on the operating table. This includes positioning of the lower extremities to avoid any potential injury. The physician will also position the monitors prior to the beginning of the case.

Description of Intra-Service Work:

An exam under anesthesia is performed and compared to preoperative findings. The patient is then prepped and draped in the usual sterile fashion in the dorsal lithotomy position. A Foley catheter is placed to provide intermittent bladder drainage. Next a weighted speculum is placed into the patient's vagina and the anterior lip of the cervix is grasped using a single tooth tenaculum. A Valchev uterine manipulator is placed after the cervix is adequately dilated to accommodate the Valchev manipulator. The weighted speculum is then removed from the patient's vagina.

Next, attention is turned to the abdominal portion of the procedure. The abdomen is tented and veries needle is inserted. An adequate pneumoperitoneum is achieved and a 10 mm trochar is placed umbillicaly. The laparoscope is then advanced through this port and a survey of the abdomen is performed to ensure no injury to any vasculature, abdominal or pelvic structures. Next, under laparoscopic guidance, two additional 10 mm trochar ports are placed in the right and left lower quadrant with care to avoid any abdominal wall vasculature. Next, a survey of the abdomen and pelvis are performed noting multiple large fibroids. Based on their large size and position a myomectomy must first be performed to allow safe removal of the uterus transvaginally. The large fibroids are injected with a solution of dilute Pittressin until adequate blanching is noted. Using the harmonic scalpel, the surface of each injected fibroid is incised and excellent hemostasis is achieved. Next, using sharp dissection, each large fibroid is removed from the myometrium using careful sharp dissection. Once removed the fibroids are suture tagged and placed into the posterior cul-de-sac to be removed at the time of the vaginal portion of the hysterectomy. This is repeated until adequate decompression is achieved. The fibroid beds within the myometrium are then cauterized until adequate hemostasis is achieved. Next, once the myomectomy portion of this procedure is complete, attention is turned to the BSO portion of the procedure where the round ligaments bilaterally are clamped, cut and transected. The ureters are inspected bilaterally. Next, infundibular pelvic ligaments are clamped, cauterized and transected. Hemostasis is assured.

Next attention is turned to the vaginal portion of the procedure and the laparoscope is removed and all gas is allowed to exsufflate from the patient's abdomen. The Valchev uterine manipulator is removed and the single tooth tenaculum is repositioned to provide traction. Next, the cervix is circumferentially incised at the cervicovaginal junction in a clockwise fashion. The anterior and posterior cul-de-sacs are entered using careful sharp dissection. Posterior the peritoneum is identified and a figure-of-eight stay suture is placed for hemostasis and securement using Haney clamps, the uterosacral, cardinal and broad ligaments are bilaterally clamped, cut and ligated. Once freed, the uterus is then delivered. All pedicles are inspected to ensure hemostasis. The specimen is then handed off the field. The vaginal portion of the procedure is then considered complete. The peritoneum and vaginal cuff are closed in the usual fashion. Attention is then turned to the abdominal incisions, which, after trochar removal, are closed, in the usual fashion.

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 is evaluated and stabilized. The family is then counseled regarding the results of the procedure and the anticipated convalescence. Once the patient is alert, she too is counseled regarding the outcome of the surgery and the anticipated hospital stay and subsequent convalescence. She is monitored the day of surgery as well as the following day in the hospital. She is discharged in the evening or afternoon of post day #1. She will be followed as an outpatient with approximately two to three office visits during the 90-day global period.

SURVEY DATA

Presenter(s):	George Hill, MD, FACOG and Sandra Reed, MD, FACOG					
Specialty(s):	American College of Obstetricians and Gynecologists (ACOG)					
CPT Code:	58554, Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)					
Sample Size:	70	**Resp n:**	34	**Resp %:**	46%	
Sample Type:	Survey was distributed at the American Association of Gynecological Laparoscopists (AAGL) annual meeting.					
		Low	**25th pctl**	**Median**	**75th pctl**	**High**
Survey RVW:		14.19	19.25	22.00	24.00	30.00
Pre-Service Time: (day preceding procedure)		5	30	~~45~~ **30**	60	120
Pre-Service Time: (day of procedure)		25	30	~~45~~ **30**	~~51~~ 25	60
Intra-Service Time:		15	148.75	**167.5**	210	240

Post-Service	**Total Min***	**CPT code / # of visits**
Immed. Post-time:	**37.5**	
Critical Care time/visit(s):	**0**	
Other Hospital time/visit(s):	**49**	**99232/1 and 99231-1**
Discharge Day Mgmt:	**36**	**99238/1**
Office time/visit(s):	**61**	**99213/2 and 99212/1**

*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
58550	Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)	10	14.19

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: 58554**	**Key Reference CPT Code: 58550**
Median Pre-Service Time	~~90~~ 60	
Median Intra-Service Time	167.5	
Median Immediate Post-service Time	37.5	
Median Critical Care Time	0	
Median Other Hospital Visit Time	49	
Median Discharge Day Management Time	36	
Median Office Visit Time	61	
Median Total Time	~~441~~ 411	

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.11	3.74
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.11	3.74
Urgency of medical decision making	3.77	3.61

Technical Skill/Physical Effort (Mean)

Technical skill required	4.88	4.13
Physical effort required	4.76	4.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.70	4.03
Outcome depends on the skill and judgement of physician	4.88	4.16
Estimated risk of malpractice suit with poor outcome	4.61	4.13

CPT Code: 58554

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.89	3.48
Intra-Service intensity/complexity	4.80	4.06
Post-Service intensity/complexity	4.05	3.61

ADDITIONAL RATIONALE

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

SURVEY METHOD

At the September 2002 RUC meeting, the RUC research subcommittee approved the revised multiple code survey instrument proposed by the American College of Obstetricians and Gynecologists (ACOG).

ACOG in collaboration with the American Association of Gynecological Laparoscopists (AAGL) disseminated the RUC survey at the November 2002 AAGL annual meeting. Thirty-four surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG and AAGL reviewed the results and drafted the final recommendations.

PANEL DISCUSSION

The panel developed the recommendation in the following manner:

1. Reviewing the survey data using IWPUT analysis
2. Reviewing survey data using the building block approach

IWPUT analysis– ACOG received thirty-four completed surveys. The median RVW from the data was 22.00. The panel tested the validity of the median surveyed RVW using IWPUT analysis.
CPT code values: 99232= 1.06; 99231= .64; 99238=1.28; 99213= .67; 99212= .45

22.00 - {.0224(90min) + .0224(37.5 min) + 1.06 + .64 + .1.28 + .67 + .67 + .45} /167.5min = .09 IWPUT

Applying the formula to the surveyed code resulted in an IWPUT of .09. The panel discussed the .09 intensity was slightly higher than 5855X2. While the panel agreed that complexity and physician skill required of this procedure should result in an intensity around that level but the difference in intensity level from CPT code 5855X2 was a result of minor flaws in a small data sample. Therefore the panel concluded that .09 was an appropriate value for this level of service.

Building block approach – The panel then used the building block approach to validate the recommendation and to identify the appropriate value for removal of tube(s) and ovary(s).
CPT code 5855X2, Laparoscopic hysterectomy greater than 250 grams = 20.00 RVUs
CPT code 58661, Laparoscopic removal of tubes and ovary(s) = 11.05

20.00 + .50(11.05) = 25.50 RVUs

Another method is to compare the difference in similar vaginal procedures.
CPT code 58260 Vaginal hysterectomy = 12.98
CPT code 58262, Vaginal hysterectomy with removal of tubes and ovary(s) = 14.77
14.77 – 12.98 = 1.79

The difference between these two codes is 1.79 RVUs. Similarly the difference in the recommended values for the laparoscopic codes is 2.00 RVUs.
CPT code 58554, Laparoscopic hysterectomy greater than 250 grams with removal of tube(s) and ovary(s) = 22.00
CPT code 5855X2, Laparoscopic hysterectomy greater than 250 grams = 20.00
22.00 – 20.00 = 2.00

The panel agreed that both methods validate the survey median of 22.00 RVW for this code.

The panel concluded discussion of this code by unanimously supporting the recommendation of 22.00 RVW for 58554.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported?
CPT code 58550, Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)

(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.

CPT Code: 58554

Specialty American Association of Gynecological Laparoscopists (AAGL)
_____Commonly
X Sometimes
_____Rarely

Specialty American College of Obstetricians and Gynecologists (ACOG)
_____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.

It is estimated that 10-15% of abdominal hysterectomies are now done laparoscopically

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.
It is unlikely that this procedure will be performed on Medicare patients.

Specialty _____ Frequency_____

Specialty _____ Frequency_____

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

	A	B	C	D	E	F	G	H	I
1			FAMILY 1						
2			CPT Code -58545		CPT Code - 58546				
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Code Descriptor - Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; excision of 1-4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas		Code Descriptor - Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams				
4	LOCATION		In Office	Out Office	In Office	Out Office			
5	GLOBAL PERIOD			90		90			
6	TOTAL CLINICAL LABOR TIME		0.0	144.0	0.0	144.0			
7	TOTAL PRE-SERV CLINICAL LABOR TIME		0.0	60.0	0.0	60.0			
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		0.0	12.0	0.0	12.0			
9	TOTAL POST-SERV CLINICAL LABOR TIME		0.0	72.0	0.0	72.0			
10	PRE-SERVICE								
11	**Start: Following visit when decision for surgery or procedure made**								
12	Complete pre-service diagnostic & referral forms			5		5			
13	Coordinate pre-surgery services			20		20			
14	Schedule space and equipment in facility			8		8			
15	Office visit before surgery/procedure: Review test and exam results			0		0			
16	Provide pre-service education/obtain consent			20		20			
17	Follow-up phone calls & prescriptions			7		7			
18	Other Clinical Activity (please specify)			0		0			
19	**End:When patient enters office/facility for surgery/procedure**								
20	SERVICE PERIOD								
21	**Start: When patient enters office/facility for surgery/procedure**								
22	**Pre-service services**								
23	Review charts			0		0			
24	Greet patient and provide gowning			0		0			
25	Obtain vital signs			0		0			
26	Provide pre-service education/obtain consent			0		0			
27	Prepare room, equipment,supplies			0		0			
28	Prepare and position patient/ monitor patient/ set up IV			0		0			
29	Sedate/apply anesthesia			0		0			
30	**Intra-service**								
31	Assist physician in performing procedure			0		0			
32	**Post-Service**								
33	Monitor pt. following service/check tubes, monitors, drains			0		0			
34	Clean room/equipment by physician staff			0		0			
35	Complete diagnostic forms, lab & X-ray requisitions			0		0			
36	Review/read X-ray, lab, and pathology reports			0		0			
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions			0		0			
38	Coordination of Care					0			
39	Discharge day management 99238 --12 minutes 99239 --15 minutes			12		12			
40	Other Clinical Activity (please specify)			0		0			
41	**End: Patient leaves office**								
42	POST-SERVICE Period								
43	**Start: Patient leaves office/facility**								
44	Conduct phone calls/call in prescriptions			0		0			
45	*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 or outpatient care								
46	*List Number and Level of Office Visits*								
47	99211 16 minutes	16		0		0			
48	99212 27 minutes	27		0		0			
49	99213 36 minutes	36		72		72			
50	99214 53 minutes	53		0		0			
51	99215 63 minutes	63		0		0			
52	Other								
53									
54	*Total Office Visit Time*		0	72	0	72			
55	Other Activity (please specify)								
56	**End: with last office visit before end of global period**								

	A	B	C	D	E	F	G	H	I
2			CPT Code -58545		CPT Code - 58546				
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Code Descriptor - Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; excision of 1-4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas		Code Descriptor - Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams				
4	LOCATION		In Office	Out Office	In Office	Out Office			
57	MEDICAL SUPPLIES								
58	OB/GYN Supply Package A			2		2			
59	OB/GYN Supply Package B			2		2			
60	Drape sheet	1106		2		2			
61									
62									
63									
64									
65	Equipment								
66	power table	E11003		80		106			
67	fiberoptic exam light	E11006		80		106			
68									
69									
70									
71									

	A	B	C	D	E	F	G	H	I	J
1			FAMILY 1							
2			CPT Code -58550		CPT Code - 58552		CPT Code - 58553		CPT Code - 58554	
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Code Descriptor - Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less		Code Descriptor - Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and /or ovary(s)		Code Descriptor - Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams		Code Descriptor - Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams, with removal of tube(s) and/or ovary(s)	
4	LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office
5	GLOBAL PERIOD			90		90		90		
6	TOTAL CLINICAL LABOR TIME		0.0	171.0	0.0	171.0	0.0	144.0	0.0	171.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME		0.0	60.0	0.0	60.0	0.0	60.0	0.0	60.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		0.0	12.0	0.0	12.0	0.0	12.0	0.0	12.0
9	TOTAL POST-SERV CLINICAL LABOR TIME		0.0	99.0	0.0	99.0	0.0	72.0	0.0	99.0
10	PRE-SERVICE									
11	Start: Following visit when decision for surgery or procedure made									
12	Complete pre-service diagnostic & referral forms			5		5		5		5
13	Coordinate pre-surgery services			20		20		20		20
14	Schedule space and equipment in facility			8		8		8		8
15	Office visit before surgery/procedure Review test and exam results			0		0		0		0
16	Provide pre-service education/obtain consent			20		20		20		20
17	Follow-up phone calls & prescriptions			7		7		7		7
18	Other Clinical Activity (please specify)			0		0		0		0
19	End:When patient enters office/facility for surgery/procedure									
20	SERVICE PERIOD									
21	Start: When patient enters office/facility for surgery/procedure									
22	Pre-service services									
23	Review charts			0		0		0		
24	Greet patient and provide gowning			0		0		0		
25	Obtain vital signs			0		0		0		
26	Provide pre-service education/obtain consent			0		0		0		
27	Prepare room, equipment,supplies			0		0		0		
28	Prepare and position patient/ monitor patient/ set up IV			0		0		0		
29	Sedate/apply anesthesia			0		0		0		
30	Intra-service									
31	Assist physician in performing procedure			0		0		0		
32	Post-Service									
33	Monitor pt following service/check tubes, monitors, drains			0		0		0		
34	Clean room/equipment by physician staff			0		0		0		
35	Complete diagnostic forms, lab & X-ray requisitions			0		0		0		
36	Review/read X-ray, lab, and pathology reports			0		0		0		
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions			0		0		0		
38	Coordination of Care			0		0		0		
39	Discharge day management 99238 --12 minutes 99239 --15 minutes			12		12		12		12
40	Other Clinical Activity (please specify)			0		0		0		
41	End: Patient leaves office									
42	POST-SERVICE Period									
43	Start: Patient leaves office/facility									
44	Typically phone calls in prescriptions			0		0		0		

	A	B	C	D	E	F	G	H	I	J
2			CPT Code -58550		CPT Code - 58552		CPT Code - 58553		CPT Code - 58554	
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Code Descriptor - Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less		Code Descriptor - Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less, with removal of tube(s) and /or ovary(s)		Code Descriptor - Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams		Code Descriptor - Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams, with removal of tube(s) and/or ovary(s)	
4	LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office
45	*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 f									
46	*List Number and Level of Office Visits*									
47	99211 16 minutes	16		0		0		0		
48	99212 27 minutes	27		27		27		0		27
49	99213 36 minutes	36		72		72		72		72
50	99214 53 minutes	53		0		0		0		
51	99215 63 minutes	63		0		0		0		
52	Other									
53										
54	*Total Office Visit Time*		0	99	0	99	0	72	0	99
55	Other Activity (please specify)									
56	**End: with last office visit before end of global period**									

	A	B	C	D	E	F	G	H	I	J
2			CPT Code -58550		CPT Code - 58552		CPT Code - 58553		CPT Code - 58554	
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Code Descriptor - Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less		Code Descriptor - Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)		Code Descriptor - Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams		Code Descriptor - Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)	
4	LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office
57	MEDICAL SUPPLIES									
58	OB/GYN Supply Package A			3		3		2		3
59	OB/GYN Supply Package B			3		3		2		3
60	Drape sheet	1106		3		3		2		3
61										
62										
63										
64										
65	Equipment									
66	power table	E11003		99		99		80		99
67	fiberoptic exam light	E11006		99		99		80		99
68										
69										
70										
71										

American Medical Association

Physicians dedicated to the health of America

James G. Hoehn, MD
Chairman
AMA/Specialty Society RVS
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May 29, 2002

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 Centers for Medicare and Medicaid Services (CMS), 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 2003. Also included in this submission are the practice expense refinement recommendations for existing CPT 2002 codes; work relative value and practice expense recommendations for a few remaining interim values for CPT 2002; and work relative value recommendations for codes that you had specifically requested the RUC review. The RUC Health Care Professionals Advisory Committee (HCPAC) Review Board are separately forwarding their recommendations to you, as well.

CPT 2003 New and Revised Codes

Enclosed is one binder of RUC recommendations for new and revised codes. The total number of coding changes for CPT 2003 is 464, including 169 additions, 262 revisions, and 33 deletions. Sixty-three of these new and revised codes are not payable on the RBRVS (eg, laboratory services, vaccines, unlisted codes, and services paid through the home health agency payment system), and accordingly, the RUC does not submit any information on these codes. In addition, 12 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 356 new and revised codes, the RUC submits 349 recommendations at this time. The RUC is recommending that two pediatric surgery codes (21742 and 21743) be carrier-priced in 2003, until the RUC has further opportunity to review data for these services. The RUC will not be submitting specific relative value recommendations for six services, including: mandated on-call services; refilling of implantable pumps; or CPT codes 21030 and 21040, recently revised at the May 2002 CPT Editorial Panel meeting.

The summary table in the attached binder, and in the enclosed CD-ROM, specifically identifies a number of "interim" work relative value recommendations. The RUC has requested the specialty societies re-present data on these services at the September 2002 RUC meeting, and we will send any new information to CMS at that time.

Also included in this binder, and on the enclosed CD-ROM, is physician time data for each of the CPT codes reviewed at the February and April 2002 RUC meetings. We will be sending you a comprehensive revision to the entire RUC database for physician time by June 30. The RUC also recommends that CMS revise its database of physician time prior to the 2003 Physician Payment Schedule publication to consistently reflect discharge day visits and time for services typically performed in the facility setting. The RUC continues to review the physician time data to ensure that more accurate data is utilized in the CMS practice expense methodology.

Practice Expense Refinements

Also enclosed is one binder and CD-ROM of practice expense refinement recommendations to existing codes resulting from the tremendous efforts of the RUC's Practice Expense Advisory Committee (PEAC) over the past year. The RUC is submitting recommendations on the direct practice expense inputs for over 1,200 existing CPT codes. The PEAC continues to standardize inputs to streamline the refinement process. For example, included in this submission is a recommendation to change time that office based clinical staff spend providing clinical support of patients in the hospital related to discharge day management to 12 minutes for 99238 and 15 minutes for 99239. These times should be applied to each surgical procedure code that includes a discharge day management service in the global package. Also included in the recommendations are additional supply packages for conscious sedation use with spine injection procedures, and pre-service clinical staff time data for 323 neurosurgery procedures.

CPT 2002 Interim Values

In September 2001, the RUC had intended to review the following issues:

- Nonbiodegradeable 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)

Due to the tragic events of September 11, the RUC meeting was cancelled and the RUC was, therefore, not able to submit recommendations on the above issues in time for the conclusion of your comment period in December. We ask that in your review of the 2002 interim values over this summer, you consider the RUC recommendations and comments on these issues.

Special CMS Requests

Finally, we are also submitting our response to issues that CMS had asked the RUC to review. CMS has recently requested that the RUC review CPT code 76092 *Screening mammography* and several gastrointestinal endoscopy services. The RUC has completed its review of both the work and direct practice expense for screening mammography and this recommendation is included in our submission. The RUC continues to review the gastrointestinal endoscopy services and will submit work relative value recommendations in the future.

The RUC appreciates CMS' participation in our meetings and your effort to ensure a fair review of the RUC recommendations.

Sincerely,

James G. Hoehn, M.D.

James G. Hoehn, MD

cc: Paul Rudolf, MD
Ken Simon, MD
James Rodgers, PhD
Carolyn Mullen
Rick Ensor
Sherry Smith
Patrick Gallagher

American Medical Association

Physicians dedicated to the health of America

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October 14, 2002

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

Dear Mr. Kay:

We are pleased to present work relative value and direct practice expense input recommendations on CPT codes recently reviewed at our September 27-28, 2002 RUC meeting.

On May 29, 2002, the RUC submitted recommendations to the Centers for Medicare and Medicaid Services related to new and revised CPT codes for CPT 2003. At that time, we indicated that several of the RUC recommendations should be considered interim. The RUC had requested that specialty societies re-present data on these services at the September 2002 RUC meeting. We are now submitting further recommendations on the following issues:

- Excision of Benign Tumor or Mandible/Maxilla (21030 and 21040)
- Bone Marrow Procedures (38207-38215)
- Therapeutic Apheresis (36511-36516)
- Minimally Invasive Repair of Pectus Excavatum (21740, 21742, and 21743)
- Refilling of Implantable Infusion Pumps (95990 and 96530)

In addition, the RUC had scheduled presentations on issues where CMS had requested further RUC review. These issues were either in follow-up to the Five-Year Review of physician work relative values or related to recent coverage policy issues. The status of each issue is outlined below:

- Gastrointestinal Endoscopy Services (43259, 43231, 43232, 43242, 45341, 45342, 43219, 43256, 43268, 43269, 44370, 44383, 44397, 45327, 45345, and 45387): The specialty has indicated that they will not seek the RUC's further review of this issue.

- Central Nervous System Assessments/Tests (96100-96117): The specialties will present data on these services at our February 2003 meeting. We will forward any resulting RUC recommendations to you after this meeting.

- Ambulatory Blood Pressure Monitoring (92784, 93786, 93788, and 93790): Work relative value and direct practice expense input recommendations are attached for your consideration.

Also, the RUC approved a statement clarifying the RUC's position on the inclusion of critical care work relative values in the global package. It is the RUC's position that that the denial of payment solely on the basis that critical care may have been recognized in a global surgical package is inappropriate. The RUC, therefore, requests that CMS instruct carriers that the post operative critical care services provided by the non-operating physician to patients are not duplicative of the post operative services that may be provided by the operating surgeon.

We appreciate your consideration of the RUC recommendations. If you have any questions regarding this submission, please contact Sherry Smith at the AMA.

Sincerely,

James G. Hoehn, M.D.

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
Summary of Recommendations

April and September 2002

Bone Marrow Procedures

Thirteen new CPT codes were added and two were deleted to provide greater granularity to accurately code the specific procedures performed for each patient receiving bone marrow or stem cell transplantation. The newer techniques used in a transplant laboratory under physician supervision are now captured in these new CPT codes. CPT codes 38205-38215 replace codes 38231 *Blood-derived peripheral stem cell harvesting for transplantation, per collection* (Work RVU = 1.50) and 86915 *Bone marrow or peripheral stem cell harvest, modification or treatment to eliminate cell type(s) (e.g., T-cells, metastatic carcinoma)* to allow for different types, work, and techniques now used for different types of cell harvesting and also transplant preparation as well as the critical work and techniques involved in stem cell processing prior to a Bone Marrow Transplant. Present codes 38231 and 86915 were not designed for modern procedures in bone marrow transplant and have virtually no relevance to the present stem cell harvesting and processing work and procedures. The RUC understands that these services are not commonly performed on the Medicare population and very few centers perform these services (50 centers), therefore, the smaller number of survey respondents (21) was expected.

38204 ***Management of recipient hematopoietic progenitor cell donor search and cell acquisition***
The RUC reviewed the survey results and the similarities in physician work of the reference code, 80502 *Clinical pathology consultation; comprehensive, for complex diagnostic problem, with review of patient's history and medical records* (Work RVU=1.33). The RUC believed that this service was more intense than 80502 as there was zero tolerance for error. The RUC understands that this newly reported service would be billed one time per recipient. The RUC also compared this service to CPT code 99204 *Office or other outpatient visit for the evaluation and management of a new patient* ... a level 4 new patient office visit representing 45 minutes of physician time (work RVU = 2.00). The RUC agreed that the time spent on this type of per patient management reflected the specialty's recommended 25th percentile surveyed intra-service time. The RUC agreed that there is no pre- and post-service time. **The RUC recommends a relative work value of 2.00 for CPT code 38204.**

38205 ***Blood derived hematopoietic progenitor cell harvest for future transplantation per collection; allogeneic***
38206 ***Blood derived hematopoietic progenitor cell harvest for future transplantation per collection; autologous***
These two codes were previously billed as code 38231 *Blood derived peripheral stem cell harvesting for transplantation, per collection* (Work RVU = 1.50). The specialty society recommended a value of 2.0 stating code 38231 had been undervalued. The

RUC however found no compelling evidence to increase the value, and believed it had been appropriately valued by the RUC when reviewed in 1995. **The RUC recommends a relative work value of 1.50 for CPT codes 38205 and 38206.**

38210 & 38207 – 38215

In April 2002, the RUC reviewed CPT code 38210 *Transplantation preparation of hematopoietic progenitor cells; cryopreservation and storage; specific cell depletion within harvest, T-cell depletion* as an anchor code for family 38205 through 38215. The RUC first recognized that the vignette did not reflect an accurate description of the service of 38210, however the RUC did believe that the work involved in code 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Work RVU = 0.94) was similar. The RUC also reviewed the codes in comparison to the work of evaluation and management services. The RUC was concerned regarding the accuracy of the survey data for these services. However, the RUC agreed that a repeated survey would not be appropriate as it would have to be circulated to the same physicians/centers. The RUC recommends that a consensus panel of physicians, with the participation of one or more RUC members, review these codes again for the September 2002 RUC meeting. The RUC however, felt strongly, that these services require physician work and recommends interim work values to be assigned for 38207-38215. The RUC emphasized that these interim values should not be viewed as a "ceiling" for the future review, but serve as the best alternative until future review is completed. Considering the similarities in work of code 86077 and 38210, the RUC had recommended an interim value of 0.94 for code 38210.

The RUC compared similarities in work and intensity of codes 86077 and 38210, and then agreed with the rank order established by the specialty society for the family of codes 38207 through 38215. The RUC agreed with the specialty society's recommended rank order for the family, but also understood that the values being established were interim pending future RUC review and consideration at the September 2002 meeting. The RUC had recommended the following interim work relative values for CPT codes 38207-38215:

CPT Code	April 2002 Interim RUC Recommendation
38207	0.47
38208	0.56
38209	0.24
38210	0.94
38211	0.71
38212	0.47
38213	0.24
38214	0.24
38215	0.55

In September 2002, the RUC formed a facilitation committee to extensively discuss each of the services described in new CPT codes 38207 – 38215 and establish work relative value recommendations. The committee affirmed the decision made in April 2002 that these services do require direct physician involvement on a per patient level and should have assigned physician work. The RUC, however, remains concerned that the survey instrument and the corresponding summary of recommendation forms were not properly constructed. In addition, the RUC was concerned that further clarification is necessary in the CPT nomenclature for a few of these codes. Therefore, the RUC recommends that after further CPT revision, the specialty society conduct a re-survey of these services. The RUC proceeded to develop revised relative value recommendations, but will consider these relative values interim until the specialty society has the opportunity to re-survey.

In April, as an attempt to assign interim values, the RUC cross-walked the work relative value for 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Work RVU = 0.94) to new CPT code 38210 *Specific cell depletion within harvest, T-cell depletion.* Work relative values were then extrapolated to the remaining codes in this family, utilizing the relativity established by the specialty society recommendations. In September, the specialty suggested, and the RUC agreed, that the 86077 should have been cross-walked to 38212 *Red blood cell removal*, rather than 38210. The RUC intra-service time for 86077 is 40 minutes, which is closer to the survey intra-time of 38212 (30 minutes) than is the survey intra-time of 38210 (60 minutes).

The RUC reviewed, in detail, the physician involvement and work in the service described in CPT code 38212. The physician work is as follows:

Pre-work: Reviewing data available prior to the time cells arrive in lab. This includes the phenotyping on donor and recipient; antibody information; and donor and recipient body weight. The committee agreed that the survey pre-time of 5 minutes seemed reasonable.

Intra-work: The intra-work begins when the cells arrive in the lab. The tech would get the Hct. The physician would then look at CD 34 (flow cytometry) on monitor. Based on the cell counts and Ab counts, the physician would decide which technique to use to deplete the red blood cells. The tech then does the process. After the bleed off of red blood cells, the physician judges where to divide the sample. A Hct and CD34 are repeated. The physician looks at the results and decides whether to recombine components and repeat the separation. The typical patient has this process one time through (without the recombining), about one-third require re-separation. The RUC agreed that 30 minutes of physician intra-service work was reasonable. This includes multiple flow cytometry readings, decision-making, and other interactions with the technician.

Post-work: Report and documentation. The RUC agreed that the specialties indication that this takes the form of a handwritten note is reasonable, given the detailed, sensitive information. The survey post-time of 15 minutes may be slightly over-stated. The RUC agreed that 10 minutes of post-service time was reasonable for the written report.

The RUC noted several additional factors in walking through the physician involvement and work in providing this service:

- The procedure requires intermittent physician time, sometimes over several hours. During that time, the physician is interacting with the technicians intermittently to determine how best to process cells.
- The procedure does not involve face-to-face patient contact. It occurs in an isolated laboratory.
- Physician work related to this procedure includes quality assurance work to support quality assurance for the lab. Physicians have not historically been separately compensated for quality assurance in the lab. Therefore, it is legitimate to consider this work as part of the work of the procedure.
- The risks to the patient are real. Mistakes can cause patient death. This adds to the stress of the procedure and decision-making.

Doctor Paul Rudolf, from the Centers for Medicare and Medicaid Services, informed the committee that deleted CPT code 86915 *Bone marrow or peripheral stem cell harvest modification or treatment to eliminate cell type(s) (e.g., T cells, metastatic carcinoma),* where the services described in 38210-38213 were previously reported is paid on the clinical lab fee schedule. He noted that currently the payment for 86915 is based on reasonable cost. The specialty and RUC agreed that CMS would need to make a technical correction to the cost reporting instructions to eliminate the physician compensation from these specific labs if compensation for the physician's professional service is included on the cost report. *Staff Note: Subsequent to the RUC meeting, the specialty determined that current program instructions provide for Code 86915 to be reimbursed on a reasonable charge basis when performed by independent laboratories and through the hospital outpatient prospective payment system when performed in outpatient departments. This information was shared with CMS.*

The RUC reviewed the proposed crosswalk of code 86077 *Blood bank physician services*, which has 40 minutes of intra-time and a work relative value of 0.94, to CPT code 38212. The RUC noted that since documentation is also required for 86077, the 40 minutes of intra-time may include some actual post-work. The RUC also agreed that the intensity of 38212 would be greater than 86077. After reviewing 38212 in detail, the RUC agreed that a comparison and cross-walk between 86077 and 38212 was reasonable.

The RUC also reviewed the appropriate work relative value for 38212 by using a building block method. CPT code 38212 includes two flow cytometry procedures. 88180 *Flow cytometry; each cell surface, cytoplasmic or nuclear marker* (work rvu = 0.36), includes a pre-time of 5 minutes, intra-time of 10 minutes, and post-time of 10 minutes. The RUC agreed that a multiple of two 88180, with

additional work for the interaction with the technician and the medical decision-making offered another validation of a work relative value of 0.94 for 38212. The RUC also recommends that a note be added to CPT to indicate that 88180 should not be reported in addition to this series of codes, as they include the work of flow cytometry.

The RUC recommends a work relative value of 0.94 for CPT code 38212. The RUC recommends physician time of 5 minutes pre-time, 30 minutes intra-time, and 10 minutes post-time.

The RUC then discussed the best way to extrapolate the appropriate value of 0.94 for 38212 to the rest of the family of codes. The RUC no longer agreed that the specialty society's recommended values were in the appropriate relativity, as these were derived from a very small consensus panel (two or three physicians). The survey medians appeared to correspond with the intra-service time for most services, so the committee agreed to use the survey medians for relativity. The RUC agreed that the intra-service survey time should be used, but felt that a standardized pre-time of 5 minutes, and standardized post-time of 10 minutes should be applied to all of the codes in this family. The RUC had significant concern, however, regarding the survey medians for three codes, 38208, 38209, and 38213. CPT code 38213 P*latelet depletion* was grossly overvalued by the survey respondents. CPT codes 38208 *thawing of previously frozen harvest* and 38209 *washing of harvest* should be referred back to CPT to create codes that describe thawing without washing and thawing with washing. The specialty had indicated a specimen must always be thawed before washing, so the current coding structure is not appropriate.

The RUC, therefore, recommends the following for this family of services:

- **CPT should add a note to this family of services to specify that CPT code 88180 *Flow cytometry* should not be reported in addition to these services as it is included in the valuation of these codes.**
- **CPT should review the coding language for codes 38208 and 38209, as thawing of the harvest must always occur prior to washing of the harvest. The codes should be formatted as thawing without washing and thawing with washing.**
- **After these changes have been made by the CPT Editorial Panel, the specialty should re-survey the entire family of services with the following improvements to the survey instrument:**
  - **a better reference service list, with other similar services included**
  - **better education of survey respondents regarding the survey process**
  - **better descriptions of the physician work involved**
  - **assistance from the RUC facilitation committee prior to dissemination of the survey instrument**
- **The work relative values developed at the September RUC meeting are more valid than the values developed in April, however, the values for CPT codes 38207 – 38215 should remain interim until after these codes have been re-surveyed and re-presented to the RUC.**

- **A standardized pre-time of 5 minutes and post-time of 10 minutes should apply to each code. The survey median intra-service time should be recorded into the RUC database for all of the services.**

- **The work relative value for CPT code 38212 should be cross-walked from CPT code 86077 and the survey median relativity should be used to extrapolate work relative values to the rest of the services in the family, as follows:**

CPT Code	September 2002 Interim RUC Recommendation
38207	0.89
38208	0.56
38209	0.24
38210	1.57
38211	1.42
38212	0.94
38213	0.24
38214	0.81
38215	0.94

38242 ***Bone marrow or blood-derived peripheral stem cell transplantation; allogenic donor lymphocyte infusions***
The specialty presented a typical patient that is severely ill and in great risk. Approximately 25% of these procedures are complicated by life threatening reactions to the infusion. The RUC agreed with the specialties description of the intensity of intra-service work and 25th percentile time of 30 minutes.

The RUC also understood that this service could be compared to several other intense procedures including critical care code 99292 *Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)* (work RVU = 2.0), however, the work for this code was not quite as intense, and could be more appropriately aligned with code 99357 *Prolonged physician service in the inpatient setting, requiring direct (face-to-face) patient contact beyond the usual service (eg, maternal fetal monitoring for high risk delivery or other physiological monitoring, prolonged care of an acutely ill inpatient); each additional 30 minutes (List separately in addition to code for prolonged physician service* (work RVU= 1.71) for its time and intensity. The RUC in addition, believed code 38242 was less intense than the reference code 38240 *Bone marrow or blood-derived peripheral stem cell transplantation; allogenic* (work RVU = 2.24, Harvard total time 53). **The RUC recommends a relative work value of 1.71 for code 38242,** which has the approval of the specialty society.

Practice Expense: The RUC and the specialty society agreed that these procedures do not have any practice expense inputs and are performed exclusively in the facility setting.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•38204	AV1	Management of recipient hematopoietic progenitor cell donor search and cell acquisition	XXX	2.00 (May 2002 RUC Recommendation)
•38205	X1	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogenic	000	1.50 (May 2002 RUC Recommendation)
•38206	X2	autologous	000	1.50 (May 2002 RUC Recommendation)
•38207	X3	Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage (For diagnostic cryopreservation and storage, see 88240)	XXX	0.89 (Interim)
•38208	X4	thawing of previously frozen harvest (For diagnostic thawing and expansion of frozen cells, see 88241)	XXX	0.56 (Interim)
•38209	X5	washing of harvest	XXX	0.24 (Interim)
•38210	X6	specific cell depletion within harvest, T-cell depletion	XXX	1.57

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
				(Interim)
•38211	X7	tumor cell depletion	XXX	1.42 (Interim)
•38212	X8	red blood cell removal	XXX	0.94 (Interim)
•38213	X9	platelet depletion	XXX	0.24 (Interim)
•38214	X10	plasma (volume) depletion	XXX	0.81 (Interim)
•38215	X11	cell concentration in plasma, mononuclear, or buffy coat layer	XXX	0.94 (Interim)
~~38231~~		~~Blood-derived peripheral stem cell harvesting for transplantation, per collection~~ (38231 has been deleted. To report, use 38205-38206)	000	N/A
•38242	X12	Bone marrow or blood-derived peripheral stem cell transplantation; allogenic donor lymphocyte infusions	XXX	1.71 (May 2002 RUC Recommendation))
~~86915~~		~~Bone marrow or peripheral stem cell harvest, modification or treatment to eliminate cell type(s) (eg, T-cells, metastatic carcinoma)~~ (86915 has been deleted. To report, use 38210-38213)	XXX	N/A

THE AMERICAN SOCIETY OF HEMATOLOGY
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October 11, 2002

American Medical Association
Dept of CPT Editorial Research and Development
515 North State Street
Chicago, IL 60610

Dear Sir/Madam:

As recommended by the AMA RUC at their September 2002 meeting, the American Society of Hematology (ASH) would like to have the phrase "with physician evaluation" added to the definition of CPT 36516 for 2004 (the code is new for 2003). This would change the descriptor to read:

▲36516 ***therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion; with physician evaluation.***

This change is needed to assure that this code is billed only when the physician is present and periodically monitoring the patient during the procedure. The terminology is similar to that already existing for CPT 90935, hemodialysis procedure.

In addition, nine new bone marrow/stem cell processing codes were reviewed by the RUC (CPT codes 38207-38215) and the recommendation made that two of these be revised for 2004 (these are new codes for 2003). Specifically, CPT 38208 and CPT 38209 should change as follows:

▲38208 ***thawing of previously frozen harvest, with washing*** ~~***thawing of previously frozen harvest***~~

▲38209 ***thawing of previously frozen harvest, without washing*** ~~***washing of harvest***~~

The rationale for this revision is that bone marrow/stem cell washing is always done with bone marrow/stem cell thawing. However, all harvests that are thawed are not necessarily washed.

Finally, the AMA RUC recommended we petition CPT to add a note to these nine bone marrow/stem cell processing codes (CPT codes 38207–38215) indicating that physicians may not report flow cytometry (CPT codes 88180, 88182, and 88199) separately.

We understand that we do not need to submit a formal CPT application for these changes. If our understanding is not correct, please advise us as soon as possible.

If you have any questions or need additional information at this time, please feel free to contact Mo Mayrides, ASH Director of Policy and Practice, at (202) 292-6005 or at mmayrides@hematology.org.

Sincerely,

Samuel M. Silver, MD, PhD
Chair, ASH Committee on Practice

CPT Code: 38207

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38207 Tracking Number: X3 Global Period: XXX ~~Recommended RVW: 1.0~~
RUC Rec. RVW: 0.89

CPT Descriptor: Cryopreservation and storage

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Peripheral blood stem cells or bone marrow have been collected. These cells are to be cryopreserved for later use as part of an autologous transplant where hematopoietic progenitor cells have to first be cryopreserved for a later autologous hematopoietic progenitor cell transplant. In many cases, the bone marrow or peripheral blood progenitor cells are also cryopreserved for allogeneic transplants. This ensures that the cells are ready and available when the patient needs them. The physcian writes separate prescriptions for cryropreservation and thawing of the product. A physcian supervises both cryropreservation and thawing of the product and in an emergency does these procedure himself/herself as a patient life is in jeopardy.
The cryopreservation process is begun. It is important to make sure the freezing process is performed correctly to ensure that the cells have been frozen in a safe manner to be acceptable for transplantation. This requires following validated standard operating procedures. Cryopreservation data are reviewed and quality assessment of the procedure is performed. Cells are stored at a low temperature under controlled monitored conditions until needed for transplant. The physcian may do this procedure in an emergency. The quality of the cryropreserved transplantation product (bone marrow, blood-derived, or umbilical cord blood-derived hematopoietic progenitor cells, allogeneic t-lymphocytes) must be assessed prior to release of product. Examples of quality assurance are nucleated cell count, differential, viability, sterility and/or immunophenotyping by flow cytometry for cd34(+) progenitor cells, T-lymphocytes, or tumor cells. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physcian then judges if this product remains suitable for transplantation or if new product needs to be collected.

Description of Pre-Service Work: Review of donor and patient data.

Description of Intra-Service Work: This is basically supervision of the cryopreservation process, review of the freezer curves to make sure they are adequate, review of the CD34 counts, and review of the viability studies to ensure the product is a viable transplant product. A life depends on this evaluation. The FDA requires physician assessment of this procedure and the product processed.

Description of Post-Service Work: Preparation of report

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 66% Median RVW: 1.42

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

25th Percentile RVW: 1.23 75th Percentile RVW: 1.88 Low: 1.00 High: 8.00

Median Pre-Service Time: ~~2.5~~ 5 Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 20 75th Percentile Intra-Svc Time: 56.25 Low: 10 High: 420

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	~~12.5~~ 10	

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
80502	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	XXX	1.33

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including 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:
~~Median Pre-Time~~	~~2.5~~ 5	~~No RUC data~~
Median Intra-Time	30	No RUC data
Median Immediate Post-service Time	~~12.5~~ 10	No RUC data
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	3.64	3.85
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.93	3.54
Urgency of medical decision making	4.14	3.92

Technical Skill/Physical Effort (Mean)

Technical skill required	4.29	3.62
Physical effort required	2.43	2.08

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.36	4.00
Outcome depends on the skill and judgement of physician	4.21	4.15
Estimated risk of malpractice suit with poor outcome	4.43	4.38

CPT Code: 38207

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.13	2.63
Intra-Service intensity/complexity	3.62	3.08
Post-Service intensity/complexity	3.22	2.63

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data an reached consensus in developing the recommended work values

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FREQUENCY INFORMATION

How was this service previously reported? 86915 (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_____ _____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: No Medicare Data on code

Specialty _____ Frequency_____

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

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CPT Code: 38208

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38208 Tracking Number: X4 Global Period: XXX ~~**Recommended RVW: 1.2**~~
RUC Rec. RVW: 0.56

CPT Descriptor: Thawing of previously frozen harvest

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The previously cryopreserved marrow and stem cells are thawed in a heated water bath. A sample is obtained for post-thaw quality assessment such as nucleated cell count and viability. Cells are infused immediately post-thaw. The physician may do this procedure in an emergency. The quality of the thawed transplantation product (bone marrow, blood-derived, or umbilical cord blood-derived hematopoietic progenitor cells, allogeneic t-lymphocytes) must be assessed prior to release of product. Examples of quality assurance are nucleated cell count, differential, viability, sterility and/or immunophenotyping by flow cytometry for cd34(+) progenitor cells, T-lymphocytes, or tumor cells. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physcian then judges if this product remains suitable for transplantation or if new product needs to be collected.

Description of Pre-Service Work: Review of donor and patient data

Description of Intra-Service Work: This is management of a thawing. This usually occurs in front of a physician as the PBSC are put in a water bath and immediately thawed. The process can have failure since the bags break frequently or if the thawing process has failure, there is no graft. The risk to the patient is high because if the thawing process lyses cells, there may be no alternative graft. The FDA requires physician assessment of this procedure and the product processed.

Description of Post-Service Work: Preparation of report.

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 76% Median RVW: 1.42

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

25th Percentile RVW: 1.00 75th Percentile RVW: 2.58 Low: 0.37 High: 5

Median Pre-Service Time: 5 Median Intra-Service Time: 45

25th Percentile Intra-Svc Time: 24 75th Percentile Intra-Svc Time: 60 Low: 5 High: 150

Median Post-Service Time:	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	~~5~~ 10	

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
80502	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	XXX	1.33

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including 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:
Median Pre-Time	5	No RUC data
Median Intra-Time	45	No RUC data
Median Immediate Post-service Time	~~5~~ 10	No RUC data
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.63	3.44
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.31	3.19
Urgency of medical decision making	4.19	3.06

Technical Skill/Physical Effort (Mean)

Technical skill required	3.88	3.19
Physical effort required	2.56	2.25

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.06	3.19
Outcome depends on the skill and judgement of physician	3.75	3.38
Estimated risk of malpractice suit with poor outcome	4.00	3.31

CPT Code: 38208

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.10	2.50
Intra-Service intensity/complexity	3.75	3.13
Post-Service intensity/complexity	3.20	2.50

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data and reached sonsensus on the recommended work value

FREQUENCY INFORMATION

How was this service previously reported? 86915 (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_____ _____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: No Medicare Data on code

Specialty _____ Frequency_____

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38209 Tracking Number: X5 Global Period: XXX ~~Recommended RVW: 0.5~~
RUC Rec. RVW: 0.24

CPT Descriptor: Washing of harvest

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Blood derived hematopoietic progenitor cells have been harvested but the patient mobilizes very poorly with few stem cells. Thus, it is necessary to freeze them in multiple aliquots. Such harvest material contains a significant number of neutrophils or mature granulocytes, which are not capable of restoring hematopoiesis. Only the primitive cells are able to do this. DMSO is necessary for the cyropreservation. Because the cells have been frozen in multiple aliquots (multiple bags of these products were frozen over many days and then thawed later), the total content of DMSO is large and the patient gets a large exposure to DMSO. Such large amounts of DMSO in the transplant can potentially cause projectile vomiting and other injury to the patient. Thus it is necessary to wash the harvest cells to minimize the DMSO content] A physcian writes a prescription for this procedure based on the review of the cryopreserved product and whether recipient needs to maximize cell dose or minimize DMSO toxicity. The physcian may do this procedure n an emergency.
The thawed cells are washed using an automated cell washer. During the wash process, cells are concentrated and resuspended in infusible grade solutions such as saline/albumin. The physcian may do this procedure in an emergency. Quality assessment of the washed product is performed. The quality of the thawed transplantation product (bone marrow, blood-derived, or umbilical cord blood-derived hematopoietic progenitor cells) must be assessed prior to release of product. Examples of quality assurance are nucleated cell count, differential, viability, sterility and/or immunophenotyping by flow cytometry for cd34(+) progenitor cells, T-lymphocytes, or tumor cells. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physcian then judges if this product remains suitable for transplantation or if new or additional product needs to be collected.

Description of Pre-Service Work: Review of donor and patient data

Description of Intra-Service Work: . This procedure is used when the cell count of the harvest is high due to excessive granulocyte contamination of the progenitor cell harvest. The cell count governs the amount of DMSO used to cryopreserve the cells. DMSO can cause projectile vomiting. This is a washing of immediately thawed stem cells. The washing has to occur over approximately one hour. Since all of these patients would have the thawing intraservice work, the physician effort is incremental to that for the washing. If the washing has a problem the entire graft could be lost and the patient could die. The FDA requires physician assessment of this procedure and the product processed.

Description of Post-Service Work: Preparation of report

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 57% Median RVW: 1.25

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

25th Percentile RVW: 0.99 75th Percentile RVW: 2.20 Low: 0.50 High: 4.00

Median Pre-Service Time: 5 Median Intra-Service Time: 37.5

25th Percentile Intra-Svc Time: 25 75th Percentile Intra-Svc Time: 60 Low: 0 High: 240

CPT Code: 38209

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:

CPT Code	CPT Descriptor	Global	Work RVU
85097	Bone marrow, smear interpretation	XXX	0.94

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:
Median Pre-Time	5	No RUC data
Median Intra-Time	37.5	No RUC data
Median Immediate Post-service Time	10	No RUC data
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	3.50	3.27
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.33	2.82
Urgency of medical decision making	4.00	3.09

Technical Skill/Physical Effort (Mean)

Technical skill required	3.92	3.09
Physical effort required	2.42	2.18

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.08	3.36

Outcome depends on the skill and judgement of physician	3.50	3.18
Estimated risk of malpractice suit with poor outcome	3.83	3.27

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.33	3.20
Intra-Service intensity/complexity	3.55	2.90
Post-Service intensity/complexity	3.43	3.17

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data and reached consensus on the reommended work value.

FREQUENCY INFORMATION

How was this service previously reported? 86915 (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_____ ____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: No Medicare Data on code

Specialty _____ Frequency_____

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

CPT Code: 38210

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38210 Tracking Number: X6 Global Period: XXX ~~**Recommended RVW: 2.0**~~
RUC Rec. RVW: 1.57

CPT Descriptor: Specific cell depletion within harvest; T-cell depletion

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient is a 10 year old boy with DiGeorge's Syndrome who needs a bone marrow/peripheral blood progenitor stem cell transplant from his father. The marrow has to be T-cell depleted for this allogeneic graft to reduce the risk of graft versus host disease. The physcian writes a prescription ordering this procedure based on recipient needs and the degree of HLA mismatching with the donor. In an emergency the physcian may do this procedure.

T-cell depletion is performed using various methods such as the Baxter Isolex device. This instrument enriches the stem cells (CD34+) and passively removes unwanted cells such as T-cells. In an emergency the physcian may do this procedure. Quality assessment of the product is performed. . The quality of the T-lymphocyte depleted hematopoietic progenitor cell product (bone marrow or blood-derived) must be assessed prior to release of product. Examples of quality assurance are nucleated cell count, differential, viability, sterility and/or immunophenotyping by flow cytometry for cd34(+) progenitor cells and T-lymphocytes. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physcian then judges if this product remains suitable for transplantation or if new product needs to be collected.

Description of Pre-Service Work: Review of donor and patient data

Description of Intra-Service Work:. Intraservice for this is supervision of the soybean lectin e-rosetting. In allogeneic graft for T-cell depletion this usually occurs in the context of a haploidentical transplant. The work is reviewing the quality control, reviewing the adequacy of the antibodies used, reviewing the adequacy of the soybean lectin. For the use of the isolex or the clinimacs cell selection devices, review of the flow cytometry pre- and post-service. This is probably the most complicated cell processing procedure. The FDA requires physician assessment of this procedure and the product processed.

Description of Post-Service Work: Preparation of report.

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 71% Median RVW: 2.50

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

25th Percentile RVW: 1.50 75th Percentile RVW: 3.25 Low: 1.08 High: 10

Median Pre-Service Time: ~~10~~ **5** Median Intra-Service Time: **60**

25th Percentile Intra-Svc Time: 23 75th Percentile Intra-Svc Time: 210 Low: 0 High: 600

Median Post-Service Time:	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	~~20~~ **10**	

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
80502	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	XXX	1.33

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including 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:
Median Pre-Time	~~10~~ 5	No RUC data
Median Intra-Time	60	No RUC data
Median Immediate Post-service Time	~~20~~ 10	No RUC data
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	4.13	3.93
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.40	3.47
Urgency of medical decision making	4.40	3.47

Technical Skill/Physical Effort (Mean)

Technical skill required	4.60	4.14
Physical effort required	2.67	2.21

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.73	3.93
Outcome depends on the skill and judgement of physician	4.47	3.79
Estimated risk of malpractice suit with poor outcome	4.27	3.79

CPT Code: 38210

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.20	2.89
Intra-Service intensity/complexity	4.21	3.47
Post-Service intensity/complexity	3.70	2.80

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data and reached sonsensus on the recommended work value

FREQUENCY INFORMATION

How was this service previously reported? 86915 (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_____ _____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: No Medicare Data on code

Specialty _____ Frequency_____

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

CPT Code: 38211

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
80502	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	XXX	1.33

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including 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:
Median Pre-Time	5	No RUC data
Median Intra-Time	60	No RUC data
Median Immediate Post-service Time	10	No RUC data
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	3.80	3.86
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.07	3.36
Urgency of medical decision making	4.07	3.21

Technical Skill/Physical Effort (Mean)

Technical skill required	4.57	4.00
Physical effort required	2.57	2.15

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.13	3.86
Outcome depends on the skill and judgement of physician	3.93	3.57
Estimated risk of malpractice suit with poor outcome	3.80	3.79

CPT Code: 38211

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.90	2.60
Intra-Service intensity/complexity	4.14	3.47
Post-Service intensity/complexity	3.50	2.80

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed and reached consensus on the recommended work value.

FREQUENCY INFORMATION

How was this service previously reported? 86915 (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_____ _____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: No Medicare Data on code

Specialty _____ Frequency_____

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

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CPT Code: 38212

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38212 Tracking Number: X8 Global Period: XXX ~~Recommended RVW: 1.0~~
RUC Rec. RVW: 0.94

CPT Descriptor: Red blood cell removal

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old female with leukemia is blood type O and requires a peripheral blood stem cell transplant. The donor is blood type A. With such a stem cell harvest, ABO blood group barriers are routinely crossed. If fresh bone marrow containing Type A red blood cells is given to the patient, those type A cells will be immediately hemolyzed. This would cause renal failure and ultimately death to the patient because they could not receive post transplant immunosuppression therapy. Because of the different blood types, red blood cell depletion is required from the harvest. The stem cell harvest is then performed. A physcian writes an order for this procedure and supervises it. In an emergency, a physcian may do this procedure.
The red cell depletion can be done by various methods such as mononuclear cell concentration using an FDA approved apheresis device, mononuclear cell enrichment using density gradient solution, hydroxyethel starch which is FDA approved as an infusible solution. In an emergency a physcian may do this procedure. Quality assessment of the product is performed. The quality of the hematopoietic progenitor cells (bone marrow, blood-derived, or umbilical cord blood-derived hematopoietic progenitor cells) must be assessed prior to release of product. Examples of quality assurance are hematocrit, red cell count, nucleated cell count, differential, viability, sterility and/or immunophenotyping by flow cytometry for cd34(+) progenitor cells. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physcian then judges if this product remains suitable for transplantation or if new product needs to be collected.

Description of Pre-Service Work: Review of donor and patient data

Description of Intra-Service Work: This procedure is done when there is major ABO incompatibility. This is a removal of red cells from the product. This is done by hetastart separation. It takes approximately 50 minutes. The physician would ensure there is an adequate CD34 count post-selection and there is minimal red cell contamination. Failure to properly assess red blood cell removal will cause an acute hemolysis with infusion of the graft. The FDA requires physician assessment of this procedure and the product processed.

Description of Post-Service Work: Preparation of report.

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 71% Median RVW: 1.50

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

25th Percentile RVW: 1.00 75th Percentile RVW: 2.10 Low: 0.50 High: 3.00

Median Pre-Service Time: 5 Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 12.5 75th Percentile Intra-Svc Time: 120 Low: 0 High: 150

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	~~15~~ 10	

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
90935	Hemodialysis procedure with single physician evaluation	000	1.22

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:
Median Pre-Time	5	0
Median Intra-Time	30	21
Median Immediate Post-service Time	~~15~~ 10	0
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	3.33	3.53
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.20	3.00
Urgency of medical decision making	3.60	3.20

Technical Skill/Physical Effort (Mean)

Technical skill required	3.80	3.53
Physical effort required	2.27	2.40

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.07	4.07
Outcome depends on the skill and judgement of physician	3.80	3.67
Estimated risk of malpractice suit with poor outcome	4.33	3.47

CPT Code: 38212

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.70	2.70
Intra-Service intensity/complexity	3.50	3.27
Post-Service intensity/complexity	3.40	2.80

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data and reached consensus on the recommended work value.

FREQUENCY INFORMATION

How was this service previously reported? 86915 (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_____ _____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: No Medicare Data on code

Specialty _____ Frequency_____

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

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38213 Tracking Number: X9 Global Period: XXX ~~Recommended RVW: 0.5~~
RUC Rec. RVW: 0.24

CPT Descriptor: Platelet depletion

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient is a 35 year old female with leukemia who requires an allogeneic peripheral blood stem cell transplant. The donor is much smaller than the intended recipient, thus requiring multiple days of harvesting. Because multiple successive days of stem cell collection causes the donor's platelets to become severely depleted, prior platelet depletion of the donor is required. The physcian assesses both donor needs and recipient needs as this procedure will deplete some of the hematopoietic progenitors collected. A physcian writes a prescription for a platelet addback to be obtained and separated from the blood-derived hematopoietic progenitor cell product. A physcian supervises this procedure. In an emergency a physcian does this procedure.
The collected apheresis product is depleted of platelets using a centrifugation method. The separated platelets are infused back to the donor and the stem cells are used for transplantation for the patient. In an emergency a physcian does this procedure. Quality assessment on both products is performed. It is critical to be sure that the donor is not harmed by an excessively low platelet count as part of the transplant process. The physician has to ascertain whether there is a quality platelet product obtained from the donor with minimal risk to the transplant product. . The quality of the platelets (bone marrow or blood-derived) must be assessed prior to release of product. Examples of quality assurance are platelet count, hematocrit,nucleated cell count, viability, and sterility. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physcian then judges if this product is suitable for infusion.

Description of Pre-Service Work: Review of donor and patient data

Description of Intra-Service Work: This is basically done via a cell selector such as the Cobe Spectra for removal of platelets from a stem cell collection. There will be loss of stem cells. The platelets will be infused in recipients. The FDA requires physician assessment of this procedure and the product processed.

Description of Post-Service Work: Preparation of report

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 52% Median RVW: 1.20

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

25th Percentile RVW: 1.00 75th Percentile RVW: 1.75 Low: 0.80 High: 3.50

Median Pre-Service Time: ~~10~~ **5** Median Intra-Service Time: **30**

25th Percentile Intra-Svc Time: 20 75th Percentile Intra-Svc Time: 67.5 Low: 0 High: 180

Median Post-Service Time:	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	**10**	

CPT Code: 38213

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
80502	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	XXX	1.33

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including 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:
Median Pre-Time	~~10~~ 5	No RUC data
Median Intra-Time	30	No RUC data
Median Immediate Post-service Time	10	No RUC data
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	3.27	3.55
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.18	3.73
Urgency of medical decision making	3.91	3.73

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	3.82
Physical effort required	2.55	2.82

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.00	3.82
Outcome depends on the skill and judgement of physician	3.55	3.73
Estimated risk of malpractice suit with poor outcome	4.00	3.45

CPT Code: 38213

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.33	3.17
Intra-Service intensity/complexity	3.30	3.45
Post-Service intensity/complexity	3.33	3.00

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data and reached consensus on the recommended work value.

FREQUENCY INFORMATION

How was this service previously reported? 86915 (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_____ _____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: No Medicare Data on code

Specialty _____ Frequency_____

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38214 Tracking Number: X10 Global Period: XXX ~~**Recommended RVW: 0.50**~~
RUC Rec. RVW: 0.81

CPT Descriptor: Plasma (volume) depletion

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient is a 35 year old female with leukemia who is type A and requires a bone marrow transplant. The only available donor is type O. The donor's type O plasma has sufficient anti-A that it may cause hemolysis with infusion of the marrow product. The plasma needs to be depleted from this product so that there can be a safe transplant. A physcian writes a prescription for and supervises this procedure. In an emergency a physcian does this procedure.
Plasma/volume depletion can be done by various methods (i.e. centrifugation or nucleated cell concentration using an FDA approved apheresis device. In this process, stem cells are concentrated and plasma/excess volume are removed. In an emergency a physcian does this procedure. Quality assessment of the product is performed. The quality of the plasma depleted hematopoietic progenitor cell transplantation product (bone marrow-derived hematopoietic progenitor cells) must be assessed prior to release of product. Examples of quality assurance are nucleated cell count, differential, viability, sterility and/or immunophenotyping by flow cytometry for cd34(+) progenitor cells or T-lymphocytes. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physcian then judges if this product remains suitable for transplantation or if the procedure needs to be repeated.

Description of Pre-Service Work: Review of donor and patient data

Description of Intra-Service Work: This is when there is minor ABO incompatibility to prevent hemolysis of the recipient's red cells by plasma depletion. This is usually done by density gradient. The FDA requires physician assessment of this procedure and the product processed.

Description of Post-Service Work: Preparation of report.

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 71% Median RVW: 1.30

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

25th Percentile RVW: 1.00 75th Percentile RVW: 1.66 Low: 0.50 High: 2.80

Median Pre-Service Time: 5 Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 10 75th Percentile Intra-Svc Time: 60 Low: 0 High: 120

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	~~5~~ 10	

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
80502	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	XXX	1.33

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including 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:
Median Pre-Time	5	No RUC data
Median Intra-Time	30	No RUC data
Median Immediate Post-service Time	10	No RUC data
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	3.27	3.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.47	3.13
Urgency of medical decision making	3.73	3.07

Technical Skill/Physical Effort (Mean)

Technical skill required	3.80	3.67
Physical effort required	2.20	2.27

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.13	3.93
Outcome depends on the skill and judgement of physician	3.67	3.60
Estimated risk of malpractice suit with poor outcome	4.07	3.60

CPT Code: 38214

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.70	2.60
Intra-Service intensity/complexity	3.36	3.27
Post-Service intensity/complexity	3.22	2.78

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data and reached consensus on the recoommended work value

FREQUENCY INFORMATION

How was this service previously reported? 86915 (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_____ _____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: No Medicare Data on code

Specialty _____ Frequency_____

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

CPT Code: 38215

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38215 Tracking Number: X11 Global Period: XXX ~~**Recommended RVW: 1.18**~~
RUC Rec. RVW: 0.94

CPT Descriptor: Cell concentration in plasma, mononuclear, or buffy coat layer

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient is a 35 year old female with leukemia who is type B and requires a peripheral blood stem cell transplant. The only available donor is type A. Thus, to prevent transplant problems, a purified hematopoietic progenitor cell population (with minimal red cell and plasma contamination) is needed for the graft. A physcian writes an order for this procedure and supervises. In an emergency a physcian may do this procedure.
In this scenario, to avoid hemolytic transfusion reaction, both the RBCs and plasma must be removed. This can be achieved by various methods such as mononuclear cell concentration using an FDA approved apheresis device or density gradients solutions. In this process, stem cells are concentrated and plasma/excess volumes are removed. In an emergency a physcian may do this procedure. Quality assessment of the product is performed. The quality of the mononuclear cell preparation of the hematopoietic progenitor cell transplantation product (bone marrow, blood-derived, or umbilical cord blood-derived hematopoietic progenitor cells) must be assessed prior to release of product. Examples of quality assurance are hematocrit,nucleated cell count, differential, viability, sterility and/or immunophenotyping by flow cytometry for cd34(+) progenitor cells and T-lymphocytes. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physcian then judges if this product remains suitable for transplantation or if the procedure needs to be repeated or if new product needs to be collected.

Description of Pre-Service Work: Review of donor and patient data

Description of Intra-Service Work: This procedure is performed for major/minor ABO incompatibility of the graft or when one standard red cell depletion has not removed all the potential red cells that have caused an acute reaction. This procedure's failure will either cause graft failure or acute hemolysis with graft infusion. Risk to the patient is quite high. Both risk and loss of graft in the allogeneic setting is high because this procedure has a great deal of stem cell loss. The FDA requires physician assessment of this procedure and the product processed.

Description of Post-Service Work: Preparation of report

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 71% Median RVW: 1.50

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

25th Percentile RVW: 1.18 75th Percentile RVW: 1.99 Low: 0.50 High: 3.60

Median Pre-Service Time: 5 Median Intra-Service Time: 40

25th Percentile Intra-Svc Time: 25 75th Percentile Intra-Svc Time: 110 Low: 0 High: 150

Median Post-Service Time:	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	~~15~~ 10	

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
80502	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	XXX	1.33

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including 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:
Median Pre-Time	5	No RUC data
Median Intra-Time	40	No RUC data
Median Immediate Post-service Time	~~15~~ 10	No RUC data
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.47	3.47
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.73	3.27
Urgency of medical decision making	4.00	3.53

Technical Skill/Physical Effort (Mean)

Technical skill required	4.20	3.80
Physical effort required	2.53	2.27

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.40	4.33
Outcome depends on the skill and judgement of physician	4.20	3.93
Estimated risk of malpractice suit with poor outcome	4.20	3.93

CPT Code: 38215

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.70	2.60
Intra-Service intensity/complexity	3.64	3.20
Post-Service intensity/complexity	3.20	2.60

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data and reached consensus on the recommended work value.

FREQUENCY INFORMATION

How was this service previously reported? 86915 (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_____ _____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: No Medicare Data on code

Specialty _____ Frequency_____

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

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002/September 2002

Excision of Mandible/Facial Bone Tumor

Two revised CPT codes (21030 and 21040) were re-reviewed by the RUC in September 2002. Previously, the RUC reviewed four new codes in this family and made recommendations to the Center's for Medicare and Medicaid in May 2002. The four new codes (21046, 21047, 21048 and 21049) were developed to reflect the increased intra-operative time, the extent of surgery and the increased intensity level required to perform these services as compared to the codes currently being used, which inadequately describe the intensity of the procedures being performed.

Codes 21030 and 21040

In April 2002, the RUC reviewed codes 21030 *Excision of benign tumor or cyst of ~~facial bone other than mandible,~~ maxilla or zygoma, by enucleation and curettage* and *21040 Excision of benign ~~cyst or tumor~~, tumor or cyst of mandible~~;~~, by enucleation and curettage ~~simple~~*. The RUC decided to table these codes pending review of the CPT panel to clarify some language issues and the possible re-surveying of these codes by the specialty societies pending the CPT decision. The CPT Editorial Panel did review these codes in May 2002 and modified the codes to state "enucleation and/or curettage."

At the September 2002 meeting, the RUC reviewed survey data obtained by the specialty society. The reference CPT code 21555, *Excision tumor, soft tissue of neck or thorax; subcutaneous*, was selected by the survey respondents as having similar total work (work RVU= 4.35), and is comparable to the survey median RUV for CPT code 21030 and the 25th percentile for CPT code 21040. In addition, IWPUT analysis demonstrated that the RVU for of 4.50 is reasonable for both codes. The survey time for codes 21030 and 21040, 30 minutes pre-service time, 33/37 minutes, respectively, intra-service time, and 15 minutes post-service time, is similar to the Harvard time for 21555 (27 minutes pre-service time, 41 minutes intra-service time, and 10- minutes post-service time). Further, the total RVU for these two codes is less than budget neutral, and therefore is appropriate. CPT code 21030 had previously been valued at 6.46 with 10,330 claims and 21040 had previously been valued at 2.11 with 2,342 claims. **The RUC recommends a work relative value of 4.50 for CPT codes 21030 and 21040.**

Previously Approved RUC Recommendations

Code 21034

The work RVU for code 21034, *Excision of malignant tumor of maxilla or zygoma*, was not revised by the RUC, as the RUC viewed the CPT changes to be editorial in nature.

Codes 21046 and 21048

The RUC examined codes 21046 *Excision of benign tumor or cyst, mandible; with intra-oral osteotomy (eg, locally aggressive or destructive lesion* and 21048 *Excision of benign tumor or cyst of maxilla, requiring intra-oral osteotomy (eg locally aggressive or destructive lesion(s)).* The RUC agreed with the specialty societies' recommendations that these codes were needed to describe the intensity level of the service being performed. The RUC also agreed that the recommended relative work value for 21046 and 21048, both the survey medians, were appropriate. Both of these services are comparable in work to CPT code 21206 *Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)* (work RVU = 14.10 with a pre-service time of 75 minutes, intra-service time of 108 minutes post-service time of 57 minutes, post-op hospital time of 41 minutes and post-op office visit time of 95 minutes. Code 21046 and 21048 both had survey time of 75 minutes for pre-service, 120 minutes of intra-service, 30 minutes of post-service 1 hospital visit, discharge day and 5 office visits. The survey respondents did indicate that 21048 was more intense than 21046, therefore an incremental increase is appropriate. **The RUC recommends a work relative value of 13.00 for 21046 and 13.50 for 21048.**

Code 21047

The RUC considered the specialty societies' recommendation for code 21047 *Excision of benign tumor or cyst, mandible; with extra-oral osteotomy and partial mandibulectomy (eg locally aggressive or destructive lesion).* The RUC compared the work of 21047 to 21046 and agreed that the additional 120 minutes of intra-service work justified the increment of 5.75 over the base code. **The RUC recommends a work relative value of 18.75 for 21047.**

Code 21049

The RUC assessed the specialty societies' recommendation for code 21049 *Excision of benign tumor or cyst, maxilla; with extra-oral osteotomy and partial maxillectomy (eg, locally aggressive or destructive lesion).* Because of the aggressive nature of the ameloblastic fibro-odontoma, which requires radical excision to obliterate them and prevent re-occurrence, the RUC agreed with the intensity of this service. Additional justification for this recommendation included the increased intensity associated with the extra-oral approach and the higher surveyed intensity as compared to the reference code 21206 *Osteotomy, maxilla, segmental (eg Wassmund or Schuchard)* (RVU = 14.10). In addition, the total time for the surveyed code (543 minutes) far exceeded that of the reference code (348 minutes). **The RUC recommends a work relative value of 18.00 for 21049.**

Practice Expense

The RUC reviewed the practice expense inputs for 21046-49 and recommends that the standard 90-day global package would be applied to all of these codes. For CPT codes 21030 and 21040, the RUC eliminated the one half 99238 discharge visit, (6 minutes) for the clinical staff time, as this service is typically performed in an office setting. All other inputs were approved.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲21030	F1	Excision of benign tumor or cyst of ~~facial bone other than mandible,~~ maxilla or zygoma, by enucleation and curettage	090	**4.50**
▲21034	F2	Excision of malignant tumor of ~~facial bone, other than mandible~~ maxilla or zygoma	090	16.17 (no change)
▲21040	F3	Excision of benign ~~cyst or tumor~~, tumor or cyst of mandible~~;~~, by enucleation and/or curettage ~~simple~~	090	**4.50**
21041(D)		~~complex~~ 21041 has been deleted. To report, see 210X1 or 210X2)	090	N/A
●21046	F4	Excision of benign tumor or cyst of mandible; with intraoral osteotomy (eg, locally aggressive or destructive lesion(s))	090	13.00 (RUC Recommendation to CMS May 2002)
●21047	F5	requiring extra-oral osteotomy and partial mandibulectomy (eg, locally aggressive or destructive lesion(s))	090	18.75 (RUC Recommendation to CMS May 2002)
●21048	F6	Excision of benign tumor or cyst of maxilla; requiring intra-oral osteotomy (eg, locally	090	13.50 (RUC

CPT Code (•New)	Track-ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
		aggressive or destructive lesion(s))		Recommendation to CMS May 2002)
●21049	F7	requiring extra-oral osteotomy and partial maxillectomy (eg, locally aggressive or destructive lesion(s))	090	18.00 (RUC Recommendation to CMS May 2002)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION (Sept 2002)

CPT Code: 21030 (F1) **Global:** 090 **Recommended RVW:** 4.50

CPT Descriptor: Excision of benign tumor or cyst of ~~facial bone other than mandible,~~ maxilla or zygoma, by enucleation and curettage

Survey Vignette (Typical Patient)

A 22-year-old female has a pear-shaped radiolucent area between her left lateral and cuspid teeth. Previous evaluation, both clinically and radiographically, has determined that this is most likely a classic globulomaxillary cyst, producing typical divergence of the roots of these vital teeth. Under local anesthesia, the lesion is approached with an appropriate incision and elevation of a mucoperiosteal flap. The lesion is removed via enucleation and curretage and the area is irrigated and the flap returned and sutured. Postoperative office visits are conducted as necessary through the 90-day global period for suture removal, review of pathology report, and review of radiographs to monitor defect correction and the health of the affected teeth. [When completing this survey please consider only the preservice work within 24 hours of the procedure, the procedure itself, and all work through the 90-day global period. You may continue to see the patient beyond the 90-day global period, but that work would be separately reportable.]

CLINICAL DESCRIPTION OF SERVICE:

PREOPERATIVE WORK:
- Review pre-operative work-up, including all radiographs
- Review planned incisions and procedure
- Answer patient and family questions and obtain informed consent

INTRA-SERVICE WORK:

Under local anesthesia, an incision is made and a mucoperiosteal flap raised. The lesion is removed via enucleation and curettage and sent for pathological diagnosis. The area is irrigated and the flap returned and sutured.

POSTOPERATIVE WORK, DAY OF PROCEDURE:
- Answer patient/family questions
- Dictate post-op report
- Review instructions for post-discharge wound care and home care with patient and family
- Write orders for medications

POSTOPERATIVE WORK, FOLLOWUP OFFICE VISITS:
- Examine and talk with patient
- Check wounds
- Review pathology report with patient/family
- Order and review radiographs to monitor defect correction and the health of the affected teeth
- Answer patient/family questions
- Answer insurance staff questions
- Write orders for medications

SURVEY DATA

Presenter(s):	Lanny Garvar, DMD					
Specialty(s):	American Association of Oral & Maxillofacial Surgeons/American Dental Association					
CPT Code:	21030					
Sample Size:	125	**Resp n:** 32	**Resp %:** 26%			
Sample Type:	Random					
		Low	**25th pctl**	**Median**	**75th pctl**	**High**
Survey RVW:		3.00	4.22	4.50	5.90	8.75
Pre-Service Time:				30		
Intra-Service Time:		20	30	33	45	60

Post-Service	**Total Min***	**CPT code / # of visits**
Day of Surgery:		
Immed. Post-time:	15	
Other Post-time/visit:	0	
After Day of Surgery:		
Critical Care time/visit(s):	0	
Other Hospital time/visit(s):	0	
Discharge Day Mgmt:	0	
Office time/visit(s):	53	99213 x 1 ; 99212 x 2

*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'02RVW	Glob
21555	Excision tumor, soft tissue of neck or thorax; subcutaneous	4.35	090

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

TIME ESTIMATES (MEDIAN)	**Svy CPT 21040**	**Ref CPT (Hvd)**
Pre-service time	30	27
Intra-service time	33	41
Same Day Immediate Post-service time	15	10
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	0	11
Total office visit time	53	42
Total Time	*130*	*131*

INTENSITY/COMPLEXITY MEASURES (mean)

TIME SEGMENTS	Svy CPT 21030	Ref CPT (Hvd)
Pre-service	2.67	2.67
Intra-service	2.33	2.56
Post-service	2.33	2.33
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	2.44	2.56
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.44	2.67
Urgency of medical decision making	1.89	2.22
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	2.44	2.56
Physical effort required	2.22	2.33
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	1.89	2.11
Outcome depends on the skill and judgment of physician	2.22	2.44
Estimated risk of malpractice suit with poor outcome	2.33	2.56

RATIONALE:

The total time for codes 21030 and 21040 shown in the RUC database represent a CMS-based proxy ("pr") for use in calculating practice expense pools and have no survey basis. Codes 21030 and 21040 have been revised, along with other new/revised/deleted codes in the family of "excision of mandible/facial bone tumor" to more clearly differentiate 'simple versus complex' and 'non-aggressive versus aggressive' lesions.

Codes 21030 and 21040, as revised, represent similar procedures, differentiated only by the lesion location (maxilla/zygoma versus mandible). The current RVWs for 21030 and 21040 are 6.46 and 2.11 respectively. Because these codes have been revised (along with other codes in the family, previously review by the RUC), and because the current RVWs do not make sense and are not based on surveys, the AAOMS conducted surveys to obtain survey-based RVWs for these revised codes, supported by time and visit data.

With respect to the reference code 21555, these codes reflect similar total work.

As stated above, these codes represent similar procedures and the survey times and visit data are almost identical. Therefore, we are recommending an RVW of 4.50 for both codes 21030 (median) and 21040 (25th percentile).

The IWPUT analysis below shows that and RVW of 4.50 for both codes is reasonable.

Further, the total RVU's for these two codes is less than budget neutral:

CPT	2000 Freq	2002 RVW	Current RVUs	Recom'd. RVW	Estimated RVUs
21030	1,599	6.46	10,330	4.50	7,196
21040	1,110	2.11	2,342	4.50	4,995
Total			**12,672**		**12,191**

IWPUT ANALYSIS		Survey CPT code: 21030			Survey CPT code: 21040		
Row	/ Column	A	B	C	D	E	F
1				MEDIAN Svy RVW: *4.50*			25th Pctl Svy RVW: *4.50*
2		Survey Data		RVW	Survey Data		RVW
3	Pre-service	Time	Intensity	(=time x intensity)	Time	Intensity	(=time x intensity)
4	Pre-service	30	0.0224	0.67	30	0.0224	0.67
6	PRE-service total:			*0.67*			*0.67*
7	Post-service	Time	Intensity	(=time x intensity)	Time	Intensity	(=time x intensity)
8	Immediate post	15	0.0224	0.34	15	0.0224	0.34
9	*Subsequent visits:*	Visit n	E/M RVW	(=n x RVW)	Visit n	E/M RVW	(=n x RVW)
19	99215	0	1.73**	0	0	1.73**	0
20	99214	0	1.08**	0	0	1.08**	0
21	99213	1	0.65**	0.65	1	0.65**	0.65
22	99212	2	0.43**	0.86	2	0.43**	0.86
23	99211	0	0.17**	0	0	0.17**	0
24	POST-service total:			*1.85*			*1.85*
25		Time	IWPUT	INTRA-RVW	Time	IWPUT	INTRA-RVW
26	INTRA-SERVICE:	33	0.060	*1.98*	37	0.054	*1.98*

**Note: Office visit RVW's shown reflect RUC/CMS "discounted" values.

FREQUENCY INFORMATION

1. How was this service previously reported (if unlisted code, please ensure that the medicare frequency for this unlisted code is reviewed)?
21030 (with and without mod -22) Excision of benign tumor or cyst of facial bone other than mandible

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: maxillofacial surgery, oral 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: maxillofacial surgery, oral surgery Frequency: 3,000

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: maxillofacial surgery, oral surgery Frequency: 1,600

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?
Many physicians would be able to perform this procedure, if necessary.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION (Sept 2002)

CPT Code: 21040 (F3) **Global:** 090 **Recommended RVW:** 4.50

CPT Descriptor: Excision of benign ~~cyst or tumor~~, tumor or cyst of mandible~~;~~, by enucleation and curettage ~~simple~~

Survey Vignette (Typical Patient)
An 18-year-old male has a painless swelling over the right posterior body of the mandible. Previous evaluation, both clinically and radiographically, has determined that this is most likely a traumatic bone cyst. The lesion runs from the second bicuspid to the second molar. Under local anesthesia, an incision is made and a mucoperiosteal flap raised. The lining is composed of a thin fibrous membrane which is curetted and the area is irrigated and the flap returned and sutured. Postoperative office visits are conducted as necessary through the 90-day global period for suture removal, review of pathology report, and review of radiographs to monitor defect correction and the health of the affected teeth. [When completing this survey please consider only the preservice work within 24 hours of the procedure, the procedure itself, and all work through the 90-day global period. You may continue to see the patient beyond the 90-day global period, but that work would be separately reportable.]

CLINICAL DESCRIPTION OF SERVICE:

PREOPERATIVE WORK:
- Review pre-operative work-up, including all radiographs
- Review planned incisions and procedure
- Answer patient and family questions and obtain informed consent

INTRA-SERVICE WORK:
Under local anesthesia, an incision is made and a mucoperiosteal flap raised. Once the defect is entered, it is noted to be an empty cavity with no fluid or solid material. The lining is composed of a thin fibrous membrane, which is curetted and sent for pathologic diagnosis. The cavity is irrigated and the flap returned and sutured.

POSTOPERATIVE WORK, DAY OF PROCEDURE:
- Answer patient/family questions
- Dictate post-op report
- Review instructions for post-discharge wound care and home care with patient and family
- Write orders for medications

POSTOPERATIVE WORK, FOLLOWUP OFFICE VISITS:
- Examine and talk with patient
- Check wounds
- Review pathology report with patient/family
- Order and review radiographs to monitor defect correction and the health of the affected teeth
- Answer patient/family questions
- Answer insurance staff questions
- Write orders for medications

SURVEY DATA

Presenter(s):	Lanny Garvar, DMD					
Specialty(s):	American Association of Oral & Maxillofacial Surgeons/American Dental Association					
CPT Code:	21040					
Sample Size:	125	**Resp n:** 32	**Resp %:** 26%			
Sample Type:	Random					
	Low	**25th pctl**	**Median**	**75th pctl**	**High**	
Survey RVW:	3.10	4.50	6.00	7.20	9.50	
Pre-Service Time:			30			
Intra-Service Time:	15	30	37	45	70	

Post-Service	**Total Min***	**CPT code / # of visits**
Day of Surgery:		
Immed. Post-time:	15	
Other Post-time/visit:	0	
After Day of Surgery:		
Critical Care time/visit(s):	0	
Other Hospital time/visit(s):	0	
Discharge Day Mgmt:	0	
Office time/visit(s):	53	99213 x 1 ; 99212 x 2

*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'02RVW	Glob
21555	Excision tumor, soft tissue of neck or thorax; subcutaneous	4.35	090

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

TIME ESTIMATES (MEDIAN)	Svy CPT 21040	Ref CPT (Hvd)
Pre-service time	30	27
Intra-service time	37	41
Same Day Immediate Post-service time	15	10
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	0	11
Total office visit time	53	42
Total Time	*135*	*131*

INTENSITY/COMPLEXITY MEASURES (mean)

TIME SEGMENTS	Svy CPT 21040	Ref CPT (Hvd)
Pre-service	2.13	2.11
Intra-service	2.13	2.11
Post-service	2.00	2.00
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	2.44	2.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.33	2.11
Urgency of medical decision making	1.78	1.89
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	2.44	2.11
Physical effort required	2.22	2.11
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	1.78	1.67
Outcome depends on the skill and judgment of physician	2.00	2.00
Estimated risk of malpractice suit with poor outcome	2.22	1.89

RATIONALE:

The total time for codes 21030 and 21040 shown in the RUC database represent a CMS-based proxy ("pr") for use in calculating practice expense pools and have no survey basis. Codes 21030 and 21040 have been revised, along with other new/revised/deleted codes in the family of "excision of mandible/facial bone tumor" to more clearly differentiate 'simple versus complex' and 'non-aggressive versus aggressive' lesions.

Codes 21030 and 21040, as revised, represent similar procedures, differentiated only by the lesion location (maxilla/zygoma versus mandible). The current RVWs for 21030 and 21040 are 6.46 and 2.11 respectively. Because these codes have been revised (along with other codes in the family, previously review by the RUC), and because the current RVWs do not make sense and are not based on surveys, the AAOMS conducted surveys to obtain survey-based RVWs for these revised codes, supported by time and visit data.

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As stated above, these codes represent similar procedures and the survey times and visit data are almost identical. Therefore, we are recommending an RVW of 4.50 for both codes 21030 (median) and 21040 (25th percentile).

The IWPUT analysis below shows that and RVW of 4.50 for both codes is reasonable.

Further, the total RVU's for these two codes is less than budget neutral:

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Total			**12,672**		**12,191**

IWPUT ANALYSIS		Survey CPT code: 21030			Survey CPT code: 21040		
Row	/ Column	A	B	C	D	E	F
1				MEDIAN Svy RVW: *4.50*			25th Pctl Svy RVW: *4.50*
2		Survey Data		RVW	Survey Data		RVW
3	Pre-service	Time	Intensity	(=time x intensity)	Time	Intensity	(=time x intensity)
4	Pre-service	30	0.0224	0.67	30	0.0224	0.67
6	PRE-service total:			*0.67*			*0.67*
7	Post-service	Time	Intensity	(=time x intensity)	Time	Intensity	(=time x intensity)
8	Immediate post	15	0.0224	0.34	15	0.0224	0.34
9	*Subsequent visits:*	Visit n	E/M RVW	(=n x RVW)	Visit n	E/M RVW	(=n x RVW)
19	99215	0	1.73**	0	0	1.73**	0
20	99214	0	1.08**	0	0	1.08**	0
21	99213	1	0.65**	0.65	1	0.65**	0.65
22	99212	2	0.43**	0.86	2	0.43**	0.86
23	99211	0	0.17**	0	0	0.17**	0
24	POST-service total:			*1.85*			*1.85*
25		Time	IWPUT	INTRA-RVW	Time	IWPUT	INTRA-RVW
26	INTRA-SERVICE:	33	0.060	*1.98*	37	0.054	*1.98*

**Note: Office visit RVW's shown reflect RUC/CMS "discounted" values.

FREQUENCY INFORMATION

1. How was this service previously reported (if unlisted code, please ensure that the medicare frequency for this unlisted code is reviewed)?
21030 (with and without mod -22) Excision of benign tumor or cyst of facial bone other than mandible

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: maxillofacial surgery, oral 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: maxillofacial surgery, oral surgery Frequency: 3,000

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: maxillofacial surgery, oral surgery Frequency: 1,600

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?
Many physicians would be able to perform this procedure, if necessary.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION (Sept 2002)

CPT Code: 21040 (F3) **Global:** 090 **Recommended RVW:** 4.50

CPT Descriptor: Excision of benign ~~cyst or tumor~~, tumor or cyst of mandible~~;~~, by enucleation and curettage ~~simple~~

Survey Vignette (Typical Patient)

An 18-year-old male has a painless swelling over the right posterior body of the mandible. Previous evaluation, both clinically and radiographically, has determined that this is most likely a traumatic bone cyst. The lesion runs from the second bicuspid to the second molar. Under local anesthesia, an incision is made and a mucoperiosteal flap raised. The lining is composed of a thin fibrous membrane which is curetted and the area is irrigated and the flap returned and sutured. Postoperative office visits are conducted as necessary through the 90-day global period for suture removal, review of pathology report, and review of radiographs to monitor defect correction and the health of the affected teeth. [When completing this survey please consider only the preservice work within 24 hours of the procedure, the procedure itself, and all work through the 90-day global period. You may continue to see the patient beyond the 90-day global period, but that work would be separately reportable.]

CLINICAL DESCRIPTION OF SERVICE:

PREOPERATIVE WORK:
- Review pre-operative work-up, including all radiographs
- Review planned incisions and procedure
- Answer patient and family questions and obtain informed consent

INTRA-SERVICE WORK:

Under local anesthesia, an incision is made and a mucoperiosteal flap raised. Once the defect is entered, it is noted to be an empty cavity with no fluid or solid material. The lining is composed of a thin fibrous membrane, which is curetted and sent for pathologic diagnosis. The cavity is irrigated and the flap returned and sutured.

POSTOPERATIVE WORK, DAY OF PROCEDURE:
- Answer patient/family questions
- Dictate post-op report
- Review instructions for post-discharge wound care and home care with patient and family
- Write orders for medications

POSTOPERATIVE WORK, FOLLOWUP OFFICE VISITS:
- Examine and talk with patient
- Check wounds
- Review pathology report with patient/family
- Order and review radiographs to monitor defect correction and the health of the affected teeth
- Answer patient/family questions
- Answer insurance staff questions
- Write orders for medications

SURVEY DATA

Presenter(s):	Lanny Garvar, DMD					
Specialty(s):	American Association of Oral & Maxillofacial Surgeons/American Dental Association					
CPT Code:	21040					
Sample Size:	125	**Resp n:** 32	**Resp %:** 26%			
Sample Type:	Random					
	Low	**25th pctl**	**Median**	**75th pctl**	**High**	
Survey RVW:	3.10	4.50	6.00	7.20	9.50	
Pre-Service Time:			30			
Intra-Service Time:	15	30	37	45	70	

Post-Service	**Total Min***	**CPT code / # of visits**
Day of Surgery:		
Immed. Post-time:	15	
Other Post-time/visit:	0	
After Day of Surgery:		
Critical Care time/visit(s):	0	
Other Hospital time/visit(s):	0	
Discharge Day Mgmt:	0	
Office time/visit(s):	53	99213 x 1 ; 99212 x 2

*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'02RVW	Glob
21555	Excision tumor, soft tissue of neck or thorax; subcutaneous	4.35	090

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

TIME ESTIMATES (MEDIAN)	Svy CPT 21040	Ref CPT (Hvd)
Pre-service time	30	27
Intra-service time	37	41
Same Day Immediate Post-service time	15	10
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	0	11
Total office visit time	53	42
Total Time	*135*	*131*

INTENSITY/COMPLEXITY MEASURES (mean)

TIME SEGMENTS	Svy CPT 21040	Ref CPT (Hvd)
Pre-service	**2.13**	**2.11**
Intra-service	**2.13**	**2.11**
Post-service	**2.00**	**2.00**
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	**2.44**	**2.00**
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	**2.33**	**2.11**
Urgency of medical decision making	**1.78**	**1.89**
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	**2.44**	**2.11**
Physical effort required	**2.22**	**2.11**
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	**1.78**	**1.67**
Outcome depends on the skill and judgment of physician	**2.00**	**2.00**
Estimated risk of malpractice suit with poor outcome	**2.22**	**1.89**

RATIONALE:

The total time for codes 21030 and 21040 shown in the RUC database represent a CMS-based proxy ("pr") for use in calculating practice expense pools and have no survey basis. Codes 21030 and 21040 have been revised, along with other new/revised/deleted codes in the family of "excision of mandible/facial bone tumor" to more clearly differentiate 'simple versus complex' and 'non-aggressive versus aggressive' lesions.

Codes 21030 and 21040, as revised, represent similar procedures, differentiated only by the lesion location (maxilla/zygoma versus mandible). The current RVWs for 21030 and 21040 are 6.46 and 2.11 respectively. Because these codes have been revised (along with other codes in the family, previously review by the RUC), and because the current RVWs do not make sense and are not based on surveys, the AAOMS conducted surveys to obtain survey-based RVWs for these revised codes, supported by time and visit data.

With respect to the reference code 21555, these codes reflect similar total work.

As stated above, these codes represent similar procedures and the survey times and visit data are almost identical. Therefore, we are recommending an RVW of 4.50 for both codes 21030 (median) and 21040 (25th percentile).

The IWPUT analysis below shows that and RVW of 4.50 for both codes is reasonable.

Further, the total RVU's for these two codes is less than budget neutral:

CPT	2000 Freq	2002 RVW	Current RVUs	Recom'd. RVW	Estimated RVUs
21030	1,599	6.46	10,330	4.50	7,196
21040	1,110	2.11	2,342	4.50	4,995
Total			**12,672**		**12,191**

IWPUT ANALYSIS		Survey CPT code: 21030			Survey CPT code: 21040		
Row	/ Column	A	B	C	D	E	F
1				MEDIAN Svy RVW: *4.50*			25th Pctl Svy RVW: *4.50*
2		Survey Data		RVW	Survey Data		RVW
3	Pre-service	Time	Intensity	(=time x intensity)	Time	Intensity	(=time x intensity)
4	Pre-service	30	0.0224	0.67	30	0.0224	0.67
6	PRE-service total:			*0.67*			*0.67*
7	Post-service	Time	Intensity	(=time x intensity)	Time	Intensity	(=time x intensity)
8	Immediate post	15	0.0224	0.34	15	0.0224	0.34
9	*Subsequent visits:*	Visit n	E/M RVW	(=n x RVW)	Visit n	E/M RVW	(=n x RVW)
19	99215	0	1.73**	0	0	1.73**	0
20	99214	0	1.08**	0	0	1.08**	0
21	99213	1	0.65**	0.65	1	0.65**	0.65
22	99212	2	0.43**	0.86	2	0.43**	0.86
23	99211	0	0.17**	0	0	0.17**	0
24	POST-service total:			*1.85*			*1.85*
25		Time	IWPUT	INTRA-RVW	Time	IWPUT	INTRA-RVW
26	INTRA-SERVICE:	33	0.060	*1.98*	37	0.054	*1.98*

**Note: Office visit RVW's shown reflect RUC/CMS "discounted" values.

FREQUENCY INFORMATION

1. How was this service previously reported (if unlisted code, please ensure that the medicare frequency for this unlisted code is reviewed)?
21040 (with and without mod -22) Excision of benign cyst or tumor of mandible; simple

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: maxillofacial surgery, oral 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: maxillofacial surgery, oral surgery Frequency: 2,500

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: maxillofacial surgery, oral surgery Frequency: 1,100

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?
Many physicians would be able to perform this procedure, if necessary.

CPT Code: See Below
Specialty Society('s) *AAOMS*

AMA/Specialty Society Update Process
PEAC Summary of Recommendation
90 Day Global Period
Non-facility and Facility Direct Inputs

CPT	DESCRIPTION	GLOBAL
21030	Excision of benign tumor or cyst of maxilla or zygoma, by enucleation and curettage	90
21040	Excision of benign tumor or cyst of mandible, by enucleation and curettage	90

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
No survey was conducted. The direct practice expense details were jointly by developed by physicians from AAOMS.

CLINICAL STAFF TIME:
Pre-service period clinical staff time: Approved typical pre-service period times of 35 minutes for office procedures and 60 minutes for facility procedures have been applied.

Service period clinical staff time (admission to discharge): In office day of procedure pre-service and post-service times are based on tasks as shown on the spreadsheet, using EM standards for most tasks. In addition to these EM tasks normally associated with an office visit: two minutes of additional time has been added to office columns for review of patient education/consent prior to performing the procedure; two minutes has been included for specimen/pathology prep and requisition; and three minutes has been included for home care instructions. Intra-service time is equal to physician time. The assignment of 6 minutes for 0.5 x 99238 for discharge management has been applied to both codes for facility columns.

Post-service period clinical staff time: Standard EM postop visit times for clinical staff have been applied as appropriate for each code. Additionally, three minutes is shown for followup phone call after patient leaves office/facility for same day.

SUPPLIES AND EQUIPMENT:
Supplies and equipment necessary to perform the procedures and for the postop office visits are indicated.

	A	B	C	D	E	F	G
1	**21030 - 2100 PE Summary**		**CPT:**	**21030**		**21040**	
2			**DESCRIPTOR:**	Excision of benign tumor or cyst of maxilla or zygoma, by enucleation and curettage		Excision of benign tumor or cyst of mandible, by enucleation and curettage	
3			**GLOBAL:**	**90**		**90**	
4			**Site and % at site:**	**Office**	**Facilty**	**Office**	**Facilty**
5	**TIME CATEGORIES**	**Code**	**Desc**	**77%**	**23%**	**81%**	**19%**
6	**PRE-service time**	130	RN/LPN/MA	**35**	**60**	**35**	**60**
7	**SERVICE time**	130	RN/LPN/MA	**64**	**3**	**68**	**3**
8	**POST-service time**	130	RN/LPN/MA	**90**	**90**	**90**	**90**
9	**PRE-SERVICE - *BEFORE ADMISSION***	**Code**	**Desc**				
10	Complete pre-service diagnostic & referral forms (5/5)	130	RN/LPN/MA	**5**	**5**	**5**	**5**
11	Coord pre-surgery services, review test/exam results (10/20)	130	RN/LPN/MA	**10**	**20**	**10**	**20**
12	Schedule space and equipment in facility (0/8)	130	RN/LPN/MA	**0**	**8**	**0**	**8**
13	Provide pre-service education/obtain consent (10/20)	130	RN/LPN/MA	**10**	**20**	**10**	**20**
14	Follow-up phone calls & prescriptions (10/7)	130	RN/LPN/MA	**10**	**7**	**10**	**7**
15	**SERVICE PERIOD - *ADMISSION TO DISCHARGE***	**Code**	**Desc**				
16	**Before service**						
17	Assemble/review X-ray, lab, pathology reports (99213=2)	130	RN/LPN/MA	**2**	**0**	**2**	**0**
18	Greet patient and provide gowning (peac std=3)	130	RN/LPN/MA	**3**	**0**	**3**	**0**
19	Obtain vital signs (Vitals 0=0; 1-3=3; 4-6=5)	130	RN/LPN/MA	**5**	**0**	**5**	**0**
20	Review history, systems, and medications (99213=6)	130	RN/LPN/MA	**6**	**0**	**6**	**0**
21	Review pre-service education/obtain consent	130	RN/LPN/MA	**2**	**0**	**2**	**0**
22	Prepare room, equipment,supplies (99213=2)	130	RN/LPN/MA	**2**	**0**	**2**	**0**
23	**Intra-service**						
24	Assist Phyisican dunng Procedure	130	RN/LPN/MA	**33**	**0**	**37**	**0**
25	**After service**						
26	Clean room/equipment (99213=3)	130	RN/LPN/MA	**3**	**0**	**3**	**0**
27	Complete diagnostic forms, lab & X-ray requisitions	130	RN/LPN/MA	**2**	**0**	**2**	**0**
28	Home care instructions /coord office vis /Rxs	130	RN/LPN/MA	**3**	**0**	**3**	**0**
29	**Other Clinical Activity (please specify)**						
30	~~99238 discharge visit~~			~~0~~	~~0.5~~	~~0~~	~~0.5~~
31	~~***99238 discharge time***~~	~~130~~	~~RN/LPN/MA~~	~~0~~	~~6~~	~~0~~	~~6~~
32	Communicate with family from office	130	RN/LPN/MA	**3**	**3**	**3**	**3**
33	**POST-SERVICE - *AFTER DISCHARGE***	**Code**	**Desc**				
34	99211 16 minutes						
35	99212 27 minutes			**2**	**2**	**2**	**2**
36	99213 36 minutes			**1**	**1**	**1**	**1**
37	99214 53 minutes						
38	99215 63 minutes						
39	***Total Office Visit Time:***	130	RN/LPN/MA	**90**	**90**	**90**	**90**
40	**Other Activity (please specify)**						

	A	B	C	D	E	F	G
1			CPT:	21030		21040	
2	**21030 - 2100 PE Summary**		DESCRIPTOR:	Excision of benign tumor or cyst of maxilla or zygoma, by enucleation and curettage		Excision of benign tumor or cyst of mandible, by enucleation and curettage	
3			GLOBAL:	90		90	
4			Site and % at site:	Office	Facilty	Office	Facilty
41	**SUPPLIES**	Code	Desc				
42	**Minimum supply package for visits**	PEAC	pack	4	3	4	3
43	***DAY OF PROCEDURE***						
44	***scrub, dress, prep***						
45	emesis basin	11506	item	1	0	1	0
46	scrub brush (impregnated)	11119	item	2	0	2	0
47	surgical mask, with face shield	11301	item	2	0	2	0
48	gown, staff, impervious, disposable	11304	item	2	0	2	0
49	surgical cap	11305	item	2	0	2	0
50	gloves, non-sterile	11302	pair	3	0	3	0
51	***procedure***						
52	Suction Canister, Disposable	93604	item	1	0	1	0
53	suction tubing, non-latex, 1' x 1/4" (Busse Co. $1.65 / ft)	new	feet	12	0	12	0
54	suction tip, yankauer (Busse Co. @ $1.35)	new	item	1	0	1	0
55	disposable scalpel # 11,15,20 blade	11504	item	1	0	1	0
56	cotton balls	31102	item	2	0	2	0
57	pad, acetone	31106	item	2	0	2	0
58	band aid, 3/4" x 3"	31502	item	1	0	1	0
59	Gauze,Sterile 4 x 4	31505	item	6	0	6	0
60	Vicryl suture 4-0 and 5-0	31708	item	2	0	2	0
61	Xylocaine w/ epinephrine 1%	51504	ml	10	0	10	0
62	syringe, 3cc, 20 to 25 gauge needle	91406	item	3	0	3	0
63	syringe, 10 cc or 12 cc	91407	item	2	0	2	0
64	syringe, 5 cc	91411	item	1	0	1	0
65	hydrogen peroxide	52303	ml	60	60	0	0
66	sterile specimen cup	14010	item	1	0	1	0
67	Burrs, disposable	new	item	1	0	1	0
68	needle, dental	91404	item	1	0	1	0
69	***Other supplies, postop office visits:***	Code	Desc				
70	gloves, non-sterile	11302	pair	3	3	3	3
71	emesis basin	11506	item	3	3	3	3
72	gloves, sterile	14005	pair	1	1	1	1
73	suture removal kit	31703	item	1	1	1	1
74	cotton balls	31102	item	2	2	2	2
75	Gauze,Sterile 4 x 4	31505	item	8	8	4	4
76	gauze, 2x2	31506	item	6	6	0	0
77	smelling salts	53083	item	1	1	1	1
78	**EQUIPMENT**	Code					
79	fiberoptic exam light	E11006		1	1	1	1
80	reclining exam chair with headrest	E11011		1	1	1	1
81	light source	E13122		1	1	1	1
82	suction machine, Gomco	E3001		1	1	1	1
83	surgical drill system	E72009		1	0	1	0

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

September 2002

Therapeutic Apheresis

New CPT codes 36511-36516 replace codes 36520 *Therapeutic apheresis; plasma and/or cell exchange* (Work RVU = 1.74) and code 35521 *Therapeutic apheresis; with extracorporeal affinity column adsorption and plasma reinfusion* (Work RVU = 1.74) to allow reporting for the different types of therapeutic apheresis that are now performed. This also allows for better recording of the frequency of the different therapeutic apheresis procedures. Previously reported codes 36520 and 36521 were too vague to code for all the different apheresis procedures now in existence.

At the April 2002 RUC meeting, the RUC reviewed these new CPT codes and determined that the specialty should coordinate a survey process to collect data to present at the September 2002 meeting. The RUC recommended interim values of 1.74 for each of the therapeutic apheresis services, which is the value cross-walked from current codes 36521 and 36520.

In summer 2002, the specialty coordinated its survey efforts with subspecialty organizations and other specialties (eg, nephrology and rheumatology and completed a survey of the work relative values for these services. The American Society of Hematology (ASH) also contacted the manufacturer associated with the supplies and equipment for this service to best determine the institutions that are currently performing this service. Data was accumulated and reviewed for presentation to the RUC in September.

The RUC reviewed the survey data and confirmed that the survey respondents understood that these six new CPT codes were assigned a global period of 000, and that all services typically provided to a patient on the day of the apheresis procedure are considered to be part of that procedure, It was understood that evalutation and management services typically provided to the patient on the day of the apheresis service would be included in the valuation of this service. Thus a separate visit code, such as an office or outpatient visit or subsequent hospital care, should generally not be reported by the physician on the day in which he/she reports an apheresis service. Separate reporting is permitted, however, for a consultation, initial hospital care or discharge day management, when these separately identifiable services are performed.

The specialty indicated that most typically two physicians are involved in the treatment of these patients, one treating the disease and one providing the apheresis treatment. The typical patient receives numerous treatments. Therefore, the majority of the services are performed on a date when a consultation service would not be performed or reported.

The RUC reviewed and discussed whether it was appropriate for all six codes to be valued the same. The RUC had initially requested the survey following the April 2002 RUC meeting, as it appeared that there should be a differentiation in the work values between these codes. The specialty argued that the specialty is unable to identify any differentiation in work between these services, at this time. The specialty indicated that it was a priority to differentiate the coding to capture the facility expense related to these services. The RUC concluded that the work relative value should be consistent between the first five codes, 36511-36515 (U1-U5).

However, the RUC was not compelled that the work has changed for these services and recommends the existing relative value of 36520 (1.74), rather than the specialty recommendation of 2.10. The RUC also recommended that the new survey time be incorporated into the RUC database for these five services. The RUC also agreed that the physician time for codes 36511 – 36515 (U1-U5) should be consistent and recommends the survey time of 40 minutes pre-time, 20 minutes intra-time, and 15 minutes post-time.

The RUC, however, noted that the work relative value of 1.74 was too high for code 36516 (U6). The RUC recommends that CPT code 90935 *Hemodialysis procedure with single physician evaluation* (work RVU = 1.22), be used as a crosswalk. The intra-service time and the types of services are similar, and there is relative proportionality with the time difference between U6 and U1-U5. **The RUC recommends that the specialty request that CPT change the descriptor to specify "with physician evaluation."**

The RUC recommends the following work relative value units for these services:

36511	**U1**	**Therapeutic apheresis; for white blood cells**	**1.74**
36512	**U2**	**for red blood cells**	**1.74**
36513	**U3**	**for platelets**	**1.74**
36514	**U4**	**for plasma pheresis**	**1.74**
36515	**U5**	**with extracorporeal immunoadsorption and plasma reinfusion**	**1.74**
36516	**U6**	**with extracorpeal selective adsorption or selective filtration and plasma reinfusion**	**1.22**

Practice Expense Inputs:
The specialty had determined these services are performed more than 95% in the facility setting and the RUC agreed that they should not be priced in the non-facility setting at this time. Therefore, there are no direct practice expense input recommendations.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Rec.
●36511	U1	Therapeutic apheresis; for white blood cells	000	1.74
●36512	U2	for red blood cells	000	1.74
●36513	U3	for platelets	000	1.74
●36514	U4	for plasma pheresis	000	1.74
●36515	U5	with extracorporeal immunoadsorption and plasma reinfusion	000	1.74
●36516	U6	with extracorporeal selective adsorption or selective filtration and plasma reinfusion	000	1.22
36520(D)		~~Therapeutic apheresis; plasma and/or cell exchange~~ (36520 has been deleted. To report use 36511-36512)	000	N/A
36521(D)		~~with extracorporeal affinity column adsorption and plasma reinfusion~~ (36521 has been deleted. To report, use 36516)	000	N/A

THE AMERICAN SOCIETY OF HEMATOLOGY
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October 11, 2002

American Medical Association
Dept of CPT Editorial Research and Development
515 North State Street
Chicago, IL 60610

Dear Sir/Madam:

As recommended by the AMA RUC at their September 2002 meeting, the American Society of Hematology (ASH) would like to have the phrase "with physician evaluation" added to the definition of CPT 36516 for 2004 (the code is new for 2003). This would change the descriptor to read:

▲36516 ***therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion; with physician evaluation.***

This change is needed to assure that this code is billed only when the physician is present and periodically monitoring the patient during the procedure. The terminology is similar to that already existing for CPT 90935, hemodialysis procedure.

In addition, nine new bone marrow/stem cell processing codes were reviewed by the RUC (CPT codes 38207-38215) and the recommendation made that two of these be revised for 2004 (these are new codes for 2003). Specifically, CPT 38208 and CPT 38209 should change as follows:

▲38208 ***thawing of previously frozen harvest, with washing*** ~~***thawing of previously frozen harvest***~~

▲38209 ***thawing of previously frozen harvest, without washing*** ~~***washing of harvest***~~

The rationale for this revision is that bone marrow/stem cell washing is always done with bone marrow/stem cell thawing. However, all harvests that are thawed are not necessarily washed.

Finally, the AMA RUC recommended we petition CPT to add a note to these nine bone marrow/stem cell processing codes (CPT codes 38207–38215) indicating that physicians may not report flow cytometry (CPT codes 88180, 88182, and 88199) separately.

We understand that we do not need to submit a formal CPT application for these changes. If our understanding is not correct, please advise us as soon as possible.

If you have any questions or need additional information at this time, please feel free to contact Mo Mayrides, ASH Director of Policy and Practice, at (202) 292-6005 or at mmayrides@hematology.org.

Sincerely,

Samuel M. Silver, MD, PhD
Chair, ASH Committee on Practice

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 36511 Tracking Number: U1 Global Period: 000 ~~Recommended RVW: 2.1~~
RUC Rec. RVW: 1.74

CPT Descriptor: Therapeutic apheresis; for white blood cells

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient is a 40 year old female with acute leukemia who is found to have a leukemic blast count of ≥50,000/μl or a total white blood cell count ≥100,000/μl. At such very high white blood cell or leukemic blast counts there is an unacceptably high risk of cerebral or pulmonary leukostasis, a potentially fatal condition that results from obstruction of small arteries or arterioles by adherent white blood cells. Patients typically suffer strokes or respiratory failure. Emergent lowering of the circulating white blood cell mass, by leukapheresis, is the only viable short-term management option. The patient is hospitalized for the apheresis procedure (any services directly related to the hospital admission should be billed separately and not included in your physician work assesment of the apheresis procedure). The apheresis physician assesses the appropriateness of the procedure and calculates the parameters of apheresis prior to the procedure. The machine's tubing system is connected to the patient's venous system through a large-bore, dual-lumen dialysis-type central venous catheter. While an apheresis nurse is operating the machine, the physician continually monitors the patient and assesses the patient at the end of the procedure.

Description of Pre-Service Work: [to be performed before every apheresis treatment, including the initial treatment]:The apheresis physician evaluates the general clinical status of the patient (including current medications), ascertaining whether he/she remains sufficiently stable to undergo the therapeutic extracorporeal procedure. In addition, the physician reviews the patient's hematological status to confirm that the treatments are having the desired effect on thehyperleukocytosis and whether the patient is clinically improving as expected. This assessment may include reviewing evaluations by other attending physicians including hematologists, nephrologists and intensivists involved in the patient's management. Current diagnostic laboratory studies are reviewed, including complete blood count and differential count, renal and liver function studies, total protein and albumin and other relevant serum chemistry studies. Urine output and the accumulation of edema fluid are assessed. The physician discusses the state of the patient's venous access with, and confirms the initial assessment of, the apheresis nurse. Finally, after determining that the parameters of the treatment (whole blood processing volume, anticoagulant-to-whole blood flow ratio, target extent of leukoreduction, etc.) as reflected in the orders are still appropriate, the physician authorizes that the treatment should proceed.

Pre-service work unique to the first treatment, in addition to all of the above, may include reviewing the patient's chest x-ray to determine proper placement of the venous access device (this is ultimately the responsibility of the apheresis physician), obtaining and reviewing the history and diagnostic studies; an examination of previous study reports; communicating with other professionals prior to the actual performance of the evaluation and procedure; and explaining the procedure to the patient or healthcare proxy and obtaining informed consent.

Description of Intra-Service Work: During the procedure, the apheresis physician is responsible for the wellbeing of the patient on the machine. The physician periodically assesses the clinical status of the patient, paying particular attention to the vital signs flow sheet, the patient's color, urine output, mental status (if patient is awake), and other relevant parameters. The physician monitors the decline in white cell count to determine whether the goals of the procedure are being met by the current treatment parameters as ordered, and ascertains that other formed elements of the blood are not being inappropriately altered as a result of the procedure. Variations in clinical status or vital signs are repeatedly evaluated to determine whether to continue the procedure to its intended extent of whole blood processing. Given the inherent level of acuity of patients undergoing this procedure, the apheresis physician is the first responder in case of adverse clinical events or emergencies that arise during the procedure.

Description of Post-Service Work: At the conclusion of the procedure the apheresis physician reviews final hematological parameters and assesses the extent to which goals for the procedure were met. The physician, in collaboration with the apheresis nurse ascertains that venous access has been properly de-accessed and that no new problems (hemorrhage, trauma, infection, etc.) have occurred as a result of the procedure. The physician prepares a final written report about the procedure for the medical record, and writes post-procedure orders should they be necessary and not already included in the apheresis orders that have already been ordered for the treatment series (this may relate to an unanticipated chest x-ray to assess caval erosion or catheter "pinch-off," for example, or a culture of a catheter exit site). The physician communicates in writing, in person and by telephone with other healthcare personnel regarding the patient's treatment and may discuss the progress of the series of treatments with the patient's family. The physician assesses the clinical condition of the patient and ascertains that no adverse effects have resulted from the procedure.

SURVEY DATA:

Presenter(s): Robert Weinstein, MD & Sam Silver, MD

Specialty(s): American Society of Hematology & Renal Physicians Association

Sample Size: 89 Response Rate: (%): 21% Median RVW: 2.05

Type of Sample (Circle One): [random], panel, convenience. Explanation of sample size: Surveys were sent to providers who have experience with the surveyed procedures.

25th Percentile RVW: 1.91 75th Percentile RVW: 2.57 Low: 1.74 High: 14.6

Median Pre-Service Time: 40 Median Intra-Service Time: 20

25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 105 Low: 5 High: 240

Median Post-Service Time:	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	**15**	
Critical Care:	0	
Other Hospital Visits:	0	
Discharge Day Mgmt.:	0	
Office Visits:	0	

CPT Code: 36511

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
36520	Therapeutic apheresis; plasma or cell exchange	000	1.74

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: 3651X1	Key Reference CPT Code: 36520
Median Pre-Time	40	20
Median Intra-Time	20	60
Median Immediate Post-service Time	15	20
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	3.84	3.94
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.95	4.11
Urgency of medical decision making	4.68	4.17

Technical Skill/Physical Effort (Mean)

Technical skill required	4.26	3.94
Physical effort required	2.95	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.47	4.11
Outcome depends on the skill and judgement of physician	4.26	4.39
Estimated risk of malpractice suit with poor outcome	3.21	3.33

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.94	3.72
Intra-Service intensity/complexity	4.26	3.95
Post-Service intensity/complexity	3.26	3.32

ADDITIONAL RATIONALE

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

The survey data for the 6 codes was reviewed by several physicians from the American Society of Hematology, the American Society for Apheresis and the Hemapheresis Committee of the American Association of Blood Banks. The Renal Physicians Association has also reviewed this data. The median work value recommended for each of the 6 codes varied very slightly, generally less than 0.1 of an RVU. We think the variation was due largely to minor differences in the mix of survey respondents for the 6 codes. We are recommending the work value of 2.1 for all 6 codes which is less than the median survey value for 4 codes (including the highest volume code) and very slightly higher than the median for 2 of the codes (2.05 for 3652X1 and 1.94 for Code 3551X3).

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? 36520 (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 Hematology ____Commonly __X__Sometimes ____Rarely

Specialty Nephrology ____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 Hematology Frequency_____

Specialty Nephrology 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 Hematology Frequency 1297 (Based on CPT Code 36520 for 2001)

Specialty Nephrology Frequency 5913 (Based on CPT Code 36520 for 2001)

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 36512 Tracking Number: U2 Global Period: 000 ~~Recommended RVW: 2.1~~

RUC Rec. RVW: 1.74

CPT Descriptor: Therapeutic apheresis; for red blood cells

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient is a 21-year-old man with sickle cell anemia who has suffered a cerebral infarction and is at very high risk of recurrent stroke. The only effective method for preventing a recurrence is to have his blood chronically replaced with non-sickling blood. Simple red blood cell transfusion therapy is not acceptable or appropriate because it would result in transfusional iron overload, a condition that results in heart failure, liver failure and death. Red blood cell exchange by apheresis does not result in iron overload. The apheresis physician assesses the patient prior to initiating the procedure and determines the treatment parameters necessary to achieve the targeted substitution of hemoglobin A blood for sickle hemoglobin blood. The patient is connected to the apheresis machine using a large-bore, dual-lumen dialysis catheter. Typically, an apheresis nurse operates the machine with the physician monitoring the patient at bedside. The patient is assessed at the end of the apheresis procedure. A final assessment is performed at the termination of the procedure.

Description of Pre-Service Work: [to be performed before every apheresis treatment, including the initial treatment]: The apheresis physician evaluates the general clinical status of the patient (including current medications), ascertaining whether he/she is sufficiently well to undergo the therapeutic extracorporeal procedure. In addition, the physician reviews the patient's hematological status to confirm that the treatments are having the desired effect on the ratio ofhemoglobins (HgbA:HgbS, for example). An interval history and brief physical assessment are performed. This assessment may include reviewing evaluations by other attending physicians including hematologists, nephrologists and neurologists involved in the patient's management. The physician discusses the state of the patient's venous access with, and confirms the initial assessment of, the apheresis nurse. Current diagnostic laboratory studies are reviewed, including complete blood count and differential count, renal and liver function studies, total protein and albumin and other relevant serum chemistry studies. The physician determines that the patient's blood group and Rh type have been properly determined and that compatible packed red blood cells have been ordered for the procedure. Finally, after determining that the parameters of the treatment (whole blood processing volume, anticoagulant-to-whole blood flow ratio, units of red packed red cells to be used, target hemoglobin ratio, final desired hemoglobin and hematocrit, etc.) as reflected in the orders are still appropriate, the physician authorizes that the treatment should proceed.

Pre-service work unique to the first treatment, in addition to all of the above, may include reviewing the patient's chest x-ray to determine proper placement of the venous access device (this is ultimately the responsibility of the apheresis physician), obtaining and reviewing the history and diagnostic studies; an examination of previous study reports; communicating with other professionals prior to the actual performance of the evaluation and procedure; and explaining the procedure to the patient or healthcare proxy and obtaining informed consent.

Description of Intra-Service Work: During the procedure, the apheresis physician is responsible for the wellbeing of the patient on the machine. The physician periodically assesses the clinical status of the patient, paying particular attention to the vital signs flow sheet, the patient's color, urine output, mental status (if patient is awake), and other relevant parameters. The physician monitors the patient's hemoglobin and hematocrit, the presence or absence of hemolysis (as detected in the extracorporeal circuit or in the color of the patient's urine), and carefully monitors the patient for intolerance to the procedure or development of signs and symptoms of a transfusion reaction. In addition, the physician ascertains that other formed elements of the blood are not being inappropriately altered as a result of the procedure. Variations in clinical status or vital signs are repeatedly evaluated to determine whether to continue the procedure to its intended extent of whole blood processing. Given the inherent potential level of acuity of patients undergoing this procedure, the apheresis physician is the first responder in case of adverse clinical events or emergencies that arise during the procedure.

Description of Post-Service Work: At the conclusion of the procedure the apheresis physician reviews final hematological parameters and assesses the extent to which goals for the procedure were met. This may include ordering post-procedure laboratory tests to be interpreted before the following procedure (vida supra). The physician, in collaboration with the apheresis nurse ascertains that venous access has been properly de-accessed and that no new problems (hemorrhage, trauma, infection, etc.) have occurred as a result of the procedure. The physician prepares a final written report about the procedure for the medical record, and writes post-procedure orders should they be necessary and not already included in the apheresis orders that have already been ordered for the treatment series (this may relate to an unanticipated chest x-ray to assess caval erosion or catheter "pinch-off," for example, or a culture of a catheter exit site). The physician communicates in writing, in person and by telephone with other healthcare personnel regarding the patient's treatment and may discuss the progress of the series of treatments with the patient's family. The physician assesses the clinical condition of the patient and ascertains that no adverse effects have resulted from the procedure.

SURVEY DATA:

Presenter(s): Robert Weinstein, MD & Sam Silver, MD

Specialty(s): American Society of Hematology & Renal Physicians Association

Sample Size: 89 Response Rate: (%): 19% Median RVW: 2.16

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: Surveys were sent to providers who have experience with the surveyed procedures.

25th Percentile RVW: 1.82 75th Percentile RVW: 2.58 Low: 1.2 High: 7.74

Median Pre-Service Time: 40 Median Intra-Service Time: 20

25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 60 Low: 5 High: 180

Median Post-Service Time:	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	**15**	
Critical Care:	0	
Other Hospital Visits:	0	
Discharge Day Mgmt.:	0	
Office Visits:	0	

CPT Code: 36512

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
36520	Therapeutic apheresis; plasma or cell exchange	000	1.74

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: 3651X2	Key Reference CPT Code: 36520
Median Pre-Time	40	20
Median Intra-Time	20	60
Median Immediate Post-service Time	15	20
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	3.59	3.88
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.82	3.94
Urgency of medical decision making	4.12	3.94

Technical Skill/Physical Effort (Mean)

Technical skill required	4.12	3.63
Physical effort required	3.00	2.81

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.29	3.94
Outcome depends on the skill and judgement of physician	4.06	4.06
Estimated risk of malpractice suit with poor outcome	3.65	3.44

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.06	3.87
Intra-Service intensity/complexity	3.94	3.88
Post-Service intensity/complexity	3.41	3.25

ADDITIONAL RATIONALE

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

The survey data for the 6 codes was reviewed by several physicians from the American Society of Hematology, the American Society for Apheresis and the Hemapheresis Committee of the American Association of Blood Banks. The Renal Physicians Association has also reviewed this data. The median work value recommended for each of the 6 codes varied very slightly, generally less than 0.1 of an RVU. We think the variation was due largely to minor differences in the mix of survey respondents for the 6 codes. We are recommending the work value of 2.1 for all 6 codes which is less than the median survey value for 4 codes (including the highest volume code) and very slightly higher than the median for 2 of the codes (2.05 for 3652X1 and 1.94 for Code 3551X3).

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? 36520 (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 Hematology ____Commonly __X__Sometimes ____Rarely

Specialty Nephrology ____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 Hematology Frequency_____

Specialty Nephrology 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 Hematology Frequency 1297 (Based on CPT Code 36520 for 2001)

Specialty Nephrology Frequency 5913 (Based on CPT Code 36520 for 2001)

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 36513 Tracking Number: U3 Global Period: 000 ~~Recommended RVW: 2.1~~
RUC Rec. RVW: 1.74

CPT Descriptor: Therapeutic apheresis; for platelets

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient is a 65-year-old male with a myeloproliferative disorder (essential thrombocythemia, chronic myelogenous leukemia or polycythemia vera) whose platelet count is unusually high ($\geq$1,000,000/µl). Because of the degree of thrombocytosis, there is a high risk of coronary or cerebral infarction. Therapeutic apheresis is performed emergently because of altered mental status resulting from the thrombocytosis. The apheresis physician assesses the patient and determines the appropriateness of therapeutic apheresis. The physician calculates the exchange parameters and writes orders for the procedure. The physician is in attendance throughout the procedure. The patient is assessed at the end of the apheresis procedure.

Description of Pre-Service Work: [to be performed before every apheresis treatment, including the initial treatment]: The apheresis physician evaluates the general clinical status of the patient (including current medications), ascertaining whether he/she remains sufficiently stable to undergo the therapeutic extracorporeal procedure. In addition, the physician reviews the patient's hematological status to confirm that the treatments are having the desired effect on the hyperthrombocytosis and whether the patient is clinically improving as expected. This assessment may include reviewing evaluations by other attending physicians including hematologists, nephrologists and intensivists involved in the patient's management. Current diagnostic laboratory studies are reviewed, including complete blood count and differential count, renal and liver function studies, total protein and albumin and other relevant serum chemistry studies. Urine output and the accumulation of edema fluid are assessed. The physician discusses the state of the patient's venous access with, and confirms the initial assessment of, the apheresis nurse. Finally, after determining that the parameters of the treatment (whole blood processing volume, anticoagulant-to-whole blood flow ratio, target extent of thromboreduction, etc.) as reflected in the orders are still appropriate, the physician authorizes that the treatment should proceed.

Pre-service work unique to the first treatment, in addition to all of the above, may include reviewing the patient's chest x-ray to determine proper placement of the venous access device (this is ultimately the responsibility of the apheresis physician), obtaining and reviewing the history and diagnostic studies; an examination of previous study reports; communicating with other professionals prior to the actual performance of the evaluation and procedure; and explaining the procedure to the patient or healthcare proxy and obtaining informed consent.

Description of Intra-Service Work: During the procedure, the apheresis physician is responsible for the wellbeing of the patient on the machine. The physician periodically assesses the clinical status of the patient, paying particular attention to the vital signs flow sheet, the patient's color, urine output, mental status (if patient is awake), and other relevant parameters. The physician monitors the decline in platelet count to determine whether the goals of the procedure are being met by the current treatment parameters as ordered, and ascertains that other formed elements of the blood are not being inappropriately altered as a result of the procedure. Variations in clinical status or vital signs are repeatedly evaluated to determine whether to continue the procedure to its intended extent of whole blood processing. Given the inherent level of acuity of patients undergoing this procedure, the apheresis physician is the first responder in case of adverse clinical events or emergencies that arise during the procedure.

Description of Post-Service Work: At the conclusion of the procedure the apheresis physician reviews final hematological parameters and assesses the extent to which goals for the procedure were met. The physician, in collaboration with the apheresis nurse ascertains that venous access has been properly de-accessed and that no new problems (hemorrhage, trauma, infection, etc.) have occurred as a result of the procedure. The physician prepares a final written report about the procedure for the medical record, and writes post-procedure orders should they be necessary and not already included in the apheresis orders that have already been ordered for the treatment series (this may relate to an unanticipated chest x-ray to assess caval erosion or catheter "pinch-off," for example, or a culture of a catheter exit site). The physician communicates in writing, in person and by telephone with other healthcare personnel regarding the patient's treatment and may discuss the progress of the series of treatments with the patient's family. The physician assesses the clinical condition of the patient and ascertains that no adverse effects have resulted from the procedure.

SURVEY DATA:

Presenter(s): Robert Weinstein, MD & Sam Silver, MD

Specialty(s): American Society of Hematology & Renal Physicians Association

Sample Size: 89 Response Rate: (%): 19% Median RVW: 1.94

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: Surveys were sent to providers who have experience with the surveyed procedures.

25th Percentile RVW: 1.8 75th Percentile RVW: 2.25 Low: 1.74 High: 14.6

Median Pre-Service Time: 40 Median Intra-Service Time: 20

25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 105 Low: 5 High: 180

Median Post-Service Time:	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	**15**	
Critical Care:	0	
Other Hospital Visits:	0	
Discharge Day Mgmt.:	0	
Office Visits:	0	

CPT Code: 36513

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
36520	Therapeutic apheresis; plasma or cell exchange	000	1.74

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: 3651X3	Key Reference CPT Code: 36520
Median Pre-Time	40	20
Median Intra-Time	20	60
Median Immediate Post-service Time	15	20
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	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.88	4.12
Urgency of medical decision making	4.71	4.18

Technical Skill/Physical Effort (Mean)

Technical skill required	4.35	3.94
Physical effort required	3.06	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.47	4.12
Outcome depends on the skill and judgement of physician	4.18	4.24
Estimated risk of malpractice suit with poor outcome	3.59	3.47

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.94	3.69
Intra-Service intensity/complexity	4.12	4.00
Post-Service intensity/complexity	3.59	3.35

ADDITIONAL RATIONALE

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

The survey data for the 6 codes was reviewed by several physicians from the American Society of Hematology, the American Society for Apheresis and the Hemapheresis Committee of the American Association of Blood Banks. The Renal Physicians Association has also reviewed this data. The median work value recommended for each of the 6 codes varied very slightly, generally less than 0.1 of an RVU. We think the variation was due largely to minor differences in the mix of survey respondents for the 6 codes. We are recommending the work value of 2.1 for all 6 codes which is less than the median survey value for 4 codes (including the highest volume code) and very slightly higher than the median for 2 of the codes (2.05 for 3652X1 and 1.94 for Code 3551X3).

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? 36520 (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 Hematology ___Commonly X Sometimes ___Rarely

Specialty Nephrology ___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 Hematology Frequency___

Specialty Nephrology 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 Hematology Frequency 1297 (Based on CPT Code 36520 for 2001)

Specialty Nephrology Frequency 5913 (Based on CPT Code 36520 for 2001)

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 36514 Tracking Number: U4 Global Period: 000 ~~Recommended RVW: 2.1~~
RUC Rec. RVW: 1.74

CPT Descriptor: Therapeutic apheresis; for plasma pheresis

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient is a 25-year-old male with thrombotic thrombocytopenic purpura. The universally accepted first line therapy for this life-threatening condition is therapeutic plasma exchange. The apheresis physician assesses the patient prior to the procedure, paying particular attention to clinical parameters that determine the patient's ability to tolerate exposure to unusually large volumes of allogeneic plasma. The apheresis physician writes orders for the procedure, which often must be performed on a daily basis, determines the appropriate biological replacement fluid, and manages blood product support. These patients are typically treated using a dual-lumen, large bore dialysis-type catheter. The apheresis physician manages the catheter and monitors the patient for catheter-related complications. The patient's blood is drawn into a centrifuge in the machine and the plasma is separated from the cellular components. The plasma is diverted to a collection bag and the cells are returned to the patient with a biological replacement fluid such as allogeneic plasma or human serum albumin as determined by the apheresis physician. The apheresis physician closely monitors the patient for allergic reactions to the biological replacement fluids and transfusion reactions that may occur when plasma is the replacement fluid. The patient is assessed at the end of the apheresis procedure.

Description of Pre-Service Work: [to be performed before every apheresis treatment, including the initial treatment]: The apheresis physician evaluates the general clinical status of the patient (including current medications), ascertaining whether he/she remains sufficiently stable to undergo the therapeutic extracorporeal procedure and is clinically responding to treatment as expected. In addition, the physician reviews disease-specific parameters (when relevant) to confirm that the treatments are having the desired effect. In the case of TTP, for example, particular attention is paid to platelet count, serum LDH and the morphology of the red blood cells on the peripheral blood film. This assessment also includes reviewing evaluations by other attending physicians including hematologists, nephrologists, neurologists and intensivists involved in the patient's management. Current diagnostic laboratory studies are reviewed, including complete blood count and differential count, renal and liver function studies, total protein and albumin and other relevant serum chemistry studies. Urine output and the accumulation of edema fluid are assessed. The physician discusses the state of the patient's venous access with, and confirms the initial assessment of, the apheresis nurse. The physician confirms that the patient's blood group has been correctly recorded and that the fresh frozen (or cryo-poor) plasma exchange fluid is compatible with the patient). When necessary the apheresis orders supplemental treatments to be applied during the procedure (a diphenhydramine drip, for example, for a patient who tolerates plasma infusions poorly). Finally, after determining that the parameters of the treatment (whole blood processing volume, anticoagulant-to-whole blood flow ratio, plasma volumes to be exchanged, etc.) as reflected in the orders are still appropriate, the physician authorizes that the treatment should proceed.

Pre-service work unique to the first treatment, in addition to all of the above, may include reviewing the patient's chest x-ray to determine proper placement of the venous access device (this is ultimately the responsibility of the apheresis physician), obtaining and reviewing the history and diagnostic studies; an examination of previous study reports; communicating with other professionals prior to the actual performance of the evaluation and procedure; and explaining the procedure to the patient or healthcare proxy and obtaining informed consent.

Description of Intra-Service Work: During the procedure, the apheresis physician is responsible for the wellbeing of the patient on the machine. The physician periodically assesses the clinical status of the patient, paying particular attention to the vital signs flow sheet, the patient's color, urine output, mental status (if patient is awake), and other relevant parameters. The physician monitors the patient for the development of reactions to the plasma exchange fluid and orders supplemental treatments as necessary. Variations in clinical status or vital signs are repeatedly evaluated to determine whether to continue the procedure to its intended extent of whole blood processing. Given the inherent level of acuity of patients undergoing this procedure, the apheresis physician is the first responder in case of adverse clinical events or emergencies that arise during the procedure.

Description of Post-Service Work: At the conclusion of the procedure the apheresis physician reviews final hematological parameters and assesses the extent to which goals for the procedure were met. The physician, in collaboration with the apheresis nurse ascertains that venous access has been properly de-accessed and that no new problems (hemorrhage, trauma, infection, etc.) have occurred as a result of the procedure. The physician prepares a final written report about the procedure for the medical record, and writes post-procedure orders should they be necessary and not already included in the apheresis orders that have already been ordered for the treatment series (this may relate to an unanticipated chest x-ray to assess caval erosion or catheter "pinch-off," for example, or a culture of a catheter exit site). The physician communicates in writing, in person and by telephone with other healthcare personnel regarding the patient's treatment and may discuss the progress of the series of treatments with the patient's family. The physician assesses the clinical condition of the patient and ascertains that no adverse effects have resulted from the procedure.

SURVEY DATA:

Presenter(s): Robert Weinstein, MD & Sam Silver, MD

Specialty(s): American Society of Hematology & Renal Physicians Association

Sample Size: 89 Response Rate: (%): 26% Median RVW: 2.16

Type of Sample (Circle One): [random], panel, convenience. Explanation of sample size: Surveys were sent to providers who have experience with the surveyed procedures.

25th Percentile RVW: 1.74 75th Percentile RVW: 2.9 Low: 1.25 High: 14.6

Median Pre-Service Time:40 ~~30~~ **Median Intra-Service Time: 20** ~~25~~

25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 70 Low: 5 High: 180

Median Post-Service Time:	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	**15**	
Critical Care:	0	
Other Hospital Visits:	0	
Discharge Day Mgmt.:	0	
Office Visits:	0	

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
36520	Therapeutic apheresis; plasma or cell exchange	000	1.74

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: 3651X4**	**Key Reference CPT Code: 36520**
Median Pre-Time	40	20
Median Intra-Time	20	60
Median Immediate Post-service Time	15	20
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	4.17	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.09	4.04
Urgency of medical decision making	4.52	4.04

Technical Skill/Physical Effort (Mean)

Technical skill required	4.17	3.91
Physical effort required	3.39	3.22

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.43	4.04
Outcome depends on the skill and judgement of physician	4.43	4.23
Estimated risk of malpractice suit with poor outcome	3.87	3.52

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.73	3.59
Intra-Service intensity/complexity	4.09	3.91
Post-Service intensity/complexity	3.57	3.35

ADDITIONAL RATIONALE

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

The survey data for the 6 codes was reviewed by several physicians from the American Society of Hematology, the American Society for Apheresis and the Hemapheresis Committee of the American Association of Blood Banks. The Renal Physicians Association has also reviewed this data. The median work value recommended for each of the 6 codes varied very slightly, generally less than 0.1 of an RVU. We think the variation was due largely to minor differences in the mix of survey respondents for the 6 codes. We are recommending the work value of 2.1 for all 6 codes which is less than the median survey value for 4 codes (including the highest volume code) and very slightly higher than the median for 2 of the codes (2.05 for 3652X1 and 1.94 for Code 3551X3).

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? 36520 (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 Hematology ____Commonly X Sometimes ____Rarely

Specialty Nephrology ____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 Hematology Frequency____

Specialty Nephrology 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 Hematology Frequency 1297 (Based on CPT Code 36520 for 2001)

Specialty Nephrology Frequency 5913 (Based on CPT Code 36520 for 2001)

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 36515 Tracking Number: U5 Global Period: 000 ~~Recommended RVW: 2.1~~
RUC Rec. RVW: 1.74

CPT Descriptor: Therapeutic apheresis; with extracorporeal immunoadsorption and plasma reinfusion

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient has moderate to severe immune thrombocytopenia, with HIV infection, and is unresponsive to medical therapy. The patient is bleeding and the procedure is performed under emergency conditions. It is necessary to increase the platelet count. The apheresis procedure is indicated for removal of high-titer, high avidity IgG anti-platelet antibodies from the patient's plasma without removing other plasma proteins such as clotting factors and fibrinogen. The apheresis machine is used to separate the patient's plasma from the cellular components of whole blood so that the plasma can be adsorbed on a special affinity column, which removes IgG and pathogenic immune complexes but allows the rest of the plasma constituents to pass through unadsorbed. The resulting immunomodulation reduces the anti-platelet antibody titer and restores the regulatory activity of the idiotypic network, thus relieving the immune thrombocytopenia. The patient is closely monitored by the physician for allergic reactions or other complications requiring physician intervention.

Description of Pre-Service Work: [to be performed before every apheresis treatment, including the initial treatment]: The apheresis physician evaluates the general clinical status of the patient (including current medications), ascertaining whether he/she remains sufficiently stable to undergo the therapeutic extracorporeal procedure and is clinically responding to treatment as expected. In addition, the physician reviews disease-specific parameters (e.g. the platelet count in the case of ITP) to confirm that the treatments are having the desired effect. This assessment also includes reviewing evaluations by other attending physicians including hematologists, nephrologists, neurologists and intensivists involved in the patient's management, and determining whether the patient has been started on medications, since the previous treatment, that would increase the risk of adverse effects of treatment. Current diagnostic laboratory studies are reviewed, including complete blood count and differential count, renal and liver function studies, total protein and albumin and other relevant serum chemistry studies. Urine output and the accumulation of edema fluid are assessed. The physician discusses the state of the patient's venous access with, and confirms the initial assessment of, the apheresis nurse. Finally, after determining that the parameters of the treatment (whole blood processing volume, anticoagulant-to-whole blood flow ratio, plasma volume to be adsorbed, supplements to be added to the crystalloid fluids to be returned to the patient, etc.) as reflected in the orders are still appropriate, the physician authorizes that the treatment should proceed.

Pre-service work unique to the first treatment, in addition to all of the above, may include reviewing the patient's chest x-ray to determine proper placement of the venous access device (this is ultimately the responsibility of the apheresis physician), obtaining and reviewing the history and diagnostic studies; an examination of previous study reports; communicating with other professionals prior to the actual performance of the evaluation and procedure; and explaining the procedure to the patient or healthcare proxy and obtaining informed cons

Description of Intra-Service Work: During the procedure, the apheresis physician is responsible for the wellbeing of the patient on the machine. The physician periodically assesses the clinical status of the patient, paying particular attention to the vital signs flow sheet, the patient's color, urine output, mental status (if patient is awake), and other relevant parameters. The physician monitors the patient for the development of reactions to the infusion of adsorbed autologous plasma and orders supplemental treatments as necessary. Variations in clinical status or vital signs are repeatedly evaluated to determine whether to continue the procedure to its intended extent of whole blood processing. Given the inherent level of acuity of patients undergoing this procedure, the apheresis physician is the first responder in case of adverse clinical events or emergencies that arise during the procedure.

Description of Post-Service Work: At the conclusion of the procedure the apheresis physician reviews final hematological parameters and assesses the extent to which goals for the procedure were met. The physician, in collaboration with the apheresis nurse ascertains that venous access has been properly de-accessed and that no new problems (hemorrhage, trauma, infection, etc.) have occurred as a result of the procedure. The physician prepares a final written report about the procedure for the medical record, and writes post-procedure orders should they be necessary and not already included in the apheresis orders that have already been written for the treatment series (this may relate to an unanticipated chest x-ray to assess caval erosion or catheter "pinch-off," for example, or a culture of a catheter exit site). The physician communicates in writing, in person and by telephone with other healthcare personnel regarding the patient's treatment and may discuss the progress of the series of treatments with the patient's family. The physician assesses the clinical condition of the patient and ascertains that no adverse effects have resulted from the procedure.

SURVEY DATA:

Presenter(s): Robert Weinstein, MD & Sam Silver, MD

Specialty(s): American Society of Hematology & Renal Physicians Association

Sample Size: 89 Response Rate: (%): 17% Median RVW: 2.11

Type of Sample (Circle One): [random], panel, convenience. Explanation of sample size: Surveys were sent to providers who have experience with the surveyed procedures.

25th Percentile RVW: 1.92 75th Percentile RVW: 3.65 Low: 1.74 High: 14.6

Median Pre-Service Time: 40 ~~30~~ **Median Intra-Service Time: 20** ~~30~~

25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 75 Low: 10 High: 180

Median Post-Service Time:	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	**15**	
Critical Care:	0	
Other Hospital Visits:	0	
Discharge Day Mgmt.:	0	
Office Visits:	0	

CPT Code: 36515

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
36520	Therapeutic apheresis; plasma or cell exchange	000	1.74

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: 3651X5	Key Reference CPT Code: 36520
Median Pre-Time	40	20
Median Intra-Time	20	60
Median Immediate Post-service Time	15	20
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	4.13	4.20
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.20	4.13
Urgency of medical decision making	4.20	4.27

Technical Skill/Physical Effort (Mean)

Technical skill required	4.47	4.20
Physical effort required	3.27	3.07

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.53	4.20
Outcome depends on the skill and judgement of physician	4.33	4.40
Estimated risk of malpractice suit with poor outcome	3.73	3.60

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.00	3.85
Intra-Service intensity/complexity	4.40	4.14
Post-Service intensity/complexity	3.60	3.43

ADDITIONAL RATIONALE

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

The survey data for the 6 codes was reviewed by several physicians from the American Society of Hematology, the American Society for Apheresis and the Hemapheresis Committee of the American Association of Blood Banks. The Renal Physicians Association has also reviewed this data. The median work value recommended for each of the 6 codes varied very slightly, generally less than 0.1 of an RVU. We think the variation was due largely to minor differences in the mix of survey respondents for the 6 codes. We are recommending the work value of 2.1 for all 6 codes which is less than the median survey value for 4 codes (including the highest volume code) and very slightly higher than the median for 2 of the codes (2.05 for 3652X1 and 1.94 for Code 3551X3).

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? 36520 (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 Hematology ____Commonly ____Sometimes __X__Rarely

Specialty Nephrology ____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 Hematology Frequency_____

Specialty Nephrology 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 Hematology Frequency 1297 (Based on CPT Code 36520 for 2001)

Specialty Nephrology Frequency 5913 (Based on CPT Code 36520 for 2001)

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 36516 Tracking Number: U6 Global Period: 000 ~~Recommended RVW: 2.1~~
RUC Rec. RVW: 1.22

CPT Descriptor: Therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient is a homozygote or heterozygote with familial hypercholesterolemia whose serum lipids have not been satisfactorily controlled with maximum medical therapy. The patient has had a history of myocardial infarctions before age 40. Weekly or semi-monthly lipid apheresis is the only effective method for controlling symptomatic hyperlipidemias. The apheresis physician is responsible for assessing the appropriateness of this therapy for the individual patient, for writing appropriate orders and for managing the patient during treatments. A venous access device is required which the apheresis physician is responsible for managing. Plasma separation is performed and LDL cholesterol is selectively removed. Depending on the specific device used, the patient's treated plasma may require post-adsorption treatment prior to being reinfused into the patient. The patient is monitored throughout the procedure for allergic reactions and for thrombocytopenia. The patient is assessed at the end of the apheresis procedure.

Description of Pre-Service Work: [to be performed before every apheresis treatment, including the initial treatment]: The apheresis physician evaluates the general clinical status of the patient (including current medications), ascertaining whether he/she remains sufficiently stable to undergo the therapeutic extracorporeal procedure and is clinically responding to treatment as expected. Particular attention is paid to potential symptoms of unstable coronary disease which may have appeared in the interval since the last treatment. In addition, the physician reviews disease-specific parameters (e.g. the total cholesterol and/or triglyceride level) to confirm that the treatments are having the desired effect. This assessment also includes reviewing evaluations by other attending physicians including cardiologists, nephrologists, neurologists and the primary care physician involved in the patient's management, and determining whether the patient has been started on medications, since the previous treatment, that would increase the risk of adverse effects of treatment. Current diagnostic laboratory studies are reviewed, including complete blood count and differential count, renal and liver function studies, total protein and albumin and other relevant serum chemistry studies. Urine output and the accumulation of edema fluid are assessed. The physician discusses the state of the patient's venous access with, and confirms the initial assessment of, the apheresis nurse. Finally, after determining that the parameters of the treatment (whole blood processing volume, anticoagulant-to-whole blood flow ratio, plasma volume to be adsorbed, supplements to be added to the crystalloid fluids to be returned to the patient, etc.) as reflected in the orders are still appropriate, the physician authorizes that the treatment should proceed.

Pre-service work unique to the first treatment, in addition to all of the above, may include reviewing the patient's chest x-ray to determine proper placement of the venous access device (this is ultimately the responsibility of the apheresis physician), obtaining and reviewing the history and diagnostic studies; an examination of previous study reports; communicating with other professionals prior to the actual performance of the evaluation and procedure; and explaining the procedure to the patient or healthcare proxy and obtaining informed consent.

Description of Intra-Service Work: During the procedure, the apheresis physician is responsible for the wellbeing of the patient on the machine. The physician periodically assesses the clinical status of the patient, paying particular attention to the vital signs flow sheet, the patient's color, urine output, mental status (if patient is awake), and other relevant parameters. The physician monitors the patient for the development of reactions to the infusion of adsorbedautologous plasma or for complaints suggestive of active coronory disease and orders supplemental treatments as necessary. Variations in clinical status or vital signs are repeatedly evaluated to determine whether to continue the procedure to its intended extent of whole blood processing. Given the inherent level of acuity of patients undergoing this procedure, the apheresis physician is the first responder in case of adverse clinical events or emergencies that arise during the procedure.

Description of Post-Service Work: At the conclusion of the procedure the apheresis physician reviews final fluid parameters and assesses the extent to which goals for the procedure were met. The physician, in collaboration with the apheresis nurse ascertains that venous access has been properly de-accessed and that no new problems (hemorrhage, trauma, infection, etc.) have occurred as a result of the procedure. The physician prepares a final written report about the procedure for the medical record, and writes post-procedure orders should they be necessary and not already included in the apheresis orders that have already been written for the treatment series (this may relate to an unanticipated chest x-ray to assess caval erosion or catheter "pinch-off," for example, or a culture of a catheter exit site). The physician communicates in writing, in person and by telephone with other healthcare personnel regarding the patient's treatment and may discuss the progress of the series of treatments with the patient's family. The physician assesses the clinical condition of the patient and ascertains that no adverse effects have resulted from the procedure.

SURVEY DATA:

Presenter(s): Robert Weinstein, MD & Sam Silver, MD

Specialty(s): American Society of Hematology & Renal Physicians Association

Sample Size: 89 Response Rate: (%): 10% Median RVW: 2.11

Type of Sample (Circle One): [random], panel, convenience. Explanation of sample size: Surveys were sent to providers who have experience with the surveyed procedures.

25th Percentile RVW: 1.8 75th Percentile RVW: 2.16 Low: 1.25 High: 14.6

Median Pre-Service Time: 25 **Median Intra-Service Time: 15**

25th Percentile Intra-Svc Time: 10 75th Percentile Intra-Svc Time: 40 Low: 1 High: 180

Median Post-Service Time:	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	**10**	
Critical Care:	0	
Other Hospital Visits:	0	
Discharge Day Mgmt.:	0	
Office Visits:	0	

CPT Code: 36516

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
90937	Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription	000	2.11

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: 3651X6	Key Reference CPT Code: 90937
Median Pre-Time	25	*
		*pre/post = 8
Median Intra-Time	15	55
Median Immediate Post-service Time	10	*
Median of Aggregate Critical Care Times	N/A	N/A
Median of Aggregate Other Hospital Visit Times	N/A	N/A
Median Discharge Day Management Time	N/A	N/A
Median of Aggregate Office Visit Times	N/A	N/A

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.56	3.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.67	3.75
Urgency of medical decision making	3.11	3.75

Technical Skill/Physical Effort (Mean)

Technical skill required	3.78	3.88
Physical effort required	2.89	2.63

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.56	3.75
Outcome depends on the skill and judgement of physician	3.78	4.25
Estimated risk of malpractice suit with poor outcome	3.22	3.13

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.38	3.75
Intra-Service intensity/complexity	3.67	3.89
Post-Service intensity/complexity	3.33	3.33

ADDITIONAL RATIONALE

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

The survey data for the 6 codes was reviewed by several physicians from the American Society of Hematology, the American Society for Apheresis and the Hemapheresis Committee of the American Association of Blood Banks. The Renal Physicians Association has also reviewed this data. The median work value recommended for each of the 6 codes varied very slightly, generally less than 0.1 of an RVU. We think the variation was due largely to minor differences in the mix of survey respondents for the 6 codes. We are recommending the work value of 2.1 for all 6 codes which is less than the median survey value for 4 codes (including the highest volume code) and very slightly higher than the median for 2 of the codes (2.05 for 3652X1 and 1.94 for Code 3551X3).

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? 90937 (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 Hematology ____Commonly ____Sometimes __X__Rarely

Specialty Nephrology ____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 Hematology Frequency_____

Specialty Nephrology 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 Hematology Frequency 1297 (Based on CPT Code 36520 for 2001)

Specialty Nephrology Frequency 5913 (Based on CPT Code 36520 for 2001)

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

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

September 2002

Minimally Invasive Repair of Pectus Excavetum

These codes were developed to describe a new minimally invasive technique in reconstructive repair of the pectus exacavatum or carinatum.

The specialty society and the RUC request that the minimally invasive approach for reconstructive repair of pectus excavatum or carinatum (CPT codes 21742 and 21743) remain carrier price until the specialty is able to acquire data for these services.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲21740	AN1	Reconstructive repair of pectus excavatum or carinatum; open	090	16.50 (no change)
●21742	AN2	minimally invasive approach (Nuss procedure) without thoracoscopy	090	Carrier Priced
●21743	AN3	minimally invasive approach (Nuss procedure) with thoracoscopy	090	Carrier Priced

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

September 2002

Refilling of Implantable Infusion Pumps

CPT created a new code 95990, *Refilling and maintenance of implantable pump or reservoir for drug delivery; spinal (intrathecal, epidural) or brain (intraventricular).* Although some providers were reporting this service with CPT code 96530, *Refilling and maintenance of an implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)* the specialty indicated that this code was inappropriately utilized. The physician services that are described by CPT code 95990 should have been previously reported using code 64999, *Unlisted procedure, nervous system.* Code 95990 describes a service requiring direct physician involvement and therefore, the service should have an assigned work value. The RUC clarified with the presenters that the physician and a registered nurse typically provide the service together. With this in mind, the RUC recommends that code 95990 include an editorial note to indicate that the physician is always present during the performance of this service.

A coalition of several specialties, including pain medicine, anesthesiology, neurosurgery, and spine surgery reviewed and surveyed the new CPT code 95990. A survey median of 1.82 was collected from 67 physicians, who indicated a pre-service time of 10 minutes, an intra-service time of 20 minutes, and a post-service time of 10 minutes. After the review of survey responses, the societies felt that the median survey value (1.82) was too high, therefore, the specialty society recommended 1.38, which is between the 25th percentile (1.11) and the median. The RUC did not agree that a work RVU of 1.38 was appropriate.

Although this code is billed often with an E/M code, the RUC understands that the survey respondents were surveyed for the specific work of the service only. The group identified relatively similar services for which they could compare work, time, and intensity. The RUC focused its comparison on two codes, 67500 *Retrobulbar injection; medication (separate procedure, does not include supply of medication)* (Work RVU = 0.79) and 62252 *Reprogramming of programmable cerebrospinal shunt* (Work RVU = 0.74). The RUC surveyed the physician time for the 62252 is 15 minutes pre-service time, 20 minutes intra-service time, and 10 minutes post-service time. This was comparable to the time for 95990 and the RUC agreed that 62252 serves as a good cross comparison to this new code. **The RUC recommends the work RVU of 0.77 for CPT code 95990.**

Physician Time

For code 95990, the RUC agreed that the 15 minutes pre-service time and the 20 minutes post-service time were reasonable. However, as the RN was also involved in the provision of the service, the RUC was concerned that the physician time in the post-operative period was too high, and the presenters agreed. The RUC recommends that the post-operative physician time should be reduced from 10 minutes to 7 minutes to eliminate this duplication of work.

Practice Expense

The RUC reviewed in detail the practice expense inputs for code 95990, and understood that with the types of drugs being administered, a RN staff type was appropriate for all the clinical staff activities except for time for cleaning the room. The RUC members agreed with the time distributions among the various clinical activities, as well as the medical supplies and equipment typically used for the service. The practice expense recommendations presented by the specialty society were accepted by the RUC.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 95990	AJ1	Refilling and maintenance of implantable pump or reservoir for drug delivery; spinal (intrathecal, epidural) or brain (intraventricular) (For analysis and/or reprogramming of implantable infusion pump, see 62367-62368) (For refill and maintenance of implanted infusion pump or reservoir for systemic drug therapy (eg, chemotherapy or insulin, use 96530)	XXX	0.77
▲96530	AJ2	Refilling and maintenance of an implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial) (For refilling and maintenance of an implantable infusion pump for spinal or brain drug infusion, use 95990)	XXX	0.00 (No Change)

Other Related Notes in CPT

36533 Insertion of implantable venous access device, with or without subcutaneous reservoir
(For refilling and maintenance of an implantable pump or reservoir ~~venous access device reservoir,~~ for intravenous or intra-arterial drug delivery, use 96530)

62350 *Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy*

62351 *with laminectomy*
(For refilling and maintenance of an implantable ~~venous access device reservoir,~~ infusion pump for spinal or brain drug therapy use 95990 ~~96530~~)

62367 *Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming*

62368 with reprogramming
(~~To report implantable pump or reservoir refill,~~ For refilling and maintenance of an implantable infusion pump for spinal or brain drug therapy, use ~~96530)~~ 95990)

90788 Intramuscular injection of antibiotic (specify)

(90790-90796 has been deleted. To report, see 95990, 96408-96414, 96420-96425, 96440, 96450, 96530, 96545, 96549)
96408 Chemotherapy administration, intralesional; up to and including 7 lesions

96410 infusion technique, up to one hour

+96412 infusion technique, one to 8 hours, each additional hour (List separately in addition to code for primary procedure)
(Use 96412 in conjunction with code 96410)

96414 infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump

(For ~~pump or reservoir~~ refilling and maintenance of an implantable infusion pump or reservoir for intravenous or intra-arterial drug delivery, see 96520, 96530)

96420 Chemotherapy administration, intra-arterial; push

96425 *infusion technique, initiation or prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump*

(For ~~implanted pump or reservoir~~ refilling and maintenance of an implantable infusion pump or reservoir for intravenous or intra-arterial drug delivery, see 96520, 96530)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 95990 Tracking Number: AJ1 Global Period: XXX RUC Recommended RVW: ~~1.38~~ 0.77

CPT Descriptor:
Refilling and maintenance of implantable pump or reservoir for drug delivery; spinal (intrathecal, epidural) or brain (intraventricular)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient is a 45 year old female with severe cancer-related pain. She has failed to obtain adequate pain relief without intolerable side effects form multiple trials of systemic medications, both narcotic and non-narcotic, as well as various blocks and injections. It is judged that the pain would not be improved by any further surgical resection, radiation therapy, and/or chemotherapy. A trial of an intrathecal infusion of morphine gave 80% pain relief at low dose rates. A permanent implanted subcutaneous programmable infusion pump was placed as well as an implanted intrathecal infusion catheter for a long-term intrathecal infusion of narcotic.

Description of Pre-Service Work: The solution to be injected into the pump/reservoir is ordered by the physician from the appropriate pharmacy. The order is to specify the name of the drug, the volume of the solution, the concentration of the solution, and the nature of the drug (preservative-free).

Description of Intra-Service Work: The center of the implanted subcutaneous continuous infusion pump or reservoir is palpated and identified. This center point is marked on the skin. The entire area over the pump or reservoir is then carefully prepped with iodine or alcohol. Throughout all this procedure, sterile technique is meticulous to prevent infection in the infusion solution, which would cause life-threatening meningitis. A special pump refill kit is then opened and an extra 20 cc syringe, 20 gauge needle, and 4x4 sponge added to the kit. Sterile gloves are then donned and a sterile drape with an open center area is taken from the refill kit and placed over the pump, being sure that all skin in the exposed center area has been prepped with iodine or alcohol.
Using sterile technique, the previously prepared drug to be injected into the pump or reservoir is then drawn from its transport or commercially-prepared vial into one of the 20 gauge needles. The solution's container is checked to be sure that the drug, the drug volume, and the drug's concentration are all correct according to what was ordered.
The 22g Huber needle in the refill kit is then attached to the overpressurization T-tubing in the kit and the tubing's stopcock closed. The Huber needle is then carefully, under sterile conditions, punctured through the skin over the center of the pump or reservoir. The needle is advanced and probed to find the actual center of the pump or reservoir and then the needle is advanced through the injection septum of the pump or reservoir to the proper depth. Once the needle has been positioned in the pump/reservoir, an empty 20 cc (or other appropriate volume) syringe is attached to the needle's tubing, stopcock opened, and the pump/reservoir emptied of its contents. The volume of the solution removed from the pump/reservoir is measured and checked against the medical records and/or pump status printout to be sure that the entire volume of the pump/reservoir has been removed. Failure to remove all the fluid can result in overfilling the pump/reservoir with the new solution and damage to the pump/reservoir or even pump/reservoir malfunction causing a potentially life-threatening intrathecal overdose of narcotic or baclofen to the patient. The stopcock is closed, the syringe removed, the syringe containing the new solution attached to the tubing, and the stopcock re-opened. The solution is then slowly over several minutes, injected into the pump/reservoir. It is double-checked that the correct volume has been injected into the pump/reservoir and then any possible overpressurization of the pump/reservoir is checked by turning the stopcock to allow pump solution to flow into the tubing's T-piece. This step of checking to avoid injecting too much solution and checking for overpressurization are critical to prevent overfilling the pump, which again could cause pump malfunction and/or sudden intrathecal overdosage of the drug that could be life-threatening.

Description of Post-Service Work: Once the T-tubing overpressurization check has been completed, the needle and tubing assembly are withdrawn from the pump and the skin. A sterile sponge is used to dry the skin and seal the puncture area. A band-aid is placed over the puncture spot. Excess iodine or alcohol is wiped from the surrounding skin. The contaminated needles, tubing, syringes, sponge, and gloves are then properly disposed.

SURVEY DATA:

Presenter(s)_Norman Cohen, MD, American Society of Anesthesiologists, Samuel Hassenbusch, MD, PHD, American Academy of Pain Medicine, Charles Mick, MD, North American Spine Society

Specialty(s):American Academy of Pain Medicine, American Society of Anesthesia, American Association of Neurological Surgeons, Congress of Neurological Surgeons

Sample Size: 4791** **Responses: 67** Response Rate: (%):_1.4%_ Median RVW:1.82

Type of Sample (Circle One): random, panel, **convenience**. Explanation of sample size: **
Surveys were sent out to all members of American Neuromodulation Society, the Pain Section of neurosurgery (AANS-CNS), and to implantable interventional pain medicine physicians of AAPM. Members of NASS and ASA were also notified of this survey on their web sites. It was difficult to determine the exact number of respondents that actually looked at the web site survey from those numbers. We used the total membership numbers because of this which make the response rate look very deflated.

25th Percentile RVW: 1.11 75th Percentile RVW: 2.00 Low: 0 High: 8.42

Median Pre-Service Time: 10 Median Intra-Service Time: 20

25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 30 Low: 3 High: 90

Median Post-Service Time: ~~10~~ 7

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

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
62368	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming	0.75

CPT Code: 95990

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: 95990**	**Key Reference CPT Code: 62368**
Median Pre-Time	10	0
Median Intra-Time	20	30
Median Immediate Post-service Time	~~10~~ 7	0
Median of Aggregate Critical Care Times	N/A	
Median of Aggregate Other Hospital Visit Times	N/A	
Median Discharge Day Management Time	N/A	
Median of Aggregate Office Visit Times	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	3.55	2.57
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.31	1.86
Urgency of medical decision making	3.25	2.00

Technical Skill/Physical Effort (Mean)

Technical skill required	3.36	2.29
Physical effort required	2.61	2.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.75	2.00
Outcome depends on the skill and judgement of physician	3.70	2.71
Estimated risk of malpractice suit with poor outcome	4.00	2.57

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.19	2.50
Intra-Service intensity/complexity	3.48	3.33
Post-Service intensity/complexity	2.65	2.67

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
The American Academy of Pain Medicine sent out surveys including four different societies and asked the members to fill out the RVS and PE surveys. The data was compiled and analyzed. The final results were presented to a committee of the Academy of Pain Medicine in a conference call. The data was discussed in great detail and a consensus was established as to what data to present to the AMA RVS, (RUC), committee. This data appears on this summary form.

The Recommended RVW of 1.38 was chosen based upon a building block methodology. Using existing times and an IWPUT of 0.047 produces an RVW of 1.38. IWPUT for some related codes are: 62284 = .047, 62270=.042 and 62272=.052. RVWs for these related codes are: 62284 - 1.18 RVWs, 62270 - 0.88 RVWs, 62272 - 1.01 RVWs. We believe that the 95990 survey median RVW of 1.82 is too high. The statistics show a high value of 8.42 with a 75th percentile of 2.0 so the curve is skewed to the high end which would drive the median higher than a normal distribution.

FREQUENCY INFORMATION

How was this service previously reported? 96530 (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 AAPM X Commonly ____ Sometimes ____ Rarely

Specialty ASA X Commonly ____ Sometimes ____ Rarely

Specialty AANS-CNS ____ 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 AAPM Frequency 15,600

Specialty ASA Frequency 23,250

Specialty AANS-CNS Frequency 8,400

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 AAPM Frequency 10,400

Specialty ASA Frequency 15,500

Specialty AANS-CNS Frequency 5,600

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

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

Sample Size: 4791 Response Rate: 1.4 (%) Global Period: XXX

Tracking Number AJ1 Reference Code 1: 62638 62368 Reference Code 2: 96530

Geographic Practice Setting %: Rural 10% Suburban 35% Urban 55%

Type of Practice %:
27% Solo Practice
39% Single Specialty Group
10% Multispecialty Group
24% 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:

Surveys were sent out to members of the North American Spine Society and American Society of Anesthesiologists web site. Surveys were sent to American Neuromodulation Society, American Academy of Pain Medicine, and Pain Section of American Association of Neurological Surgeons-Congress of Neurological Surgeons by either fax or email. The data were collated and analyzed. The data were then presented to the American Academy of Pain Medicine, American Society of Anesthesiologists, and American Association of Neurological Surgeons-Congress of Neurological Surgeons, and The North American Spine Society who called together their coding/socio-economic committees to further disseminate the information. A multi-specialty RVS practice expense committee, consisting of practitioners involved in both in-office and out-of-office interventional pain management in multiple practice settings in widespread geographic areas was utilized. The committees after much discussion and thought came to a consensus on the final data to present on this summary form and to the RUC.

The practice expense direct inputs for clinical staff, supplies and equipment for this code have been determined with the assumption that typically a separate E/M visit will also be coded on the same day. We have deleted necessary clinical staff activities such as obtaining vital signs and greeting and gowning of the patient that are captured under the E/M code to avoid duplication. Insurance refusal to cover the same day E/M visit would result in under-valuation of this code.

Please describe the clinical activities of your staff:

Pre Service period – An RN handles the order for the patient specific, custom formulated narcotic mixture. The RN receives the medication, confirms the correct formulation, records receiving the medication and assures safe storage until the procedure. When the medication has arrived the patient is contacted, instructions are reviewed and the pump refill is scheduled. We believe the recently developed 0-10 day global pre-service time for in office procedures of 18 minutes reflects these activities for the first pump refill. When the patient returns for repeat refills many of the staff activities remain constant, however the 7 minutes allotted by the PEAC

for pre-service education/consent is less after the patient becomes familiar with the procedure. We have accordingly decreased the final pre-service recommendation by 3 minutes (from 18 minutes to 15 minutes).

Service period- No time has been requested for greeting and gowning of the patient or for obtaining vital signs because this is captured by the E/M visit which typically occurs at the same time. An RN reviews the chart, prepares the room, equipment and supplies and positions the patient. The RN then assists the physician during the pump refill. We have recommended 10 minutes of time to assist the physician (one-half of the intra-service MD time). The patient is then monitored for approximately 30 minutes to assure that none of the narcotic has leaked from the pump into the subcutaneous tissue. We have recommended 10 minutes of RN monitoring time (one-third of the total) to account for multi-tasking.

Post Service period – One phone call is typically made following the refill for pump specific follow-up. Because an E/M visit will be coded at the same time and that code includes a follow-up phone call we have not included a separate call to avoid duplication.

Supplies: In-office supplies are fairly standard and include CPEP recommended supplies and supplies particular to this procedure. A standard E/M package is utilized but is accounted for in the E/M visit.

Equipment: A power exam table is utilized for the procedure.

Pre-Service Clinical Labor Activities:
Coordinate pre-procedure services (Check pump drug ordering is correct, Call in prescription/order, Obtain drug(s), Store drug(s) in safe location

Intra-Service Clinical Labor Activities:
Review charts
Greet patient and provide gowning
Obtain vital signs
Provide preservice education, obtain consent
Prepare room, equipment, supplies
Prepare and position patient, monitor patient

Post Procedure:

Monitor pt. following service/check tubes, monitors, drains
Clean room/equipment by physician staff
Check dressings & wound/ home care instructions/coordinate office visits/prescriptions

Post-Service Clinical Activities
Conduct phone calls/call in prescriptions

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	RN	15	32		0.422/min
1130	RN/LPN/MA		3		0.317/min

* 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)
NEW	Medtronic refill kit/ Model 8551 SynchroMed refill kit	1 kit		28.00 each
14005	Sterile pair of gloves	1 pr	Box	0.89
11306	Surgical mask	1	Case	0.30
91409	20 cc syringes	2	Case	1.24 each .62
52305	Betadine pre sticks	1 pkg	Case	0.44
31508	4x4 sponge/gauze	1 pack	Case	1.47
31502	Band aid	1	Box	0.05
91402	20-gauge needle	2	Box	0.24
11102	Chuck pad	1	Case	0.05

* 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		27		

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

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	5	RN
Coordinate pre-procedure services	3	RN
Office visit before surgery/procedure Review test and exam results	0	
Provide pre-service education/obtain consent	4	RN
Follow-up phone calls & prescriptions	3	RN
Other Clinical Activity (please specify)	0	
End: When patient enters office for surgery/procedure		
Service Period		
Start: When patient enters office for surgery/procedure		
Pre-service services		
Review charts	3	RN
Greet patient and provide gowning	0	
Obtain vital signs	0	
Provide pre-service education/obtain consent	0	
Prepare room, equipment, supplies	2	RN
Prepare and position patient/ monitor patient	2	RN
Sedate/apply anesthesia	0	
Intra-service		
Assist physician in performing procedure	10	RN
Monitor pt. following service/check tubes, monitors, drains	10	RN
Clean room/equipment by physician staff	3	RN/LPN/MA
Complete diagnostic forms, lab & X-ray requisitions	0	

Review/read X-ray, lab, and pathology reports	0	
Check dressings & wound/ home care instructions/coordinate office visits/prescriptions	5	RN
Other Clinical Activity (please specify) *End: Patient leaves office*		
Post-Service		
Post-Op Visit (99212 x1)	0	
Phone calls/call in prescriptions	0	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

September 2002

Ambulatory Blood Pressure Monitoring

The RUC reviewed four new codes that were established to describe the use of an ambulatory blood pressure monitoring system.

CPT codes 93784 and 93790

Two codes 93784, *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* and 93790, *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; physician review with interpretation and report* describe the physician work component. The RUC agreed with the specialty society that 0.38 work RVU is roughly equivalent to the work involved in 93734, *Electronic analysis of single chamber pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); without reprogramming.* The RUC did not agree that there would be pre- or post- physician times and, therefore, deleted these times. **The RUC recommends a work RVU of 0.38 for CPT codes 93784 and 93790.**

CPT codes 93786 and 93788

Both CPT Codes 93786 and CPT code 93788 describe technical components of the procedure and do not include values for physician work. The RUC questioned the need for four codes, two that describe similar work procedures with similar technical components. The presenters clarified that two different physician codes are necessary, as the procedures can either be conducted in the office where the device does not require a third party, or in the office where a third party is necessary to obtain the devise and the readings. Therefore, the different types of technical procedures performed could not be separated from the two descriptions of physician work.

Practice Expense

The practice expense direct inputs for codes 93784, 93786, and 93788 were modified. For codes 93784 and 93786 the amount of time required clinical staff to fill out paper work prior to providing ABPM services was reduced from 7 to 4 minutes and the service period was reduced from 28 minutes to 18 minutes. The staff type for the procedures of all three codes were modified from RN/Tech to RN/LPN/MTA. The amount of time for education/instruction/counseling was reduced from 10 minutes to 5 minutes. The amount of time for applying the monitor, calibrating and obtaining blood pressure readings was reduced from 15 minutes to 10 minutes. The

specialty society request that 93786 and 93788 remain in the zero-work pool. The specialty indicated that an appropriate crosswalk of practice expense values is to the holter monitor codes, 93225 and 93226 respectively.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
93784	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report	XXX	0.38
93786	recording only	XXX	0.00
93788	scanning analysis with report	XXX	0.00
93790	physician review with interpretation and report	XXX	0.38

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 93784 Tracking Number: Global Period: XXX **Recommended RVW:** 0.38

CPT Descriptor: Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

An elderly patient has elevated blood pressure readings on several consecutive visits to her physician, but reports that blood pressures taken with her home blood pressure cuff or at the local drug store are consistently normal. The physician suspects white coat hypertension and refers the patient for ABPM.

Description of Pre-Service Work:

None

Description of Intra-Service Work:

Scan the report for spurious values (e.g., blood pressure of 140/130). Analyze report in conjunction with patient's medical history and in relationship to reported activities. Document analysis and interpretation of ABPM results. Communicate results and recommendations to the referring physician.

Description of Post-Service Work:

None

SURVEY DATA:

Presenter(s) (1) James Maloney, MD, FACC; (2) Doug Leahy, MD, FACP

Specialty(s): American College of Cardiology
American College of Physicians–American Society of Internal Medicine

Sample Size: 80 Response Rate: (%): 27.5 Median RVW: 0.52

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

Explanation of sample size: ABPM equipment manufacturers provided us with the names of physicians who purchased ABPM equipment. We were able to communicate the survey instrument to the 66 physicians for whom we had current contact information. In addition, ACC surveyed its Hypertensive Diseases Committee and ACP–ASIM surveyed its Payment and Coding Committee.

25th Percentile RVW: 0.50 75th Percentile RVW: 0.94 Low: 0.35 High: 1.25

Median Pre-Service Time: ~~6 min.~~ 0 min Median Intra-Service Time: 15 min.

25th Percentile Intra-Svc Time: 10 min 75th Percentile Intra-Svc Time: 20 min. Low: 0 High: 45 min.

Median Post-Service Time: ~~10 min~~ 0 min

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	~~10~~ 0	
Critical Care:	0	
Other Hospital Visits:	0	
Discharge Day Mgmt.:	0	
Office Visits:	0	

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
93224	Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage, with visual superimposition scanning; includes recording, scanning analysis with report, physician review and interpretation	XXX	0.52

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: 93784**	**Key Reference CPT Code: 93224**
Median Pre-Time	~~6~~ 0	0 (Harvard)
Median Intra-Time	15	16 (Harvard)
Median Immediate Post-service Time	~~10~~ 0	0 (Harvard)
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)	**CPT Code 93784**	**Reference Service 93224**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.14	2.17
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be	3.14	3.53

reviewed and analyzed		
Urgency of medical decision making	2.27	2.93
Technical Skill/Physical Effort (Mean)		
Technical skill required	3	3.57
Physical effort required	1.71	1.79
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.27	3
Outcome depends on the skill and judgment of physician	3	3
Estimated risk of malpractice suit with poor outcome	2.14	3

INTENSITY/COMPLEXITY MEASURES	**CPT Code 93784**	**Reference Service 93224**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.27	2.29
Intra-Service intensity/complexity	3.05	3.36
Post-Service intensity/complexity	3.05	2.71

ADDITIONAL RATIONALE

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

The ACC Cardiovascular RUC Committee, representing general cardiology and the cardiology subspecialties, and the ACP–ASIM Third Party Relations Payment and Coding Subcommittee, representing general internal medicine and internal medicine subspecialties, communicated via phone conference call and e-mail to arrive at a work RVU recommendation of 0.38.

We decided that the survey-identified median work RVU of 0.52 is too high. Approximately 73% of the survey respondents (16 of 22) selected CPT 93224 as the key reference service code. We believe that while the selection of CPT 93224 as the reference is logical because it is structured similar to CPT 93784, the physician work involved in CPT 93784 is more straightforward and less complex than CPT 93224. Our contention is supported by the fact that survey respondents generally rated the key reference service, CPT 93224, as more intense than CPT 93784, as evidenced by the higher median survey values for the "Intensity/Complexity Measures."

Therefore, we decided that a work RVU lower than the .0.52 survey median/CPT 93224 value is appropriate. We attempted to identify a service for which the CPT code is assigned a work RVU that is roughly equivalent to work involved in CPT 93784. We selected CPT 93734—with its 0.38 work RVU. CPT 93734 is defined as: electronic analysis of single chamber pacemaker system (including evaluation of programmable parameters at rest and during activity, where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response), without reprogramming. We believe the physician work

involved in CPT 93734 is similar to CPT 93784. Thus, we recommend a work RVU of 0.38. We note that our 0.38 work RVU recommendation is close to the low survey-recommended work RVU of 0.35 for CPT 93784.

The ACC and ACP–ASIM recommend that the RUC approve 15 minutes of total physician time, consisting of the survey-identified median intra-service time of 15 minutes, and include it in the RUC database. We list the survey-identified median pre-, intra-, and post- time for CPT 93784 as called for on the Summary of Recommendation form. However, we recommend no pre- or post- service time be included in the RUC database for CPT 93784. We believe that pre- and post- survey time that was reported is performed by the clinical staff.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? Same Code (93784) but it was carrier-priced (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 ___X___Rarely

Specialty: Internal Medicine _____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 _____ 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.

Frequency information for CPT 93784 is generally unavailable since the coverage decision is left to the discretion of individual carriers and the service is carrier-priced. National Medicare utilization data is not available.

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

CPT Long Descriptor Code 93784:
Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report.

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 approach was used between the ACC and ACP-ASIM to recommend the direct practice inputs. Three companies providing ambulatory blood pressure monitoring equipment provided practice expense information for our consideration.

The ACC, representing 29,000 cardiologists used its Cardiovascular Relative Value Update Committee of 15 representatives from all cardiovascular specialties and general cardiologists who practice in a variety of settings. The CVRUC reviewed the data, standard PEAC approved packages, and PEAC approved inputs for similar procedures and arrived at the attached recommendations via consensus.

The American College of Physicians-American Society of Internal Medicine (ACP-ASIM), representing approximately 115,000 internists and medical students, used its Third Party Relations Payment and Coding (TPRPC) subcommittee to arrive at its direct practice expense input recommendations. The ACP-ASIM TPRPC subcommittee is comprised of 12 physicians that are representative of the ACP-ASIM membership, a geographically diverse mix of general internists and physicians practicing internal medicine subspecialties.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Filling out paper work associated with providing ambulatory blood pressure monitoring.

Intra-Service Clinical Labor Activities:

Greeting patient. Explaining/providing directions to the patient on how the ambulatory blood pressure monitor works, and how to record measurements in the diary. Applying monitor on patient, calibrating and taking blood pressure measurements several minutes apart.

Post-Service Clinical Labor Activities:

Removing the device and verifying that the device worked properly and that the patient recorded events in the diary. Entering appropriate documentation into the patient's clinical record and collecting billing information. Reading and printing out data, resetting machine, verifying the device is still operational and checking batteries, cuffs and connections to make it ready for next use. Forwarding the device and diary to the person/facility that is performing the analysis.

CMS'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)
~~1141~~ 1130	~~RN/Tech~~ RN/LPN/MTA	~~7~~ 4	~~28~~ 18	25	

From CMS's Labor, Medical Supply, and Equipment List. If not listed, provide full description, estimated cost, and cost source.

CMS's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	AA Batteries	2 to 4 depending on model	1 pack (replace for each patient)	
	Patient diaries	50	1 (use 1 per patient per test)	$15.46 total or $.31 each

From CMS's Labor, Medical Supply, and Equipment List. If not listed, provide full description, estimated cost, and cost source.

CMS's Equipment Code*	Medical Equipment	Minutes of use per procedure	Cost Estimate and Source (if applicable)
	Ambulatory Blood Pressure Monitor	24 hour period per patient	$3,000
	Software	24 hour period per patient	See Attachment
	Cable	24 hour period per patient	See Attachment

Note: we recommend that an ambulatory blood pressure monitor be assigned a separate supply code from a blood pressure monitor (code E55006)

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*		RN, LPN, MTA, Other _____
Review/read X-ray, lab, and pathology reports		RN/Tech
Other Clinical Activity (please specify)		
Filling out paperwork prior to providing ABPM services	~~7~~ 4	~~RN/Tech~~ RN/LPN/MTA
End: Patient arrival at office for service		
Service Period *Start: Patient arrival at office for service*		
Greet patient/provide gowning	3	~~RN/Tech~~ RN/LPN/MTA
Obtain vital signs	_____	RN, LPN, MTA, Other _____
Prep and position patient	_____	RN, LPN, MTA, Other _____
Prepare room, equipment, supplies	_____	RN, LPN, MTA, Other _____
Assist physician during exam	_____	RN, LPN, MTA, Other _____
Education/instruction/counseling	~~10~~ 5	~~RN/Tech~~ RN/LPN/MTA
Coordinate home or outpatient care	_____	RN, LPN, MTA, Other _____
Clean room/equipment	_____	RN, LPN, MTA, Other _____
Other Clinical Activity (please specify)		
Applying monitor, calibrating and obtaining blood pressure readings	~~15~~ 10	~~RN/Tech~~ RN/LPN/MTA

End: Patient leaves office

Post-Service Period
Start: Patient leaves office

Phone calls between visits with patient, family pharmacy	_____	RN, LPN, MTA, Other _____
Other Activity (please specify)		
Removing device and making sure diary information was recorded correctly.	5	~~RN/Tech~~ RN/LPN/MTA
Entering appropriate documentation into the patients clinical record ~~and collecting billing information.~~ Forwarding the device and diary to the person/facility that is performing the analysis.	10	~~RN/Tech~~ RN/LPN/MTA
Reading and printing out the data	5	~~RN/Tech~~ RN/LPN/MTA
Resetting machine	5	~~RN/Tech~~ RN/LPN/MTA

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

CPT Long Descriptor Code 93786:
Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; recording only.

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 approach was used between the ACC and ACP-ASIM to recommend the direct practice inputs. Three companies providing ambulatory blood pressure monitoring equipment provided practice expense information for our consideration.

The ACC, representing 29,000 cardiologists used its Cardiovascular Relative Value Update Committee of 15 representatives from all cardiovascular specialties and general cardiologists who practice in a variety of settings. The CVRUC reviewed the data, standard PEAC approved packages, and PEAC approved inputs for similar procedures and arrived at the attached recommendations via consensus.

The American College of Physicians-American Society of Internal Medicine (ACP-ASIM), representing approximately 115,000 internists and medical students, used its Third Party Relations Payment and Coding (TPRPC) subcommittee to arrive at its direct practice expense input recommendations. The ACP-ASIM TPRPC subcommittee is comprised of 12 physicians that are representative of the ACP-ASIM membership, a geographically diverse mix of general internists and physicians practicing internal medicine subspecialties.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Filling out paper work associated with providing ambulatory blood pressure monitoring.

Intra-Service Clinical Labor Activities:

Greeting patient. Explaining/providing directions to the patient on how the ambulatory blood pressure monitor works, and how to record measurements in the diary. Applying monitor on patient, calibrating and taking blood pressure measurements several minutes apart.

Post-Service Clinical Labor Activities:

Removing the device and verifying that the device worked properly and that the patient recorded events in the diary. Entering appropriate documentation into the patients clinical record and collecting billing information. Forwarding the device and diary to the person/facility that is performing the analysis.

CMS'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)
~~1141~~ 1130	~~RN/Tech~~ RN/LPN/MTA	~~7~~ 4	~~28~~ 18	15	

From CMS's Labor, Medical Supply, and Equipment List. If not listed, provide full description, estimated cost, and cost source.

CMS's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	AA Batteries	2 to 4 depending on model	1 pack (replace for each patient)	
	Patient diaries	50	1 (use 1 per patient per test)	$15.46 total or $.31 each

From CMS's Labor, Medical Supply, and Equipment List. If not listed, provide full description, estimated cost, and cost source.

CMS's Equipment Code*	Medical Equipment	Minutes of use per procedure	Cost Estimate and Source (if applicable)
	Ambulatory Blood Pressure Monitor	24 hour period per patient	$3,000
	Software	24 hour period per patient	See Attachment
	Cable	24 hour period per patient	See Attachment

Note: we recommend that an ambulatory blood pressure monitor be assigned a separate supply code from a blood pressure monitor (code E55006)

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*		RN, LPN, MTA, Other _____
Review/read X-ray, lab, and pathology reports		RN/Tech
Other Clinical Activity (please specify)		
Filling out paperwork prior to providing ABPM services	~~7~~ 4	~~RN/Tech~~ RN/LPN/MTA
End: Patient arrival at office for service		
Service Period *Start: Patient arrival at office for service*		
Greet patient/provide gowning	3	~~RN/Tech~~ RN/LPN/MTA
Obtain vital signs	_____	RN, LPN, MTA, Other _____
Prep and position patient	_____	RN, LPN, MTA, Other _____
Prepare room, equipment, supplies	_____	RN, LPN, MTA, Other _____
Assist physician during exam	_____	RN, LPN, MTA, Other _____
Education/instruction/counseling	~~10~~ 5	~~RN/Tech~~ RN/LPN/MTA
Coordinate home or outpatient care	_____	RN, LPN, MTA, Other _____
Clean room/equipment	_____	RN, LPN, MTA, Other _____
Other Clinical Activity (please specify)		
Applying monitor, calibrating and obtaining blood pressure readings	~~15~~ 10	~~RN/Tech~~ RN/LPN/MTA

End: Patient leaves office

Post-Service Period
Start: Patient leaves office

Phone calls between visits with patient, family pharmacy	_____	RN, LPN, MTA, Other _____
Other Activity (please specify)		
Removing device and making sure diary information was recorded correctly.	5	~~RN/Tech~~ RN/LPN/MTA
Entering appropriate documentation into the patients clinical record ~~and collecting billing information~~. Forwarding the device and diary to the person/facility that is performing the analysis.	10	~~RN/Tech~~ RN/LPN/MTA

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

CPT Long Descriptor Code 93788:
Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; scanning analysis with report.

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 approach was used between the ACC and ACP-ASIM to recommend the direct practice inputs. Three companies providing ambulatory blood pressure monitoring equipment provided practice expense information for our consideration.

The ACC, representing 29,000 cardiologists used its Cardiovascular Relative Value Update Committee of 15 representatives from all cardiovascular specialties and general cardiologists who practice in a variety of settings. The CVRUC reviewed the data, standard PEAC approved packages, and PEAC approved inputs for similar procedures and arrived at the attached recommendations via consensus.

The American College of Physicians-American Society of Internal Medicine (ACP-ASIM), representing approximately 115,000 internists and medical students, used its Third Party Relations Payment and Coding (TPRPC) subcommittee to arrive at its direct practice expense input recommendations. The ACP-ASIM TPRPC subcommittee is comprised of 12 physicians that are representative of the ACP-ASIM membership, a geographically diverse mix of general internists and physicians practicing internal medicine subspecialties.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

None

Intra-Service Clinical Labor Activities:

None

Post-Service Clinical Labor Activities:

Reading and printing out data, resetting machine, verifying the device is still operational and checking batteries, cuff and connections to make it ready for next use.

CMS'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)
~~1141~~ 1130	~~RN/Tech~~ RN/LPN/MTA	0	0	10	

From CMS's Labor, Medical Supply, and Equipment List. If not listed, provide full description, estimated cost, and cost source.

CMS's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	AA Batteries	2 to 4 depending on model	1 pack (replace for each patient)	
	Patient diaries	50	1 (use 1 per patient per test)	$15.46 total or $.31 each.

From CMS's Labor, Medical Supply, and Equipment List. If not listed, provide full description, estimated cost, and cost source.

CMS's Equipment Code*	Medical Equipment	Minutes of use per procedure	Cost Estimate and Source (if applicable)
	Ambulatory Blood Pressure Monitor	24 hour period per patient	$3,000
	Software	24 hour period per patient	See attachment
	Cable	24 hour period per patient	See attachment

Note: we recommend that an ambulatory blood pressure monitor be assigned a separate supply code from a blood pressure monitor (code E55006)

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, MTA, Other _____
Other Clinical Activity (please specify)		
_____	_____	RN, LPN, MTA, Other _____
End: Patient arrival at office for service		
Service Period *Start: Patient arrival at office for service*		
Greet patient/provide gowning	_____	RN, LPN, MTA, Other _____
Obtain vital signs	_____	RN, LPN, MTA, Other _____
Prep and position patient	_____	RN, LPN, MTA, Other _____
Prepare room, equipment, supplies	_____	RN, LPN, MTA, Other _____
Assist physician during exam	_____	RN, LPN, MTA, Other _____
Education/instruction/ counseling	_____	RN, LPN, MTA, Other _____
Coordinate home or outpatient care	_____	RN, LPN, MTA, Other _____
Clean room/equipment	_____	RN, LPN, MTA, Other _____
Other Clinical Activity (please specify)		
_____	_____	RN, LPN, MTA, Other _____

End: Patient leaves office

Post-Service Period
Start: Patient leaves office

Phone calls between visits with patient, family pharmacy	_____	RN, LPN, MTA, Other _____
Other Activity (please specify)		
Reading and printing out the data	5	~~RN/Tech~~ RN/LPN/MTA
Resetting machine	5	~~RN/Tech~~ RN/LPN/MTA

End: When appointment for next office visit is made.

MEMORANDUM

TO: AMA/Specialty Society Relative Value Update Committee

FROM: American College of Cardiology
American College of Physicians/American Society of Internal Medicine

DATE: September 3, 2002

RE: Practice Expense Inputs for Ambulatory Blood Pressure Monitoring

Below are estimated costs for medical equipment and supplies for ambulatory blood pressure monitoring for consideration by RUC and CMS. Cost information was provided by the three leading companies reflecting six different device models.

Medical Equipment

Monitor Costs

Spacelabs models are $2500 and $3500, estimated life 5-10 years
SUNtech models are $3500, $2500 and $2390, estimated life 5 years all models
Welch-Allyn model is $2417, estimated life 5-7 years

Rental cost is approximately $50 per test.

Software Costs

Spacelabs software is $1,500 and is priced separately.
SUNTech software costs $495 and is included in the price of one of their models.
Welch Allyn's software is included in the cost of the device. Sold separately for $363.33.

Cable Costs

Spacelabs models – cable costs $105

Medical Supplies

All models use batteries and some form of a patient diary.

SUNTech models use electrodes ($.10-$.15 each) and microphone pads ($.90) replaced after each test.
Welch Allyn models use cuff anchor pads (quantity 50 at $49.23) replaced after every test.

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

April 2002

Screening Mammography

In February 2002, the RUC extensively discussed the survey data and comparisons of CPT 76092 *Screening mammography, bilateral (two view film study of each breast)* with other services (with similar service times or work RVU's similar to that requested). However, the RUC found that there was a disparity between the perceived service and the information available. Based upon the information available, the specialty society had difficulty sustaining an argument for its recommended work relative value of 0.70 to the Facilitation Committee and the RUC. The Facilitation Committee could not determine a reasonable and defensible methodology for delineating a relevant work RVU. The consensus was that the information available was not fully adequate and additional information should be collected regarding physician work related to the unique quality assurance aspects of this service. The RUC recommended that 76092 be resurveyed by interested specialty societies for presentation at the April RUC meeting, and that the specialties work with AMA RUC staff regarding the survey instrument and vignette development for the service.

In April 2002, the RUC reviewed new survey data for CPT 76092, which specifically addressed and included physician work related to second readings of the screening mammography films and issues related to the Mammography Quality Standards Act (MQSA). The RUC agreed that the use of a second review of images by a different or same physician (double reading), prior to the submission of the final report was indicative of the intensity of the procedure. The RUC also agreed that it would be inappropriate to report 76092 for a re-read, as this intensity has been factored into the work valuation of this service. The RUC reviewed the physician time related to screening mammography and compared this time to both unilateral and bilateral diagnostic mammography and agreed that the relationship in physician work and time was appropriate. The RUC also noted that the specialty recommended a work RVU below the 25th percentile of their survey data. After reviewing all of this information, the RUC agreed that the original CMS work relative value of 0.70 is appropriate.

The RUC recommends a work relative value of 0.70 for CPT code 76092.

Practice Expense Inputs:

The RUC adopted the direct practice expense inputs as presented by the specialty society, with a change in the staff type to mammography technologist. The RUC understands that the radiologists may address the broader issue of adding staff activities related to MQSA to all of the mammography codes with the PEAC.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
76092	Screening mammography, bilateral (two view film study of each breast)	XXX	0.70

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:	76092	Tracking Number:	N/A	Global Period:	XXX	Recommended RVW:	0.70

CPT Descriptor: **Screening mammography, bilateral (two view film study of each breast)**

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
An asymptomatic woman 45 years old presents for screening mammography.

Description of Pre-Service Work:
The pre-service period includes all clinical activities performed by the physician prior to image interpretation and may include the following:

- Review of clinical information provided by referring physician or obtained from the patient including age, parity, estrogen replacement status, availability of prior mammograms or any history of breast disease that would necessitate converting the screening mammogram to a diagnostic mammogram
- Discussions with the patient prior to the examination may be required to clarify clinical information or to answer the questions patients frequently have regarding the risk of radiation exposure, the risk of compression and potential injury to breast implants

Description of Intra-Service Work:
The intra-service period includes all clinical activities related to image interpretation and rendering the radiological report and may include the following:

- Initial review of images for technical quality, proper positioning and complete anatomic coverage (need for additional views)
- Interpretation of images including image magnification and "hot light" viewing and comparison with two prior examinations when available
- Determine significance of abnormal findings and formulate recommendations
- Code each examination using BIRADS terminology
- Dictate report to referring physician documenting findings, BIRADS classification and follow-up recommendations
- Second review of images by a different or the same physician (double reading) prior to submission of the final report

Description of Post-Service Work:
The post service period includes all clinical activities that occur after image interpretation (many of which are federally mandated by MQSA) and multiple quality assurance, patient notification and tracking activities related to compliance with federally mandated quality assurance programs. These activities may include the following:

Clinical Activities

- Because of patient anxiety, findings are often discussed with the patient
- Review and authentication of the dictated report
- Complete second interpretation of some studies when prior mammograms that were unavailable initially become available for comparison at a later date

- Review of films and discussion with referring physician as needed

Federally Mandated Clinical Activities Related to MQSA and Screening Mammography

- Preparation of separate report to the patient explaining her results in lay language
- Abnormal results suspicious for cancer are personally communicated by telephone with the referring physician

Federally Mandated Non-clinical Activities Related to MQSA and Screening Mammography

- Re-review of images on all patients who undergo biopsy and correlation with pathology report
- Regular review of personal and practice statistics for call-back rate, false positive rate and false negative rate
- Regular review of Quality Assurance data including densitometry, sensitometry and processing problems including troubleshooting problems with the physicist
- Mammography dedicated CME required by MQSA (15 hours every 3 years)
- Oversee initial entry and full Mammography Accreditation/Certification application including selection of phantom and clinical images
- Supervision of assembly of update application
- Radiologist time spent preparing for and during annual MQSA inspection
- Documentation of physician compliance with MQSA requirements

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SURVEY DATA:

Presenter(s) Bibb Allen, Jr., M.D., ACR RUC advisor

Specialty(s) American College of Radiology

Sample Size: 75 Response Rate: (%): 49 (65%) Median RVW: 0.80

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

25th Percentile RVW: 0.73 75th Percentile RVW: 0.86 Low: 0.50 High: 1.80

Median Pre-Service Time: 2.00 Median Intra-Service Time: 5.00

25th Percentile Intra-Service Time: 3.00 75th Percentile Intra-Svc Time: 8.00 Low: 1.00 High: 20.00

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	5.00	
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
76091	Mammography; bilateral	0.87

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

TIME ESTIMATES (Median)	CPT Code	Reference Service 1 CPT (Taken from RUC Database – 2nd 5 year review)
Median Pre-Time	2.00	5.00
Median Intra-Time	5.00	10.00
Median Immediate Post-service Time	5.00	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	3.04	3.57
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.23	3.74
Urgency of medical decision making	3.04	4.13
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.32	3.78
Physical effort required	2.26	2.74
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.19	3.78
Outcome depends on the skill and judgement of physician	4.64	4.22
Estimated risk of malpractice suit with poor outcome	4.96	4.26

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.54	3.30
Intra-Service intensity/complexity	3.79	3.96
Post-Service intensity/complexity	3.10	3.70

ADDITIONAL RATIONALE

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

The ACR RUC Committee has reviewed the survey data and concludes that the 25th percentile RVU value most accurately reflects the survey data. In order to be consistent with our previous RUC recommendation and with the 2002 MFS, the ACR RUC Committee recommends 0.70 RVU for CPT code 76092, which is a value just below the 25th percentile of our survey data.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) CPT Code 76092, Screening mammography, bilateral (two view film study of each breast)

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

Specialty Radiology ___ X ___ Commonly ___ Sometimes ___ Rarely

Specialty _____ ___ 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 32 million (including Medicare)

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 4.6 million

Specialty _____ Frequency _____

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

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CPT Code 76092
Specialty Society('s) ACR

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

CPT Descriptor: **Screening mammography, bilateral (two view film study of each breast)**

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

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:

.he 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:

Pre-Service Clinical Labor Activities:
The Mammography Technologist (RT) pulls prior mammograms to review technical parameters.

Intra-Service Clinical Labor Activities:
The MT greets the patient and provides clinical history form. The MT assists the patient complete the mammography questionnaire and reviews the clinical history. The MT explains the procedure to the patient and answers questions. The MT provides gown and accompanies patient to the mammography room. The MT positions patient obtains two mammographic views of each breast. Films are processed in a dedicated mammography processor. The films are reviewed for technical quality and compared to prior examinations when available. Inadequate views are repeated. When exam is completed, MT answers questions and provides instructions. The MT then cleans the room/equipment.

Post-Service Clinical Labor Activities:
The MT hangs the films on a dedicated mammography alternator for interpretation by the physician, with prior films for a comparison (when available).

CPT Code 76092
Specialty Society('s) ACR

Total Staff Time In Office: 28 minutes 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)
	Mammography Technologist (MT)	2	23	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)
	Cassette cleaner	½	oz	
	Date Stickers	4	Item	
	Dated film file inserts	1	Item	
	Film, 18 x 24 cm	4	Item	
73405	Film, Jacket	1	Item	
	Gauze Sponges	4	Item	
11302	Gloves, non-sterile	1	Pair	
	Mammo Wipes	2	Item	
	Mole / Skin Markers	1	Each	
11107	Patient gown, disposable	1	Item	
73423	Processor Chemicals	1	item	
	Spray disinfectant	½	oz	

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)
E51080	Dedicated mammography processor	1	3	20	$55,000
No number assigned on HCFA's list	Film Alternator	1		20	$30,000
	Mammography cassette	4		20	
E51016	Mammo room	1		20	$130,000
	Sensitometer	1	2	20	$2500

CPT Code 76092
Specialty Society('s) ACR

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)		
Retrieve prior films to review technical parameters	2	RN, LPN, MA, Other MT
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 MT
Obtain vital signs		RN, LPN, MA, Other
Prep and position patient and obtain films		RN, LPN, MA, Other
Prepare room, equipment, supplies	2	RN, LPN, MA, Other MT
~~Assist physician during exam~~		
Prep/position patient and acquire images	6	RN, LPN, MA, Other MT
Education/instruction/ counseling	4	RN, LPN, MA, Other MT
Coordinate home or outpatient care		RN, LPN, MA, Other
Clean room/equipment	3	RN, LPN, MA, Other MT
Other Clinical Activity (please specify)		RN, LPN, MA, Other

CPT Code 76092
Specialty Society('s) ACR

Process films in mammography processor and review for technical quality	5 •	RN, LPN, MA, Other	MT
End: Patient leaves office			
Post-Service Period			
Start: Patient leaves office			
Phone calls between visits with patient, family pharmacy		RN, LPN, MA, Other	
Other Activity (please specify)			
Hang films on the dedicated mammography alternator for interpretation by the physician, with prior films for a comparison (when available)	3	RN, LPN, MA, Other	MT
End: When appointment for next office visit is made.			

CPT 2003 RUC Recommendations

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	Specialty Rec	RUC Rec	Same RVU as last year?	MFS Rec	Comments
00320	XXX	R	Nov01	V	Ansesthesia Services for Larynx and Trachea Procedures in Children Under the Age of 1	N1	Apr02	16	6.00	**6.00**	Yes	Yes	
00326	XXX	N	Nov01	V	Ansesthesia Services for Larynx and Trachea Procedures in Children Under the Age of 1	N2	Apr02	16	8.00	**7.00**		Yes	
00539	XXX	N	Nov01	V	Anesthesia Services: Intrathoracic	O4	Apr02	17	18.00	**18.00**		Yes	
00540	XXX	R	Nov01	V	Anesthesia Services: Intrathoracic	O2	Apr02	17	12.00	**12.00**		Yes	
00541	XXX	N	Nov01	V	Anesthesia Services: Intrathoracic	O3	Apr02	17	15.00	**15.00**		Yes	
00640	XXX	N	Aug01	14	Anesthesia for closed procedures on cervical/thoracic/lumbar	D1	Feb02	12	3.00	**3.00**		Yes	
00830	XXX	R	Nov01	V	Anesthesia Services for Pediatric Hernia	P1	Apr02	18	4.00	**4.00**	Yes	Yes	
00832	XXX	R	Nov01	V	Anesthesia Services for Pediatric Hernia	P2	Apr02	18	6.00	**6.00**	Yes	Yes	
00834	XXX	N	Nov01	V	Anesthesia Services for Pediatric Hernia	P3	Apr02	18	5.00	**5.00**		Yes	
00836	XXX	N	Nov01	V	Anesthesia Services for Pediatric Hernia	P4	Apr02	18	6.00	**6.00**		Yes	
00869	XXX	D	Feb02	EC-	Anesthesia for Obstetrical and Vasectomy Procedures		Deleted					Yes	
00921	XXX	N	Feb02	EC-	Anesthesia for Obstetrical and Vasectomy Procedures		Renum		3.00	**3.00**		Yes	Renumbered code from 00869
01382	XXX	R	Nov01	W	Anesthesia Service for Arthroscopy	R1	Apr02	19	3.00	**3.00**	Yes	Yes	
01400	XXX	R	Nov01	W	Anesthesia Service for Arthroscopy	R2	Apr02	19	4.00	**4.00**	Yes	Yes	
01464	XXX	R	Nov01	W	Anesthesia Service for Arthroscopy	R3	Apr02	19	3.00	**3.00**	Yes	Yes	

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01622	XXX	R	Nov01	W	Anesthesia Service for Arthroscopy	R4	Apr02	19	4.00	**4.00**	Yes	Yes
01630	XXX	R	Nov01	W	Anesthesia Service for Arthroscopy	R5	Apr02	19	5.00	**5.00**	Yes	Yes
01732	XXX	R	Nov01	W	Anesthesia Service for Arthroscopy	R6	Apr02	19	3.00	**3.00**	Yes	Yes
01740	XXX	R	Nov01	W	Anesthesia Service for Arthroscopy	R7	Apr02	19	4.00	**4.00**	Yes	Yes
01829	XXX	N	Feb02	E	Anesthesia for Arthoscopic/Endoscopic Procedures on the Hand	R8	Apr02	20	3.00	**3.00**		Yes
01830	XXX	R	Feb02	E	Anesthesia for Arthoscopic/Endoscopic Procedures on the Hand	R9	Apr02	20	3.00	**3.00**	Yes	Yes
01832	XXX	R	Feb02	E	Anesthesia for Arthoscopic/Endoscopic Procedures on the Hand		Apr02	20	6.00	**6.00**	Yes	Yes
01960	XXX	R	Feb02	EC-	Anesthesia for Obstetrical and Vasectomy Procedures		Editorial		5.00	**5.00**	Yes	Yes
01961	XXX	R	Feb02	EC-	Anesthesia for Obstetrical and Vasectomy Procedures		Editorial		7.00	**7.00**	Yes	Yes
01962	XXX	R	Feb02	EC-	Anesthesia for Obstetrical and Vasectomy Procedures		Editorial		8.00	**8.00**	Yes	Yes
01963	XXX	R	Feb02	EC-	Anesthesia for Obstetrical and Vasectomy Procedures		Editorial		8.00	**8.00**	Yes	Yes
01964	XXX	R	Feb02	EC-	Anesthesia for Obstetrical and Vasectomy Procedures		Editorial		4.00	**4.00**	Yes	Yes
01968	XXX	R	Feb02	EC-	Anesthesia for Obstetrical and Vasectomy Procedures		Editorial		2.00	**2.00**	Yes	Yes
01969	XXX	R	Feb02	EC-	Anesthesia for Obstetrical and Vasectomy Procedures		Editorial		5.00	**5.00**	Yes	Yes
01991	XXX	N	Feb02	EC-	Anesthesia Services for Diagnostic or Therapeutic Nerve Block Injections	Q1	Feb02	13	3.00	**3.00**		Yes
01992	XXX	N	Feb02	EC-	Anesthesia Services for Diagnostic or Therapeutic Nerve Block Injections	Q2	Feb02	13	5.00	**5.00**		Yes

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01996	XXX	R	Nov01	E	Daily Hospital Management of Epidural		Feb02	27	3.00	**3.00**	Yes	Yes	
11400	010	R	Aug01	L	Excision of Lesions: Wide Margins	E1	Apr02	B	0.85	**0.85**		Yes	
11401	010	R	Aug01	L	Excision of Lesions: Wide Margins	E2	Apr02	B	1.23	**1.23**		Yes	
11402	010	R	Aug01	L	Excision of Lesions: Wide Margins	E3	Apr02	B	1.51	**1.51**		Yes	
11403	010	R	Aug01	L	Excision of Lesions: Wide Margins	E4	Apr02	B	1.79	**1.79**		Yes	
11404	010	R	Aug01	L	Excision of Lesions: Wide Margins	E5	Apr02	B	2.06	**2.06**		Yes	
11406	010	R	Aug01	L	Excision of Lesions: Wide Margins	E6	Apr02	B	2.76	**2.76**	Yes	Yes	
11420	010	R	Aug01	L	Excision of Lesions: Wide Margins	E7	Apr02	B	0.98	**0.98**		Yes	
11421	010	R	Aug01	L	Excision of Lesions: Wide Margins	E8	Apr02	B	1.42	**1.42**		Yes	
11422	010	R	Aug01	L	Excision of Lesions: Wide Margins	E9	Apr02	B	1.63	**1.63**		Yes	
11423	010	R	Aug01	L	Excision of Lesions: Wide Margins	E10	Apr02	B	2.01	**2.01**		Yes	
11424	010	R	Aug01	L	Excision of Lesions: Wide Margins	E11	Apr02	B	2.43	**2.43**		Yes	
11426	010	R	Aug01	L	Excision of Lesions: Wide Margins	E12	Apr02	B	3.78	**3.78**	Yes	Yes	
11440	010	R	Aug01	L	Excision of Lesions: Wide Margins	E13	Apr02	B	1.06	**1.06**		Yes	
11441	010	R	Aug01	L	Excision of Lesions: Wide Margins	E14	Apr02	B	1.48	**1.48**		Yes	
11442	010	R	Aug01	L	Excision of Lesions: Wide Margins	E15	Apr02	B	1.72	**1.72**		Yes	
11443	010	R	Aug01	L	Excision of Lesions: Wide Margins	E16	Apr02	B	2.29	**2.29**		Yes	
11444	010	R	Aug01	L	Excision of Lesions: Wide Margins	E17	Apr02	B	3.14	**3.14**		Yes	
11446	010	R	Aug01	L	Excision of Lesions: Wide Margins	E18	Apr02	B	4.49	**4.49**	Yes	Yes	
11600	010	R	Aug01	L	Excision of Lesions: Wide Margins	E19	Apr02	B	1.31	**1.31**		Yes	
11601	010	R	Aug01	L	Excision of Lesions: Wide Margins	E20	Apr02	B	1.80	**1.80**		Yes	
11602	010	R	Aug01	L	Excision of Lesions: Wide Margins	E21	Apr02	B	1.95	**1.95**		Yes	

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11603	010	R	Aug01	L	Excision of Lesions: Wide Margins	E22	Apr02	B	2.19	**2.19**		Yes	
11604	010	R	Aug01	L	Excision of Lesions: Wide Margins	E23	Apr02	B	2.40	**2.40**		Yes	
11606	010	R	Aug01	L	Excision of Lesions: Wide Margins	E24	Apr02	B	3.43	**3.43**	Yes	Yes	
11620	010	R	Aug01	L	Excision of Lesions: Wide Margins	E25	Apr02	B	1.19	**1.19**		Yes	
11621	010	R	Aug01	L	Excision of Lesions: Wide Margins	E26	Apr02	B	1.76	**1.76**		Yes	
11622	010	R	Aug01	L	Excision of Lesions: Wide Margins	E27	Apr02	B	2.09	**2.09**		Yes	
11623	010	R	Aug01	L	Excision of Lesions: Wide Margins	E28	Apr02	B	2.61	**2.61**		Yes	
11624	010	R	Aug01	L	Excision of Lesions: Wide Margins	E29	Apr02	B	3.06	**3.06**		Yes	
11626	010	R	Aug01	L	Excision of Lesions: Wide Margins	E30	Apr02	B	4.30	**4.30**	Yes	Yes	
11640	010	R	Aug01	L	Excision of Lesions: Wide Margins	E31	Apr02	B	1.35	**1.35**		Yes	
11641	010	R	Aug01	L	Excision of Lesions: Wide Margins	E32	Apr02	B	2.16	**2.16**		Yes	
11642	010	R	Aug01	L	Excision of Lesions: Wide Margins	E33	Apr02	B	2.59	**2.59**		Yes	
11643	010	R	Aug01	L	Excision of Lesions: Wide Margins	E34	Apr02	B	3.10	**3.10**		Yes	
11644	010	R	Aug01	L	Excision of Lesions: Wide Margins	E35	Apr02	B	4.03	**4.03**		Yes	
11646	010	R	Aug01	L	Excision of Lesions: Wide Margins	E36	Apr02	B	5.95	**5.95**	Yes	Yes	
15756	090	R	Nov01	X	Free Muscle Myocutaneous Flap		Editorial		35.23	**35.23**	Yes	Yes	
17304	000	R	Aug01	Q	Mohs Micrographic Surgery	M1	Apr02	C	7.60	**7.60**	Yes	Yes	
17305	000	R	Aug01	Q	Mohs Micrographic Surgery	M2	Apr02	C	2.85	**2.85**	Yes	Yes	
17306	000	R	Aug01	Q	Mohs Micrographic Surgery	M3	Apr02	C	2.85	**2.85**	Yes	Yes	
17307	000	R	Aug01	Q	Mohs Micrographic Surgery	M4	Apr02	C	2.85	**2.85**	Yes	Yes	
17310	ZZZ	R	Aug01	Q	Mohs Micrographic Surgery	M5	Apr02	C	1.26	**0.95**	Yes	Yes	Interim. To be reviewed at September 2002 RUC Meeting.

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20550	000	R	Feb02	V	Therapeutic Injections	AM2	Apr02	5	0.80	**0.75**		Yes	
20552	000	R	Feb02	V	Therapeutic Injections	AM4	Apr02	5	0.70	**0.66**		Yes	
20553	000	R	Feb02	V	Therapeutic Injections	AM5	Apr02	5	0.80	**0.75**		Yes	
20600	000	R	Feb02	V	Therapeutic Injections	AM7	Apr02	5	0.66	**0.66**	Yes	Yes	
20605	000	R	Feb02	V	Therapeutic Injections	AM8	Apr02	5	0.68	**0.68**	Yes	Yes	
20612	000	N	Feb02	V	Therapeutic Injections	AM6	Apr02	5	0.75	**0.70**		Yes	
21030	090	R	Aug01	F	Excision of Mandible/Facial Bone Tumor	F1	Apr02	21	6.46			Yes	No RUC Recommendation
21034	090	R	Aug01	F	Excision of Mandible/Facial Bone Tumor	F2	Apr02	21	16.17	**16.17**	Yes	Yes	
21040	090	R	Aug01	F	Excision of Mandible/Facial Bone Tumor	F3	Apr02	21	2.11			Yes	No RUC Recommendation
21041	090	D	Aug01	F	Excision of Mandible/Facial Bone Tumor		Deleted					Yes	
21046	090	N	Aug01	F	Excision of Mandible/Facial Bone Tumor	F4	Apr02	21	13.00	**13.00**		Yes	
21047	090	N	Aug01	F	Excision of Mandible/Facial Bone Tumor	F5	Apr02	21	18.75	**18.75**		Yes	
21048	090	N	Aug01	F	Excision of Mandible/Facial Bone Tumor	F6	Apr02	21	13.50	**13.50**		Yes	
21049	090	N	Aug01	F	Excision of Mandible/Facial Bone Tumor	F7	Apr02	21	18.00	**18.00**		Yes	
21740	090	R	Feb02	W	Minimally Invasive Repair of Pectus Excavatum	AN1	Apr02	22	16.50	**16.50**	Yes	Yes	
21742	090	N	Feb02	W	Minimally Invasive Repair of Pectus Excavatum	AN2	Apr02	22				Yes	Carrier Price. RUC to review in September 2002
21743	090	N	Feb02	W	Minimally Invasive Repair of Pectus Excavatum	AN3	Apr02	22				Yes	Carrier Price. RUC to review in September 2002
23410	090	R	Feb02	E	Arthroscopic Rotator Cuff	AO1	Apr02	9	12.45	**12.45**	Yes	Yes	

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	Specialty Rec	RUC Rec	Same RVU as last year?	MFS Comments
23412	090	R	Feb02	E	Arthroscopic Rotator Cuff		Apr02	9	13.31	**13.31**	Yes	Yes
24516	090	R	Feb02	Y	Fracture Treatment Procedures		Editorial		11.65	**11.65**	Yes	Yes
25320	090	R	Feb02	D	Open Orthopedic Arthroscopy Procedures	AP1	Apr02	10	10.77	**10.77**	Yes	Yes
27235	090	R	Feb02	Y	Fracture Treatment Procedures		Editorial		12.16	**12.16**	Yes	Yes
27244	090	R	Feb02	Y	Fracture Treatment Procedures		Editorial		15.94	**15.94**	Yes	Yes
27245	090	R	Feb02	Y	Fracture Treatment Procedures		Editorial		20.31	**20.31**	Yes	Yes
27425	090	R	Feb02	D	Open Orthopedic Arthroscopy Procedures	AP7	Apr02	10	5.22	**5.22**	Yes	Yes
27730	090	R	Feb02	D	Open Orthopedic Arthroscopy Procedures		Apr02	10	7.41	**7.41**	Yes	Yes
27732	090	R	Feb02	D	Open Orthopedic Arthroscopy Procedures		Apr02	10	5.32	**5.32**	Yes	Yes
27734	090	R	Feb02	D	Open Orthopedic Arthroscopy Procedures		Apr02	10	8.48	**8.48**	Yes	Yes
27759	090	R	Feb02	Y	Fracture Treatment Procedures		Editorial	10	13.76	**13.76**	Yes	Yes
27870	090	R	Feb02	D	~~Open Orthopedic Arthroscopy Procedures~~ Arthroscop Strct	AP2	Apr02	10	13.91	**13.91**	Yes	Yes
29540	000	R	Nov01	Y	Stapping Ankle or Foot		Editorial		0.51	**0.51**	Yes	Yes
29806	090	R	Feb02	D	Open Orthopedic Arthroscopy Procedures	AP3	Apr02	10	14.37	**14.37**	Yes	Yes
29827	090	N	Feb02	E	~~Open Orthopedic Arthoscopy Procedures~~ Arthroscopic Rotator Cuff	AO2	Apr02	9	16.00	**15.36**		Yes
29873	090	N	Feb02	D	Open Orthropedic Arthoscopy Procedures	AP5	Apr02	10	6.00	**6.00**		Yes
29899	090	N	Feb02	D	Open Orthropedic Arthoscopy Procedures	AP6	Apr02	10	13.91	**13.91**		Yes
31625	000	R	Aug01	G	Bronchoscopic Biopsy Procedures		Editorial		3.37	**3.37**	Yes	Yes

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	Specialty Rec	RUC Rec	Same RVU as last year?	MFS Comments
31628	000	R	Aug01	G	Bronchoscopic Biopsy Procedures		Editorial		3.81	**3.81**	Yes	Yes
31629	000	R	Aug01	G	Bronchoscopic Biopsy Procedures		Editorial		3.37	**3.37**	Yes	Yes
33215	090	N	Feb02	G	Insertion/Repositioning Venous Pacing Electrode for Biventricular Pacing	AQ1	Apr02	23	5.37	**4.44**		Yes
33216	090	R	Feb02	G	Insertion/Repositioning Venous Pacing Electrode for Biventricular Pacing	AQ2	Apr02	23	5.39	**5.39**	Yes	Yes
33217	090	R	Feb02	G	Insertion/Repositioning Venous Pacing Electrode for Biventricular Pacing Electrode	AQ3	Apr02	23	5.75	**5.75**	Yes	Yes
33224	000	N	Feb02	G	Insertion/Repositioning Venous Pacing Electrode for Biventricular Pacing Electrode	AQ4	Apr02	23	11.00	**9.05**		Yes
33225	ZZZ	N	Feb02	G	Insertion/Repositioning Venous Pacing Electrode for Biventricular Pacing Electrode	AQ5	Apr02	23	10.00	**8.34**		Yes
33226	000	N	Feb02	G	Insertion/Repositioning Venous Pacing Electrode for Biventricular Pacing Electrode	AQ6	Apr02	23	10.64	**8.69**		Yes
33508	ZZZ	N	Nov01	1	Minimally Invasive Vein Harvest for CABG Procedures	S1	Apr02	11	0.31	**0.31**		Yes
34812	000	R	Feb02	3	Endovascular Repair of Abdominal Aortic Aneurysm		Apr02	25	6.75	**6.75**	Yes	Yes
34825	090	R	Feb02	3	Endovascular Repair of Abdominal Aortic Aneurysm		Apr02	25	12.00	**12.00**	Yes	Yes
34826	ZZZ	R	Feb02	3	Endovascular Repair of Abdominal Aortic Aneurysm		Apr02	25	4.13	**4.13**	Yes	Yes
34833	000	N	Feb02	1	Open Iliac and Brachial Artery Exposure	AR1	Apr02	24	12.00	**12.00**		Yes
34834	000	N	Feb02	1	Open Iliac and Brachial Artery Exposure	AR2	Apr02	24	5.76	**5.35**		Yes

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	Specialty Rec	RUC Rec	Same RVU as last year?	MFS	Comments
34900	090	N	Feb02	3	Endovascular Repair of Iliac Artery Aneurysm	AS1	Apr02	25	16.38	**16.38**		Yes	
35572	ZZZ	N	Feb02	4	Harvest of Femoropopliteal Vein Segment	AT1	Apr02	26	7.20	**6.82**		Yes	
36415	XXX	R	Nov01	20	Venipuncture: G Code Transition to CPT	T1	Feb02	16	0.00	**0.00**	Yes	Yes	PE Inputs referred to the PEAC - Refer to PEAC Recommendations
36416	XXX	N	Nov01	20	Venipuncture: G Code Transition to CPT	T2	Feb02	16	0.00	**0.00**	Yes	Yes	PE Inputs referred to the PEAC - Refer to PEAC Recommendations
36511	000	N	Nov01	2	Therapeutic Apheresis	U1	Apr02	15	1.74	**1.74**		Yes	Interim. To be reviewed at September 2002 RUC Meeting.
36512	000	N	Nov01	2	Therapeutic Apheresis	U2	Apr02	15	1.74	**1.74**		Yes	Interim. To be reviewed at September 2002 RUC Meeting.
36513	000	N	Nov01	2	Therapeutic Apheresis	U3	Apr02	15	1.74	**1.74**		Yes	Interim. To be reviewed at September 2002 RUC Meeting.
36514	000	N	Nov01	2	Therapeutic Apheresis	U4	Apr02	15	1.74	**1.74**		Yes	Interim. To be reviewed at September 2002 RUC Meeting.
36515	000	N	Nov01	2	Therapeutic Apheresis	U5	Apr02	15	1.74	**1.74**		Yes	Interim. To be reviewed at September 2002 RUC Meeting.
36516	000	N	Nov01	2	Therapeutic Apheresis	U6	Apr02	15	1.74	**1.74**		Yes	Interim. To be reviewed at September 2002 RUC Meeting.
36520	000	D	Nov01	2	Therapeutic Apheresis		Deleted					Yes	
36521	000	D	Nov01	2	Therapeutic Apheresis		Deleted					Yes	
36536	000	N	Nov01	3	Fibrin Sheath/Intraluminal Obstruction Removal CVD	V1	Feb02	18	4.83	**3.60**		Yes	

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36537	000	N	Nov01	3	Fibrin Sheath/Intraluminal Obstruction Removal CVD	V2	Feb02	18	1.00	**0.75**		Yes	
36540	XXX	R	Nov01	20	Venipuncture: G Code Transition to CPT	T3	Feb02	16	0.00	**0.00**	Yes	Yes	PE Inputs referred to the PEAC - Refer to PEAC Recommendations
36830	090	R	Aug01	S	Biological Collegen Nonautogenous Arterial Grafting		Editorial		12.00	**12.00**	Yes	Yes	
37140	090	R	Feb02	D	Transjugular Intrahepatic Portosystemic Shunt(s) (TIPS)		Editorial		23.60	**23.60**	Yes	Yes	
37181	090	R	Feb02	D	Transjugular Intrahepatic Portosystemic Shunt(s) (TIPS)		Editorial		26.68	**26.68**	Yes	Yes	
37182	000	N	Feb02	D	Transjugular Intrahepatic Portosystemic Shunt(s) (TIPS)	W1	Feb02	19	22.00	**17.00**		Yes	
37183	000	N	Nov01	3	Transjugular Intrahepatic Portosystemic Shunt(s) (TIPS)	W2	Feb02	19	12.25	**8.00**		Yes	
37500	090	N	Feb02	27	Endoscopic Ligation Subfacial Perforator Veins (SEPS)	AU1	Apr02	27	12.00	**11.00**		Yes	
37501	YYY	N	Feb02	27	Endoscopic Ligation Subfacial Perforator Veins (SEPS)		Unlisted	27				No	
37760	090	R	Feb02	27	Endoscopic Ligation Subfacial Perforator Veins (SEPS)		Apr02	27	10.47	**10.47**	Yes	Yes	
38204	XXX	N	Feb02	H	Bone Marrow Transplantion Procedures	AV1	Apr02	14	2.00	**2.00**		Yes	
38205	000	N	Nov01	2	Bone Marrow Procedures	X1	Apr02	14	2.00	**1.50**		Yes	
38206	000	N	Nov01	2	Bone Marrow Procedures	X2	Apr02	14	2.00	**1.50**		Yes	
38207	XXX	N	Nov01	2	Bone Marrow Procedures	X3	Apr02	14	1.00	**0.47**		Yes	Interim. To be reviewed at September 2002 RUC Meeting.
38208	XXX	N	Nov01	2	Bone Marrow Procedures	X4	Apr02	14	1.20	**0.56**		Yes	Interim. To be reviewed at September 2002 RUC Meeting.

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	Specialty Rec	RUC Rec	Same RVU as last year?	MFS	Comments
38209	XXX	N	Nov01	2	Bone Marrow Procedures	X5	Apr02	14	0.50	**0.24**		Yes	Interim. To be reviewed at September 2002 RUC Meeting.
38210	XXX	N	Nov01	2	Bone Marrow Procedures	X6	Apr02	14	2.00	**0.94**		Yes	Interim. To be reviewed at September 2002 RUC Meeting.
38211	XXX	N	Nov01	02	Bone Marrow Procedures	X7	Apr02	14	1.50	**0.71**		Yes	Interim. To be reviewed at September 2002 RUC Meeting.
38212	XXX	N	Nov01	2	Bone Marrow Procedures	X8	Apr02	14	1.00	**0.47**		Yes	Interim. To be reviewed at September 2002 RUC Meeting.
38213	XXX	N	Nov01	2	Bone Marrow Procedures	X9	Apr02	14	0.50	**0.24**		Yes	Interim. To be reviewed at September 2002 RUC Meeting.
38214	XXX	N	Nov01	2	Bone Marrow Procedures	X10	Apr02	14	0.50	**0.24**		Yes	Interim. To be reviewed at September 2002 RUC Meeting.
38215	XXX	N	Nov01	2	Bone Marrow Procedures	X11	Apr02	14	1.18	**0.55**		Yes	Interim. To be reviewed at September 2002 RUC Meeting.
38220	XXX	R	Nov01	2	Bone Marrow Aspiration		Editorial		1.08	**1.08**	Yes	Yes	
38221	XXX	R	Nov01	2	Bone Marrow Aspiration		Editorial		1.37	**1.37**	Yes	Yes	
38231	XXX	D	Nov01	2	Bone Marrow Procedures		Deleted					Yes	
38242	XXX	N	Nov01	2	Bone Marrow Procedures	X12	Apr02	14	2.00	**1.71**		Yes	
43201	000	N	Aug01	H	Endoscopic Balloon Dilation of Intestinal Strictures	G1	Apr02	28	2.35	**2.09**		Yes	
43236	000	N	Aug01	H	Endoscopic Balloon Dilation of Intestinal Strictures	G2	Apr02	28	3.19	**2.92**		Yes	
43245	000	R	Aug01	H	Endoscopic Balloon Dilation of Intestinal Strictures		Apr02	28	3.64	**3.18**		Yes	
44206	090	N	Feb02	I	Laproscopic Colectomy Procedures	AW1	Apr02	O	27.46	**27.00**		Yes	

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44207	090	N	Feb02	I	Laproscopic Colectomy Procedures	AW2	Apr02	O	31.55	**30.00**		Yes	
44208	090	N	Feb02	I	Laproscopic Colectomy Procedures	AW3	Apr02	O	34.89	**32.00**		Yes	
44209	YYY	D	Feb02	I	Laproscopic Colectomy Procedures		Deleted					Yes	
44210	090	N	Feb02	I	Laproscopic Colectomy Procedures	AW4	Apr02	O	28.60	**28.00**		Yes	
44211	090	N	Feb02	I	Laproscopic Colectomy Procedures	AW5	Apr02	O	34.89	**35.00**		Yes	
44212	090	N	Feb02	I	Laproscopic Colectomy Procedures	AW6	Apr02	O	33.27	**32.50**		Yes	
44238	YYY	N	Feb02	I	Laproscopic Colectomy Procedues		Unlisted					No	
44239	YYY	N	Feb02	I	Laproscopic Colectomy Procedures		Unlisted					No	
44701	ZZZ	N	Feb02	7	Intraoperative Colonic Lavage	AX1	Apr02	P	3.50	**3.10**		Yes	
44799	YYY	D	Feb02	I	Laproscopic Colectomy Procedures		Unlisted					No	
45335	000	N	Aug01	H	Endoscopic Balloon Dilation of Intestinal Strictures	G3	Apr02	28	1.53	**1.46**		Yes	
45340	000	N	Aug01	H	Endoscopic Balloon Dilation of Intestinal Strictures	G4	Apr02	28	1.96	**1.96**		Yes	
45381	000	N	Aug01	H	Endoscopic Balloon Dilation of Intestinal Strictures	G5	Apr02	28	4.30	**4.30**		Yes	
45386	000	N	Aug01	H	Endoscopic Balloon Dilation of Intestinal Strictures	G6	Apr02	28	4.95	**4.58**		Yes	
46706	010	N	Feb02	8	Anal Fistula Glue Repair	AY1	Apr02	Q	3.20	**2.95**		Yes	
49200	090	R	Nov01	EC-	Digestive Surgery Excision Codes		Editorial		10.25	**10.25**	Yes	Yes	
49201	090	R	Nov01	EC-	Digestive Surgery Excision Codes		Editorial		14.84	**14.84**	Yes	Yes	
49419	090	N	Aug01	T	Insertion of Permanent Intraperitoneal Catheter for Chemotherapy	H1	Apr02	20	6.65	**6.65**		Yes	
49904	090	N	May01	N	Omental Flap	B2	Feb02	21	20.00	**20.00**		Yes	
49905	ZZZ	R	May01	N	Omental Flap	B1	Feb02	21	6.55	**6.55**	Yes	Yes	

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50542	090	N	Nov01	7	Laproscopic Urological Procedures	Y1	Feb02	22	20.00	**20.00**		Yes	
50543	090	N	Nov01	7	Laproscopic Urological Procedures	Y2	Feb02	22	25.50	**25.50**		Yes	
50562	000	N	Nov01	7	Renal Endoscopy	Y3	Apr02	G	13.98	**10.90**		Yes	
51701	000	N	Nov01	20	Insertion of Bladder Catheters (G Code Transition to CPT)	Z1	Apr02	E	0.50	**0.50**		Yes	
51702	000	N	Nov01	20	Insertion of Bladder Catheters (G Code Transition to CPT)	Z2	Apr02	E	0.50	**0.50**		Yes	
51703	000	N	Nov01	20	Insertion of Bladder Catheters (G Code Transition to CPT)	Z3	Apr02	E	1.47	**1.47**		Yes	
51798	XXX	N	Nov01	20	Measurement of Post-Voiding Residual Urine/Bladder Capacity	AA1	Apr02	F	0.58	**0.38**		Yes	
52001	000	R	Feb02	09	Urological Editorial Revisions		Editorial		2.37	**2.37**	Yes	Yes	
52354	000	R	Feb02	09	Urological Editorial Revisions		Editorial		7.34	**7.34**	Yes	Yes	
52355	000	R	Feb02	09	Urological Editorial Revisions		Editorial		8.82	**8.82**	Yes	Yes	
53440	090	R	Nov01	H	Male Urinary Incontinence Procedures	AB1	Feb02	24	14.06	**13.62**		Yes	
53442	090	R	Nov01	H	Male Urinary Incontinence Procedures	AB2	Feb02	24	14.00	**11.57**		Yes	
53670	000	D	Nov01	20	Male Urinary Procedures		Deleted					Yes	
53675	000	D	Nov01	20	Male Urinary Procedures		Deleted					Yes	
55866	090	N	Nov01	7	Laproscopic Urological Procedures	Y4	Apr02	22	30.74	**30.74**		Yes	
56820	000	N	Feb02	J	Colposcopy Procedures	AZ1	Apr02	30	1.50	**1.50**		Yes	
56821	000	N	Feb02	J	Colposcopy Procedures	AZ2	Apr02	30	2.05	**2.05**		Yes	
57420	000	N	Feb02	J	Colposcopy Procedures	AZ3	Apr02	30	1.60	**1.60**		Yes	
57421	000	N	Feb02	J	Colposcopy Procedures	AZ4	Apr02	30	2.75	**2.20**		Yes	
57452	000	R	Feb02	J	Colposcopy Procedures	AZ5	Apr02	30	2.00	**1.50**		Yes	

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57454	000	R	Feb02	J	Colposcopy Procedures	AZ6	Apr02	30	2.61	**2.33**		Yes	
57455	000	N	Feb02	J	Colposcopy Procedures	AZ7	Apr02	30	2.49	**1.99**		Yes	
57456	000	N	Feb02	J	Colposcopy Procedures	AZ8	Apr02	30	2.12	**1.85**		Yes	
57460	000	R	Feb02	J	Colposcopy Procedures	AZ9	Apr02	30	2.80	**2.83**	Yes	Yes	
57461	000	N	Feb02	J	Colposcopy Procedures	AZ10	Apr02	30	3.01	**3.44**		Yes	
58140	090	R	Nov01	8	Vaginal Hysterectomy/Myomectomy Procedures	AC1	Apr02	31	14.60	**14.60**	Yes	Yes	
58145	090	R	Nov01	8	Vaginal Hysterectomy/Myomectomy Procedures	AC2	Apr02	31	8.04	**8.04**	Yes	Yes	
58146	090	N	Nov01	8	Vaginal Hysterectomy/Myomectomy Procedures	AC3	Apr02	31	19.00	**19.00**		Yes	
58260	090	R	Nov01	8	Vaginal Hysterectomy/Myomectomy Procedures	AC4	Apr02	31	12.98	**12.98**	Yes	Yes	
58262	090	R	Nov01	8	Vaginal Hysterectomy/Myomectomy Procedures	AC5	Apr02	31	14.77	**14.77**	Yes	Yes	
58263	090	R	Nov01	8	Vaginal Hysterectomy/Myomectomy Procedures	AC6	Apr02	31	16.06	**16.06**	Yes	Yes	
58267	090	R	Nov01	8	Vaginal Hysterectomy/Myomectomy Procedures	AC7	Apr02	31	17.04	**17.04**	Yes	Yes	
58270	090	R	Nov01	8	Vaginal Hysterectomy/Myomectomy Procedures	AC8	Apr02	31	14.26	**14.26**	Yes	Yes	
58290	090	N	Nov01	8	Vaginal Hysterectomy/Myomectomy Procedures	AC9	Apr02	31	19.50	**19.00**		Yes	
58291	090	N	Nov01	8	Vaginal Hysterectomy/Myomectomy Procedures	AC10	Apr02	31	21.29	**20.79**		Yes	
58292	090	N	Nov01	8	Vaginal Hysterectomy/Myomectomy Procedures	AC11	Apr02	31	22.58	**22.08**		Yes	
58293	090	N	Nov01	8	Vaginal Hysterectomy/Myomectomy Procedures	AC12	Apr02	31	23.56	**23.06**		Yes	

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58294	090	N	Nov01	8	Vaginal Hysterectomy/Myomectomy Procedures	AC13	Apr02	31	20.78	**20.28**		Yes	
58545	090	N	Feb02	30	Laproscopic Hysterectomy/Myomectomy Procedures	BA1	Apr02	A	14.21	**14.60**		Yes	Interim. To be reviewed at the September 2002 RUC Meeting.
58546	090	N	Feb02	30	Laproscopic Hysterectomy/Myomectomy Procedures	BA2	Apr02	A	18.47	**19.00**		Yes	Interim. To be reviewed at the September 2002 RUC Meeting.
58550	090	R	Feb02	30	Laproscopic Hysterectomy/Myomectomy Procedures	BA3	Apr02	A	14.19	**14.19**	Yes	Yes	Interim. To be reviewed at the September 2002 RUC Meeting.
58551	090	D	Feb02	30	Laproscopic Hysterectomy/Myomectomy Procedures		Deleted	A				Yes	
58552	090	N	Feb02	30	Laproscopic Hysterectomy/Myomectomy Procedures	BA4	Apr02	A	15.09	**14.19**		Yes	Interim. To be reviewed at the September 2002 RUC Meeting.
58553	090	N	Feb02	30	Laproscopic Hysterectomy/Myomectomy Procedures	BA5	Apr02	A	19.94	**19.00**		Yes	Interim. To be reviewed at the September 2002 RUC Meeting.
58554	090	N	Feb02	30	Laproscopic Hysterectomy/Myomectomy Procedures	BA6	Apr02	A	21.73	**19.00**		Yes	Interim. To be reviewed at the September 2002 RUC Meeting.
61316	ZZZ	N	Feb02	10	Craniotomy/Cranial Bone Flap Procedures	BB4	Apr02	H	1.39	**1.39**		Yes	
61322	090	N	Feb02	10	Craniotomy/Cranial Bone Flap Procedures	BB1	Apr02	H	29.50	**29.50**		Yes	
61323	090	N	Feb02	10	Craniotomy/Cranial Bone Flap Procedures	BB2	Apr02	H	31.00	**31.00**		Yes	
61340	090	R	Feb02	10	Craniotomy/Cranial Bone Flap Procedures	BB3	Apr02	H	18.66	**18.66**	Yes	Yes	
61517	ZZZ	N	Feb02	11	Implantation Brain Interstitial/Intracavitary Chemotherapy	BC1	Apr02	I	1.38	**1.38**		Yes	

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61623	000	N	Feb02	1B	Endovascular Temporary Balloon Occlusion	BD1	Apr02	J	12.00	**9.96**		Yes	
61624	000	R	Feb02	1B	Endovascular Temporary Balloon Occlusion	BD2	Apr02	J	20.15	**20.15**	Yes	Yes	
61751	090	R	Feb02	1A	Radiological Editorial Revisions		Editorial		17.62	**17.62**	Yes	Yes	
62148	ZZZ	N	Feb02	10	Craniotomy/Cranial Bone Flap Procedures	BB5	Apr02	H	2.00	**2.00**		Yes	
62160	ZZZ	N	Aug01	U	Neuroendoscopic Surgical Procedures	I1	Feb02	25	3.15	**3.00**		Yes	
62161	090	N	Aug01	U	Neuroendoscopic Surgical Procedures	I2	Feb02	25	20.00	**20.00**		Yes	
62162	090	N	Aug01	U	Neuroendoscopic Surgical Procedures	I3	Feb02	25	28.23	**25.25**		Yes	
62163	090	N	Aug01	U	Neuroendoscopic Surgical Procedures	I4	Feb02	25	20.00	**15.50**		Yes	
62164	090	N	Aug01	U	Neuroendoscopic Surgical Procedures	I5	Feb02	25	29.50	**27.50**		Yes	
62165	090	N	Aug01	U	Neuroendoscopic Surgical Procedures	I6	Feb02	25	23.00	**22.00**		Yes	
62201	090	R	Aug01	U	Neuroendoscopic Surgical Procedures		Feb02	25	14.86	**14.86**	Yes	Yes	
62263	010	R	Aug01	V	Lysis of Epidural Adhesions Procedures	AD1	Apr02	K	6.14	**6.14**	Yes	Yes	
62264	010	N	Aug01	V	Lysis of Epidural Adhesions Procedures	AD2	Apr02	K	5.20	**4.43**		Yes	
62284	000	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.54	**1.54**	Yes	Yes	
64415	000	R	Nov01	E	Nerve Injection/Block and Daily Mgmt of Continuous Drug Administration	AE1	Apr02	L	1.48	**1.48**	Yes	Yes	Relative value shouild be work neutral
64416	010	N	Nov01	E	Nerve Injection/Block and Daily Mgmt of Continuous Drug Administration	AE2	Apr02	L	3.73	**3.50**		Yes	
64445	000	R	Nov01	E	Nerve Injection/Block and Daily Mgmt of Continuous Drug Administration	AE5	Apr02	L	1.48	**1.48**	Yes	Yes	Relative value should be work neutral
64446	010	N	Nov01	E	Nerve Injection/Block and Daily Mgmt of Continuous Drug Administration	AE6	Apr02	L	3.25	**3.25**		Yes	

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64447	000	N	Nov01	E	Nerve Injection/Block and Daily Mgmt of Continuous Drug Administration	AE3	Apr02	L	1.51	**1.50**		Yes	
64448	010	N	Nov01	E	Nerve Injection/Block and Daily Mgmt of Continuous Drug Administration	AE4	Apr02	L	3.73	**3.00**		Yes	
64450	000	R	Nov01	E	Nerve Injection/Block and Daily Mgmt of Continuous Drug Administration		Apr02	L	1.27	**1.27**	Yes	Yes	Relative value should be work neutral
66990	ZZZ	N	Aug01	J	Opthalmic Endoscopy	J1	Apr02	12	1.70	**1.51**		Yes	
69424	000	R	May01	O	Ventilating Tube Removal		Editorial		0.85	**0.85**	Yes	Yes	
70450	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		0.85	**0.85**	Yes	Yes	
70460	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.13	**1.13**	Yes	Yes	
70470	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.27	**1.27**	Yes	Yes	
70480	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.28	**1.28**	Yes	Yes	
70481	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.38	**1.38**	Yes	Yes	
70482	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.45	**1.45**	Yes	Yes	
70486	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.14	**1.14**	Yes	Yes	
70487	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.30	**1.30**	Yes	Yes	
70488	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.42	**1.42**	Yes	Yes	
70490	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.28	**1.28**	Yes	Yes	
70491	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.38	**1.38**	Yes	Yes	
70492	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.45	**1.45**	Yes	Yes	
71250	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.16	**1.16**	Yes	Yes	
71260	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.24	**1.24**	Yes	Yes	
71270	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.38	**1.38**	Yes	Yes	
72125	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.16	**1.16**	Yes	Yes	

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72126	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.22	**1.22**	Yes	Yes	
72127	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.27	**1.27**	Yes	Yes	
72128	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.16	**1.16**	Yes	Yes	
72129	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.22	**1.22**	Yes	Yes	
72130	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.27	**1.27**	Yes	Yes	
72131	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.16	**1.16**	Yes	Yes	
72132	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.22	**1.22**	Yes	Yes	
72133	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.27	**1.27**	Yes	Yes	
72192	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.09	**1.09**	Yes	Yes	
72193	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.16	**1.16**	Yes	Yes	
72194	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.22	**1.22**	Yes	Yes	
73200	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.09	**1.09**	Yes	Yes	
73201	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.16	**1.16**	Yes	Yes	
73202	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.22	**1.22**	Yes	Yes	
73700	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.09	**1.09**	Yes	Yes	
73701	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.16	**1.16**	Yes	Yes	
73702	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.22	**1.22**	Yes	Yes	
74022	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		0.32	**0.32**	Yes	Yes	
74150	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.19	**1.19**	Yes	Yes	
74160	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.27	**1.27**	Yes	Yes	
74170	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.40	**1.40**	Yes	Yes	
75901	XXX	N	Nov01	3	Fibrin Sheath/Intraluminal Obstruction Removal CVD	V3	Feb02	18	0.49	**0.49**		Yes	

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75902	XXX	N	Nov01	3	Fibrin Sheath/Intraluminal Obstruction Removal CVD	V4	Feb02	18	0.39	**0.39**		Yes	
75953	XXX	R	Feb02	3	Endovascular Repair of Iliac Artery Aneurysm		Apr02	25	1.36	**1.36**	Yes	Yes	
75954	XXX	N	Feb02	3	Endovascular Repair of Iliac Artery Aneurysm	AS2	Apr02	25	2.93	**2.93**		Yes	
76006	XXX	R	Aug01	R	Radiological Exam, Stress View		Editorial		0.41	**0.41**	Yes	Yes	
76070	XXX	R	Feb02	1A	Bone Density Studies (G Transition to CPT)	AF1	Feb02	29	0.25	**0.25**	Yes	Yes	
76071	XXX	N	Feb02	1A	Bone Density Studies (G Transition to CPT)	AF2	Feb02	29	0.22	**0.22**		Yes	
76085	ZZZ	R	Feb02	1C	Computer Aided Detection Diagnostic Mammography		Editorial		0.06	**0.06**	Yes	Yes	
76355	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.21	**1.21**	Yes	Yes	
76360	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.16	**1.16**	Yes	Yes	
76370	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		0.85	**0.85**	Yes	Yes	
76380	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		0.98	**0.98**	Yes	Yes	
76496	XXX	N	Nov01	3	Unlisted Radiology Procedures		Unlisted					No	
76498	XXX	N	Nov01	3	Unlisted Radiology Procedures		Unlisted					No	
76499	XXX	R	Nov01	3	Unlisted Radiology Procedures		Unlisted					No	
76797	XXX	N	Nov01	3	Unlisted Radiology Procedures		Unlisted					No	
76801	XXX	N	Feb02	K	Obstetrical Ultrasound	BE1	Apr02	29	0.99	**0.99**		Yes	
76802	ZZZ	N	Feb02	K	Obstetrical Ultrasound	BE2	Apr02	29	0.83	**0.83**		Yes	
76805	XXX	R	Feb02	K	Obstetrical Ultrasound	BE3	Apr02	29	1.00	**0.99**		Yes	
76810	ZZZ	R	Feb02	K	Obstetrical Ultrasound	BE4	Apr02	29	0.97	**0.98**		Yes	
76811	XXX	N	Feb02	K	Obstetrical Ultrasound	BE5	Apr02	29	1.90	**1.90**		Yes	

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76812	ZZZ	N	Feb02	K	Obstetrical Ultrasound	BE6	Apr02	29	1.78	**1.78**		Yes	
76815	XXX	R	Feb02	K	Obstetrical Ultrasound	BE7	Apr02	29	0.65	**0.65**	Yes	Yes	
76816	XXX	R	Feb02	K	Obstetrical Ultrasound	BE8	Apr02	29	0.85	**0.85**		Yes	
76817	XXX	N	Feb02	K	Obstetrical Ultrasound	BE9	Apr02	29	0.76	**0.75**		Yes	
76999	XXX	R	Nov01	3	Unlisted Radiology Procedures		Unlisted					No	
77326	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		0.93	**0.93**	Yes	Yes	
77327	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		1.39	**1.39**	Yes	Yes	
77328	XXX	R	Feb02	1A	Radiological Editorial Revisions		Editorial		2.09	**2.09**	Yes	Yes	
80900	XXX	D	Feb02	1F	TORCH Panel		CLFS					No	
83015	XXX	R	Feb02	1I	Heavy Metal Screening		CLFS					No	
83880	XXX	N	Feb02	1I	Natriuretic Peptide		CLFS					No	
83907	XXX	N	Feb02	1P	Cystic Fibrosis Mutations		CLFS					No	
84302	XXX	N	Feb02	1I	Sweat Collection Iontophoresis		CLFS					No	
85004	XXX	N	Feb02	EC-	Hematology Revision		CLFS					No	
85007	XXX	R	Nov01	K	Hematology Revision		CLFS					No	
85008	XXX	R	Nov01	K	Hematology Revision		CLFS					No	
85009	XXX	R	Nov01	K	Hematology Revision		CLFS					No	
85013	XXX	R	Nov01	K	Hematology Revisions		CLFS					No	
85014	XXX	R	Nov01	K	Hematology Revision		CLFS					No	
85018	XXX	R	Nov01	K	Hematology Revision		CLFS					No	
85021	XXX	D	Nov01	K	Hematology Revision		CLFS					No	
85022	XXX	D	Nov01	K	Hematology Revision		CLFS					No	

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85023	XXX	D	Nov01	K	Hematology Revision		CLFS					No	
85024	XXX	D	Nov01	K	Hematology Revision		CLFS					No	
85025	XXX	R	Nov01	K	Hematology Revision		CLFS					No	
85027	XXX	R	Nov01	K	Hematology Revision		CLFS					No	
85031	XXX	D	Nov01	K	Hematology Revision		CLFS					No	
85032	XXX	N	Nov01	K	Hematology Revision		CLFS					No	
85041	XXX	R	Nov01	K	Hematology Revision		CLFS					No	
85044	XXX	R	Nov01	K	Hematology Revision		CLFS					No	
85045	XXX	R	Nov01	K	Hematology Revision		CLFS					No	
85046	XXX	R	Nov01	K	Hematology Revisions		CLFS					No	
85048	XXX	R	Nov01	K	Hematology Revision		CLFS					No	
85049	XXX	N	Nov01	K	Hematology Revision		CLFS					No	
85378	XXX	R	Feb02	1J	Fibrin Degradation Products D-dimer		CLFS					No	
85379	XXX	R	Feb02	1J	Fibrin Degradation Products D-dimer		CLFS					No	
85380	XXX	N	Feb02	1J	Fibrin Degradation Products D-dimer		CLFS					No	
85576	XXX	R	Nov01	K	Hematology Revision		CLFS					No	
85585	XXX	D	Nov01	K	Hematology Revision		CLFS					No	
85590	XXX	D	Nov01	K	Hematology Revision		CLFS					No	
85595	XXX	D	Nov01	K	Hematology Revision		CLFS					No	
86348	XXX	N	Nov01	20	Fecal Leukocyte Count: G Code Transition to CPT		CLFS					No	
86915	XXX	D	Nov01	2	Bone Marrow Procedures		CLFS					No	
86930	XXX	R	Feb02	1K	Frozen Blood Laboratory Services		CLFS					No	

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	Specialty Rec	RUC Rec	Same RVU as last year?	MFS	Comments
86931	XXX	R	Feb02	1K	Frozen Blood Laboratory Services		CLFS					No	
86932	XXX	R	Feb02	1K	Frozen Blood Laboratory Services		CLFS					No	
87207	XXX	R	Aug01	Y	Hematology Revisions		Editorial		0.37	**0.37**	Yes	Yes	
87254	XXX	R	Feb02	1L	Virus Isolation: Herpes Simplex Genetically Engineered Host Cells w/o CPE Observation		CLFS					No	
87255	XXX	R	Feb02	1L	Virus Isolation: Herpes Simplex Genetically Engineered Host Cells w/o CPE Observation		CLFS					No	
88144	XXX	D	Feb02	1L	Cytopathology, Cervical or Vaginal		CLFS					No	
88145	XXX	D	Feb02	1L	Cytopathology, Cervical or Vaginal		CLFS					No	
88174	XXX	N	Feb02	1O	Cytopathology, Cervical or Vaginal		CLFS					No	
88175	XXX	N	Feb02	1O	Cytopathology, Cervical or Vaginal		CLFS					No	
89310	XXX	R	Nov02	20	Semen Analysis Not Including Huhner Test (G Code Transition to CPT)		CLFS					No	
90709	XXX	D	Feb02	12	Rubella and Mumps Virus Vaccine Live		Vaccine					No	
92612	XXX	N	Feb02	N	Speech and Language Hearing Procedures	BF12	Apr02	13	1.27	**1.27**		Yes	
92613	XXX	N	Feb02	N	Speech and Language Hearing Procedures	BF13	Apr02	13	0.99	**0.99**		Yes	
92614	XXX	N	Feb02	N	Speech and Language Hearing Procedures	BF14	Apr02	13	1.38	**1.27**		Yes	
92615	XXX	N	Feb02	N	Speech and Language Hearing Procedures	BF15	Apr02	13	0.88	**0.88**		Yes	
92616	XXX	N	Feb02	N	Speech and Language Hearing Procedures	BF16	Apr02	13	1.88	**1.88**		Yes	
92617	XXX	N	Feb02	N	Speech and Language Hearing Procedures	BF17	Apr02	13	1.10	**1.10**		Yes	

CPT Code	Global Period	Coding Change	CPT Issue Date	CPT Tab		Tracking Number	RUC Date	RUC Tab	Specialty Rec	RUC Rec	Same RVU as last year?	MFS	Comments
92700	XXX	N	Feb02	N	Speech and Language Hearing Procedures		Unlisted					No	
93012	XXX	R	Nov01	20	Telephonic Transmissionn Post-Symptom ECG (G Code Transition to CPT)		Editorial		0.00	**0.00**	Yes	Yes	
93014	XXX	R	Nov01	20	Telephonic Transmissionn Post-Symptom ECG (G Code Transition to CPT)		Editorial		0.52	**0.52**	Yes	Yes	
93268	XXX	R	Nov01	20	Patient Event Recording (G Code Transition to CPT)		Editorial		0.52	**0.52**	Yes	Yes	
93270	XXX	R	Nov01	20	Patient Event Recording (G Code Transition to CPT)		Editorial		0.00	**0.00**	Yes	Yes	
93271	XXX	R	Nov01	20	Patient Event Recording (G Code Transition to CPT)		Editorial		0.00	**0.00**	Yes	Yes	
93272	XXX	R	Nov01	20	Patient Event Recording (G Code Transition to CPT)		Editorial		0.52	**0.52**	Yes	Yes	
93580	000	N	Feb02	EC-	Percutaneous Cardiac Procedures	L1	Feb02	30	18.00	**18.00**		Yes	
93581	000	N	Feb02	EC-	Percutaneous Cardiac Procedures	L2	Feb02	30	25.00	**24.43**		Yes	
93620	000	R	Feb02	EC-	Repositioning of Electrode Catheters		Editorial		11.59	**11.59**	Yes	Yes	
93621	ZZZ	R	Feb02	EC-	Repositioning of Electrode Catheters		Editorial		2.10	**2.10**	Yes	Yes	
93622	ZZZ	R	Feb02	EC-	Repositioning of Electrode Catheters		Editorial		3.10	**3.10**	Yes	Yes	
94640	XXX	R	May02	F	Pulmonary Treatment		Editorial		0.00	**0.00**	Yes	Yes	
94650	XXX	D	May02	F	Pulmonary Treatment		Deleted					Yes	
94651	XXX	D	May02	F	Pulmonary Treatment		Deleted					Yes	
94652	XXX	D	May02	F	Pulmonary Treatment		Deleted					Yes	
94664	XXX	R	May02	F	Pulmonary Treatment		Editorial		0.00	**0.00**	Yes	Yes	
94665	XXX	D	May02	F	Pulmonary Treatment		Deleted					Yes	

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	Specialty Rec	RUC Rec	Same RVU as last year?	MFS	Comments
95015	XXX	R	Feb02	EC-	Allergy Testing		Editorial		0.15	**0.15**	Yes	Yes	
95024	XXX	R	Feb02	EC-	Allergy Testing		Editorial		0.00	**0.00**	Yes	Yes	
95027	XXX	R	Feb02	EC-	Allergy Testing		Editorial		0.00	**0.00**	Yes	Yes	
95028	XXX	R	Nov01	14	Allergy Testing		Editorial		0.00	**0.00**	Yes	Yes	
95812	XXX	R	Nov01	O	Neurology Editorial Revisions		Editorial		1.08	**1.08**	Yes	Yes	
95816	XXX	R	Nov01	O	Neurology Editorial Revisions		Editorial		1.08	**1.08**	Yes	Yes	
95819	XXX	R	Nov01	O	Neurology Editorial Revisions		Editorial		1.08	**1.08**	Yes	Yes	
95822	XXX	R	Nov01	O	Neurology Editorial Revisions		Editorial		1.08	**1.08**	Yes	Yes	
95824	XXX	R	Nov01	O	Neurological Editorial Revisions		Editorial		0.74	**0.74**	Yes	Yes	
95827	XXX	R	Nov01	O	Neurology Editorial Revisions		Editorial		1.08	**1.08**	Yes	Yes	
95867	XXX	R	Nov01	O	Neurology Editorial Revisions		Editorial		0.79	**0.79**	Yes	Yes	
95869	XXX	R	Nov01	O	Neurology Editorial Revisions		Editorial		0.37	**0.37**	Yes	Yes	
95875	XXX	R	Nov01	O	Neurology Editorial Revisions		Editorial		1.10	**1.10**	Yes	Yes	
95990	XXX	N	Nov01	15	Refilling of Implantable Infusion Pumps	AJ1	Apr02	M				Yes	No RUC recommendation. RUC to review at the September 2002 RUC meeting.
96530	XXX	R	Nov01	15	Refilling of Implantable Infusion Pumps	AJ2	Apr02	M	0.00	**0.00**	Yes	Yes	
96920	000	N	Feb02	M	Laser Treatment for Inflammatory Skin Diseases	BG1	Apr02	D	1.81	**1.15**		Yes	
96921	000	N	Feb02	M	Laser Treatment for Inflammatory Skin Diseases	BG2	Apr02	D	2.00	**1.17**		Yes	
96922	000	N	Feb02	M	Laser Treatment for Inflammatory Skin Diseases	BG3	Apr02	D	2.79	**2.10**		Yes	
99026	XXX	N	May01	J	Mandated On-call Service; In Hospital	C1	Feb02					Yes	No RUC recommendation

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	Specialty Rec	RUC Rec	Same RVU as last year?	MFS	Comments
99027	XXX	N	Aug01	J	Mandated Physican On-Call Services	C2	Feb02					Yes	No RUC recommendation
99289	XXX	R	Feb02	18	Patient Transport Codes		Feb02		2.75	**2.75**		Yes	RUC recommends adoption of relative values as submitted in May 2001.
99290	XXX	R	Feb02	18	Patient Transport Codes		Feb02		2.50	**2.50**		Yes	RUC recommends adoption of relative values as submitted in May 2001.
99293	XXX	N	Nov01	18	Pediatric Intensive Care - Neonatal Intensive Care	AK1	Feb02	C	18.00	**16.00**		Yes	
99294	XXX	N	Nov01	18	Pediatric Intensive Care - Neonatal Intensive Care	AK2	Feb02	C	9.00	**8.00**		Yes	
99295	XXX	R	Nov01	18	Pediatric Intensive Care - Neonatal Intensive Care	AK3	Apr02	N	20.00	**18.49**		Yes	
99296	XXX	R	Nov01	18	Pediatric Intensive Care - Neonatal Intensive Care	AK4	Apr02	N	8.00	**8.00**	Yes	Yes	
99297	XXX	D	Nov01	18	Pediatric Intensive Care - Neonatal Intensive Care		Deleted					Yes	
99298	XXX	R	Nov01	18	Pediatric Intensive Care - Neonatal Intensive Care	AK5	Apr02	N	2.75	**2.75**	Yes	Yes	
99299	XXX	N	Nov01	18	Pediatric Intensive Care - Neonatal Intensive Care	AK6	Apr02	N	2.50	**2.50**		Yes	
99504	XXX	R	Nov01	Q	Home Health Procedures/Services		HHA					No	
99508	XXX	D	Nov01	Q	Home Health Procedures/Services		HHA					No	
99539	XXX	D	Nov01	Q	Home Health Procedures/Services		HHA					No	
99551	XXX	R	Nov01	Q	Home Health Procedures/Services		HHA					No	
99552	XXX	R	Nov01	Q	Home Health Procedures/Services		HHA					No	
99553	XXX	R	Nov01	Q	Home Health Procedures/Services		HHA					No	
99554	XXX	R	Nov01	Q	Home Health Procedures/Services		HHA					No	
99555	XXX	R	Nov01	Q	Home Health Procedures/Services		HHA					No	

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	Specialty Rec	RUC Rec	Same RVU as last year?	MFS	Comments
99556	XXX	R	Nov01	Q	Home Health Procedures/Services		HHA					No	
99557	XXX	R	Nov01	Q	Home Health Procedures/Services		HHA					No	
99558	XXX	R	Nov01	Q	Home Health Procedures/Services		HHA					No	
99559	XXX	R	Nov01	Q	Home Health Procedures/Services		HHA					No	
99560	XXX	R	Nov01	Q	Home Health Procedures/Services		HHA					No	
99561	XXX	R	Nov01	Q	Home Health Procedures/Services		HHA					No	
99562	XXX	R	Nov01	Q	Home Health Procedures/Services		HHA					No	
99563	XXX	R	Nov01	Q	Home Health Procedures/Services		HHA					No	
99564	XXX	R	Nov01	Q	Home Health Procedures/Services		HHA					No	
99565	XXX	R	Nov01	Q	Home Health Procedures/Services		HHA					No	
99566	XXX	R	Nov01	Q	Home Health Procedures/Services		HHA					No	
99567	XXX	R	Nov01	Q	Home Health Procedures/Services		HHA					No	
99568	XXX	R	Nov01	Q	Home Health Procedures/Services		HHA					No	
99569	XXX	R	Nov01	Q	Home Health Procedures/Services		HHA					No	
99600	XXX	N	Nov01	Q	Home Health Procedures/Services		HHA					No	

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CPT Code	RUC Meeting Month	Median Pre-Service Time	Median Intra-Service Time	Immediate Post Service Time	99291 Visit	99292 Visit	99231 Visit	99232 Visit	99233 Visit	99238 Visit	99239 Visit	99211 Visit	99212 Visit	99213 Visit	99214 Visit	99215 Visit	Global Period	Tracking Number	Total Time
00326	April 2002	30	50	20													XXX	N2	100.00
00539	April 2002	30	240	30													XXX	O4	300.00
00540	April 2002	30	150	25													XXX	O2	205.00
00541	April 2002	30	150	22.5													XXX	O3	202.50
00640	February 2002	15	27.5	10													XXX	D1	52.50
00834	April 2002	20	60	15													XXX	P3	95.00
00836	April 2002	30	60	20													XXX	P4	110.00
01382	April 2002	15	47.5	10													XXX	R1	72.50
01400	April 2002	15	120	15													XXX	R2	150.00
01464	April 2002	17.5	75	10													XXX	R3	102.50
01622	April 2002	15	75	15													XXX	R4	105.00
01630	April 2002	20	90	15													XXX	R5	125.00
01732	April 2002	20	75	15													XXX	R6	110.00
01740	April 2002	20	90	15													XXX	R7	125.00
01829	April 2002	15	60	10													XXX	R8	85.00
01830	April 2002	19	90	15													XXX	R9	124.00
01991	February 2002	15	30	10	~~20~~?												XXX	Q1	55.00
01992	February 2002	15	30	10	~~20~~												XXX	Q2	55.00
11981	April 2002																XXX		39.00
11982	April 2002																XXX		44.00
11983	April 2002																XXX		69.00
17310	April 2002		20														ZZZ	M5	20.00
20526	April 2002	6	5	5													000	AM1	16.00
20550	April 2002	10	5	5													000	AM2	20.00
20551	April 2002	10	5	5													000	AM3	20.00
20552	April 2002	5	5	3.5													000	AM4	13.50
20553	April 2002	7	10	5													000	AM5	22.00
20612	April 2002	10	5	5													000	AM6	20.00
21046	April 2002	75	120	30			1			1			3	3			090	F4	394.00
21047	April 2002	90	240	40			2			1			3	3			090	F5	558.00
21048	April 2002	75	120	30			1			1			3	3			090	F6	394.00
21049	April 2002	90	225	40			2			1			3	3			090	F7	543.00
24344	February 2002	60	120	30			1			1			3	3			090	JJ6	379.00
24346	February 2002	60	120	30			1			1			3	3			090	JJ8	379.00

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29827	April 200	75	120	40						0.5			5				090	AO2	328.00
29873	April 2002	75	45	30						0.5			5				090	AP5	243.00
29899	April 2002	75	120	30			2			1				4			090	AP6	391.00
33215	April 2002	20	60	25			1			1			1				090	AQ1	175.00
33224	April 2002	20	135	30						0.5							000	AQ4	203.00
33225	April 2002		120														ZZZ	AQ5	120.00
33226	April 2002	25	120	25						0.5							000	AQ6	188.00
33508	April 2002		10														ZZZ	S1	10.00
33979	April 2002	120	410	150													XXX	KK5	680.00
33980	April 2002	178	360	108	5	4	2	9	2		1			2	3		090	KK7	1999.00
34833	April 2002	75	100	27						0.5							000	AR1	220.00
34834	April 2002	70	30	35						0.5							000	AR2	153.00
34900	April 2002	105	120	30			1			1			1	1			090	AS1	348.00
35572	April 2002		60														ZZZ	AT1	60.00
36536	February 2002	30	45	15													000	V1	90.00
36537	February 2002	23	9	5													000	V2	37.00
37182	February 2002	30	150	30													000	W1	210.00
37183	February 2002	27.5	77.5	30													000	W2	135.00
37500	April 2002	60	90	30						0.5			1	2			090	AU1	259.00
38204	April 2002	0	~~20~~	~~52.5~~	0												XXX	AV1	~~72.50~~
38205	April 2002	38	~~38~~	~~60~~ 45	30	OK all											000	~~XXX~~	~~113.00~~
38206	April 2002	40	35	20													000	X2	95.00
38207	April 2002	2.5	20	12.5													XXX	X3	35.00
38208	April 2002	5	24	5													XXX	X4	34.00
38209	April 2002	5	25	10													XXX	X5	40.00
38210	April 2002	10	23	20													XXX	X6	53.00
38211	April 2002	5	25	10													XXX	X7	40.00
38212	April 2002	5	12.5	15													XXX	X8	32.50
38213	April 2002	10	20	10													XXX	X9	40.00
38214	April 2002	5	10	5													XXX	X10	20.00
38215	April 2002	5	25	15													XXX	X11	45.00
38242	April 2002	30	30	20													XXX	X12	80.00
43201	April 2002	12	25	27.5													000	G1	64.50
43236	April 2002	27	35	23.5													000	G2	85.50
43245	April 2002	27	40	23.5													000		90.50
44206	April 2002	70	180	35			2	1	3	1			1	1	1		090	AW1	588.00
44207	April 2002	75	195	35			1	2	1	1			1	2			090	AW2	522.00
44208	April 2002	75	205	35			3	3		1			1	2			090	AW3	559.00

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44210	April 2002	75	240	35			3	2		1			1	2	1		090	AW4	602.00
44211	April 2002	80	300	35			3	2		1			1	2	1		090	AW5	667.00
44212	April 2002	75	270	35			3	2		1			1	2	1		090	AW6	632.00
44701	April 2002		35														ZZZ	AX1	35.00
45335	April 2002	7	23	10													000	G3	40.00
45340	April 2002	17	25	16													000	G4	58.00
45381	April 2002	45	49	22													000	G5	116.00
45386	April 2002	45	54	22													000	G6	121.00
46706	April 2002	35	15	15						0.5			1				010	AY1	98.00
47370	February 2002	80	180	30			1	1		1			1	2			090		436.00
47371	February 2002	80	180	35			1	1		1			1	2			090		441.00
47380	February 2002	85	200	45			2	2		1			1	2			090		525.00
47381	February 2002	85	210	45			2	2		1			1	2			090		535.00
47382	February 2002	30	180	30						0.5			1				010		273.00
49419	February 2002	60	60	30			1			1				1			090	H1	228.00
49904	February 2002	83	205	30			5	3		1			3	2			090	B2	630.00
50542	February 2002	75	180	30				1		1				2	1		090	Y1	435.00
50543	February 2002	60	240	30			2	1		1				3	1		090	Y2	541.00
50562	April 2002	46	92.5	30						0.5							000	Y3	186.50
51701	April 2002																000	Z1	25
51702	April 2002		8														000	Z2	20
51703	April 2002		30														000	Z3	56
51798	April 2002	5	4														XXX	AA1	9.00
53440	February 2002	58	100	30				2		1				4 X	+	need to AR	090	376 AB1	391.00
53442	February 2002	65	90	30				2		1				4 ~~3~~	+	need to AR	090	373 AB2	~~388.00~~
55866	February 2002	80	310	40				2		1			1	2	1		090	Y4	625.00
56820	April 2002	15	15	10													000	AZ1	40.00
56821	April 2002	15	20	10													000	AZ2	45.00
57420	April 2002	14.14	18.52	10													000	AZ3	42.66
57421	April 2002	15	20	10													000	AZ4	45.00
57452	April 2002	15	15	10													000	AZ5	40.00
57454	April 2002	15	20	10													000	AZ6	45.00
57455	April 2002	15	20	10													000	AZ7	45.00
57456	April 2002	15	20	10													000	AZ8	45.00
57460	April 2002	15	25	10													000	AZ9	50.00
57461	April 2002	15	28	15													000	AZ10	58.00
58146	April 2002	70	150	30			2		1	1				2			090	AC3	411.00
58290	April 2002	75	120	30				2		1				2			090	AC9	367.00

	Physician Time																		
58291	April 2002	75	141	30				2		1				2			090	AC10	388.00
58292	April 2002	75	154	30				2		1				2			090	AC11	401.00
58293	April 2002	75	164	30				2		1				2			090	AC12	411.00
58294	April 2002	75	136	30				2		1				2			090	AC13	383.00
58545	April 2002	60	120	30			2	1		1				2			090	BA1	360.00
58546	April 2002	70	150	30			2		1	1				2			090	BA2	411.00
58552	April 2002																090	BA4	351.00
58553	April 2002	75	120	30				2		1				1			090	BA5	344.00
58554	April 2002	75	120	30				2		1				2			090	BA6	367.00
61316	April 2002		20														ZZZ	BB4	20.00
61322	April 2002	90	150	50			7	3	4	1			1	3			090	BB1	797.00
61323	April 2002	90	180	50			8	3	3	1			1	2			090	BB2	782.00
61517	April 2002		15														ZZZ	BC1	15.00
61623	April 2002	50	90	45													000	BD1	185.00
62148	April 2002		30														ZZZ	BB5	30.00
62160	February 2002		40														ZZZ	I1	40.00
62161	February 2002	85	90	45			2	1		1			1	2			090	I2	385.00
62162	February 2002	108	148	40			2	2		1			1	2			090	I3	491.00
62163	February 2002	78	90	30			3			1			1	2			090	I4	352.00
62164	February 2002	90	165	40			2	3		1			2	2			090	I5	535.00
62165	February 2002	85	180	45			2	1		1			1	2			090	I6	475.00
62263	April 2002	40	30	20			2			1			2				010	AD1	194.00
62264	April 2002	40	30	20						0.5							010	AD2	108.00
64416	April 2002	30	30	20			3										010	AE2	137.00
64446	April 2002	15	27.5	15			3										010	AE6	114.50
64447	April 2002	25	15	12.5													000	AE3	52.50
64448	April 2002	23.5	25	15			3										010	AE4	120.50
66990	April 2002		20														ZZZ	J1	20.00
75901	February 2002	4	9	5													XXX	V3	18.00
75902	February 2002	5	10	5													XXX	V4	20.00
75954	April 2002	20	45	20													XXX	AS2	85.00
76071	February 2002	3	12	5													XXX	AF2	20.00
76085	February 2002		1														ZZZ		1.00
76092	April 2002	2	5	5													XXX		12.00
76362	February 2002	20	120	15													XXX		155.00
76394	February 2002	20	165	15													XXX		200.00
76490	February 2002	20	120	15													XXX		155.00
76801	April 2002	5	15	7													XXX	BE1	27.00

	Physi[redacted]Time																		
76802	April 2002		10														ZZZ	BE2	10.00
76805	April 2002	5	15	6													XXX	BE3	26.00
76810	April 2002		20														ZZZ	BE4	20.00
76811	April 2002	10	30	12													XXX	BE5	52.00
76812	April 2002		25														ZZZ	BE6	25.00
76815	April 2002	5	5.5	5													XXX	BE7	15.50
76816	April 2002	6	15	10													XXX	BE8	31.00
76817	April 2002	5	10	8													XXX	BE9	23.00
92612	April 2002	10	15	7													XXX	BF12	32.00
92613	April 2002	3	10	10													XXX	BF13	23.00
92614	April 2002	8	15	5													XXX	BF14	28.00
92615	April 2002	2	10	10													XXX	BF15	22.00
92616	April 2002	10	25	10													XXX	BF16	45.00
92617	April 2002	3	15	10													XXX	BF17	28.00
93580	February 2002	30	120	60													000	L1	210.00
93581	February 2002	30	180	60													000	L2	270.00
93609	February 2002		90														ZZZ	VV4	90.00
93613	February 2002		120														ZZZ	VV3	120.00
96004	February 2002		73														XXX		73.00
96920	April 2002	5	17	5													000	BG1	27.00
96921	April 2002	5	20	5													000	BG2	30.00
96922	April 2002	5	30	5													000	BG3	40.00
99293	April 2002	30	180	30													XXX	AK1	240.00
99294	April 2002	20	90	30													XXX	AK2	140.00
99295	April 2002	60 ~~45~~	~~105~~ 180	60 ~~48.75~~													XXX	AK3	~~273.75~~ 325
99296	April 2002	30 ~~25~~	~~70~~ 90	30													XXX	AK4	~~145~~ 132.00
99299	April 2002	10	30	15													XXX	AK6	55.00

120
145
265

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Anesthesia Service for Larynx and Trachea Procedures in Children under the Age of 1

CPT created code 00326 and revised 00320 to differentiate the anesthesia work in infants less than 1 year of age and patients greater than one year. The new code was created to specifically recognize the greater work, method, and risk of anesthesia for these young patients as opposed to the typical patient currently reflected in code 00320.

00326
The RUC focused on placing the new code 00326 in proper rank order with other ASA codes. The RUC agreed that the provision of anesthesia in children less that 1 year of age involves additional physician work. In these patients, pulmonary and cardiac reserve are significantly reduced compared to older children and healthy adults. In practice, the anesthesiologist faces a much greater probability of managing hypoxemia. Also, the work of breathing is directly proportional to airway resistance. Since the dimensions of the airway are much smaller than in the adult, even small amounts of airway edema or trauma produces dramatic increases in the work of breathing and the potential for respiratory failure. Surgical procedures involving the larynx and trachea are associated with a much higher risk of airway edema and trauma. This issue is particularly relevant to code 00326. To account for the additional physician work, the RUC agreed that code 00326 should have one additional base unit. Therefore the resulting value of 7 base units is equal to code 00320 *Anesthesia for all procedures on esophagus, thyroid, larynx, trachea and lymphatic system of neck; not otherwise specified, age one year or older* (base unit 6), plus code 99100 *Anesthesia for patient of extreme age, under one year and over seventy (List separately in addition to code for primary anesthesia procedure)* (base unit 1), resulting in a base unit value of 7. **The RUC recommends 7 base units for code 00326.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Base Unit Recommendation
▲00320	N1	Anesthesia for all procedures on esophagus, thyroid, larynx, trachea and lymphatic system of neck; not otherwise specified, age 1 year or older	XXX	6 (no change)
●00326	N2	Anesthesia for all procedures on the larynx and trachea in children less than 1 year of age (Do not report 00326 in conjunction with code 99100)	XXX	7

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 00326 Tracking Number: N2 Global Period: XXX **Recommended Base Unit Value:** ~~8~~
RUC Recommendation: 7

CPT Descriptor: Anesthesia for all procedures on the larynx and trachea in children less than 1 year of age

(Do not report 0032X in conjunction with code 99100)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is a 4 month-old, 5 kg infant noted to have noisy breathing worsening on excitement. The patient was born at 35 weeks gestational age. The patient was discharged home on day four after bilirubin levels were noted to be decreasing. Stridor was noted to be present on inspiration when crying and has become worse in the past two weeks. The baby is noted to be of normal color and has a mild suprasternal notch tug on quiet inspiration. When crying there is inspiratory stridor associated with significant chest retractions. A laryngoscopy and rigid bronchoscopy are planned.

Description of Pre-Service Work: There is no significant family history for congenital diseases or adverse anesthesia reactions. The patient is on iron fortified formula and takes no medications. There are no known allergies. The patient weighs 5 kg. Vital signs are appropriate for age. The baby is noted to be of normal color and has a mild suprasternal notch tug on quiet inspiration. When crying there is inspiratory stridor associated with significant chest retractions. No change in color is noted. The airway is noted to be of normal appearance. The breath sounds are clear bilaterally. The heart is auscultated with normal rate and rhythm. No murmur is heard. No other obvious congenital abnormalities are noted. Significant laboratory results include a hematocrit of 32%. After discussion of the anesthetic options, the parents agree to a general anesthetic with induction by ma Anesthesia risk with particular attention to the heightened risk of respiratory complications in this particular ca are discussed and informed consent is obtained. Before initiating anesthesia, anesthetic drugs are prepared and the anesthesia machine is checked for correct operation following the manufacturer's guidelines.

Description of Intra-Service Work: An intramuscular injection of atropine is administered. The baby is transported to the operating room where monitors are placed. A forced air mattress is in place as are heating lamps. Anesthesia is gradually induced by volatile agent through a mask. Intravenous access is secured. The anesthetic is slowly deepened with careful attention to blood pressure. When the baby is sufficiently anesthetized, laryngoscopy is performed and topical local anesthesia is sprayed in the trachea and on the larynx. The airway is again secured by mask, vital signs are checked. Caffeine 10 mg/kg is intravenously administered.

The baby is turned to the bronchoscopist with careful attention to the patency of the airway. The mask is removed and the bronchoscopist performs laryngoscopy and placement of a rigid bronchoscope into the trachea. The anesthesia circuit is attached to the bronchoscope and adequate ventilation is determined by carbon dioxide monitoring, chest excursion with positive pressure ventilation and auscultation of breath sounds. Pulse oximetry and end tidal carbon dioxide are continuously and closely monitored throughout the procedure. An endotracheal tube is placed by the anesthesiologist after bronchoscopy ends. During the direct laryngoscopy, the anesthesiologist evaluates the airway for trauma and edema. If either is present in significant amount, the anesthesiologist must determine whether the patient needs to remain intubated in the post-operative period. Due to the very small tracheal diameter of the neonate and infant, even small amounts of edema, secretions or airway trauma can significantly increase the patient's work of breathing, leading to potential respiratory failure. In this case, trauma and edema are minimal thus the anesthetic gases are discontinued. Emergence from anesthesia ensues.

When the infant demonstrates sufficient strength and awareness by opening the eyes, the endotrachea tube is removed and the patient observed for air movement with inspiration. The patient is carefully evaluated for increased work of breathing as evidenced by stridor, sternal and intercostal retraction, and tachypnea. Pulse oximetry and end tidal carbon dioxide are verified. When the patient is stable, transport to recovery with monitors and supplemental oxygen takes place.

Description of Post-Service Work: The anesthesiologist provides a report to the post-anesthesia nurse, covering the patient's history and anesthetic course. Vital signs are obtained and the anesthesiologist provides orders for oxygen therapy, analgesia and nausea treatment. The anesthesiologist remains available to the PACU nurse by pager, until the patient is discharged from the recovery area. The patient is monitored for a prolonged period in the recovery room prior to transfer to the inpatient unit. The infant is placed on continuous pulse oximetry and respiratory monitors. When the baby has been stable for a period of at least six hours, with no evidence of apnea, discharge to home occurs.

SURVEY DATA:

Presenter(s) Karl E. Becker, MD, Norman A. Cohen, MD

Specialty(s): American Society of Anesthesiologists

Sample Size: 34_ Response Rate: (%): 24% Median Base Unit Value: 8.0

Type of Sample (Circle One): random, **panel**, convenience. Explanation of sample size: Sent e-mails to 142 physicians

25th Percentile Base Unit Value: 7.0 75th Percentile Base Unit Value: 10.0 Low: 6.0 High: 14.0

Median Pre-Service Time: 30.0 Median Intra-Service Time: 50.0

25th Percentile Intra-Svc Time: 45.0 75th Percentile Intra-Svc Time: 60.0 Low: 15.0 High: 120.0

Median Post-Service Time: 20.0

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	20	Included
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Base Unit Value
00520	Anesthesia for closed chest procedures; (including bronchoscopy) NOS	XXX	6

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including 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: 0032X**	**Key Reference CPT Code: 00520 RUC**
Median Pre-Time	30	N/A
Median Intra-Time	50	N/A
Median Immediate Post-service Time	20	N/A
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	3.94	3.17
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.59	3.25
Urgency of medical decision making	4.44	3.67

Technical Skill/Physical Effort (Mean)

Technical skill required	4.68	3.67
Physical effort required	3.91	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.79	3.67
Outcome depends on the skill and judgement of physician	4.65	3.75

Estimated risk of malpractice suit with poor outcome	4.71	4.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service
Time Segments (Mean)		
Pre-Service intensity/complexity	4.00	2.82
Intra-Service intensity/complexity	4.64	3.45
Post-Service intensity/complexity	4.06	3.09

ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after deliberation of this procedure by the ASA RVS Committee 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 as well as the pre- and post- service times all support a base unit value the same as the survey median, 2 units greater than the reference service base unit value.

FREQUENCY INFORMATION

How was this service previously reported? ____00320_____ (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

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___<100____

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

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AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Anesthesia Services: Intrathoracic

CPT created two new codes to better describe current clinical practice for anesthetic management of patients undergoing thoracic surgery procedures.

00528 The specialty society requested to withdraw code 00528 so that it can be brought back to CPT for further refinement. The specialty society requested that CPT delete the change for 2003, and at the May 2002 CPT Meeting the changes were rescinded. In addition, the specialty society will consider whether they will return to CPT to create an additional code.

00540 The recommended value of 12 base units is based on a comparison with the reference service, 00520 *Anesthesia for closed chest procedures; (including bronchoscopy) not otherwise specified* (base unit 13). Evaluation of the results of the survey intensity/complexity measures supports a base unit value the same as the base unit value for CPT code 00540 (13). However, since approximately 35-40% of procedures reported under 00540 will now be reported under 00541, the overall work for 00540 will decrease. The RUC agreed with the presenters that a base unit value of 12 accounts for this change and is an appropriate work neutrality adjustment. **The RUC recommends 12 base units for code 00540**

00541 The RUC compared code 00541 to other ASA codes with base units of 15 and concluded that the results of the survey intensity/complexity measures supports a base unit value the same as the survey median of 15 base units. Also, in comparison to the reference service 00546, *Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); pulmonary resection with thoracoplasty* (base unit = 15), the RUC concluded that the two codes involve similar anesthesia work and therefore should have the same base unit value of 15 units. Additionally, to achieve proper rank order, the new code should have 2 units more than base units than CPT code 00540, *Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); not otherwise specified* (base unit = 13), which this new CPT code now enhances and defines to account for the increased work, intensity and complexity of one lung anesthesia. It is estimated that this service will only be provided to Medicare beneficiaries 100 times a year. **The RUC recommends 15 base units for code 00541**

00539 The RUC based its recommendation primarily by comparing the code to the reference procedure 00546 *Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); pulmonary resection with thoracoplasty* (base unit = 13), as well as the other codes in the family. The RUC concluded that to maintain proper

rank order, the code should have a base unit value 3 more than the reference service base unit value, and 5 units more than the base unit value for current CPT code 00540, *Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); not otherwise specified* (base unit = 13), which this new CPT code now refines and enhances to account for the increased work, intensity and complexity measures (especially stress and technical skill required for anesthesia for tracheal-bronchial reconstruction). **The RUC recommends 18 base units for code 00539.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Base Unit Recommendation
▲*00528*	O1	Anesthesia for closed chest procedures; mediastinoscopy and diagnostic thoracoscopy (For tracheobroncial reconstruction, use 0054X2)	*XXX*	CPT changes withdrawn, pending further refinement
▲*00540*	O2	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); not otherwise specified	*XXX*	12
●00541	O3	utilizing one lung ventilation	*XXX*	15
●00539	O4	Anesthesia for tracheobronchial reconstruction	*XXX*	18

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 00540 Tracking Number: O2 Global Period: XXX **Recommended Base Unit Value:** 12

CPT Descriptor: Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); not otherwise specified

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67 year old female with a 50 pack year smoking history, COPD, diet-controlled diabetes mellitus, and hypertension presents with a right lower lobe mass and lung washings positive for malignancy. ECG shows non-specific changes; hemoglobin, blood sugar and electrolytes are within normal limits. PFTs show a decreased FEV_1. The patient is scheduled for a thoracotomy, lung biopsy and probable RLL resection.

Description of Pre-Service Work: Pre-service work includes the pre-operative visit and evaluation of the patient's cardiovascular, neurological and pulmonary systems with special attention to pulmonary function. Pre-service work also includes the review of appropriate pulmonary function tests, ECG, ABGs, other laboratory tests, medications, allergies, past medical and surgical history, and any consultant reports. Alternatives to anesthesia management and associated risks are explained and discussed with the patient. Questions are answered. Consent for anesthesia is obtained. On the day of surgery, the patient is identified, the surgical and anesthesia consents are verified, and the site of surgery is confirmed. The chart is reviewed with particular attention to the vital signs, relevant laboratory tests and other pre-operative studies. The medical and surgical history is again briefly reviewed with the patient. Discussion of the options for anesthesia care, including relative risks and advantages, is again explained. In addition IV access is secured and suitable monitoring equipment (arterial pressure, CVP or Swan-Ganz monitoring transducers) is setup and calibrated. Before initiating anesthesia, anesthetic drugs are prepared and the anesthesia machine is checked for correct operation following the manufacturer's guidelines

Description of Intra-Service Work: Intra-service work includes: transporting patient to OR; positioning of patient on OR table; and application of routine monitors (ECG, BP cuff, pulse oximeter); connection and calibration of arterial line and central venous catheter or PA catheter; preoxygenation by mask; induction of anesthesia with intravenous lidocaine, fentanyl, propofol and a neuromuscular blocking agent; laryngoscopy and insertion of an endotracheal tube; confirmation of correct endotracheal tube position and securing the endotracheal tube; protection of eyes; delivery of inhalational and intravenous anesthetics; constant attention to vital signs; constant monitoring of oxygenation and respiratory status and degree of neuromuscular block; intervening to maintain normothermia, regulation of depth of anesthesia and control of blood pressure and cardiac output. The patient remains paralyzed and his ventilation controlled throughout the procedure. During the case, ABG's are obtained and respiratory parameters changed as needed to ensure patient stability and homeostasis. Increased oxygen concentrations, hand ventilation, or application of PEEP may be necessary during surgical manipulation or resection of the lung to maintain adequate oxygenation of the patient. Intravenous fluids are given to maintain hydration and treat hypotension. Following completion of the surgical procedure, the inhalation agents are withdrawn and residual neuromuscular blockade is reversed using anticholinesterase and anticholinergic drugs. Adequacy of spontaneous ventilation and return of neuromuscular function is determined, and, if satisfactory, the trachea is extubated. Spontaneous ventilation is further assessed by mask. If ventilation and oxygenation are satisfactory, and if emergence from anesthesia is apparent, the patient is then moved to a stretcher and transferred with supplemental oxygen by facemask to the post-anesthesia care unit.

Description of Post-Service Work: The patient is transported to the recovery room and stabilized. Vital signs are checked, and level of consciousness is determined. Adequacy of ventilation, maintenance of airway, and ability to handle secretions are again assessed. Cardiovascular and respiratory status is closely monitored. A brief summary of the procedure and the patient's medical history is conveyed to the PACU n' and the patient's immediate care is transferred to the recovery room personnel. The patient's condition is repo. frequently to the anesthesiologist who makes appropriate medical decisions regarding: control of pain, adequacy of respiration, and discharge to the intensive care unit. Interpretation of ABG's and regulation of blood pressure and circulation are required in the immediate post-operative period. After the patient's vital signs are stable, after an appropriate level of consciousness has returned, after oxygenation is adequate, and after the analgesic needs are satisfied, the patient is discharged from the PACU to the intensive care unit.

The patient is seen on the first post-operative day and evaluated for any post-anesthesia problems. The patient's questions and concerns are addressed.

SURVEY DATA:

Presenter(s) Karl E. Becker, MD, Norman A. Cohen, MD

Specialty(s): American Society of Anesthesiologists

Sample Size: 25 Response Rate: (%): 17% Median Base Unit Value: 15.0

Type of Sample (Circle One): random, **panel**, convenience. Explanation of sample size: Sent e-mails to 142 physicians

25th Percentile Base Unit Value: 14.5 75th Percentile Base Unit Value: 15.0 Low: 13.0 High: 30.0

Median Pre-Service Time: 30.0 Median Intra-Service Time: 150.0

25th Percentile Intra-Svc Time: 120.0 75th Percentile Intra-Svc Time: 180.0 Low: 90.0 High: 500.0

Median Post-Service Time: 25.0

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	25	Included
Critical Care:		
Other Hospital Visits:	19	99231, Included
Discharge Day Mgmt.:		
Office Visits:		

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Base Unit Value
00546	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); pulmonary resection with thoracoplasty	XXX	15

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: 00540**	**Key Reference CPT Code: 00546**
Median Pre-Time	30.0	not available
Median Intra-Time	150.0	not available
Median Immediate Post-service Time	25.0	not available
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	4.16	4.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.08	4.25
Urgency of medical decision making	4.16	4.58

Technical Skill/Physical Effort (Mean)

Technical skill required	4.36	4.50
Physical effort required	4.04	4.42

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.20	4.58
Outcome depends on the skill and judgement of physician	4.36	4.50

Estimated risk of malpractice suit with poor outcome	3.68	3.83

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service
Time Segments (Mean)		
Pre-Service intensity/complexity	3.96	4.27
Intra-Service intensity/complexity	4.38	4.50
Post-Service intensity/complexity	4.04	4.18

ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after deliberation of this procedure by the ASA RVS committee 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 2 less than the survey median but the same as the base unit value for current CPT code 00540 (13).

Since approximately 35-40% of procedures reported under 00540 will now be reported under 0054X1, the ove work for 00540 will decrease. We recommend a base unit value of 12 for 00540 to account for this change.

FREQUENCY INFORMATION

How was this service previously reported? 00540 (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 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 Anesthesiology Frequency 60,000

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 28,000

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 00541 Tracking Number: O3 Global Period:XXX **Recommended Base Unit Value:** 15

CPT Descriptor: Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastii. (including surgical thoracoscopy); utlilzing one lung ventilation

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 64-year-old male is scheduled for a thoracoscopic left upper lobectomy for carcinoma of the lung. The patient has a long smoking history. He has coronary artery disease with previous myocardial infarction, although his ventricular function is good; he has had no recent chest pain. The surgeon is concerned about possible post-obstructive infection in the left upper lobe. To facilitate the surgical procedure, the surgeon has requested isolation of the lung. A double lumen endotracheal tube will be placed and the positioning of the tube confirmed by fiberoptic bronchoscopy.

Description of Pre-Service Work: The patient is seen in the pre-operative clinic the day before surgery. The anesthesiologist reviews the surgical history, physical and consent, consultant notes, nursing notes, pulmonary function tests, ECG, ABG and other laboratory tests. The anesthesiologist interviews the patient covering the history of present illness, medications, allergies, previous surgical and anesthetic history, family history of anesthetic complications, personal and social history including tobacco and alcohol use, and a complete review of systems with particular emphasis on the cardiovascular, respiratory and neurological systems. Due to the impact of one-lung ventilation on the patient, the anesthesiologist must evaluate the patient's ability to tolerate the stress of selective ventilation. In particular, a preoperative assessment of pulmonary vascular resistance or non-invasive assessment of cardiac function (e.g., trans-thoracic or trans-esophageal echocardiography) may be part of the medical decision making of the evaluating anesthesiologist. A focused physical examination evaluates the patient's airway, neck range of motion, heart and lungs. General anesthesia and its associated risks with emphasis on respiratory complications are discussed at length with the patient. The patient's questions are answered and informed consent is obtained. Any additional, clinically indicated laboratory studies are ordered. The patient is given instructions to consume no food or fluid 6 hours before surgery and to take his anti-anginals and anti-hypertensive medications on the morning of surgery.

On the day of surgery, the anesthesiologist again reviews the chart, evaluates additional laboratory studies, interviews the patient and confirms that the patient has remained NPO. The patient's questions and concerns are addressed. IV access is secured and suitable monitoring equipment (arterial pressure, CVP or Swan-Ganz monitoring transducers) is setup and calibrated. Before initiating anesthesia, anesthetic drugs are prepared and the anesthesia machine is checked for correct operation following the manufacturer's guidelines. Selective lung ventilation requires either placement of a double lumen endobronchial tube or, less commonly, a bronchial blocker. To place a double lumen tube, the anesthesiologist selects an appropriate size, considering the height and gender of the patient. Additionally, the anesthesiologist determines whether to use a right or left sided tube, considering the site of surgery. The tube is assembled and cuffs are tested during the pre-service period. A fiberoptic bronchoscope is used to confirm correct positioning, and the bronchoscopic equipment is assembled and tested before bringing the patient to the room.

Description of Intra-Service Work: The patient is brought to the operating room and transferred to the operating table. ECG, blood pressure cuff, and pulse oximeter are applied. Any invasive monitors placed pre-operatively (separately reported) are connected and calibrated. The patient receives 100% oxygen for several minutes, follow by intravenous induction with propofol, fentanyl and vecuronium. After adequate neuromuscular blockade is obtained, the anesthesiologist performs a direct laryngoscopy. He carefully passes the endobronchial tube into the trachea, being careful to not tear the cuff on the patient's teeth. The tube is rotated 90 degrees to allow the tip to pass into the left mainstem bronchus. The tracheal cuff is inflated and the anesthesiologist ventilates the patient and

auscultates both lungs. Carbon dioxide is present, confirming tracheal placement. The anesthesiologist clamps the tracheal lumen and performs a fiberoptic brochoscopy down the tracheal lumen. He locates the carina and confirms that the tube tip is in the left mainstem bronchus. He carefully inflates the bronchial cuff to confirm that the cuff does not herniate into the trachea. The tube is secured with tape. Eyes are taped closed. The patient is turned to the lateral position with the operative side up. He is secured into the operative position, using a bean bag positioner and is taped in place. Pressure points are checked and padded. A forced air warming blanket is applied to maintain normothermia. A repeat bronchoscopic examination is performed to confirm that the tube has remained in the correct position. After skin preparation and draping, the surgeon makes the incision. Once the thoracic cavity is entered, the anesthesiologist initiates one-lung ventilation by clamping the lumen to the operative lung. He and the surgeon confirm deflation of the lung. During the period of single-lung ventilation, the anesthesiologist carefully monitors the patient's oxygenation status with pulse oximetry and serial ABG's. Ventilation is adjusted as needed and CPAP may be applied to the operative lung if oxygenation cannot be maintained at adequate levels. Anesthetic depth is adjusted using opiates and inhalational agents to match the level of surgical stimulation. Blood pressure and heart rate are closely observed. Episodes of hypotension and arrhythmias may be due to mechanical compression of the heart, and the anesthesiologist must observe the surgical field and advise the surgeon if these events occur. The anesthesiologist records vital signs, administered medications and significant events on the anesthesia record consistent with facility policies. At the conclusion of the lung resection, the anesthesiologist resumes two lung ventilation, adjusting ventilation to assure complete re-expansion of the operative lung. The patient is gently hand ventilated during closure of the chest wall, facilitating closure. At the conclusion of the procedure and once the chest tubes are connected to suction, the patient is turned to the supine position. Anesthetic agents are discontinued and neuromuscular blockade is reversed with anticholinesterase and anticholinergic agents. The patient is evaluated for adequacy of respiratory effort, level of consciousness, and reversal of neuromuscular agents. If the patient meets requirements, extubation will occur. On occasion, the patient will not be able to tolerate early extubation. In this circumstance, the anesthesiologist will perform a direct laryngoscopy and exchange the double-lumen tube for a single-lumen tube. The patient is transferred to the PACU, receiving oxygen and with ECG and pulse oximetry monitored.

Description of Post-Service Work: The patient is transported to the recovery room and stabilized. Cardiovascular and respiratory status is closely monitored. If the patient remains intubated and requires ventilatory assistance, the anesthesiologist will provide initial ventilator settings. The anesthesiologist provides a report of the patient's history and anesthetic course to the post-anesthesia nurse. The anesthesiologist orders analgesics and anti-emetics as indicated by the patient's condition. The patient's immediate care is transferred to the recovery room personnel and the patient's condition is reported frequently to the anesthesiologist who makes appropriate medical decisions regarding control of pain, adequacy of respiration, control of mechanical ventilation, timing of extubation and discharge to the intensive care unit. Interpretation of ABG's and regulation of blood pressure and circulation are required in this immediate post-op period

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SURVEY DATA:

Presenter(s) Karl E. Becker, MD, Norman A. Cohen, MD

Specialty(s): American Society of Anesthesiologists

Sample Size: 26 Response Rate: (%): 18% Median Base Unit Value: 15.0

Type of Sample (Circle One): random, **panel**, convenience. Explanation of sample size: Sent e-mails to 142 physicians

25th Percentile Base Unit Value: 15.0 75th Percentile Base Unit Value: 17.0 Low: 12.0 High: 45.0

Median Pre-Service Time: 30.0 Median Intra-Service Time: 150.0

25th Percentile Intra-Svc Time: 125.0 75th Percentile Intra-Svc Time: 180.0 Low: 30.0 High: 300.0

Median Post-Service Time: 22.5 Level of Service by CPT Code

	Total Time	(List CPT Code & # of Visits)
Immediate Post Service Time:	22.5	Included
Critical Care:		
Other Hospital Visits:	19	99231, included
Discharge Day Mgmt.:		
Office Visits:		

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Base Unit Value
00546	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm and mediastinum (including surgical thorascoscopy); pulmonary resection with thoracoplasty	XXX	15

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: 0054X1	Key Reference CPT Code: 00546
Median Pre-Time	30.0	not available
Median Intra-Time	150.0	not available
Median Immediate Post-service Time	22.5	not available
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	4.38	4.13
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.23	4.07
Urgency of medical decision making	4.38	4.27

Technical Skill/Physical Effort (Mean)

Technical skill required	4.73	4.40
Physical effort required	4.42	4.07

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.54	4.33
Outcome depends on the skill and judgement of physician	4.62	4.33

Estimated risk of malpractice suit with poor outcome	3.96	3.93

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service
Time Segments (Mean)		
Pre-Service intensity/complexity	4.23	4.40
Intra-Service intensity/complexity	4.58	4.33
Post-Service intensity/complexity	4.23	4.07

ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after deliberation of this procedure by the ASA RVS committee 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 the same as the survey median, the same as the reference service base unit value, and 2 units more than base unit value for current CPT code 00540, which this new CPT code now enhances and defines to account for the increased work, intensity and complexity of one lung anesthesia.

FREQUENCY INFORMATION

How was this service previously reported? 00540 (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 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 Anesthesiology Frequency 40,000

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

Specialty Anesthesiology Frequency 18,000

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 00539 Tracking Number: O4 Global Period:XXX **Recommended Base Unit Value:** 18

CPT Descriptor: Anesthesia for tracheobronchial reconstruction

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 47-year-old woman is scheduled to undergo tracheal resection and reconstruction for tracheal stenosis. The patient sustained chest and abdominal trauma from a motor vehicle accident 5 years ago. As a result of the injuries, she had a prolonged hospitalization complicated by ARDS, sepsis and renal failure. The patient required mechanical ventilatory support for 6 weeks. During that hospitalization the patient underwent tracheotomy to facilitate long term mechanical ventilation and bronchopulmonary hygiene. Since removal of the tracheotomy tube, the patient has had clinical evidence of severe tracheal stenosis and several episodes of severe stridor.

Description of Pre-Service Work: The patient requiring tracheobronchial reconstruction has known abnormalities of the airways, necessitating a more thorough preoperative evaluation and more careful planning for airway management at the time of surgery. The evaluation includes review of neck and chest radiographs, cine-radiographs and CT or MRI scans to assess the caliber of the airway and the degree of tracheomalacia. This assessment is essential in order to determine the most appropriate approach to tracheal intubation and airway management during the procedure. Because of the known tracheal abnormalities, the patient is also at increased risk for infection and aspiration, necessitating preoperative preparation with medications to reduce the likelihood of respiratory failure.

Pre-service work includes the pre-operative visit and evaluation of the patient's cardiovascular, neurological & pulmonary systems with special attention to pulmonary function. Pre-service work also includes the review of appropriate pulmonary function tests, ECG, ABGs, other laboratory tests, medications, allergies, past medical and surgical history, and available reports from consultants. Alternatives to anesthesia management and associated risks are explained and discussed with the patient. Questions are answered. Consent for anesthesia is obtained. On the day of surgery, the patient is identified, the surgical and anesthesia consents are verified, and the site of surgery is confirmed. The chart is reviewed with particular attention to the vital signs relevant laboratory tests and other pre-operative studies. The medical and surgical history is again briefly reviewed with the patient. Discussion of the options for anesthesia care, including relative risks and advantages, is again explained. In addition IV access is secured and suitable monitoring equipment (arterial pressure, CVP or Swan-Ganz monitoring transducers) is setup and calibrated. Before initiating anesthesia, anesthetic drugs are prepared and the anesthesia machine is checked for correct operation following the manufacturer's guidelines.

Description of Intra-Service Work: In order to provide the surgical conditions necessary to complete the tracheal reconstruction, the surgeon and anesthesiologist must carefully coordinate the intraoperative management of the patient's airway, ventilation and gas exchange. Since both the surgeon and anesthesiologist are sharing the airway during tracheobronchial reconstruction, the anesthesiologist and surgeon must coordinate the manipulation of the trachea and artificial airway to allow the surgical procedure to be completed without loss of airway integrity or life-threatening compromise in ventilation and oxygenation. The anesthesiologist must carefully coordinate mechanical ventilation, hand ventilation and airway suctioning to ensure that the airway remains clear of blood and secretions that would be aspirated into the lungs. The endotracheal tube position must be frequently adjusted to provide surgical conditions that facilitate the repair of the trachea and ensure ventilation and oxygenation of the patient. Because of the blood and secretions in the surgical field, the anesthesiologist must provide regular suctioning of the airway and repositioning of the endotracheal tube. After completion of the surgical repair, the anesthesiologist must ensure that the airway is properly positioned to protect the airway from aspiration, ensure gas exchange and prevent pressure necrosis on surgical suture lines.

Intra-service work includes: transporting patient to OR; positioning of patient on OR table; and application of routine monitors (ECG, BP cuff, pulse oximeter); connection and calibration of arterial line and central venous catheter or PA catheter; preoxygenation by mask; induction of anesthesia with intravenous lidocaine, fentanyl, propofol and a neuromuscular blocking agent; laryngoscopy and insertion of an endotracheal tube; confirmation of correct endotracheal tube position and securing the endotracheal tube; protection of eyes; delivery of inhalational and intravenous anesthetics; intervening to assure normothermia, constant attention to vital signs; constant monitoring of oxygenation and respiratory status and degree of neuromuscular block; regulation of depth of anesthesia and control of blood pressure and cardiac output. The patient remains paralyzed and his ventilation controlled throughout the procedure. During the case, ABG's are obtained and respiratory parameters changed as needed to ensure patient stability and homeostasis. Increased oxygen concentrations and hand ventilation may be necessary during surgical manipulation to maintain adequate oxygenation of the patient. Intravenous fluids are given to maintain hydration and treat hypotension. Following completion of the surgical procedure, the inhalation agents are withdrawn and residual neuromuscular blockade is reversed using anticholinesterase and anticholinergic drugs. If ventilation, oxygenation, and restoration of neuromuscular function are satisfactory, and if emergence from anesthesia is apparent, the patient is then moved to a stretcher and transferred with supplemental oxygen by endotracheal tube to the post-anesthesia care unit.

Description of Post-Service Work: The patient who undergoes tracheal resection requires meticulous management after the surgical procedure to ensure that the suture line remains intact and that there is no compromise in tracheal blood flow. The initial goal is to remove the endotracheal tube as soon as possible, after the procedure, while also ensuring that the patient has a clear airway. After the tracheal resection, mucociliary clearance is impaired, necessitating intensive respiratory care and careful suctioning of pulmonary secretions to optimize bronchopulmonary hygiene without disrupting the tracheal anastomosis. Pain relief is carefully titrated to achieve patient comfort.

On admission to PACU, vital signs are checked, and level of consciousness is determined. Adequacy of ventilation, maintenance of airway, and ability to handle secretions are again assessed. Cardiovascular and respiratory status is closely monitored. A brief summary of the procedure and the patient's medical history is conveyed to the PACU nurse and the patient's immediate care is transferred to the recovery room personnel. The anesthesiologist orders analgesics, anti-emetics, and respiratory treatments as indicated. The patient's condition is reported frequently to the anesthesiologist who makes appropriate medical decisions regarding: control of pain, adequacy of respiration, and discharge to the intensive care unit. Interpretation of ABG's and regulation of blood pressure and circulation are required in this immediate post-op period. After the patient's vital signs are stable, after an appropriate level of consciousness has returned, after oxygenation is adequate, and after the analgesic needs are satisfied, the patient is extubated and discharged from the PACU to the intensive care unit.

The patient is seen on a post-op visit the first post-op day and evaluated for any post-anesthesia problems. The patient's questions and concerns about the anesthetic are addressed by the anesthesiologist.

SURVEY DATA:

Presenter(s) Karl e. Becker, MD, Norman A. Cohen, MD

Specialty(s): American Society of Anesthesiologists

Sample Size: 19 Response Rate: (%): 13% Median Base Unit Value: 20.0

Type of Sample (Circle One): random, **panel**, convenience. Explanation of sample size: Sent e-mails to 142 physicians

25th Percentile Base Unit Value: 15.75 75th Percentile Base Unit Value: 25.0 Low: 8.0 High: 30.0

Median Pre-Service Time: 30.0 Median Intra-Service Time: 240.0

25th Percentile Intra-Svc Time: 205.0 75th Percentile Intra-Svc Time: 300.0 Low: 120.0 High: 430.0

Median Post-Service Time: 30.0

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	30	Included
Critical Care:		
Other Hospital Visits:	19	99231, Included
Discharge Day Mgmt.:		
Office Visits:		

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Base Unit Value
00546	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); pulmonary resection with thoracoplasty	XXX	15

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: 0054X2**	**Key Reference CPT Code: 00546**
Median Pre-Time	30	not available
Median Intra-Time	240	not available
Median Immediate Post-service Time	30	not available
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	4.26	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.32	4.13
Urgency of medical decision making	4.53	4.00

Technical Skill/Physical Effort (Mean)

Technical skill required	4.58	4.50
Physical effort required	4.42	4.38

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.79	4.25
Outcome depends on the skill and judgement of physician	4.68	4.63

Estimated risk of malpractice suit with poor outcome	4.47	4.25

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service
Time Segments (Mean)		
Pre-Service intensity/complexity	4.21	4.00
Intra-Service intensity/complexity	4.79	4.00
Post-Service intensity/complexity	4.37	4.00

ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after deliberation of this procedure by the ASA RVS committee 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 2 less than the survey median, 3 more than the reference service base unit value, and 5 units more than the base unit value for current CPT code 00540, which this new CPT code now refines and enhances to account for the increased work. intensity and complexity measures (especially stress and technical skill required for anesthesia for trach bronchial reconstruction).

FREQUENCY INFORMATION

How was this service previously reported? 00540 (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 100

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

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2002

Anesthesia for Closed Procedures on Cervical/Thoracic/Lumbar Spine

00640 Anesthesia for manipulation of the spine or for closed procedures on the cervical, thoracic or lumbar spine
CPT created this code so that the anesthesia services provided in conjunction with CPT code 22505 *Manipulation of spine requiring anesthesia, any region* can be accurately reported. The RUC examined the survey results and agreed with the ASA analysis that the results of the survey intensity/ complexity measures supports a base unit value lower than both reference services' base unit values due to the decreased work associated with the absence of surgical incision and supine positioning. Since the median survey value of 4 base units would create rank order anomalies and was not supported by intensity/complexity measures obtained via survey, the RUC agreed that a base unit of 3, the lowest number of base units assigned to anesthesia codes, was appropriate.

The RUC recommends a base unit value of 3.00 for CPT code 00640.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Recommended Base Unit Value
●00640	D1	Anesthesia for manipulation of the spine or for closed procedures on the cervical, thoracic or lumbar spine	XXX	3

AMA/Specialty RVS Update Process
Summary of Recommendations

CPT Code: 00640 Tracking Number: D1 Global Period: XXX Recommended Base Unit Value: 3

CPT Descriptor: Anesthesia for manipulation of the spine or for closed procedures on the cervical, thoracic or lumbar spine

Clinical Description of Service:

Vignette Used in Survey: The typical patient is a middle-aged, moderately obese male with lumbar back pain secondary to a workplace injury. The patient has been treated by multiple practitioners, including a chiropractor, whose office manipulations of the lumbar spine have failed to relieve the pain syndrome. The patient is unable to work, his activities are restricted and he resists further office therapy because of the pain involved. He is receiving multiple medications, including an oral opioid and an antihypertensive, with only moderate pain relief. He is scheduled for manipulation of his lumbar spine under general anesthesia. He does not have any medical allergies and does not smoke.

Description of Pre-Service Work: The patient is evaluated one week prior to the procedure by the anesthesiologist. A medical history is taken and a systems review is conducted along with a physical examination to determine the presence of coexisting medical illness. Special emphasis is given to current drug therapy that may affect the conduct of anesthesia. For example, the use of non-steroidal anti-inflammatory drugs may interfere with coagulation, which has implications for anesthetic management. The patient is questioned about previous allergic reactions to drugs. A surgical and family history is obtained to determine if there have been any previous anesthetic complications. A history of hypertension was elicited and his antihypertensive medications were reviewed. He was instructed to take his medications on the day of surgery. Physical examination included airway evaluation, cardiopulmonary exam, and a brief neurological evaluation. Blood pressure was normal. Diagnostic studies reviewed included an EKG, electrolytes, and complete blood count. At this point the patient is counseled about the plans for general anesthesia and the risks and benefits of the anesthetic are explained. Alternative anesthetic techniques are described as well. Instructions relating to the anesthetic, including the appropriate period of time for fasting prior to the surgery, are given. An informed consent is obtained. On the day of the procedure, the patient is re-evaluated by the anesthesia provider who starts a peripheral intravenous line and begins an infusion of lactated ringers. The anesthesia providers will have assured themselves that all equipment and drugs necessary for resuscitation are available and working.

Description of Intra-Service Work: The patient is placed on the operating room table, monitoring devices are applied (ECG, NIBP, pulse oximetry) and baseline values are obtained. Intravenous anesthetics, usually propofol, a benzodiazepine and an opioid are most commonly used. Supplemental oxygen is administered and a patent airway is maintained throughout the procedure. Maintenance of the airway is especially important and sometimes difficult during manipulation of the cervical spine. Additional intravenous medication is given as required. Hemodynamic and ventilatory variables are monitored every 3-5 minutes or more frequently if indicated. As the procedure nears its conclusion, anesthetic agents are withdrawn to prepare the patient for awakening. Hemodynamic stability, adequacy of ventilation, and level of consciousness are evaluated, and if these parameters are acceptable, the patient is transferred to the post anesthesia care unit. The procedure usually takes approximately 30 minutes. The anesthesia provider maintains a complete record.

Description of Post-Service Work: In the post anesthesia care unit, the patient is recovered according to ASA guidelines. Any side effects of anesthesia, such as nausea and vomiting, are assessed and treated if necessary. The patient is evaluated to see whether he meets the criteria for discharge such as appropriate level of consciousness, adequate respiratory function, the ability to ambulate without assistance and the availability of an escort. Discharge instructions are given. Discharge criteria are documented in the patient's record.

Survey Data:

:senter(s): Karl E.Becker, MD, Norm Cohen, MD

Specialty(s): Joint survey by ASA, AANS/CNS, AAPM and NASS

Sample Size: 28 Response rate: (%): 0.7% Median Base Unit Value: 4.00

Type of Sample: Random

Explanation of sample size: Approximately 4,000 e-mails sent out directing physicians to a website

25th Percentile Base Unit Value:	3.0	Low:	2.0
75th Percentile Base Unit Value:	6.5	High:	9.0
Median Pre-Service Time:	15.0		
Median Intra-Service Time:	27.5		
Median Post-Service Time:	10.0		
25th Percentile Intra-Service time:	15.0	Low:	10.0
th Percentile Intra-Service time:	30.0	High:	120.0

Level of Service by CPT Code

	Total Time:	(List CPT code & # of Visits)
Immediate Post Service Time:	20	Included
Critical Care:		
Other Hospital Visits:	10	Included
Discharge Day Mgmt:		
Office Visits:		

Key Reference Service

CPT Code: **00630 and 00635**

CPT Descriptor: 00630 - Anesthesia for procedures in lumbar region; not otherwise specified
Base Unit Value: 8.0

CPT Descriptor: 00635 - Anesthesia for procedures in lumbar region; diagnostic or therapeutic lumbar puncture
Base Unit Value: 4.0

Relationship of code Being Reviewed to Key Reference Service(s):

Compare the pre, intra, and post service times (by median) and the intensity (by 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 Code 0064X:	Key Reference CPT:00630	Key Reference CPT:00635
Median Pre-time	15.0	10.0	15.0
Median Intra time	27.5	20.0	30.0
Median Immediate Post service time	10.0	10.0	15.0
Median of aggregate critical care times			
Median of aggregate other hospital visit times			
Median of discharge day management times			
Median of aggregate office visit times			

Intensity/Complexity Measures (Mean)

Mental Effort & Judgment (Mean)	New/Revised Code 0064X:	Key Reference CPT:00630	Key Reference CPT:00635
The number of possible diagnosis and/or number of management options that must be considered	2.5	1.91	2.89
Amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.63	2.18	2.78
Urgency of Medical Decision making	2.11	1.55	2.56

Technical Skill/Physical Effort (Mean)

	New/Revised Code 0064X:	Key Reference CPT:00630	Key Reference CPT:00635
Technical skill required	2.3	1.73	2.67
Physical effort required	2.48	1.73	2.78

Psychological Stress (Mean)

	New/Revised Code 0064X:	Key Reference CPT:00630	Key Reference CPT:00635
Risk of significant complications, morbidity and/or mortality	2.44	1.82	2.67
Outcome depends on the skill and judgment of physician	2.44	1.73	2.78
Estimated risk of malpractice suit with poor outcome	2.70	2.09	2.89

Time Segments (Mean)

	New/Revised Code 0064X:	Key Reference CPT:00630	Key Reference CPT:00635
Pre-service intensity/complexity	2.46	2.27	2.78
Intra-service intensity/complexity	2.43	1.82	2.78
Post-service intensity/complexity	2.0	1.64	2.67

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 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 lower than both reference services' base unit values due to the decreased work associated with absence of surgical incision and supine positioning. The ASA RVS Committee determined that the median survey value of 4 would create rank order anomalies and was not supported by intensity/complexity measures obtained via survey.

Frequency Information

How was this service previously reported? 00600, 00620 00630
(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 from 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 from each specialty)

Specialty:	Anesthesiology	Frequency: 5000
Specialty:		Frequency:

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

Specialty:	Anesthesiology	Frequency: 1500
Specialty:		Frequency:

Do many physicians perform this service across the United States? Yes_____ No___X_____

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
April 2002

Anesthesia Services for Pediatric Hernia Repair

00834 and 00836

CPT created two new codes to describe the provision of anesthesia for hernia repair of infants. The specialty stated that due to the creation of new surgical codes stratified by age for children undergoing inguinal hernia repair, new anesthesia codes are also needed to recognize the increased work and risk that exists in anesthetizing children for these procedures. The RUC reviewed these codes together to ensure proper relativity. The RUC felt that anesthetic management of pediatric patients under one year of age entails additional work since in these patients, pulmonary and cardiac reserve are significantly reduced compared to older children and healthy adults. In practice, the anesthesiologist faces a much greater probability of managing hypoxemia. Also, the work of breathing is directly proportional to airway resistance. The therapeutic range in which the anesthesiologist must operate is much narrower than in older children or adults, bounded by too "light" an anesthetic in which the patient may move, develop a life-threatening laryngospasm or develop vagally-stimulated bradycardia. On the opposite side, too "deep" an anesthetic can cause severe respiratory and cardiac depression. Intravenous access is typically very difficult in children less than a year. Since this age group is often uncooperative, anesthesiologists will typically induce anesthesia with volatile anesthetics, often referred to as a "mask induction," without the benefit of intravenous access. Management of bradycardia, hypotension, or other common untoward reactions is much more difficult when the anesthesiologist is unable to administer intravenous medications. Finally, infants under one year, and particularly the premature infant at less than 50 weeks gestational age, have been shown to be in a much higher risk group for adverse respiratory and cardiovascular sequalae both under anesthesia and in the immediate post operative period and the immature renal, hepatic and nervous system is this subset of patient increases the risk of adverse drug reactions. For the above reasons, the RUC agreed that increases in basic unit value for these procedures is warranted. To account for the additional physician work, the RUC agreed that code 00834 should have one additional base unit. Therefore the resulting value of 5 base units is equal to code 00830 *Anesthesia for hernia repairs in lower abdomen; not otherwise specified* (base unit 4), plus code 99100 *Anesthesia for patient of extreme age, under one year and over seventy (List separately in addition to code for primary anesthesia procedure)* (base unit 1). Therefore, the new base unit value of 5 is work neutral. The RUC agreed that code 00836 should have 2 additional base units above the base code 00830 to maintain proper rank order. The presenters stated that this code will be provided to Medicare beneficiaries less than 100 times a year, thus no requiring any work neutrality do to the very low frequency anticipated for this code. **The RUC recommends 5 base units for code 00834. The RUC recommends 6 base units for code 00836.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Base Unit Recommendation
00830	P1	*Anesthesia for hernia repairs in lower abdomen; not otherwise specified*	XXX	4 (no change)
00832	P2	*ventral and incisional hernias* (For hernia repairs in the infant 1 year of age or younger, see 0083~~X1~~4, 0083~~X2~~6)	XXX	6 (no change)
●00834	P3	Anesthesia for hernia repairs in lower abdomen not otherwise specified, under 1 year of age (Do not report 0083~~X1~~4 in conjunction with code 99100)	XXX	5
●00836	P4	Anesthesia for hernia repair in the lower abdomen not otherwise specified, infants less than 37 weeks gestational age at birth and less than 50 weeks gestational age at time of surgery (Do not report 0083~~X1~~6 in conjunction with code 99100) 00836	XXX	6

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 00834 Tracking Number:P3 Global Period:XXX **Recommended Base Unit Value:** 5

CPT Descriptor: Anesthesia for hernia repairs in lower abdomen; under 1 year of age.

(Do not report 0083~~X1~~ 4 in conjunction with code 99100)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is an eleven-month-old male who was noted to have a groin mass per mother. The pediatrician diagnosed an inguinal hernia and referred the patient to a pediatric surgeon. The patient now presents for bilateral inguinal hernia repair.

Description of Pre-Service Work: The patient's birth history was normal. The only history of significance is the patient recently finished antibiotics for a middle ear infection. Family history is negative for significant diseases or difficulty with anesthesia. The patient is on no medications and has no allergies. Physical examination with emphasis on the airway, lungs, heart and nervous system is performed. After discussing anesthetic options and reviewing anesthetic risks with the parents an inhalational induction general anesthetic is planned. Informed consent is obtained. Before initiating anesthesia, anesthetic drugs are prepared and the anesthesia machine is checked for correct operation following the manufacturer's guidelines. The operating room is warmed to help prevent hypothermia.

Description of Intra-Service Work: The patient is transferred to the operating room and EKG, pulse oximeter and blood pressure monitors are applied. Anesthesia is induced with a volatile agent by mask. Intravenous access is obtained in the lower extremity. Muscle relaxation is administered and monitored by a twitch monitor. The airway is secured with an orally placed endotracheal tube. Appropriate tube placement is determined by carbon dioxide monitoring and auscultation of breath sounds bilaterally. A temperature monitor is placed. Continuous monitoring and charting ensue with adjustments to the anesthetic depth made to accommodate the level of surgical stimulation. A forced warm air heater is placed around the patient to preserve normothermia. Intravenous fluids are administered accounting for hourly maintenance and deficit from denial of oral intake preoperatively. At the end of the surgical procedure the anesthetic gases are discontinued and the muscle relaxation is pharmacologically reversed. When the patient is making strong purposeful movement and the neuromuscular blockade is adequately reversed, the trachea is extubated. The patient is observed prior to transfer to the post anesthesia care unit for stability of vital signs, patency of airway, and satisfactory pulse oximetry results.

Description of Post-Service Work: The anesthesiologist provides a report to the post-anesthesia nurse, covering the patient's history and anesthetic course. Vital signs are obtained and the anesthesiologist provides orders for oxygen therapy, analgesia and nausea treatment. The anesthesiologist remains available to the PACU nurse by pager, until the patient is discharged from the recovery area. The patient is observed in the PACU for a minimum of 30 minutes or until the patient satisfies discharge criteria. Additional analgesia is provided as needed. The patient is then transferred to the ambulatory care unit and observed for another 30 minutes or until deemed ready to be discharged home. The anesthesiologist remains available to evaluate the patient before discharge from the outpatient unit.

SURVEY DATA:

Presenter(s) Karl E. Becker, MD, Norman A. Cohen, MD

Specialty(s): American Society of Anesthesiologists

Sample Size: 30 Response Rate: (%): 21% Median Base Unit Value: 6.0

Type of Sample (Circle One): random, **panel**, convenience. Explanation of sample size: Sent e-mails to 142 physicians

25th Percentile Base Unit Value: 5.0 75th Percentile Base Unit Value: 6.0 Low: 4.0 High: 10.0

Median Pre-Service Time: 20.0 Median Intra-Service Time: 60.0

25th Percentile Intra-Svc Time: 46.25 75th Percentile Intra-Svc Time: 75.0 Low: 30.0 High: 120.0

Median Post-Service Time: 15.0

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

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Base Unit Value
00830	Anesthesia for hernia repairs in lower abdomen; NOS	XXX	4

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: 0083[illegible]**	**Key Reference CPT Code: 00830**
Median Pre-Time	20	not available
Median Intra-Time	60	not available
Median Immediate Post-service Time	15	not available
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	2.77	2.10
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.80	2.10
Urgency of medical decision making	3.07	2.35

Technical Skill/Physical Effort (Mean)

Technical skill required	3.56	2.37
Physical effort required	3.10	2.25

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.37	2.20
Outcome depends on the skill and judgement of physician	3.67	2.60
Estimated risk of malpractice suit with poor outcome	3.90	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service
Time Segments (Mean)		
Pre-Service intensity/complexity	2.93	2.10
Intra-Service intensity/complexity	3.27	2.25
Post-Service intensity/complexity	2.90	1.95

ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after deliberation of this procedure by the ASA RVS committee 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 and the pre- and post- service times all support a base unit value of this revised CPT code 0083X1 4 one less than the survey median, and 1 unit greater than the reference service (00830) base unit value, which this new code now refines and enhances to account for the increased work, intensity, and complexity of anesthesia in infants under 1 year of age.

FREQUENCY INFORMATION

How was this service previously reported? 00830 (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 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 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 <100

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 00836 Tracking Number: P4 Global Period: XXX **Recommended Base Unit Value:** 6

CPT Descriptor: Anesthesia for hernia repairs in the lower abdomen; infants less than 37 weeks gestational age birth and less than 50 weeks gestational age at time of surgery (Do not report 00832 in conjunction with code 99100)

6

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is a 4 week old male born at 28 weeks gestational age. The patient was endotracheally intubated in the delivery room with Apgar scores of 2 and 5. The patient's trachea was extubated at one week of age after the administration of surfactant and indomethacin. A grade 2 intraventricular hemorrhage was diagnosed in week two. At present there are no significant sequelae from the previous problems. The patient is presently gaining weight with oral feeding supplementation. Discharge planning is taking place, but hindered by the presence of a large right inguinal hernia.

Description of Pre-Service Work: Currently the patient receives calcium supplementation. There are no allergies. The patient's weight is currently 2 kg. The heart rate is 140 beats per minute, respiratory rate of 45 breaths per minute and a systolic blood pressure of 50 mm Hg. Laboratory data includes normal electrolytes and a hematocrit of 30%. Aside from the patient's low weight and the presence of a large right inguinal hernia the airway appears appropriate and patent, the lung fields are clear and the heart is auscultated revealing normal rate and rhythm with no appreciable murmur. Also noted are multiple ecchymotic areas from previous venous access attempts. There is no venous access at present nor are any veins easily visible. There are no parents present for discussion regarding anesthetic plans. Surgical consent was obtained by phone a day earlier. The parents are contacted by telephone and the anesthetic options and risks are discussed. The parents' questions are answered and telephone consent is obtained. A general anesthetic is planned with induction by intravenous technique. Before initiating anesthesia, anesthetic drugs are prepared and the anesthesia machine is checked for correct operation following the manufacturer's guidelines. The operating room is warmed to 80 degrees F to help prevent hypothermia.

Description of Intra-Service Work: The patient is transferred from the neonatal intensive care unit while monitored to the operating room. The patient is transferred to the operating table and the monitors are placed for EKG, pulse oximetry and blood pressure. A warming mattress and heat lamps are used to keep the patient normothermic. A 22 gauge intravenous catheter is placed in the saphenous vein blindly. Anesthesia is induced slowly with intravenous agents constantly monitoring the vital signs. Muscle relaxation is administered. A volatile anesthetic agent is slowly titrated to effect with careful attention to blood pressure. The baby's trachea is intubated with a 2.5 mm endotracheal tube. After determining appropriate placement by the presence of carbon dioxide and auscultation of bilateral breath sounds the endotracheal tube is secured. To help prevent the sequelae of oxygen toxicity, the inspired oxygen concentration is decreased to 25% oxygen or less by monitoring pulse oximety. Surgery is performed with continuous monitoring of vital signs recording all pertinent data on the anesthesia chart. The anesthetic depth is adjusted to match the level of surgical stimulation. To prevent postoperative apnea as is possible in this age group, 10 mg/kg of caffeine is administered by the intravenous route. At the end of the surgical procedure, the anesthetic agents are discontinued and the muscle relaxant is reversed. Upon demonstration of adequate emergence from anesthesia noted by purposeful movement and reversal of muscle relaxation by spontaneous flexion of the hips off the bed, the endotracheal tube is removed. The patient is observed for stability of vital signs, patency of airway, and adequacy of oxygenation.

Description of Post-Service Work: The patient is transferred to the isolette and monitored. An emergency resuscitation kit is made specific to the baby's weight including airway equipment. The baby is transported back to the neonatal intensive care unit. Vital signs are again taken and a full report is given to the nurse and the primary caring physician. Analgesic needs are assessed and medication given as necessary to achieve patient comfort. The anesthesiologist visits the patient on post-operative day one to evaluate any complications associated with the anesthetic and to address the parents' concerns and questions.

SURVEY DATA:

Presenter(s) Karl E. Becker, MD, Norman A. Cohen, MD

Specialty(s): American Society of Anesthesiologists

Sample Size: 27 Response Rate: (%): 19% Median Base Unit Value: 7.0

Type of Sample (Circle One): random, **panel**, convenience. Explanation of sample size: Sent e-mails to 142 physicians

25th Percentile Base Unit Value: 6.0 75th Percentile Base Unit Value: 8.0 Low: 5.0 High: 15.0

Median Pre-Service Time: 30.0 Median Intra-Service Time: 60.0

25th Percentile Intra-Svc Time: 60.0 75th Percentile Intra-Svc Time: 75.0 Low: 20.0 High: 90.0

Median Post-Service Time: 20.0

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	20	Included
Critical Care:		
Other Hospital Visits:	19	99231 – 1 visit (Included)
Discharge Day Mgmt.:		
Office Visits:		

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Base Unit Value
00830	Anesthesia for hernia repairs in lower abdomen; not otherwise specified	XXX	4

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: 0083X2	Key Reference CPT Code: 00830
Median Pre-Time	30	not available
Median Intra-Time	60	not available
Median Immediate Post-service Time	20	not available
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	3.85	2.20
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.11	2.25
Urgency of medical decision making	4.04	2.20

Technical Skill/Physical Effort (Mean)

Technical skill required	4.56	2.40
Physical effort required	3.96	2.15

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.44	2.20
Outcome depends on the skill and judgement of physician	4.48	2.35
Estimated risk of malpractice suit with poor outcome	4.37	3.30

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service
Time Segments (Mean)		
Pre-Service intensity/complexity	4.07	2.30
Intra-Service intensity/complexity	4.52	2.30
Post-Service intensity/complexity	4.07	2.05

ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after deliberation of this procedure by the ASA RVS committee 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 and the pre- and post- service times all support a base unit value of this revised CPT code 0083X2 one less than the survey median, and 2 units greater than the reference service (00830) base unit value, which this new code now refines and enhances to account for the increased work, intensity, complexity and stress of performing anesthesia on neonates.

FREQUENCY INFORMATION

How was this service previously reported? 00830 (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 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 Anesthesiology 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 Anesthesiology Frequency <100

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

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
April 2002
Anesthesia Services for Arthroscopy

01382, 01400, 01464, 01622, 01630, 01732, and 01740

CPT revised a series of codes to differentiate between anesthesia services for diagnostic arthroscopic procedures and open or surgical arthroscopic procedures. Since the original development of codes for anesthesia for arthroscopy more than 20 years ago, major advances in arthroscopic techniques have occurred and these changes are needed to accommodate increasingly complex arthroscopic and arthroscopically assisted joint procedures. The RUC reviewed these codes as a family. The anesthesia work for the surgical arthroscopic procedures are very similar to an open procedure as opposed to more simple diagnostic procedures. The recommended values reflect the differences in anesthesia work for these diagnostic vs. surgical arthroscopic procedures and the RUC agreed that the CPT changes did not affect the anesthesia work associated with these codes. However, the surgical arthroscopic procedures now will receive a higher base unit and the presenters justified this increase due to more complicated anesthetic management with greater intensity as compared to the diagnostic arthroscopic procedures. The presenters clarified that when these codes were originally valued, they were valued based solely on diagnostic arthroscopy since surgical arthroscopy was not widely used. **The RUC recommends no change in base unit value for codes 01382, 01400, 01464, 01622, 01630, 01732, and 01740.**

Surgical endoscopy/arthroscopy always includes a diagnostic endoscopy/arthroscopy.

CPT Code (•New)	Track-ing Number	CPT Descriptor	Global Period	Base Unit Recommendation
▲01382	R1	Anesthesia for diagnostic arthroscopic procedures of knee joint	XXX	3 (no change)
▲01400	R2	Anesthesia for open or surgical arthroscopic procedures on knee joint; not otherwise specified	XXX	4 (no change)
▲01464	R3	Anesthesia for arthroscopic procedures of ankle ~~joint~~ and/or foot	XXX	3 (no change)
▲01622	R4	Anesthesia for diagnostic arthroscopic procedures of shoulder joint	XXX	4 (no change)

Surgical endoscopy/arthroscopy always includes a diagnostic endoscopy/arthoscopy.

CPT Code (•New)	Track-ing Number	CPT Descriptor	Global Period	Base Unit Recommendation
▲01630	R5	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified	XXX	5 (no change)

Surgical endoscopy/arthroscopy always includes a diagnostic endoscopy/arthoscopy.

▲01732	R6	Anesthesia for diagnostic arthroscopic procedures of elbow joint	XXX	3 (no change)
▲01740	R7	Anesthesia for open or surgical arthroscopic procedures ofn ~~humerus and~~ the elbow; not otherwise specified	XXX	4 (no change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 01382 Tracking Number: R1 Global Period: XXX **Recommended Base Unit Value:** 3

CPT Descriptor: Anesthesia for diagnostic arthroscopic procedures of knee joint

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old male athlete injured his knee in a football game. He now complains of decreased knee motion and pain on extension of his knee. Examination of his knee reveals decreased range of motion, a moderate effusion and marked tenderness. He takes no medications except NSAIDs for his knee pain. He is otherwise healthy. He is scheduled for a diagnostic arthroscopy of his knee.

Description of Pre-Service Work: The 30-year healthy gentleman is seen initially in the preoperative preparation area. Because he had no pre-existing health problems, his orthopedic surgeon did not refer him to the preoperative evaluation clinic. The anesthesiologist reviews the surgeon's history and physical, the nursing notes and the consent for surgery. The patient is identified and the operative site is confirmed and marked The anesthetic history is performed which covers the present illness, past anesthetics, medications and allergies, family history of anesthetic problems, smoked and smokeless tobacco use, alcohol and recreational drug use and a complete review of systems. The anesthetic examination focuses on the airway, cardiac and pulmonary systems. This patient's history and physical examination was remarkable only for use of an NSAID for pain control. Because of his age and health status, no preoperative tests are ordered. He is assigned ASA physical status 1. He has previously told his surgeon he wants to be "asleep" for the arthroscopy. Anesthetic options and risks are discussed with the patient, who agrees to a general anesthetic. The patient's questions are answered and informed consent is obtained. IV access is obtained using an 18-gauge catheter inserted through a local anesthetic wheal. By this time, he expresses some mild anxiety and he is given 2 milligrams of midazolam intravenously. Pulse oximetry is instituted to assure proper oxygenation prior to entry into the OR. After producing adequate anxiolysis, the patient is transferred to the operating suite. Before initiating anesthesia, anesthetic drugs are prepared and the anesthesia machine is checked for correct operation following the manufacturer's guidelines.

Description of Intra-Service Work: Upon arrival in the OR, identification of the patient and the operative knee are confirmed. Monitors are applied including a pulse oximeter, ECG leads, a skin temperature strip, and a blood pressure cuff. Initial vital signs are checked and recorded. The arms are positioned to assure patient comfort and care is taken to avoid any pressure points. A facemask with 100% oxygen is gently applied and an IV induction of general anesthesia using Propofol is performed. Mask ventilation is accomplished without difficulty and a #5 LMA is inserted via the mouth into the hypopharygnx. End-tidal CO2 demonstrated a good fit and inhalational anesthetic agents, nitrous oxide and Sevoflurane are administered. The eyelids are taped closed to prevent corneal abrasions. The patient is positioned to meet surgical requirements. The patient is covered with warm blankets to help prevent hypothermia. The patient's ECG, end-tidal CO2 and oxygen saturation are closely monitored and vital signs are recorded every 4-5 minutes during the intraoperative period. Anesthetic depth is adjusted to meet the level of surgical stimulation. At the end of the surgical procedure, the nitrous oxide and Sevoflurane are discontinued and 100% oxygen is administered. When the patient is judged able to maintain a patent airway, the LMA is removed. When the patient is able to both maintain an adequate airway and oxygenation, he is transported via stretcher to the PACU.

Description of Post-Service Work: Upon arrival in the PACU, a report of the patient's history and anesthetic course is given to the PACU nurse. Initial vital signs are reported and recorded. Orders for analgesics and anti-emetics are written. The anesthesiologist remains available via pager until the patient is discharged from the PACU and evaluates the patient before discharge from the outpatient unit.

SURVEY DATA:

Presenter(s) Karl E. Becker, MD, Norman A. Cohen, MD

Specialty(s): American Society of Anesthesiologists

Sample Size: 28 Response Rate: (%): 20% Median Base Unit Value: 4.0

Type of Sample (Circle One): random, **panel**, convenience. Explanation of sample size: Sent e-mails to 142 physicians

25th Percentile Base Unit Value: 3.0 75th Percentile Base Unit Value: 4.0 Low: 3.0 High: 5.0

Median Pre-Service Time: 15.0 Median Intra-Service Time: 47.5

25th Percentile Intra-Svc Time: 45.0 75th Percentile Intra-Svc Time: 60.0 Low: 30.0 High: 150.0

Median Post-Service Time: 10.0

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

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Base Unit Value
01380	Anesthesia for all closed procedures on knee jointXXX	XXX	3

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: 01382**	**Key Reference CPT Code: 01380**
Median Pre-Time	15.0	not available
Median Intra-Time	47.5	not available
Median Immediate Post-service Time	10.0	not available
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	2.04	1.88
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.26	1.71
Urgency of medical decision making	1.86	1.71

Technical Skill/Physical Effort (Mean)

Technical skill required	2.25	2.24
Physical effort required	2.11	2.12

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.96	1.94
Outcome depends on the skill and judgement of physician	2.36	2.47
Estimated risk of malpractice suit with poor outcome	3.50	3.24

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service
Time Segments (Mean)		
Pre-Service intensity/complexity	1.93	1.88
Intra-Service intensity/complexity	2.14	2.00
Post-Service intensity/complexity	2.04	2.00

ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after deliberation of this procedure by the ASA RVS committee 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 1 less than the survey median, but the same as the reference service base unit value, and the same as the base unit value for old CPT code 01382, which this revised CPT code defines in more specific detail to account for advances in arthroscopic procedures and techniques.

FREQUENCY INFORMATION

How was this service previously reported? 01382 (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 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 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 2,000

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 01400 Tracking Number:R2 Global Period:XXX **Recommended Base Unit Value:** 4

CPT Descriptor: Anesthesia for open or surgical arthroscopic procedures on knee joint; not otherwise specified

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A typical patient is a young adult athlete, male or female, who has sustained an injury to the knee and now has a painful and unstable knee, which precludes participation in his/her sport. An MRI reveals a torn anterior cruciate ligament and arthroscopic assisted surgical repair of the torn anterior cruciate ligament is scheduled

Description of Pre-Service Work: The patient is evaluated in the outpatient preanesthetic clinic. The surgical history physical and consent are reviewed, as well as clinic notes, nursing notes and laboratory studies. The patient is identified and the operative site is confirmed and marked. The anesthetic history is performed which covers the present illness, past anesthetic, medications and allergies, family history of anesthetic problems, smoked and smokeless tobacco use, alcohol and recreational drug use and a complete review of systems. The anesthetic examination focuses on the airway, cardiac and pulmonary systems. The surgeon has requested that a peripheral nerve block be offered the patient for post-operative analgesia. Various options and associated risks for anesthetic management are discussed with the patient. Options that are discussed include general anesthetic with peripheral nerve block for post operative pain and regional anesthesia to include either spinal, epidural or continuous peripheral nerve block. The patient requests spinal anesthesia with peripheral nerve block for post-operative pain control, as the patient desires to observe the surgery on the video monitors. In the pre-anesthesia area, the patient is re-examined and the choice of anesthetic is reaffirmed. Monitors are applied, intravenous access is obtained and sedation is given. Prophylactic antibiotics are administered as ordered by the surgeon. A femoral nerve block (separately reportable) is done utilizing a nerve stimulator to assure appropriate needle placement. After completion of the femoral nerve block, the patient is taken to the operating room. Before initiating anesthesia, anesthetic drugs are prepared and the anesthesia machine is checked for correct operation following the manufacturer's guidelines.

Description of Intra-Service Work: The patient is transferred to the operating table and ECG, non-invasive blood pressure cuff, and pulse oximetry are applied. After receiving an intravenous bolus of crystalloid solution, the patient is given additional intravenous sedatives and placed in the lateral position with the operative side down. The circulating nurse helps position the patient in the fetal position. The lower lumbar region is prepared with betadine solution, and a sterile drape is applied to the patient's skin. Local anesthetic is infiltrated subcutaneously and deep between the 3rd and 4th lumbar vertebrae. A 22-gauge introducer needle is inserted and then a 27 gauge Whitacre pencil point spinal needle, used to decrease the risk of spinal headache, is advanced through the introducer needle into the intrathecal space. After assurance of adequate and clear CSF flow, an appropriate dose of intermediate to long lasting local anesthetic (typically bupivacaine or tetracaine) diluted with 10% dextrose is injected into the spinal fluid. The needle is removed and a dressing is applied to the insertion site if indicated. After evidence of spinal blockade initiation is obtained, the patient is positioned to meet surgical requirements and the patient is examined to assure that pressure points are appropriately protected. The patient is tested using touch or pin-prick to determine adequacy of the spinal level. The surgical preparation then is allowed to commence. A forced-air warming blanket is applied to preserve normothermia. The procedure, which includes an open harvest of the patellar tendon graft and the arthroscopic preparation of the joint and placement of the graft, proceeds without problem. Tourniquet time is noted and reported to the operating surgeon hourly. Vital signs are monitored continuously during the procedure with charting no less frequently then every five minutes. Depth of sedation is adjusted to meet the patient's needs and desire to observe the video monitors. Intravenous fluids are administered to treat hypotension, which is not uncommon after spinal anesthesia, and replace both insensible and blood losses. Unresponsive hypotension is treated with vasoconstrictors such as ephedrine or phenylephrine. At the end of the procedure, and

after the placement of a brace on the operated knee, the sedation is discontinued. The patient is taken to the post-anesthesia care unit (PACU).

Description of Post-Service Work: Upon arrival in the PACU, a report of the patient's history and anesthetic course is given to the PACU nurse. Initial vital signs are reported and recorded. The anesthesiologist writes orders to deal with postoperative problems such as pain and nausea. The anesthesiologist remains available via pager until the patient is discharged from the PACU and evaluates the patient before discharge from the outpatient unit. The patient is assessed for adequate resolution of the motor component of the spinal block. The patient is advised of the signs and symptoms of spinal headache and given contact information in the event such a side effect is to occur.

SURVEY DATA:

Presenter(s) Karl E. Becker, MD, Norman A. Cohen, MD

Specialty(s): American Society of Anesthesiologists

Sample Size: 22 Response Rate: (%): 15% Median Base Unit Value: 4.0

Type of Sample (Circle One): random, **panel**, convenience. Explanation of sample size: Sent e-mails to 142 physicians

25th Percentile Base Unit Value: 4.0 75th Percentile Base Unit Value: 4.0 Low: 3.0 High: 6.0

Median Pre-Service Time: 15.0 Median Intra-Service Time: 120.0

25th Percentile Intra-Svc Time: 90.0 75th Percentile Intra-Svc Time: 120.0 Low:45.0 High: 200.0

Median Post-Service Time: 15.0

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

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Base Unit Value
01392	Anesthesia for all open procedures on upper ends of tibia, fibula, and/or patella	XXX	4

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: 01400**	**Key Reference CPT Code: 01392**
Median Pre-Time	15	not available
Median Intra-Time	120	not available
Median Immediate Post-service Time	15	not available
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	2.20	2.29
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.05	2.18
Urgency of medical decision making	2.19	2.24

Technical Skill/Physical Effort (Mean)

Technical skill required	2.45	2.47
Physical effort required	2.32	2.35

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.09	2.65
Outcome depends on the skill and judgement of physician	2.50	2.53

Estimated risk of malpractice suit with poor outcome	3.29	3.18

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service
Time Segments (Mean)		
Pre-Service intensity/complexity	2.05	2.12
Intra-Service intensity/complexity	2.36	2.41
Post-Service intensity/complexity	2.23	2.29

ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after deliberation of this procedure by the ASA RVS committee 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 the same as the survey median, the same as the reference service base unit value, and the same as the base unit value for old CPT code 01400, which this revised CPT code now encompasses and defines to account for advances in surgical techniques and medical technology.

FREQUENCY INFORMATION

How was this service previously reported? 01400 (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 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 Anesthesiology Frequency 500,000

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 100,000

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 01464 Tracking Number: R3 Global Period: XXX **Recommended Base Unit Value:** 3

CPT Descriptor: Anesthesia for arthroscopic procedures on ankle and/or foot

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old female twisted her ankle while climbing stairs. The ankle is swollen and tender. She has marked pain when walking. Radiographs of the ankle do not reveal a fracture. Pain and swelling in the ankle have persisted for 2 weeks despite the use of NSAIDs and conservative therapy. MRI reveals evidence of osteochrondritis dissecans. She is scheduled for a diagnostic arthroscopy with debridement and repair.

Description of Pre-Service Work: Having been assessed by her orthopedic surgeon three days earlier, the patient is contacted by phone by her anesthesiologist on the evening prior to surgery. Pertinent information discussed includes any history of previous anesthetic and surgical experiences, any family history of untoward anesthetic reactions, current drug usage, drug allergies, smoking history, and a medical review of major organ systems. Alternatives to anesthesia management and associated risks are explained and discussed with the patient. Questions are answered. With a history of good health, no recommendations for anesthetic choice are offered pending a review of the chart and physical examination on the day of surgery. On the day of surgery, the patient is identified, the surgical consent is verified, and the site of surgery is confirmed. The chart is reviewed with particular attention to the pre-operative anesthesia questionnaire, the vital signs, the history and physical examination by the operating surgeon, relevant laboratory tests and other pre-operative studies. The medical and surgical history is again briefly reviewed with the patient. Physical examination focuses on neck mobility, the oral airway, and the cardiorespiratory system. Discussion of the options for anesthesia care, including relative risks and advantages, are explained. The anesthesiologist recommends a general anesthetic, and informed consent is obtained. The patient agrees to the recommended general anesthetic. Before initiating anesthesia, anesthetic drugs are prepared and the anesthesia machine is checked for correct operation following the manufacturer's guidelines.

Description of Intra-Service Work: Following the establishment of intravenous access in the non-dominant arm and the intravenous administration of a hypnotic sedative, the patient is transported by gurney to the operating room while careful attention is paid to the level of consciousness. In the surgical suite, the patient is transferred to the operating table. EKG, blood pressure, and pulse oximetry monitors are applied. Vital signs are obtained. Pre-oxygenation is provided, and induction of general anesthesia is achieved with intravenous medications. The patency of the airway is ensured by the careful insertion of a laryngeal mask airway, its proper location then verified by auscultation of the lungs and by the presence of carbon dioxide in the exhaled gas. A pre-tracheal stethoscope is placed to assess breath sounds during the procedure. Adequate depth of anesthesia is maintained with the use of inhalational agents. Vulnerable pressure points and peripheral nerves are padded and protected. The patient is covered with warm blankets to help preserve normothermia. The eyes are taped closed. Variations in blood pressure, pulse rate, and oxygenation are observed, recorded, and maintained at satisfactory levels by adjusting the levels of the various agents. Intravenous antibiotics are administered at the request of the surgeon. A surgical tourniquet is applied, and inflation pressures and times of inflation are noted. Additional intravenous narcotics, hypnotic sedatives, and muscle relaxants are provided to ensure adequate analgesia, amnesia, and lack of involuntary movement during the operation. During spontaneous breathing by the patient, adequate ventilation is monitored by periodic observance of the depth of respirations and of end-tidal carbon dioxide levels. Intravenous fluids are given to maintain hydration and to treat hypotension. Following completion of the surgery and application of dressings, the inhalation agents are withdrawn and the patient is allowed to emerge from anesthesia. In the event that neuromuscular blocking drugs were employed and residual effect remain as assessed by a neuromuscular blockade monitor, reversal of these drugs is achieved using anti-cholinergic and anti-cholinesterase medications. The laryngeal mask airway is carefully removed. The adequacy of ventilation, the ability to maintain a patent airway, and the ability to handle secretions is assessed prior to transport to the post-

anesthesia care unit.

Description of Post-Service Work: In the PACU, oxygen is administered. Vital signs are checked, and the le of consciousness is determined. Adequacy of ventilation, maintenance of airway, and the ability to handle secretions are again assessed. A brief summary of the procedure and the patient's medical history is conveyed to the PACU nurse. While in PACU, the anesthesiologist ensures adequate levels of analgesia. Medical problems are also assessed and treated. After achieving an improved level of consciousness as determined by the modified Aldrete scoring system, after satisfactory analgesia has been obtained, and after stability of vital signs is confirmed, the patient is discharged from the PACU. The anesthesiologist remains available by pager to manage problems in the PACU and to assess the patient before discharge from the outpatient surgery unit.

SURVEY DATA:

Presenter(s) Karl E. Becker, MD, Norman A. Cohen, MD

Specialty(s): American Society of Anesthesiologists

Sample Size: 20 Response Rate: (%): 14% Median Base Unit Value: 3.0

Type of Sample (Circle One): random, **panel,** convenience. Explanation of sample size: Sent e-mails to 142 physicians

25th Percentile Base Unit Value: 3.0 75th Percentile Base Unit Value: 4.0 Low: 3.0 High: 5.0

Median Pre-Service Time: 17.5 Median Intra-Service Time: 75.0

25th Percentile Intra-Svc Time: 58.75 75th Percentile Intra-Svc Time: 90.0 Low: 45.0 High: 120.0

Median Post-Service Time: 10.0

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

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Base Unit Value
01462	Anesthesia for all closed procedures on lower leg, ankle, and foot	XXX	3

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: 01464**	**Key Reference CPT Code: 01462**
Median Pre-Time	17.5	not available
Median Intra-Time	75.0	not available
Median Immediate Post-service Time	10.0	not available
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	2.15	1.78
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.10	1.89
Urgency of medical decision making	1.95	1.78

Technical Skill/Physical Effort (Mean)

Technical skill required	2.30	1.89
Physical effort required	2.00	1.78

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.10	1.78
Outcome depends on the skill and judgement of physician	2.30	2.00

Estimated risk of malpractice suit with poor outcome	3.15	3.25

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service
Time Segments (Mean)		
Pre-Service intensity/complexity	2.15	2.00
Intra-Service intensity/complexity	2.15	2.00
Post-Service intensity/complexity	1.90	1.78

ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after deliberation of this procedure by the ASA RVS committee 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 the same as the survey median, the same as the reference service base unit value and the same as the base unit value for old CPT code 01464, which this revised CPT code now encompasses.

FREQUENCY INFORMATION

How was this service previously reported? 01464 or 01480 (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 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 Anesthesiology Frequency 7,500

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 1,500

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 01622 Tracking Number: R4 Global Period: XXX **Recommended Base Unit Value:** 4

CPT Descriptor: Anesthesia for diagnostic arthroscopic procedures of shoulder joint

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 58-year-old female tennis player has developed pain in her shoulder, especially when playing tennis. Lifting of packages has become painful. Despite conservative therapy and several steroid injections, pain has persisted. MRI does not reveal a rotator cuff tear. Laboratory studies are normal. Medications include only vitamins and refecoxib. She is scheduled for a diagnostic arthroscopy.

Description of Pre-Service Work: The patient was assessed at the office of her orthopedic surgeon two days prior to surgery and is contacted by phone by her anesthesiologist the evening prior to surgery. Her past medical history, including coexisting medical illnesses, chronic drug therapy, allergies, prior anesthetic experiences and family history of anesthetic reactions of prior anesthetic experiences are elicited. Alternatives in anesthesia management and associated risks are discussed at that time, though no decisions are made until the patient is examined and the patient's chart is reviewed on the day of surgery. On the day of surgery, the patient is again interviewed in the pre-op holding area and all questions are once again answered. The medical record is reviewed with attention to the surgical history and physical, nursing notes, and the surgical consent. A physical examination is performed, including vital signs, neck mobility, examination of dentition and assessment of airway (in preparation for endotracheal intubation), and examination of heart and lungs. If not already available, preoperative studies would be ordered, to include a hematocrit and EKG. An informed consent for anesthesia is obtained. The patient requests a general anesthetic. Before initiating anesthesia, anesthetic drugs are prepared and the anesthesia machine is checked for correct operation following the manufacturer's guidelines.

Description of Intra-Service Work: Intravenous access is achieved in the contra-lateral arm. Under intravenous sedation, the patient is transported to the operating room and transferred to the operating table. EKG, blood pressure, and pulse oximetry monitors are applied. Oxygen by mask is given, and then general anesthesia is induced using intravenous fentanyl, propofol, and a neuromuscular blocking agent to facilitate intubation. After carbon dioxide is detected in the exhaled gas, and after breath sounds are detected bilaterally, the endotracheal tube is secured to the face with tape. The patient is then turned to the right lateral decubitus position, on a pre-placed bean bag which is deflated to maintain an optimal position for the procedure. Vulnerable pressure points and peripheral nerves are padded and protected. The patient is further secured to the operating table with surgical tape and straps. Anesthesia is maintained with inhalation anesthesia agents, and anesthetic depth is adjusted to match the level of surgical stimulation. Intravenous fluids are given to maintain hydration and to treat hypotension. Depth of anesthesia is maintained by assessing blood pressure, pulse rate, respiratory effort, and neuromuscular blockade. Additional narcotics, neuromuscular blocking drugs, and inhalation agents are provided as needed. Large volumes of irrigating fluid are infused into the surgical site to facilitate the arthroscopic procedure, resulting in increased systemic fluid uptake as well as shoulder swelling. Following completion of the surgical procedure, the inhalation agents are withdrawn and residual neuromuscular blockade is reversed using anticholinesterase and anticholinergic drugs. Adequacy of spontaneous ventilation and neuromuscular blockade reversal is determined, and, if satisfactory, the trachea is extubated. Spontaneous ventilation is further assessed by mask. If ventilation and oxygenation are satisfactory, and if emergence from anesthesia is apparent, the patient is then moved to a stretcher and transferred to the post-anesthesia care unit.

Description of Post-Service Work: In PACU, the patient is recovered according to ASA guidelines. A brief summary of the procedure and the patient's medical history is conveyed to the PACU nurse. Vital signs are checked, and level of consciousness is determined. While in PACU, the anesthesiologist ensures adequate levels

of analgesia and treating nausea and vomiting should it occur. After achieving an improved level of consciousness as determined by the modified Aldrete scoring system, after satisfactory analgesia has been obtained, and after stability of vital signs is confirmed, the patient is discharged from the PACU. The anesthesiologist remains available by pager while the patient is in the PACU to manage anesthetic related issues and assesses the patient before discharge from the outpatient unit.

SURVEY DATA:

Presenter(s) Karl E. Becker, MD, Norman A. Cohen, MD

Specialty(s): American Society of Anesthesiologists

Sample Size: 23 Response Rate: (%): 16% Median Base Unit Value: 5.0

Type of Sample (Circle One): random, **panel,** convenience. Explanation of sample size: Sent e-mails to 142 physicians

25th Percentile Base Unit Value: 4.0 75th Percentile Base Unit Value: 5.0 Low: 4.0 High: 7.0

Median Pre-Service Time: 15.0 Median Intra-Service Time: 75.0

25th Percentile Intra-Svc Time: 60.0 75th Percentile Intra-Svc Time: 90.0 Low: 20.0 High: 120.0

Median Post-Service Time: 15.0

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

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Base Unit Value
01620	Anesthesia for all closed procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint	XXX	4

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: 01622	Key Reference CPT Code: 01620
Median Pre-Time	15	not available
Median Intra-Time	75	not available
Median Immediate Post-service Time	15	not available
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	2.57	2.73
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.35	2.45
Urgency of medical decision making	2.43	2.55

Technical Skill/Physical Effort (Mean)

Technical skill required	2.91	2.82
Physical effort required	2.96	2.73

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.70	2.73
Outcome depends on the skill and judgement of physician	2.91	2.73

Estimated risk of malpractice suit with poor outcome	3.39	3.55

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service
Time Segments (Mean)		
Pre-Service intensity/complexity	2.39	2.36
Intra-Service intensity/complexity	3.00	2.82
Post-Service intensity/complexity	2.43	2.45

ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after deliberation of this procedure by the ASA RVS committee 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 and consideration of rank order issues within the anesthesia relative value system supports a base unit value 1 less than the survey median, but the same as the reference service base unit value, and the same as the base unit value for old CPT code 01622, which this revised CPT code defines in more specific detail to account for advances in arthroscopic procedures and techniques.

FREQUENCY INFORMATION

How was this service previously reported? 01622 (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 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 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 2,000

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 01630 Tracking Number: R5 Global Period: XXX **Recommended Base Unit Value:** 5

CPT Descriptor: Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year old female has a six month history of increasing pain in the right shoulder and progressive limitation of motion despite three courses of steroid injection into the joint. Attempts at physical therapy have likewise been unsuccessful. An MRI examination reveals no tears of the rotator cuff. Impingement syndrome of the subacromial space is suspected. The patient is scheduled for arthroscopic subacromial decompression.

Description of Pre-Service Work: Having been assessed at the office of her orthopedic surgeon two days earlier, the patient is contacted by phone by her anesthesiologist on the evening prior to surgery. A medical history including coexisting medical illnesses, chronic drug therapy, allergies, prior anesthetic experiences and family history of anesthetic reactions are elicited. Alternatives in anesthesia management and associated risks are discussed at that time, though no decisions are made until the patient is examined and the patient's chart is reviewed on the day of surgery. On the day of surgery, the patient is again interviewed in the pre-op holding area. The medical record is reviewed with attention to the surgical history and physical, nursing notes, and the surgical consent. Physical examination is performed with principle attention to vital signs, the cardiorespiratory system, oral airway, and neck mobility. The chart is reviewed including relevant laboratory values and EKG. Informed consent for anesthesia is obtained. The patient's questions about anesthesia are answered. The patient declines use of an interscalene block, general anesthesia being preferred. Before initiating anesthesia, anesthetic drugs are prepared and the anesthesia machine is checked for correct operation following the manufacturer's guidelines.

Description of Intra-Service Work: Intravenous access is achieved in the contra-lateral arm. Under intravenous sedation, the patient is transported to the operating room and transferred to the operating table. EKG, blood pressure, and pulse oximetry monitors are applied. Oxygen by mask is given, and then general anesthesia is induced using intravenous fentanyl, propofol, and a neuromuscular blocking agent to facilitate intubation. After carbon dioxide is detected in the exhaled gas, and after breath sounds are detected bilaterally, the endotracheal tube is secured to the face with tape. Anesthesia is maintained with inhalation anesthesia agents, and the anesthetic depth is adjusted to match the level of surgical stimulation. Intravenous fluids are given to maintain hydration and treat hypotension. The patient is then turned to the left lateral decubitus position, a pre-placed bean bag is inflated to retain ideal positioning. Vulnerable pressure points and peripheral nerves are padded and protected. The patient is further secured to the operating table with surgical tape and straps. Depth of anesthesia is maintained by assessing blood pressure, pulse rate, respiratory effort, and neuromuscular blockade. Additional narcotics, neuromuscular blocking drugs, and inhalation agents are provided as needed. Large volumes of irrigating fluid are infused into the surgical site to facilitate the arthroscopic procedure, resulting in increased systemic fluid uptake as well as shoulder swelling. Following completion of the surgical procedure, the inhalation agents are withdrawn and residual neuromuscular blockade is reversed using anticholinesterase and anticholinergic drugs. Adequacy of spontaneous ventilation and neuromuscular blockade reversal is determined, and, if satisfactory, the trachea is extubated. Spontaneous ventilation is further assessed by mask. If ventilation and oxygenation are satisfactory, and if emergence from anesthesia is apparent, the patient is then moved to a stretcher and transferred to the post-anesthesia care unit.

Description of Post-Service Work: In PACU, a brief summary of the procedure and the patient's medical history is conveyed to the PACU nurse. Vital signs are checked, and level of consciousness is determined. While in PACU, the anesthesiologist ensures adequate levels of analgesia. After achieving an improved level of consciousness as determined by the modified Aldrete scoring system, after satisfactory analgesia has been obtained, and after stability of vital signs is confirmed, the patient is discharged from the PACU. The

anesthesiologist remains available by pager while the patient is in the PACU to manage anesthetic related issues and assesses the patient before discharge from the outpatient unit.

SURVEY DATA:

Presenter(s) Karl E. Becker, MD, Norman A. Cohen, MD

Specialty(s) American Society of Anesthesiologists

Sample Size: 21 Response Rate: (%): 15% Median Base Unit Value: 5.0

Type of Sample (Circle One): random, **panel**, convenience. Explanation of sample size: Sent e-mails to 142 physicians

25th Percentile Base Unit Value: 5.0 75th Percentile Base Unit Value: 5.0 Low: 4.0 High: 10.0

Median Pre-Service Time: 20.0 Median Intra-Service Time: 90.0

25th Percentile Intra-Svc Time: 75.0 75th Percentile Intra-Svc Time: 120.0 Low: 30.0 High: 180.0

Median Post-Service Time: 15.0

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

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Base Unit Value
01610	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of shoulder and axilla	XXX	5

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including 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: 01630	Key Reference CPT Code: 01610
Median Pre-Time	20	not available
Median Intra-Time	90	not available
Median Immediate Post-service Time	15	not available
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	2.57	2.45
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.33	2.18
Urgency of medical decision making	2.48	2.27

Technical Skill/Physical Effort (Mean)

Technical skill required	2.90	3.09
Physical effort required	2.90	2.73

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.62	2.55
Outcome depends on the skill and judgement of physician	2.67	2.64

Estimated risk of malpractice suit with poor outcome	3.33	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service
Time Segments (Mean)		
Pre-Service intensity/complexity	2.48	2.50
Intra-Service intensity/complexity	4.62	3.09
Post-Service intensity/complexity	2.52	2.55

ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after deliberation of this procedure by the ASA RVS committee 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 the same as the survey median, the same as the reference service base unit value, and the same as the base unit value for old CPT code 01630, which this revised CPT code now encompasses and defines to account for advances in surgical techniques and medical technology.

FREQUENCY INFORMATION

How was this service previously reported? 01630 (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 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 Anesthesiology Frequency 215,000

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 43,000

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 01732 Tracking Number: R6 Global Period: XXX **Recommended Base Unit Value:** 3

CPT Descriptor: Anesthesia for diagnostic arthroscopic procedures of elbow joint

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 63 year old female has a 12 month history of increasing pain in the left elbow, secondary to osteoarthritis exacerbated by a fall down a flight of stairs. She has experienced progressive limitation of motion and increased pain despite immobilization, anti-inflammatory medications and physical therapy. Radiographs of her elbow do not reveal a fracture. Laboratory studies and ECG are normal. She is scheduled for a diagnostic arthroscopic evaluation of her left elbow.

Description of Pre-Service Work: The patient was assessed at the office of her orthopedic surgeon two days prior to surgery and is contacted by phone by her anesthesiologist the evening prior to surgery. Her past medical history, including coexisting medical illnesses, tobacco use history, chronic drug therapy, allergies, prior anesthetic experiences, and family history of anesthetic reactions are elicited. Alternatives in anesthesia management and associated risks are discussed at that time, though no decisions are made until the patient is examined and the patient's chart is reviewed on the day of surgery. On the day of surgery, the patient is again interviewed in the pre-op holding area and all questions are once again answered. The medical record is reviewed with attention to the surgical history and physical, nursing notes, and the surgical consent. A physical examination is performed, including vital signs, neck mobility, examination of dentition and assessment of airway (in preparation for endotracheal intubation), and examination of heart and lungs. If not already available, preoperative studies would be ordered, to include a hematocrit and EKG. An informed consent for anesthesia ' obtained. The patient's questions regarding the planned anesthetic are answered. The patient desires a regiona block as she has a phobia concerning general anesthesia, and requests an interscalene anesthetic. Before initiating anesthesia, anesthetic drugs and nerve block supplies are prepared and the anesthesia machine is checked for correct operation following the manufacturer's guidelines.

Description of Intra-Service Work: Intravenous access is achieved in the contra-lateral arm. Under intravenous sedation, the patient is transported to the operating room and transferred to the operating table. EKG, blood pressure, and pulse oximetry monitors are applied. Oxygen by mask is given, and then the patient is positioned for the interscalene block on the operative side. The interscalene groove is identified and the skin is prepared with an antiseptic solution. Local anesthesia is injected subcutaneously, creating a skin wheal. Using anatomic landmarks, a nerve block needle with electrical stimulating capabilities is inserted. The needle tip position is adjusted until either a paresthesia or a motor response to the upper extremity is obtained. Position of the needle tip is refined until motor and sensory stimulation is obtained in the region of the elbow at a milliamperage of approximately 0.5mA. The needle is aspirated, confirming no blood return. The patient then receives a test dose of epinephrine containing local anesthetic to confirm that the needle tip is not in a vascular structure. The patient receives approximately 40 cc of the chosen local anesthetic, which is given in divided doses with frequent aspiration. The needle is removed and the patient is closely observed for signs of local anesthetic toxicity, respiratory compromise from either the anticipated phrenic nerve block or from a pneumothorax. Once adequate sensory anesthesia is obtained, the surgical site preparation is allowed to commence. Intravenous sedatives are provided to achieve the desired level of anxiolysis. Intravenous fluids are given to maintain hydration and treat hypotension. Vulnerable pressure points and peripheral nerves are padded and protected. The patient is secured to the operating table with straps. Depth of sedation is maintained by assessing blood pressure, pulse rate, respiratory effort, and patient response. Vital signs are charted no less frequently than every five minutes. Tourniquet time is noted and the surgeon is advised of the tourniquet time hourly. Adjustments to the level of sedation are made as necessary. Following completion of the surgical procedure, the sedation agents are discontinued. The patient is then moved to a stretcher and transferred to the post-anesthesia care unit.

Description of Post-Service Work: In PACU the patient is recovered according to ASA guidelines. A brief summary of the procedure and the patient's medical history is conveyed to the PACU nurse. Vital signs are checked, and level of consciousness is determined. While in PACU, the anesthesiologist ensures adequate levels of analgesia and treating nausea and vomiting should it occur. After achieving an improved level of consciousness as determined by the modified Aldrete scoring system, after satisfactory analgesia has been obtained, and after stability of vital signs is confirmed, the patient is discharged from the PACU. The anesthesiologist remains available by pager while the patient is in the PACU to manage anesthetic related issues and assesses the patient before discharge from the outpatient unit. This assessment will include an evaluation of the extent of the interscalene block and assurance of adequate respiratory function. The anticipated duration of the block is discussed with the patient, who is given contact information in the event of late-onset complications, such as persistent nerve injury.

SURVEY DATA:

Presenter(s) Karl E. Becker, MD, Norman A. Cohen, MD

Specialty(s): American Society of Anesthesiologists

Sample Size: 18 Response Rate: (%): 12% Median Base Unit Value: 3.0

Type of Sample (Circle One): random, **panel**, convenience. Explanation of sample size: Sent e-mails to 142 physicians

25th Percentile Base Unit Value: 3.0 75th Percentile Base Unit Value: 4.0 Low: 3.0 High: 6.0

Median Pre-Service Time: 20.0 Median Intra-Service Time: 75.0

25th Percentile Intra-Svc Time: 60.0 75th Percentile Intra-Svc Time: 86.25 Low: 40.0 High: 120.0

Median Post-Service Time: 15.0

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

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Base Unit Value
01730	Anesthesia for all closed procedures on humerus and elbow	XXX	3

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: 01732	Key Reference CPT Code: 01730
Median Pre-Time	20	not available
Median Intra-Time	75	not available
Median Immediate Post-service Time	15	not available
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	2.61	2.13
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.44	2.13
Urgency of medical decision making	2.33	2.13

Technical Skill/Physical Effort (Mean)

Technical skill required	2.61	2.33
Physical effort required	2.56	2.33

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.56	2.27
Outcome depends on the skill and judgement of physician	2.65	2.40

Estimated risk of malpractice suit with poor outcome	3.00	2.80

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service
Time Segments (Mean)		
Pre-Service intensity/complexity	2.56	2.33
Intra-Service intensity/complexity	2.78	2.53
Post-Service intensity/complexity	2.44	2.27

ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after deliberation of this procedure by the ASA RVS committee 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 the same as the survey median, the same as the reference service base unit value, and the same as the base unit value for old CPT code 01732, which this revised CPT code defines in more specific detail to account for advances in arthroscopic procedures and techniques.

FREQUENCY INFORMATION

How was this service previously reported? 01732 (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 Fequency 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 Anesthesiology Fequency 300

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:01740 Tracking Number: R7 Global Period: XXX **Recommended Base Unit Value:** 4

CPT Descriptor: Anesthesia for open or surgical arthroscopic procedures of the elbow; not otherwise specified

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65 year old male has a nine month history of increasing pain in the left elbow secondary to post traumatic arthritis following a fracture of the radial head. He experienced progressive limitation of motion despite immobilization, anti-inflammatory medications and physical therapy without pain relief. He is scheduled for arthroscopic resection of the radial head.

Description of Pre-Service Work: Having been assessed by his orthopedic surgeon two days earlier, the patient is contacted by phone by his anesthesiologist on the evening prior to surgery. Pertinent information discussed includes any history of previous anesthetic and surgical experiences, any family history of untoward anesthetic reactions, current drug usage, drug allergies, tobacco use history, and a medical review of major organ systems. Alternatives to anesthesia management and associated risks, specifically general anesthesia or brachial plexus block by a variety of approaches, are explained and discussed with the patient. Questions are answered. No recommendations for anesthetic choice are offered pending a review of the chart and physical examination on the day of surgery. On the day of surgery, the patient is identified, the surgical consent is verified, and the site of surgery is confirmed. The chart is reviewed with particular attention to the pre-operative anesthesia questionnaire, the vital signs, the history and physical examination by the operating surgeon, relevant laboratory tests and other pre-operative studies. The medical and surgical history is again briefly reviewed with the patient. Physical examination focuses on neck mobility, the oral airway, and the cardiorespiratory system. Because of his age and history of hypertension, an EKG is performed and interpreted. Discussion of the options for anesthesia care, including relative risks and advantages, are explained. The anesthesiologist recommends that a regional anesthetic be employed, specifically a brachial plexus block by the interscalene approach. Informed consent is obtained, and the patient agrees to the recommended interscalene block. Before initiating anesthesia, anesthetic drugs are prepared and the anesthesia machine is checked for correct operation following the manufacturer's guidelines.

Description of Intra-Service Work: Following the establishment of intravenous access in the non-surgical arm and the intravenous administration of a hypnotic sedative, the patient is transported by gurney to the operating room while careful attention is paid to the level of consciousness. In the surgical suite, the patient is transferred to the operating table. EKG, blood pressure, and pulse oximetry monitors are applied. Supplemental oxygen by means of a nasal cannula is initiated. The head is positioned facing away from the surgical site, and the muscular and skeletal landmarks for the interscalene block are identified on the neck. Using sterile technique, the skin over the intended area is infiltrated with local anesthetic. A short, small gauge needle is directed toward the interscalene groove. With minimal sedation to allow the patient to respond to unusual sensations, attempts are made to elicit paresthesias. A nerve stimulator connected to the probing needle is used to confirm correct location. Local anesthetic medication is then deposited in the interscalene groove. The patient is monitored for local anesthetic. The extent and intensity of the block is assessed. Vulnerable pressure points and peripheral nerves are padded and protected. After a surgical tourniquet is applied, and inflation pressures and times of inflation are noted, the patient is then prepped and draped for surgery. Intravenous fluids are given to maintain hydration and to treat any hypotension. Intravenous antibiotics are administered at the request of the surgeon. Additional hypnotic sedatives to provide patient comfort are infused by means of a continuous infusion pump. Regular attention is directed to the patient's level of consciousness to ensure that a patent airway is maintained and protective reflexes remain intact. With the potential of phrenic nerve anesthesia as well as pneumothorax on the same side as the interscalene block, adequacy of ventilation is constantly assessed. Variations in blood pressure are treated with appropriate drugs. With the completion of the procedure, the sedative infusion is

discontinued. Monitors are removed, and the patient transported to the PACU.

Description of Post-Service Work: In the PACU, oxygen is administered. Vital signs are checked, and level of consciousness is determined. Adequacy of ventilation, maintenance of airway, and ability to handle secretions again assessed. The extent of diminished sensation in the field of anesthesia is determined by simple touch or pin prick. A brief summary of the procedure and the patient's medical history is conveyed to the PACU nurse. While in the PACU, the anesthesiologist orders additional analgesics as needed. Post-operative hypertension and other medical problems are also assessed and treated. After the patient's vital signs are stable, an appropriate level of consciousness has returned as determined by the modified Aldrete scoring system, and the analgesic needs are satisfied, the patient is discharged from the PACU. The anesthesiologist remains available by pager while the patient is in the PACU to manage anesthetic related issues and assesses the patient before discharge from the outpatient unit.

SURVEY DATA:

Presenter(s): Karl E. Becker, MD, Norman A. Cohen, MD

Specialty(s): American Society of Anesthesiologists

Sample Size: 16 Response Rate: (%): 11% Median Base Unit Value: 4.0

Type of Sample (Circle One): random, **panel**, convenience. Explanation of sample size: Sent e-mails to 142 physicians

25th Percentile Base Unit Value: 4.0 75th Percentile Base Unit Value: 4.25 Low: 3.0 High: 6.0

Median Pre-Service Time: 20.0 Median Intra-Service Time: 90.0

25th Percentile Intra-Svc Time: 73.75 75th Percentile Intra-Svc Time: 120.0 Low: 45.0 High: 200.0

Median Post-Service Time: 15.0

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

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Base Unit Value
01730	Anesthesia for all closed procedures on humerus and elbow	XXX	3

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: 01740	Key Reference CPT Code: 01730
Median Pre-Time	20	not available
Median Intra-Time	90	not available
Median Immediate Post-service Time	15	not available
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	2.75	2.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.81	2.20
Urgency of medical decision making	2.50	2.00

Technical Skill/Physical Effort (Mean)

Technical skill required	2.75	2.20
Physical effort required	2.63	2.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.50	2.00
Outcome depends on the skill and judgement of physician	2.69	2.00

Estimated risk of malpractice suit with poor outcome	3.06	2.60

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service
Time Segments (Mean)		
Pre-Service intensity/complexity	2.75	2.40
Intra-Service intensity/complexity	2.88	2.40
Post-Service intensity/complexity	2.44	2.00

ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after deliberation of this procedure by the ASA RVS committee 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 the same as the survey median, the same as the reference service base unit value, and the same as the base unit value for old CPT code 01400, which this revised CPT code now encompasses and defines to account for advances in surgical techniques and medical technology.

FREQUENCY INFORMATION

How was this service previously reported? 01740 (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 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 Anesthesiology Frequency 72,500

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 14,500

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

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Anesthesia for Arthroscopic/Endoscopic Procedures on the Hand

01829 and 01830 CPT created a new code and revised existing code 01830 to account for new arthroscopic techniques and procedures. Arthroscopy is no longer limited to diagnostic procedures, and now surgical repairs are done using an arthroscopic approach or a combination of an open and arthroscopic approach. Theses CPT changes revision will bring the code descriptors in line with current practice. The RUC agreed that the changes to code 01830 did not change the value of the code and the median survey value of 3 base units supports the current value. The RUC also agreed that new code 01829 should be valued at 3 base units since both codes involve the same amount of anesthesia work and place the codes in proper relativity with other Anesthesia codes. **The RUC recommends 3 base units for code 01829. The RUC recommends 3 base units for code 01830.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Base Unit Recommendation
●01829	R8	Anesthesia for diagnostic arthroscopic procedures on the wrist	XXX	3
▲01830	R9	Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist or hand~~, bones~~/joints; not otherwise specified	XXX	3 (no change)
▲01832		Anesthesia for open procedures on radius, ulna, wrist, or hand bones; total wrist replacement	XXX	6 (no change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 01829 Tracking Number R8 Global Period: XXX **Recommended Base Unit Value:** 3

CPT Descriptor: Anesthesia for diagnostic arthroscopic procedures on the wrist

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25-year-old baseball pitcher has developed marked pain and significant swelling in his right wrist. There is no history of significant trauma. Cold packs, anti-inflammatory medications, immobilization have not relieved his wrist pain. Radiographs do not reveal an obvious fracture. He is otherwise healthy. He is scheduled for a diagnostic arthroscopy of his right wrist.

Description of Pre-Service Work: The 25-year-old healthy athlete was seen in the office of his orthopedic sports medicine surgeon 3 days prior to admission and was contacted by telephone by his anesthesiologist the night before surgery. An appropriate medical history was elicited, including a review of past surgeries and anesthetics, the presence of any medical illnesses, current drug therapy including herbals and other over the counter medications, drug sensitivities and allergies, and family history of anesthetic reactions. In addition the patient was questioned about his use of smokeless tobacco and alcohol to which he had admitted. A review of systems revealed no cardiac, pulmonary, hepatic, gastrointestinal, renal, endocrine, central nervous system or peripheral nervous system history. Various alternatives in choice of anesthetics- the relative advantages and disadvantages- were discussed though no firm decision was made until the day of surgery when the patient would be examined and the medical chart reviewed. On the morning of surgery, the patient is identified and interviewed again in the pre-op preparation area. The right wrist is verified as the site of surgery and all questions are once again answered. The patient's NPO status is evaluated. A focused physical examination including vital signs, neck extension and mobility, assessment of airway including dentition and examination of heart and lungs is performed. Because of his excellent health and age no preoperative tests were ordered. The patient refused a regional block and an informed consent for general anesthesia was obtained. Intravenous access is achieved in the left arm and 3 mg of midazolam is administered. Under intravenous sedation, the patient is transported to the operating room with continuous observation of his respiratory effort, anxiety level and consciousness. Before initiating anesthesia, anesthetic drugs are prepared and the anesthesia machine is checked for correct operation following the manufacturer's guidelines.

Description of Intra-Service Work: In the operating room the patient is safely transferred to the operating table. Pulse oximetry, blood pressure and EKG monitors are placed. Oxygen by mask is given to achieve 100% saturation for several minutes, then general anesthesia is induced using intravenous fentanyl and propofol. A #4 LMA is carefully inserted through the mouth into the hypopharynx. The presence of end tidal CO2 is documented and a good fit is established and the tube secured in place with wide tape. Sevoflurane and nitrous oxide are added to the oxygen. Eyes are padded and protective tape is applied to maintain closure. Peripheral nerves and pressure points are padded and protected. The patient is further secured to the operating table with surgical tape and straps. Warm blankets are placed to achieve normothermia. Anesthesia is maintained with inhalation anesthesia agents. Intravenous fluids are given to maintain hydration and to treat hypotension. Depth of anesthesia is maintained by continuous assessment of blood pressure, pulse rate, and respiratory effort. Additional narcotics and inhalation agents are provided as needed. Toward the end of the procedure, the inhalation agents are gradually withdrawn and narcotics are slowly added, titrating the dose to maintain the patient's respiration. At the end of the surgical procedure, adequacy of spontaneous ventilation, tidal volume and emergence from anesthesia is determined and if adequate the LMA is removed. A green mask providing O2 is placed on the patient's face and if ventilation and oxygenation are satisfactory the patient is then moved to a stretcher and transferred to the post-anesthesia care unit.

Description of Post-Service Work: In PACU the patient is recovered according to ASA guidelines. A brief summary of the procedure and the patient's medical history is conveyed to the PACU nurse. Vital signs are checked, and level of consciousness is determined. While in PACU, the anesthesiologist ensures adequate levels of analgesia and orders anti-emetic therapy should nausea and vomiting occur. After achieving an adequate level of consciousness as determined by the modified Aldrete scoring system, after satisfactory analgesia has been obtained, and after stability of vital signs is confirmed, the patient is discharged from the PACU. The anesthesiologist remains available to assess the patient before discharge from the outpatient surgery unit.

SURVEY DATA:

Presenter(s) Karl E. Becker, MD, Norman A. Cohen, MD

Specialty(s): American Society of Anesthesiologists

Sample Size: 19 Response Rate: (%): 13% Median Base Unit Value: 3.0

Type of Sample (Circle One): random, **panel,** convenience. Explanation of sample size: Sent e-mails to 142 physicians

25th Percentile Base Unit Value: 3.0 75th Percentile Base Unit Value: 4.0 Low: 3.0 High: 5.0

Median Pre-Service Time: 15.0 Median Intra-Service Time: 60.0

25th Percentile Intra-Svc Time: 50.0 75th Percentile Intra-Svc Time: 82.50 Low: 35.0 High: 120.0

Median Post-Service Time: 10.0

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

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Base Unit Value
01820	Anesthesia for all closed procedures on radius, ulna, wrist, or hand bones	XXX	3

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: 018X1**	**Key Reference CPT Code: 01820**
Median Pre-Time	15	not available
Median Intra-Time	60	not available
Median Immediate Post-service Time	10	not available
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	2.00	1.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.84	1.83
Urgency of medical decision making	1.89	1.83

Technical Skill/Physical Effort (Mean)

Technical skill required	2.16	1.89
Physical effort required	1.95	1.78

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.00	1.89
Outcome depends on the skill and judgement of physician	2.05	1.94

Estimated risk of malpractice suit with poor outcome	3.32	3.11

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service
Time Segments (Mean)		
Pre-Service intensity/complexity	1.89	1.83
Intra-Service intensity/complexity	2.00	1.89
Post-Service intensity/complexity	1.89	1.83

ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after deliberation of this procedure by the ASA RVS committee 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 the same as the survey median, the same as the reference service base unit value and the same as the base unit value for old CPT code 01830, which this revised CPT code now refines to account for new arthroscopic techniques and procedures.

FREQUENCY INFORMATION

How was this service previously reported? 01820 or 01830 (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

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 7,500

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 1,500

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 01830 Tracking Number: R9 Global Period:XXX **Recommended Base Unit Value:** 3

CPT Descriptor: Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist or hand joints; not otherwise specified

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 15-year-old female develops a compound fracture of her right distal radius and ulna in a fall. Closed reduction is not feasible due to the extent of the fractures and an open reduction with internal fixation is planned. She is on no medications and is otherwise healthy. Last meal was 8 hours ago

Description of Pre-Service Work: The 15-year-old female is seen in the emergency department by the Emergency physician, who requests evaluation by an orthopedic surgeon. The surgeon decides to operate as soon as an OR is available. Her anesthesiologist is called to the emergency department where an appropriate medical history is elicited; seeking any current or past medical illnesses, any past procedures, surgeries or anesthetics, current drug therapy including herbals and other over the counter medications, drug sensitivities or allergies, last menstrual period and family history of anesthetic reactions. In addition the patient is questioned about her use of tobacco, alcohol and recreational drugs all of which she denies. A review of systems reveals no cardiac, pulmonary, hepatic, gastrointestinal, renal, endocrine, central nervous system or peripheral nervous system history. She exhibits normal growth and development. Details of time and content of last food ingestion are discussed. A focused physical examination including vital signs, neck extension and mobility, assessment of airway including dentition and examination of heart and lungs is performed and because of the patient's age and health status only a hematocrit is ordered. Then in the presence of her parents, alternatives in choice of anesthetics including the relative advantages and disadvantages are detailed. Regional block is refused and the decision is made to undergo general endotracheal anesthesia after the patient and her parents confirm their understanding of the anesthetic options. The patient expresses fear of being awake and "needles". The informed consent is explained to and signature is obtained from the patient's mother. Because the patient expressed considerable anxiety, a local anesthetic cream is applied to the dorsum of her left hand and intravenous access is obtained using a 20-gauge catheter. 2.5 mg of Midazalam is administered IV. An hour later the patient arrives to the receiving desk of the general operating room where she is re-identified and re-assessed prior to transport to the operating suite. The right wrist is verified as the site of surgery and all questions are once again answered. The patient is transported to the operating room with continuous observation of her respiratory effort and anxiety level. Before initiating anesthesia, anesthetic drugs are prepared and the anesthesia machine is checked for correct operation following the manufacturer's guidelines.

Description of Intra-Service Work: In the operating room the patient is safely transferred to the operating table. Pulse oximetry, blood pressure and EKG monitors are placed. Oxygen by mask is given to achieve 100% saturation for several minutes, then general anesthesia is induced using intravenous fentanyl and propofol and a neuromuscular blocking agent to facilitate intubation. After carbon dioxide is detected in the exhaled gas, and after breath sounds are detected bilaterally, the endotracheal tube is secured to the face with tape. Sevoflurane and nitrous oxide are added to the oxygen. Eyes are padded and protective tape is applied to maintain closure. Anesthesia is maintained with inhalation anesthesia agents. Peripheral nerves and pressure points are padded and protected. The patient is further secured to the operating table. A forced air-warming blanket is applied to maintain normothermia. Intravenous fluids are given to maintain hydration and treat hypotension. Depth of anesthesia is maintained by assessing blood pressure, pulse rate, respiratory effort, and neuromuscular blockade. Additional narcotics, neuromuscular blocking drugs, and inhalation agents are provided as needed. Following completion of the surgical procedure, the inhalation agents are withdrawn and residual neuromuscular blockade is reversed using anticholinesterase and anticholinergic drugs. Additionally, narcotics are slowly titrated to maintain adequate respiratory rate and achieve analgesia. At the end of the surgical procedure adequacy of spontaneous ventilation, tidal volume and emergence from anesthesia is determined and if adequate the patient is suctioned and the endotracheal tube is removed. A green mask and O2 are placed on the patient's face and, if

ventilation and oxygenation are satisfactory, the patient is then moved to a stretcher and transferred to the post-anesthesia care unit.

Description of Post-Service Work: In PACU the patient is recovered according to ASA guidelines. A brief summary of the procedure and the patient's excellent health status is conveyed to the PACU nurse. Vital signs checked, and level of consciousness is determined. While in PACU, the anesthesiologist ensures adequate level of analgesia and g orders anti-emetics should nausea and vomiting occur. After achieving an adequate level of consciousness as determined by the modified Aldrete scoring system, after satisfactory analgesia has been obtained, and after stability of vital signs is confirmed, the patient is discharged from the PACU. The anesthesiologist remains available to evaluate the patient before discharge from the outpatient surgery unit.

SURVEY DATA:

Presenter(s) Karl E. Becker, MD, Norman A. Cohen, MD

Specialty(s): American Society of Anesthesiologists

Sample Size: 20 Response Rate: (%): 14% Median Base Unit Value: 4.0

Type of Sample (Circle One): random, **panel**, convenience. Explanation of sample size: Sent e-mails to 142 physicians

25th Percentile Base Unit Value: 4.0 75th Percentile Base Unit Value: 4.25 Low: 3.0 High: 6.0

Median Pre-Service Time: 19.0 Median Intra-Service Time: 90.0

25th Percentile Intra-Svc Time: 75.0 75th Percentile Intra-Svc Time: 121.25 Low: 60.0 High: 210.0

Median Post-Service Time: 15.0

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

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Base Unit Value
01832	Anesthesia for open procedures on radius, ulna, wrist, or hand bones; total wrist replacement	XXX	6

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including 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: 01830	Key Reference CPT Code: 01832
Median Pre-Time	19	not available
Median Intra-Time	90	not available
Median Immediate Post-service Time	15	not available
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	2.25	2.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.95	2.40
Urgency of medical decision making	2.20	2.20

Technical Skill/Physical Effort (Mean)

Technical skill required	2.40	2.53
Physical effort required	2.10	2.20

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.30	2.53
Outcome depends on the skill and judgement of physician	2.55	2.80

Estimated risk of malpractice suit with poor outcome	3.50	3.60

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service
Time Segments (Mean)		
Pre-Service intensity/complexity	2.11	2.15
Intra-Service intensity/complexity	2.37	2.50
Post-Service intensity/complexity	2.05	2.36

ADDITIONAL RATIONALE

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

The ASA reached its final conclusion after deliberation of 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 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 1 less than the survey median but the same as the base unit value for old CPT code 01830, which this revised CPT code defines in more specific detail to account for advances in arthroscopic procedures and techniques.

FREQUENCY INFORMATION

How was this service previously reported? 01830 (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 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 Anesthesiology Frequency 140,000

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 35,000

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

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
February 2002

Anesthesia Services for Diagnostic or Therapeutic Nerve Block Injections

01991 Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); other than the prone position.

01992 Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); prone position

The RUC examined these two new codes together to ensure proper relativity. These codes were created to describe the work involved in delivering the typical anesthesia service for nerve blocks or injections performed by another provider. The difference between the codes is the patient's position, with the prone position entailing more work and risk. The ASA and RUC agreed that the median survey base unit values were not supported by the survey intensity and complexity measures. Therefore, the RUC agreed with the ASA recommendation of base units below the median values, so that they would be in proper rank order with other anesthesia services. The RUC felt that a base unit of 3 for 01991 was appropriate since a number of similar less invasive anesthesia procedures are valued at 3 base units. Assigning 5 base units to 01992 is equivalent to the base units assigned to more invasive anesthesia procedures.

The RUC recommends a base unit value of 3.00 for CPT code 01991.

The RUC recommends a base unit value of 5.00 for CPT code 01992.

CPT Code (•New)	Track-ing Number	CPT Descriptor	Global Period	Base Unit Value Recommendation
●01991	Q1	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); other than the prone position	XXX	3
●01992	Q2	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); prone position (Do not report code 01991 or 01992 in conjunction with 99141)	XXX	5

AMA/Specialty RVS Update Process
Summary of Recommendations

CPT Code: 01991 Tracking Number: Q1 Global Period: XXX Recommended Base Unit Value: 3

CPT Descriptor: Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); other than the prone position

Clinical Description of Service:

Vignette Used in Survey: A 47-year-old woman presents to the pain clinic with chronic pain in the left buttock and leg. She has had three previous lumbar spine procedures including microdiscectomy, decompressive lumbar laminectomy and posterior lumbar interbody arthrodesis and pedicle screw fixation. Her buttock and leg pain persisted and she failed a dorsal column stimulator trial. She also suffers from an anxiety disorder. The pain physician determines that the patient has neuropathic pain and a trial of epidural opioids and/or alpha-2 agonists via indwelling lumbar epidural catheter (CPT 62319) is indicated. If successful, the physician will recommend implantation of a subarachnoid drug delivery system. The patient had a very unpleasant experience with the dorsal column stimulator and insists upon general anesthesia for the epidural catheter placement. General anesthesia in the lateral position is planned.

Description of Pre-Service Work: The anesthesiologist meets the patient in the preoperative holding area. After reviewing the medical record and available laboratory studies, the anesthesiologist completes the pre-anesthesia history and physical examination. Particular attention is paid to the present illness, the cardiac and respiratory systems, time of last oral intake, family history of anesthetic problems, medications, drug allergies, airway anatomy, and availability of intravenous access for drug delivery. The anesthesiologist discusses anesthetic alternatives with the patient, develops an anesthetic plan, and obtains informed consent for the anesthetic. The anesthesiologist agrees to perform a general anesthetic for the patient. The anesthesiologist documents his history, physical findings and anesthetic plan in the medical record.

Description of Intra-Service Work: The patient is taken to the operating room where she is met by the anesthesiologist, who has already completed the anesthetic machine checkout and prepared the anesthetic medications. After assuring adequate intravenous access, the anesthesiologist applies monitors, including a non-invasive blood pressure cuff, a pulse oximeter, and a three lead electrocardiogram. The patient receives oxygen via a face mask for about 5 minutes, followed by propofol and a short-acting muscle relaxant after the ability to ventilate by mask is confirmed. The anesthesiologist performs direct laryngoscopy and intubates the patient without difficulty. Auscultation of the lungs and monitoring of end-tidal carbon dioxide levels confirms tracheal intubation. After securing the endotracheal tube with tape and taping the eyelids closed, the patient is placed in the lateral decubitus position with an axillary roll. The anesthesiologist reviews the patient position to assure that peripheral nerves are adequately protected from injury. A skin temperature probe is applied. The circulating nurse prepares the lumbar region with an iodine based solution and the operating physician sterilely drapes the field. During the operative phase of the procedure, the anesthesiologist completes the anesthetic record while monitoring the patient's oxygenation, blood pressure, heart rate, temperature and end-tidal carbon dioxide levels. He adjusts the anesthetic drug delivery to match the level of surgical stimulation. If the surgeon injects any substances before emergence from anesthesia, the anesthesiologist monitors the patient for any adverse sequelae. Once the surgeon successfully places the epidural catheter and a dressing is applied by the circulating nurse, the anesthesiologist supervises repositioning of the patient to the supine position. Anesthetic drug delivery is discontinued and emergence proceeds uneventfully. The anesthesiologist employs a neuromuscular stimulator to determine adequate spontaneous recovery from the non-depolarizing neuromuscular blocker used to facilitate intubation. Once the anesthesiologist determines that the patient has adequate protective airway reflexes, he removes the endotracheal tube. After a brief period of monitoring in the operating room, the patient is taken to the post-anesthesia care unit in stable condition. The nurse obtains admitting vital signs and the anesthesiologist provides a report to the nurse summarizing the history and anesthetic course. The anesthesiologist prescribes medications to treat pain and post-operative nausea and vomiting on an as needed basis.

Description of Post-Service Work: The anesthesiologist remains available for management of problems in the post-anesthesia care unit. He visits the patient on the inpatient ward later that day to determine if any anesthetic complications occurred. He also discusses the anesthetic course with the patient and makes an entry in the medical record.

Survey Data:

Presenter(s): Karl E. Becker, MD and Norm Cohen, MD

Specialty(s): Joint survey by ASA, AANS/CNS, AAPM and NASS

Sample Size: 31 Response rate: (%): 0.7% Median Base Unit Value: 4.0

Type of Sample: Random

Explanation of sample size: Approximately 4,000 e-mails sent out directing physicians to a website

25th Percentile Base Unit Value:	2.50	Low:	0.0
75th Percentile Base Unit Value:	6.0	High:	20.0
Median Pre-Service Time:	15.0		
Median Intra-Service Time:	30.0		
Median Post-Service Time:	10.0		
25th Percentile Intra-Service time:	20.0	Low:	5.0
75th Percentile Intra-Service time:	45.0	High:	120.0

Level of Service by CPT Code

	Total Time:	(List CPT code & # of Visits)
Immediate Post Service Time:	20	Included
Critical Care:		
Other Hospital Visits:	10	Included
Discharge Day Mgmt:		
Office Visits:		

:y Reference Service

CPT Code: **00635**

CPT Descriptor: Anesthesia for procedures in lumbar region; diagnostic or therapeutic lumbar puncture
Base Unit Value: 4

Relationship of code Being Reviewed to Key Reference Service(s):

Compare the pre, intra, and post service times (by median) and the intensity (by 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 Code 019X1:	Key Reference CPT 00635:
Median Pre-time	15.0	15.0
Median Intra time	30.0	42.5
Median Immediate Post service time	10.0	12.5
Median of aggregate critical care times		
Median of aggregate other hospital visit times		
Median of discharge day management times		
:dian of aggregate office visit times		

Intensity/Complexity Measures (Mean)

Mental Effort & Judgment (Mean)	New/Revised Code 019X1:	Key Reference CPT 00635:
The number of possible diagnosis and/or number of management options that must be considered	2.23	2.80
Amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.48	3.15
Urgency of Medical Decision making	1.94	2.35

Technical Skill/Physical Effort (Mean)

	New/Revised Code 019X1:	Key Reference CPT 00635:
Technical skill required	2.35	2.95
Physical effort required	2.23	2.75

Psychological Stress (Mean)

	New/Revised Code019X1:	Key Reference CPT 00635:
Risk of significant complications, morbidity and/or mortality	2.39	2.75
Outcome depends on the skill and judgment of physician	2.61	3.2
Estimated risk of malpractice suit with poor outcome	2.81	3.55

Intensity/Complexity Measures (Mean) continued

Time Segments (Mean)

	New/Revised Code 019X1:	Key Reference CPT 00635:
Pre-service intensity/complexity	2.28	2.89
Intra-service intensity/complexity	2.21	2.89
Post-service intensity/complexity	1.90	2.22

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 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 lower than the reference service base unit value.

Frequency Information

How was this service previously reported? 00300, 00400, 00820
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 from 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 from each specialty)

Specialty:	Anesthesiology	Frequency: 40,000
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 the recommendation is from multiple specialties, please provide information from each specialty)

Specialty:	Anesthesiology	Frequency: 12,500
Specialty:		Frequency:

o many physicians perform this service across the United States? Yes__X__ No_____

AMA/Specialty RVS Update Process
Summary of Recommendations

CPT Code: 01992 Tracking Number: Q2 Global Period: XXX Recommended Base Unit Value: 5

CPT Descriptor: Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); prone position

Clinical Description of Service:
Vignette Used in Survey: A 67 year old man with lumbar facet syndrome demonstrated by previous diagnostic lumbar facet injections at L4-5 bilaterally presents to the pain clinic for radiofrequency medial branch neurolysis at L3, L4, and L5 bilaterally in the prone position (CPT 64622 and 64623) Due to his history of obesity, obstructive sleep apnea and right heart failure, the pain physician requests anesthesia care from the department of anesthesiology

Description of Pre-Service Work: The anesthesiologist meets the patient in the preoperative holding area. After reviewing the medical record and available laboratory studies, the anesthesiologist completes the pre-anesthesia history and physical examination. Particular attention is paid to the present illness, the cardiac and respiratory systems. Time of last oral intake, family history of anesthetic problems, medications, drug allergies, airway anatomy, and availability of intravenous access for drug delivery. During the interview, the anesthesiologist learns that the patient had significant difficulty breathing with prone positioning during his diagnostic facet blocks. The anesthesiologist discusses anesthetic alternatives with the patient, develops an anesthetic plan, and obtains informed consent for the anesthetic. The anesthesiologist recommends general anesthesia given the patient's previous ventilatory difficulties along with the longer duration of this procedure. The anesthesiologist documents his history, physical findings and anesthetic plan in the medical record.

Description of Intra-Service Work: The patient is taken to the operating room where he is met by the anesthesiologist, who has already completed the anesthetic machine checkout and prepared the anesthetic medications. After assuring adequate intravenous access, the anesthesiologist applies monitors, including a non-invasive blood pressure cuff, a pulse oximeter, and a three lead electrocardiogram. The patient receives oxygen via a face mask for about 5 minutes, followed by propofol and a short-acting muscle relaxant after the ability to ventilate by mask is confirmed. The anesthesiologist performs direct laryngoscopy and intubates the patient without difficulty. Auscultation of the lungs and monitoring of end-tidal carbon dioxide levels confirms tracheal intubation. After securing the endotracheal tube with tape and taping the eyelids closed, the patient is placed in the prone position. Padding has been pre-placed to provide appropriate positioning for the procedure without impeding respiratory excursion. The anesthesiologist reviews the patient position to assure that peripheral nerves are adequately protected from injury. In addition, the anesthesiologist confirms the presence of lung sounds and determines that ventilatory pressures are not excessive. A skin temperature probe is applied. The circulating nurse prepares the lumbar region with an iodine-based solution and the operating physician sterilely drapes the field. During the operative phase of the procedure, the anesthesiologist completes the anesthetic record while monitoring the patient's oxygenation, blood pressure, heart rate, temperature and end-tidal carbon dioxide levels. He adjusts the anesthetic drug delivery to match the level of surgical stimulation. If the surgeon injects any local anesthetics before emergence from anesthesia, the anesthesiologist monitors the patient for any adverse sequelae. Once the surgeon successfully lesions the medial branch nerves at the desired levels and a dressing is applied by the circulating nurse, the anesthesiologist supervises repositioning of the patient to the supine position. Anesthetic drug delivery is discontinued and emergence proceeds uneventfully. The anesthesiologist employs a neuromuscular stimulator to determine adequate spontaneous recovery from the non-depolarizing neuromuscular blocker used to facilitate intubation. Once the anesthesiologist determines that the patient has adequate protective airway reflexes, he removes the endotracheal tube. After a brief period of monitoring in the operating room. the patient is taken to the post-anesthesia care unit in stable condition. The nurse obtains admitting vital sings and the anesthesiologist provides a report to the nurse summarizing the history and anesthetic course. The anesthesiologist prescribes medications to treat pain and post-operative nausea and vomiting on an as needed basis.

Description of Post-Service Work: The anesthesiologist remains available for management of problems in the post-anesthesia care unit. He visits the patient in the outpatient surgery department before discharge to determine if any anesthetic

complications have occurred. He also discusses the anesthetic course with the patient. He makes an entry in the medical record.

Survey Data:

Presenter(s): Karl E. Becker, MD, Norm Cohen, MD

Specialty(s): Joint survey by ASA, AANS/CNS, AAPM and NASS

Sample Size: 31 Response rate: (%): 0.7% Median Base Unit Value: 6.0

Type of Sample: Random

Explanation of sample size: Approximately 4,000 e-mails sent out directing physicians to a website

25th Percentile Base Unit Value:	2.35	Low:	0.0
75th Percentile Base Unit Value:	7.0	High:	10.0
Median Pre-Service Time:	15.0		
Median Intra-Service Time:	30.0		
Median Post-Service Time:	10.0		
25th Percentile Intra-Service time:	15.0	Low:	5.0
75th Percentile Intra-Service time:	55.0	High:	90.0

Level of Service by CPT Code

	Total Time:	(List CPT code & # of Visits)
Immediate Post Service Time:	20	Included
Critical Care:		
Other Hospital Visits:	10	Included
Discharge Day Mgmt:		
Office Visits:		

Key Reference Service

CPT Code: **00635**

CPT Descriptor: Anesthesia for procedures in lumbar region; diagnostic or therapeutic lumbar puncture
Base Unit Value: 4.0

Relationship of code Being Reviewed to Key Reference Service(s):
Compare the pre, intra, and post service times (by median) and the intensity (by 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 Code 019X2:	Key Reference CPT 00635:
Median Pre-time	15.0	15.0
Median Intra time	30.0	50.0
Median Immediate Post service time	10.0	15.0
Median of aggregate critical care times		
Median of aggregate other hospital visit times		
Median of discharge day management times		
Median of aggregate office visit times		

Intensity/Complexity Measures (Mean)

Mental Effort & Judgment (Mean)	New/Revised Code 019X2:	Key Reference CPT 00635:
The number of possible diagnosis and/or number of management options that must be considered	2.66	3.56
Amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.86	3.75
Urgency of Medical Decision making	2.52	3.25-

Technical Skill/Physical Effort (Mean)

	New/Revised Code 019X2:	Key Reference CPT 00635:
Technical skill required	2.79	3.75
Physical effort required	2.83	3.56

Psychological Stress (Mean)

	New/Revised Code 019X2:	Key Reference CPT 00635:
k of significant complications, morbidity and/or ortality	3.03	3.94
Outcome depends on the skill and judgment of physician	3.24	4.13
Estimated risk of malpractice suit with poor outcome	3.38	4.5

Intensity/Complexity Measures (Mean) continued

Time Segments (Mean)

	New/Revised Code 019X2:	Key Reference CPT 00635:
Pre-service intensity/complexity	2.57	3.44
Intra-service intensity/complexity	2.75	3.5
Post-service intensity/complexity	2.21	3.19

Additional Rationale:
escribe 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. Evaluation of the results of the survey intensity/ complexity measures supports a base unit value higher than the reference service base unit value due to the increased work associated with prone positioning. The ASA RVS Committee determined that the median survey value of 6 would create rank order anomalies and was not supported by intensity/complexity measures obtained via survey.

Frequency Information

How was this service previously reported? 00300, 00400, 00820
(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 from 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 from each specialty)

Specialty:	Anesthesiology	Frequency: 10,000
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 the recommendation is from multiple specialties, please provide information from each specialty)

Specialty:	Anesthesiology	Frequency: 3125
Specialty:		Frequency:

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

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Excisions of Lesions: Wide Margins

CPT requested the review of 36 revised excision of benign and malignant lesion codes based on the revisions to the descriptors to include the margins of the lesions. The Dermatology, Family Physician, General Surgery and Plastic Surgery specialty societies chose not to survey these revised codes, rather they proposed increases based on the frequency that would maintain the 2002 family RVU ratio for the first 5 codes in each family remain work neutral. However, the last code in the family will remain the same. This rational is derived from the estimation that with the inclusion of the lesion's margins, codes that previously described larger lesion sizes will now be more appropriately coded using a higher level code. For example, the specialty societies estimated that for benign lesion types, the frequency for higher level codes would increase by 30 percent. For malignant codes, the specialty societies estimated that the frequency for code usage for the next higher level code would increase by about 50 percent. Since the description of the last code in the family is inclusive of margins at a certain level and higher, the society determined that by holding the work value for the last code in the family the same, the family will remain work neutral. The RUC agreed with this rationale. The RUC also agreed that it would be appropriate to review the actual Medicare utilization data in two years to determine the actual change in coding. **The RUC recommends the following work relative values for codes 11400-11646:**

CPT 11400	**0.85**	**CPT 11420**	**0.98**	**CPT 11440**	**1.06**
CPT 11401	**1.23**	**CPT 11421**	**1.42**	**CPT 11441**	**1.48**
CPT 11402	**1.51**	**CPT 11422**	**1.63**	**CPT 11442**	**1.72**
CPT 11403	**1.79**	**CPT 11423**	**2.01**	**CPT 14443**	**2.29**
CPT 11404	**2.06**	**CPT 11424**	**2.43**	**CPT 11444**	**3.14**
CPT 11406	**2.76**	**CPT 11426**	**3.78**	**CPT 11446**	**4.49**
CPT 11600	**1.31**	**CPT 11620**	**1.19**	**CPT 11640**	**1.35**
CPT 11601	**1.80**	**CPT 11621**	**1.76**	**CPT 11641**	**2.16**
CPT 11602	**1.95**	**CPT 11622**	**2.09**	**CPT 11642**	**2.59**
CPT 11603	**2.19**	**CPT 11623**	**2.61**	**CPT 11643**	**3.10**
CPT 11604	**2.40**	**CPT 11624**	**3.06**	**CPT 11644**	**4.03**
CPT 11606	**3.43**	**CPT 11626**	**4.30**	**CPT 11646**	**5.95**

Practice Expenses
No changes to the practice expense inputs were recommended.

Integumentary System
Excision – Benign Lesions

Excision (including simple closure) of benign lesions of skin ~~or subcutaneous tissues~~ (eg, neoplasm, cicatricial, fibrous, inflammatory, congenital, cystic lesions), includes local anesthesia. See appropriate size and body area below. For shave removal, see 11300 et seq., and for electrosurgical and other methods see 17000 et seq.

Excision is defined as full-thickness (through the dermis) removal of ~~the~~ a ~~following~~ lesion~~s~~, including margins, and includes simple (non-layered) closure when performed. Report separately each benign lesion excised. Code selection is determined by measuring the greatest clinical diameter of the apparent lesion plus that margin required for complete excision (lesion diameter plus the most narrow margins required equals the excised diameter). The margins refer to the most narrow margin required to adequately excise the lesion, based on the physician's judgment. The measurement of lesion plus margin is made prior to excision. The excised diameter is the same whether the surgical defect is repaired in a linear fashion, or reconstructed, eg with a skin graft.

The closure of defects created by incision, excision, or trauma may require intermediate or complex closure. Repair by intermediate or complex closure should be reported separately. For excision of benign lesions requiring more than simple closure, ie, requiring intermediate or complex closure, report 11400-11466 in addition to appropriate intermediate (12031-12057) or complex closure (13100-13153) codes. For reconstructive closure, see 11400-14300, 15000-15261, 15570-15770. *See page 53 for definition of intermediate or complex closure.*

~~(For excision of benign lesions requiring more than simple closure, i.e., requiring intermediate or complex closure, report 11400-11446 in addition to appropriate intermediate (12031-12057) or complex closure (13100-13153) codes. For reconstructive closure, see 14000-14300, 15000-15261, 15570-15770)~~

~~(For electrosurgical and other methods, see 17000 et seq)~~

CPT Code (•New)	Track-ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲11400	E1	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; ~~lesion~~ excised diameter 0.5 cm or less	010	0.85
▲11401	E2	~~lesion~~ excised diameter 0.6 to 1.0 cm	010	1.23
▲11402	E3	~~lesion~~ excised diameter 1.1 to 2.0 cm	010	1.51
▲11403	E4	~~lesion~~ excised diameter 2.1 to 3.0 cm	010	1.79
▲11404	E5	~~lesion~~ excised diameter 3.1 to 4.0 cm	010	2.06
▲11406	E6	~~lesion~~ excised diameter over 4.0 cm *(For unusual or complicated excision, add modifier –22)*	010	2.76
▲11420	E7	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; ~~lesion~~ excised diameter 0.5 cm or less	010	0.98
▲11421	E8	~~lesion~~ excised diameter 0.6 to 1.0 cm	010	1.42
▲11422	E9	~~lesion~~ excised diameter 1.1 to 2.0 cm	010	1.63
▲11423	E10	~~lesion~~ excised diameter 2.1 to 3.0 cm	010	2.01
▲11424	E11	~~lesion~~ excised diameter 3.1 to 4.0 cm	010	2.43
▲11426	E12	~~lesion~~ excised diameter over 4.0 cm *(For unusual or complicated excision, add modifier –22)*	010	3.78

CPT Code (•New)	Track-ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲11440	E13	Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; ~~lesion~~ excised diameter 0.5 cm or less	010	1.06
▲11441	E14	~~lesion~~ excised diameter 0.6 to 1.0 cm	010	1.48
▲11442	E15	~~lesion~~ excised diameter 1.1 to 2.0 cm	010	1.72
▲11443	E16	~~lesion~~ excised diameter 2.1 to 3.0 cm	010	2.29
▲11444	E17	~~lesion~~ excised diameter 3.1 to 4.0 cm	010	3.14
▲11446	E18	~~lesion~~ excised diameter over 4.0 cm *(For unusual or complicated excision, add modifier '–22')* *(For eyelids involving more than skin, see also 67800 et seq)*	010	4.49

Integumentary System
Excision – Malignant Lesions

Excision (including simple closure) of malignant lesions of skin ~~or subcutaneous tissues~~ (eg, basal cell carcinoma, squamous cell carcinoma, melanoma), includes~~ing~~ local anesthesia ~~each lesion.~~ (See appropriate size and body area below.) For ~~removal~~ destruction of malignant lesions of skin ~~by any method other than excision, as defined above,~~ see destruction codes ~~17000-17999~~ 17260-17286.

Excision is defined as full-thickness (through the dermis) removal of ~~the~~ a ~~following~~ lesion~~s~~, including margins, and includes simple (non-layered) closure when performed. Report separately each malignant lesion excised. Code selection is determined by measuring the greatest clinical diameter of the apparent lesion plus that margin required for complete excision (lesion diameter plus the most narrow margins required equal~~s~~ the excised diameter). The margins refer to the most narrow margin required to adequately excise the

lesion, based on the physician's judgment. The measurement of lesion plus margin is made prior to excision. ~~Note t That t~~The excised diameter is the same whether the surgical defect is repaired in a linear fashion, or reconstructed, eg with a skin graft.

The closure of defects created by incision, excision, or trauma may require intermediate or complex closure. Repair by intermediate or complex closure should be reported separately. For excision of malignant lesions requiring more than simple closure, ie, requiring intermediate or complex closure, report 11600-11646 in addition to appropriate intermediate (12031-12057) or complex closure (13100-13153) codes. For reconstructive closure, see 14000-14300, 15000-15261, 15570-15770. *See page 53 for definition of intermediate or complex closure.*

When frozen section pathology shows the margins of excision were not adequate, an ~~the~~ additional excision may be necessary for complete tumor removal. Use only one code to report the additional excision and re-excision(s) ~~to achieve wider margins at the same operative session is reported with one malignant excision code~~ based on the final widest excised diameter required for complete tumor removal at the same operative session..

To report a re-excision procedure performed to widen margins at a subsequent operative session, see codes 11600-11646, as appropriate. Append the modifier '-58' if the re-excision procedure is performed during the postoperative period of the primary excision procedure.

~~(For excision of malignant lesions requiring more than simple closure, ie, requiring intermediate or complex closure, report 11600-11646 in addition to appropriate intermediate (12031-12057) or complex closure (13100-13153) codes. For reconstructive closure, see 14000-14300, 15000-15261, 15570-15770)~~

CPT Code (•New)	Track-ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲11600	E19	Excision, malignant lesion including margins, trunk, arms or legs; ~~lesion~~ excised diameter 0.5 cm or less	010	1.31
▲11601	E20	~~lesion~~ excised diameter 0.6 to 1.0 cm	010	1.80
▲11602	E21	~~lesion~~ excised diameter 1.1 to 2.0 cm	010	1.95

CPT Code (•New)	Track-ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲11603	E22	~~lesion~~ excised diameter 2.1 to 3.0 cm	010	2.19
▲11604	E23	~~lesion~~ excised diameter 3.1 to 4.0 cm	010	2.40
▲11606	E24	~~lesion~~ excised diameter over 4.0 cm	010	3.43
▲11620	E25	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; ~~lesion~~ excised diameter 0.5 cm or less	010	1.19
▲11621	E26	~~lesion~~ excised diameter 0.6 to 1.0 cm	010	1.76
▲11622	E27	~~lesion~~ excised diameter 1.1 to 2.0 cm	010	2.09
▲11623	E28	~~lesion~~ excised diameter 2.1 to 3.0 cm	010	2.61
▲11624	E29	~~lesion~~ excised diameter 3.1 to 4.0 cm	010	3.06
▲11626	E30	~~lesion~~ excised diameter over 4.0 cm	010	4.30
▲11640	E31	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; ~~lesion~~ excised diameter 0.5 cm or less	010	1.35
▲11641	E32	~~lesion~~ excised diameter 0.6 to 1.0 cm	010	2.16

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲11642	E33	~~lesion~~ excised diameter 1.1 to 2.0 cm	010	2.59
▲11643	E34	~~lesion~~ excised diameter 2.1 to 3.0 cm	010	3.10
▲11644	E35	~~lesion~~ excised diameter 3.1 to 4.0 cm	010	4.03
▲11646	E36	~~lesion~~ excised diameter over 4.0 cm (For eyelids involving more than skin, see also 67800 et seq)	010	5.95

PROPOSAL: Maintain 2002 family RVW RATIO for FIRST 5 codes - Do not change RVW for LAST code,

Estimate upcoded frequency (30%-benign, 50%-malignant), Calc recommended RVW as family budget neutral (ie, Col G total = Col I total)

			RVW	ratio	RVW	w-RVUs	w-RVUs	w-RVUs	2000 Actual Freq (total & -modifiers)					2003 Estimated "upcoded" Frequency				
CPT	Lesion Type	Lesion Size	2002 RVW	Maintain Ratio in 2002 MFS	2003 Recom'd RVW	2002 workRVUs = 2002 RVW x 2000 freq	2003 Est workRVUs = 2002 RVW x upcode freq	2003 Est workRVUs = Rec'd RVW x upcode freq	2000 FRQ (Total)	FRQ (blank, -22,-52) @100%	FRQ -51 @50%	FRQ - 54 @70%	FRQ - 55 @20%	Estimated 2003 "upcoded" FRQ (Total)	FRQ (blank, -22,-52) @100%	FRQ -51 @50%	FRQ - 54 @70%	FRQ - 55 @20%
11400	Benign-trunk, arms or legs	0.5 cm or less	0.91	0.6	0.85	49,932	34,952	32,673	63,686	46,054	17,632	0	0	44,580	32,238	12,342	0	0
11401	Benign-trunk, arms or legs	0.6 to 1.0 cm	1.32	0.8	1.23	115,098	102,297	95,626	102,767	71,624	31,143	0	0	91,043	63,953	27,090	0	0
11402	Benign-trunk, arms or legs	1.1 to 2.0 cm	1.61	1.0	1.51	150,218	147,268	137,663	108,549	78,057	30,492	0	0	106,814	76,127	30,687	0	0
11403	Benign-trunk, arms or legs	2.1 to 3.0 cm	1.92	1.2	1.79	82,046	111,175	103,924	48,173	37,292	10,881	0	0	66,286	49,522	16,764	0	0
11404	Benign-trunk, arms or legs	3.1 to 4.0 cm	2.20	1.4	2.06	36,975	54,086	50,559	19,056	14,558	4,498	0	0	27,791	21,378	6,413	0	0
11406	Benign-trunk, arms or legs	over 4.0 cm	2.76		2.76	52,396	66,312	66,312	20,415	17,553	2,862	0	0	26,132	21,920	4,211	0	0
						486,665	516,091	486,757	362,646	265,138	97,508	0	0	362,646	265,138	97,508	0	0
11420	Benign-scalp, neck, hands, feet, genitalia	0 5 cm or less	1.06	0.7	0.98	36,869	25,809	23,953	39,803	29,762	10,041	0	0	27,862	20,833	7,029	0	0
11421	Benign-scalp, neck, hands, feet, genitalia	0.6 to 1.0 cm	1.53	1.0	1.42	65,352	61,711	57,275	49,048	36,379	12,669	0	0	46,275	34,394	11,881	0	0
11422	Benign-scalp, neck, hands, feet, genitalia	1.1 to 2.0 cm	1.76	1.2	1.63	73,112	73,731	68,430	47,434	35,648	11,786	0	0	47,918	35,867	12,051	0	0
11423	Benign-scalp, neck, hands, feet, genitalia	2.1 to 3 0 cm	2.17	1.4	2.01	36,981	52,930	49,125	19,077	15,007	4,070	0	0	27,584	21,199	6,385	0	0
11424	Benign-scalp, neck, hands, feet, genitalia	3.1 to 4.0 cm	2.62	1.7	2.43	14,482	23,532	21,841	6,131	4,924	1,207	0	0	10,015	7,949	2,066	0	0
11426	Benign-scalp, neck, hands, feet, genitalia	over 4.0 cm	3.78		3.78	17,309	23,577	23,577	4,851	4,307	544	0	0	6,690	5,784	908	0	0
						244,105	261,290	244,200	166,344	126,027	40,317	0	0	166,344	126,027	40,317	0	0
11440	Benign-face, ears, eyelids, nose, lips, muc	0.5 cm or less	1.15	0.7	1.06	79,422	55,596	51,037	80,654	57,460	23,165	29	0	56,458	40,222	16,216	20	0
11441	Benign-face, ears, eyelids, nose, lips, muc	0.6 to 1.0 cm	1.61	1.0	1.48	113,623	112,893	103,637	81,490	59,652	21,828	10	0	81,239	58,994	22,229	16	0
11442	Benign-face, ears, eyelids, nose, lips, muc	1.1 to 2.0 cm	1.87	1.2	1.72	90,086	102,652	94,236	55,926	40,423	15,503	0	0	63,595	46,192	17,401	3	0
11443	Benign-face, ears, eyelids, nose, lips, muc	2.1 to 3.0 cm	2.49	1.5	2.29	34,208	59,932	55,018	15,561	11,915	3,646	0	0	27,671	20,467	7,203	0	0
11444	Benign-face, ears, eyelids, nose, lips, muc	3.1 to 4.0 cm	3.42	2.1	3.14	13,288	23,397	21,479	4,268	3,503	765	0	0	7,656	6,027	1,629	0	0
11446	Benign-face, ears, eyelids, nose, lips, muc	over 4.0 cm	4.49		4.49	12,734	17,967	17,967	3,032	2,640	392	0	0	4,312	3,691	622	0	0
						343,361	372,437	343,375	240,931	175,593	65,299	39	0	240,931	175,593	65,299	39	0
11600	Malignant-trunk, arms or legs	0.5 cm or less	1.41	0.7	1.31	14,400	7,200	6,704	12,167	8,258	3,909	0	0	6,084	4,129	1,955	0	0
11601	Malignant-trunk, arms or legs	0.6 to 1.0 cm	1.93	0.9	1.80	83,904	51,807	48,238	53,347	33,600	19,747	0	0	32,757	20,929	11,828	0	0
11602	Malignant-trunk, arms or legs	1.1 to 2.0 cm	2.09	1.0	1.95	148,887	119,874	111,614	87,548	54,928	32,620	0	0	70,448	44,264	26,184	0	0
11603	Malignant-trunk, arms or legs	2.1 to 3.0 cm	2.35	1.1	2.19	73,866	120,638	112,326	35,648	27,217	8,431	0	0	61,598	41,073	20,526	0	0
11604	Malignant-trunk, arms or legs	3.1 to 4.0 cm	2.58	1.2	2.40	32,966	57,031	53,101	14,545	11,010	3,535	0	0	25,097	19,114	5,983	0	0
11606	Malignant-trunk, arms or legs	over 4.0 cm	3.43		3.43	43,853	65,766	65,766	14,187	11,383	2,804	0	0	21,460	16,888	4,572	0	0
						397,876	422,315	397,749	217,442	146,396	71,046	0	0	217,442				
11620	Malignant-scalp, neck, hands, feet, genital	0.5 cm or less	1.34	0.6	1.19	7,970	3,985	3,553	7,169	4,727	2,442	0	0	3,585	2,364	1,221	0	0
11621	Malignant-scalp, neck, hands, feet, genital	0 6 to 1.0 cm	1.97	0.8	1.76	45,561	28,639	25,531	28,565	17,690	10,875	0	0	17,867	11,209	6,659	0	0
11622	Malignant-scalp, neck, hands, feet, genital	1.1 to 2.0 cm	2.34	1.0	2.09	81,330	67,724	60,373	39,755	29,758	9,997	0	0	34,160	23,724	10,436	0	0
11623	Malignant-scalp, neck, hands, feet, genital	2.1 to 3.0 cm	2.93	1.3	2.61	38,688	70,262	62,635	14,966	11,442	3,524	0	0	27,361	20,600	6,761	0	0
11624	Malignant-scalp, neck, hands, feet, genital	3.1 to 4.0 cm	3.43	1.5	3.06	16,346	30,818	27,473	5,492	4,039	1,453	0	0	10,229	7,741	2,489	0	0
11626	Malignant-scalp, neck, hands, feet, genital	over 4.0 cm	4.30		4.30	16,071	26,317	26,317	4,411	3,064	1,347	0	0	7,157	5,084	2,074	0	0
						205,966	227,746	205,881	100,358	70,720	29,638	0	0	100,358				
11640	Malignant-face, ears, eyelids, nose, lips, n	0.5 cm or less	1.53	0.6	1.35	57,074	28,537	25,262	44,494	30,113	14,381	0	0	22,247	15,057	7,191	0	0
11641	Malignant-face, ears, eyelids, nose, lips, n	0.6 to 1 0 cm	2.44	1.0	2.16	247,279	169,150	149,739	118,298	84,397	33,889	0	12	81,396	57,255	24,135	0	6
11642	Malignant-face, ears, eyelids, nose, lips, n	1.1 to 2.0 cm	2.93	1.2	2.59	298,796	297,867	263,685	115,687	88,269	27,418	0	0	116,993	86,333	30,654	0	6
11643	Malignant-face, ears, eyelids, nose, lips, n	2.1 to 3.0 cm	3.50	1.4	3.10	107,909	232,416	205,745	35,439	26,223	9,216	0	0	75,563	57,246	18,317	0	0
11644	Malignant-fa[illegible] eyelids, nose, lips, n	3.1 to 4.0 cm	4.55	1.9	4.03	45,457	92,869	82,212	11,605	8,376	3,229	0	0	23,522	17,300	6,2[illegible]	0	0
11646	Malignant-[illegible]yelids, nose, lips, n	over 4.0 cm	5.95		5.95	38,532	68,254	8,254	7,375	5,577	1,798	0	0	13,178	9,765	3,	0	0
						795,046	889,092	34,898	332,898	242,955	89,931	0	12	332,898				

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002 and February 2003

Mohs Micrographic Surgery

RUC Recommendation from April 2002:

For CPT 2003, the American Academy of Dermatology recommended changes that would clarify that a biopsy and frozen pathology could be done on the same day as Mohs surgery. In addition, the specialty proposed changes to special procedures such as decalcification of the bone during Mohs surgery or specialty stains (i.e. immunostaining for melanoma). Finally, modifications to code 17310 were recommended to clarify that each specimen after the first 5 specimens in each layer is separately reimbursable. The Center's for Medicare and Medicaid recommended that the work value for 17310 be changed from 000 to ZZZ. CPT approved these changes.

Modification to codes 17304, 17305, 17306, and 17307 were considered editorial changes, and were not reviewed by the RUC. The specialty survey for code 17310 did not provide calculations that were work neutral. In addition, RUC members were unclear on the historical information regarding whether the code could be billed more than one time on the same day for greater than 5 specimens, as the interpretation from CPT differed from the interpretation put forth by CMS in 1994 letter from a CMS Chief Medical Officer. Therefore, the RUC approved a motion to let the value stand for the CPT 2003 cycle as interim. Between the April 2002 RUC Meeting and the February 2003 RUC Meeting, an ad-hoc committee would further clarify with CPT the intent of code 17310. In addition, the specialty society would revise their survey based on the agreed upon interpretation of the descriptor and the new ZZZ global period.

The RUC recommends an interim work relative value for CPT code 17310 of 0.95.

Practice Expense
The RUC referred practice expense inputs for this family of codes to the September 2002 Practice Expense Advisory Committee.

RUC Recommendation from February 2003:

A workgroup of the RUC reviewed this issue at the February 2003 meeting and concluded that a number of issues should be addressed regarding these services, including:

- The code descriptors for these services remain confusing and open to various interpretations. Although the RUC understands that many in the Mohs community and payors had historically interpreted CPT code 17310 as an add-on code to be reported for each additional specimen beyond the first five specimens, concern was expressed regarding the potential for over-utilization of this code. In addition, the workgroup noted that the nomenclature for these services is not consistent with other integumentary coding conventions in CPT, which are based on the size of the lesion, rather than the number of specimens. The RUC, therefore, recommends that the specialty work with the CPT Editorial Panel to re-define the Mohs Micrographic Surgery section in CPT. After this revision is complete, the RUC believes that these codes can be appropriately re-evaluated.

- In the interim, the RUC recommends that CMS retain the 2002 work relative value of 0.95 for CPT code 17310. In the December 31, 2002 *Final Rule*, CMS had published that it had reduced the RUC's interim recommendation of 0.95 to 0.62. CMS concluded that intent of the code had changed as it will now be described as an add-on code. The RUC believes that CMS should research its past policies regarding this code, as the specialty has provided documentation that CMS had already been under the assumption that this service was an add-on and could be reported once for each additional specimen beyond the first five specimens. Specifically, the specialty has referred to the November 25, 1991 *Final Rule*, which states that "Code 17310, which is described as *Mohs', more than 5 specimens, fixed or fresh tissue, any stage*, should be treated as a single specimen; that is, if more than 5 specimens are necessary at any stage, each additional specimen beyond 5 should be separately paid. The work RVUs have been established according to the above interpretation." The RUC is also concerned that CMS' approach to determining a new value of 0.62 may be flawed. CMS only considered the pathology work and the specialty has presented that the work of the additional excision should also be factored into the work relative value.

- The RUC's Practice Expense Advisory Committee had reviewed the direct practice expense inputs for these services in April 1999. The RUC recommends that these recommendations remain "interim" pending re-definition and re-evaluation of this family of codes.

- The workgroup that extensively examined this issue at the February 2003 meeting will be assigned to review this issue again after the codes are re-defined by CPT.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery **Integumentary System** **Mohs Micrographic Surgery** *Mohs Micrographic surgery, for the removal of complex or ill-defined skin cancer, requires a single physician to act in two integrated, but separate and distinct capacities: surgeon and pathologist. If either of these responsibilities is delegated to another physician who reports his services separately, these codes are not appropriate. If repair is performed, use separate repair, flap, or graft codes.* If a biopsy of a suspected skin cancer is performed on the same day as Mohs surgery because there was no prior pathology confirmation of a diagnosis, then report diagnostic skin biopsy (11100, 11101) and frozen section pathology (88331) with modifier –59 to distinguish from the subsequent definitive surgical procedure of Mohs surgery.				
▲17304	M1	Chemosurgery (Mohs micrographic technique), including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and complete histopathological preparation including the first routine stain (eg, hematoxylin and eosin, toluidine blue); first stage, fresh tissue technique, up to 5 specimens. (If additional special pathology procedures, stains or immunostains are required, use 88311-88314, 88342)	000	7.60 (no change)
▲17305	M2	*second stage, fixed or fresh tissue, up to five specimens*	000	2.85 (no change)
▲17306	M3	*third stage...*	000	2.85 (no change)
▲17307	M4	*additional stage(s),...*	000	2.85 (no change)
+▲17310	M5	each additional specimen, ~~more than~~ after the first 5 specimens, fixed or fresh tissue, any stage (List separately in addition to code for primary procedure) Use 17310 in conjunction with codes 17304-17307)	ZZZ* *Change in global from 000	0.95 (interim)

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Mohs Micrographic Surgery

For CPT 2003, the American Academy of Dermatology recommended changes that would clarify that a biopsy and frozen pathology could be done on the same day as Mohs surgery. In addition, the specialty proposed changes to special procedures such as decalcification of the bone during Mohs surgery or specialty stains (i.e. immunostaining for melanoma). Finally, modifications to code 17310 were recommended to clarify that each specimen after the first 5 specimens in each layer is separately reimbursable. The Center's for Medicare and Medicaid recommended that the work value for 17310 be changed from 000 to ZZZ. CPT approved these changes.

Modification to codes 17304, 17305, 17306, and 17307 were considered editorial changes, and were not reviewed by the RUC. The specialty survey for code 17310 did not provide calculations that were work neutral. In addition, RUC members were unclear on the historical information regarding whether the code could be billed more than one time on the same day for greater than 5 specimens, as the interpretation from CPT differed from the interpretation put forth by CMS in 1994 letter from a CMS Chief Medical Officer. Therefore, the RUC approved a motion to let the value stand for the CPT 2003 cycle as interim. Between the April 2002 RUC Meeting and the February 2003 RUC Meeting, an ad-hoc committee would further clarify with CPT the intent of code 17310. In addition, the specialty society would revise their survey based on the agreed upon interpretation of the descriptor and the new ZZZ global period.

The RUC recommends an interim work relative value for CPT code 17310 of 0.95.

Practice Expense
The RUC referred practice expense inputs for this family of codes to the September 2002 Practice Expense Advisory Committee.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery **Integumentary System** **Mohs Micrographic Surgery** *Mohs Micrographic surgery, for the removal of complex or ill-defined skin cancer, requires a single physician to act in two integrated, but separate and distinct capacities: surgeon and pathologist. If either of these responsibilities is delegated to another physician who reports his services separately, these codes are not appropriate. If repair is performed, use separate repair, flap, or graft codes.* <u>If a biopsy of a suspected skin cancer is performed on the same day as Mohs surgery because there was no prior pathology confirmation of a diagnosis, then report diagnostic skin biopsy (11100, 11101) and frozen section pathology (88331) with modifier –59 to distinguish from the subsequent definitive surgical procedure of Mohs surgery.</u>				
▲17304	M1	Chemosurgery (Mohs micrographic technique), including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and complete histopathological preparation <u>including the first routine stain (eg, hematoxylin and eosin, toluidine blue)</u>; first stage, fresh tissue technique, up to 5 specimens. <u>(If additional special pathology procedures, stains or immunostains are required, use 88311-88314, 88342)</u>	000	7.60 (no change)
▲17305	M2	*second stage, fixed or fresh tissue, up to five specimens*	000	2.85 (no change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲17306	M3	*third stage...*	000	2.85 (no change)
▲17307	M4	*additional stage(s),...*	000	2.85 (no change)
+▲17310	M5	each additional specimen, ~~more than~~ after the first 5 specimens, fixed or fresh tissue, any stage (List separately in addition to code for primary procedure) Use 17310 in conjunction with codes 17304-17307)	ZZZ* *Change in global from 000	0.95 (interim)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
PHYSICIAN TIME SUMMARY OF RECOMMENDATION

CPT Code: 17310 Tracking Number: M-5 Global Period: ZZZ RUC Recommended Interim RVW: ~~1.26~~ 0.95

CPT Descriptor: CHEMOSURGERY OF SKIN LESION
Chemosurgery (Mohs micrographic technique), including removal of all gross tumor, surgical excision of tissue specimens, mapp color coding of specimens, microscopic examination of specimens by the surgeon, and complete histopathologic preparation; l than 5 specimens, fresh tissue technique, any stage

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
Patient is 49-year-old white male with poorly defined recurrent malignant skin lesion on right side of nose, approximately 2.5 cm with invasion of basal cell carcinoma of upper right cheek.

Description of Pre-Service Work:

Description of Intra-Service Work:
Surgeon performs a lamellar excision of the tumor, carefully excising a thin layer of tissue around the surgical wound created by the previous procedures. The intensity of this lamellar excision is high since the typical malignancy is located at highly sensitive areas of the face, ears, eyes, nose and lips where risk of loss of substantial tissue mass and nerve function is high. Tissue excised may include epidermis, dermis, subcutaneous fat, muscle, cartilage and bone.

The lamellar excision, to ensure the pathologic examination that immediately follows, must be perfectly flat, uniform of thickness and contain no holes in the layer of excised tissue. The tissue excised is cut and divided into four or five sections for smaller tissue excisions and substantially more sections for larger tissue excisions. The number of divisions varies according to the shape and pliability of the tissue excised. In addition the tissue must be sized to allow the specimen(s) to fit on a slide.

The surgeon's primary objective is to obtain a complete microscopic examination of the margins surrounding the excised tissue. T maintain the orientation of the excised tissue to the patient's wound, the excised tissue is marked with color dyes. The dye colors, w can be identified in frozen sections, permit accurate orientation of excised tissue. The surgeon will manipulate the specimen to m sure it lies flat in a two-dimensional plane for precise orientation to the patient. A detailed map with identical dye markings is drawn by the surgeon of the excised tissues and the corresponding surgical site. Photos may be taken to further insure proper orientation of specimens to wound site.

The surgeon hands over the excised tissue specimens to the histologic technician and provides any special instructions necessary for proper preparation of the tissue specimens for the surgeon's subsequent examination. As soon as the specimens have been prepared and stained (45 to 90 minutes) by the histologic technician, the Mohs surgeon, in the role of pathologist, examines the complete margins of each of the prepared tissue slides. The Mohs slides are prepared horizontally as opposed to standard "vertical" tissue preparation for standard frozen section tissue examinations. This facilitates finding of a malignancy in the first level of slides to indicate the lamellar excision has cut through the malignancy rather than around it. If residual malignancy is found, the precise location is marked by the surgeon on the map of the excision area and in relation to the anatomical landmarks of the tumor.

Description of Post-Service Work:

SURVEY DATA:

Presenter(s) John A. Zitelli, MD, Brett Coldiron, MD, and Daniel M. Siegel, MD

Specialty(s): **American College of Mohs Micrographic Surgery and Cutaneous Oncology**
American Academy of Dermatology _____

Sample Size: **75**____ Response Rate: (%): **45**_____

Type of Sample (Circle One): **random,** panel, convenience.
Explanation of sample size: **Survey sent to every 8th name on ACMMSCO member list**

Median Pre-Service Time: **N/A** ___ Median Intra-Service Time: **20** _____

25th Percentile Intra-Svc Time: **14.25**____ 75th Percentile Intra-Svc Time: **55**____ Low: **5**____ High: **90**

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

Original Harvard Total Time:__31 (source=pr)__

Revised Total Time: _____

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
17305	2nd Stage Chemosurgery (Mohs micrographic technique); second stage, fixed or fresh tissue technique, up to five specimens	2.85

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: 17310**	**Key Reference CPT Code: 17305**
Median Pre-Time	0	
Median Intra-Time	20	62
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	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	4	4

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	5	4
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	Reference Service 1
	17310	17305
Time Segments (Mean)		
Pre-Service intensity/complexity	3	5
Intra-Service intensity/complexity	5	5
Post-Service intensity/complexity	4	4

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

The American Academy of Dermatology's Coding and Reimbursement Task Force members as well as members of the American College of Mohs Micrographic Surgery and Cutaneous Oncology's Task Force on Coding and Classification. have reviewed the survey results as well as the pertinent CPEP and RUC data. They have specifically reviewed physician work which may not have addressed the pathology function required (equivalent to an 88332-26, 0.59 RVW). The survey also provides statistical support for the number and level of clinical staff required. Medical supplies and equipment reflect survey data adjusted to correct code global change from 000 global to ZZZ global as well as for RUC approved standard times and/or PEAC approved labor times and standard supply packages. A small but significant proportion of both survey respondents and reviewers felt that the vignette patient was younger and the lesion smaller than that seen in their typical patient.

FREQUENCY INFORMATION

How was this service previously reported? Same Code 17310 (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 Dermatology ___Commonly __X___Sometimes _____Rarely
Specialty Mohs Micrographic Surgery _X___Commonly ____Sometimes _____Rarely
Specialty Plastic Surgery _____ ____Commonly __X___Sometimes _____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period?
Approximately 54,900 (Includes Medicare)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty ___Dermatology _____ Frequency_88% __48,312_____
Specialty ___Plastic Surgery _____ Frequency_11% 6039

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
24,926 If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty ___Dermatology _____ Frequency_87.46% __21,800_____
Specialty ___Plastic Surgery _____ Frequency_10.54% 2,627_____

Do many physicians perform this service across the United States? __x___Yes Approx 2500

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Excision of Mandible/Facial Bone Tumor

Four new codes (21046, 21047, 21048 and 21049) were developed to reflect the increased intra-operative time, the extent of surgery and the increased intensity level required to perform these services as compared to the codes currently being used, which inadequately describe the intensity of the procedures being performed.

Codes 21046 and 21048

The RUC examined codes 21046 *Excision of benign tumor or cyst, mandible; with intra-oral osteotomy (eg, locally aggressive or destructive lesion* and 21048 *Excision of benign tumor or cyst of maxilla, requiring intra-oral osteotomy (eg locally aggressive or destructive lesion(s))*. The RUC agreed with the specialty societies' recommendations that these codes were needed to describe the intensity level of the service being performed. The RUC also agreed that the recommended relative work value for 21046 and 21048, both the survey medians, were appropriate. Both of these services are comparable in work to CPT code 21206 *Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)* (work RVU = 14.10 with a pre-service time of 75 minutes, intra-service time of 108 minutes post-service time of 57 minutes, post-op hospital time of 41 minutes and post-op office visit time of 95 minutes. Code 21046 and 21048 both had survey time of 75 minutes for pre-service, 120 minutes of intra-service, 30 minutes of post-service 1 hospital visit, discharge day and 5 office visits. The survey respondents did indicate that 21048 was more intense than 21046, therefore an incremental increase is appropriate. **The RUC recommends a work relative value of 13.00 for 21046 and 13.50 for 21048.**

Code 21047

The RUC considered the specialty societies' recommendation for code 21047 *Excision of benign tumor or cyst, mandible; with extra-oral osteotomy and partial mandibulectomy (eg locally aggressive or destructive lesion)*. The RUC compared the work of 21047 to 21046 and agreed that the additional 120 minutes of intra-service work justified the increment of 5.75 over the base code. **The RUC recommends a work relative value of 18.75 for 21047.**

Code 21049

The RUC assessed the specialty societies' recommendation for code 21049 *Excision of benign tumor or cyst, maxilla; with extra-oral osteotomy and partial maxillectomy (eg, locally aggressive or destructive lesion)*. Because of the aggressive nature of the ameloblastic fibro-odontoma, which requires radical excision to obliterate them and prevent re-occurrence, the RUC agreed with the intensity of this service. Additional justification for this recommendation included the increased intensity associated with the extra-

oral approach and the higher surveyed intensity as compared to the reference code 21206 *Osteotomy, maxilla, segmental (eg Wassmund or Schuchard)* (RVU = 14.10). In addition, the total time for the surveyed code (543 minutes) far exceeded that of the reference code (348 minutes). **The RUC recommends a work relative value of 18.00 for 21049.**

Codes 21030 and 21040

The RUC then reviewed codes 21030 *Excision of benign tumor or cyst of ~~facial bone other than mandible,~~ maxilla or zygoma, by enucleation and curettage* and *21040 Excision of benign ~~cyst or tumor~~, tumor or cyst of mandible~~;~~, by enucleation and curettage ~~simple~~* The RUC decided to table these codes pending review of the CPT panel to clarify some language issues and the possible re-surveying of these codes by the specialty societies pending the CPT decision. *The CPT Editorial Panel did review these codes in May 2002 and made only a minor change to "enucleation and/or curettage." The Panel commented that they viewed the original code changes as editorial.*

Practice Expense

The RUC reviewed the practice expense inputs for 21046-49 and recommends that the standard 90-day global package would be applied to all of these codes.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲21030	F1	Excision of benign tumor or cyst of ~~facial bone other than mandible,~~ maxilla or zygoma, by enucleation and curettage	090	No RUC recommendation at this time Referred to CPT – CPT no further changes-considered original changes editorial
▲21034	F2	Excision of malignant tumor of ~~facial bone, other than mandible~~ maxilla or zygoma	090	16.17 (no change)
▲21040	F3	Excision of benign ~~cyst or tumor~~, tumor or cyst of mandible~~;~~, by enucleation and curettage ~~simple~~	090	No RUC recommendation at this time Referred to CPT – CPT no further changes-considered original changes editorial No RUC recommendation at this time

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
21041(D)		~~complex~~ 21041 has been deleted. To report excision of benign tumor or cyst or mandible not requiring osteotomy, use 21040.	090	N/A
●21046	F4	Excision of benign tumor or cyst of mandible; with intraoral osteotomy (eg, locally aggressive or destructive lesion(s))	090	13.00
●21047	F5	requiring extra-oral osteotomy and partial mandibulectomy (eg, locally aggressive or destructive lesion(s))	090	18.75
●21048	F6	Excision of benign tumor or cyst of maxilla; requiring intra-oral osteotomy (eg, locally aggressive or destructive lesion(s))	090	13.50
●21049	F7	requiring extra-oral osteotomy and partial maxillectomy (eg, locally aggressive or destructive lesion(s))	090	18.00

CPT Code: 21046 (F4) **Global**: 090 **Recommended RVW**: 13.00

CPT Descriptor: Excision of benign tumor or cyst, mandible; with intra-oral osteotomy (eg, locally aggressive or destructive lesion)

Survey Vignette (Typical Patient)

A 27-year-old female presents with a 3 x 4 cm radiolucent lesion of the right anterior mandible extending from teeth #26 to #28. Initial biopsy had shown odontogenic myxoma. At operation, utilizing an intra-oral approach, the adjacent teeth #26 and #28 are extracted, and a mandibular osteotomy is performed to resect the lesion with clear 1 cm margins, maintaining continuity of the mandible. The patient is followed in the hospital/office, as necessary, through the 90-day global period. [When completing this survey please consider only the preservice work within 24 hours of the procedure, the procedure itself, and all work through the 90-day global period. You may continue to see the patient beyond the 90-day global period, but that work would be separately reportable.]

CLINICAL DESCRIPTION OF SERVICE:

PREOPERATIVE WORK:
- Write pre-operative orders for peri-operative medications including antibiotics and steroids
- Review pre-operative work-up, including all radiographs and CT Scans
- Review planned incisions and procedure with emphasis on closure and delayed reconstruction
- Change into scrub clothes
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions and obtain informed consent
- Review length and type of anesthesia with anesthesiologist (ie, nasal as opposed to oral tube)
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

INTRA-SERVICE WORK:
Under general anesthesia, utilizing an intra-oral approach, the adjacent teeth #26 and #28 are extracted, and a mandibular osteotomy is performed to resect the lesion with clear 1 cm margins, maintaining continuity of the mandible. The mental nerve is identified and repositioned. Flaps are undermined and advanced to obtain closure. Great attention is used to guarantee hemostasis in the floor of the mouth, after which the defect is packed with iodoform gauze and the flap returned and sutured. Gauze dressing sponges are applied to assist with hemostasis.

POSTOPERATIVE WORK, IN HOSPITAL:
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Answer patient/family questions
- Dictate post-op report
- Repack wound until discharge, as necessary
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company
- Assess airway prior to discharge to determine the safety of breathing in an unmonitored setting
- Reassess postoperative oral intake before discharge
- Review instructions for post-discharge wound care and home care with patient and family
- Answer insurance staff questions
- Write orders for post-discharge medications
- Chart patient discharge notes
- Assess adequacy of oral intake before discharge

POSTOPERATIVE WORK, IN OFFICE:

- Examine and talk with patient
- Review any neurology deficit and monitor patients recovery
- Check wounds and repack weekly – under local anesthesia, in the office - until the mandible bone fills the defect
- Order and review radiographs to assess the osteotomy cuts and dental status compared with pre-operative films
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician
- Write orders for medications
- Discuss progress with patient/family
- Dictate patient progress notes for medical chart
- Dictate procedure outcome letter for referring physician, including plan for dental reconstruction

SURVEY DATA

Presenter(s): Lanny Garvar, DMD

Specialty(s): American Association of Oral & Maxillofacial Surgeons/American Dental Association
American Society of Plastic Surgeons

CPT: 21046

Sample Size: 120 **Resp n:** 33 **Resp %:** 28%

Sample Type: Random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	10.00	11.00	13.00	15.00	18.00
Pre-Service			75		
Intra-Service	60	90	120	145	300

Post-Service	**Total Min**	**CPT code / # of visits**
Day of Surgery:		
Immediate	30	
Other	19	99231x1
After Day of Surgery:		
Critical Care	0	
Other Hospital	0	
Dischg Day Mgmt	36	99238
Office Visits	114	99213x3 99212x3

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'02RVW	Glob
21206	Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)	14.10	090

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

	Svy CPT 21046	Ref CPT (hvd)
TIME ESTIMATES (MEDIAN)		
Pre-service time	75	75
Intra-service time	120	108
Same Day Immediate Post-service time	30	29
Same Day Other Post-service time	19	41
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	114	95
Total Time	*394*	*348*
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	2.89	3.22
Intra-service	3.11	3.44
Post-service	2.56	2.89
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3.11	2.89
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.11	3.56
Urgency of medical decision making	3.22	2.78
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	3.11	3.56
Physical effort required	3.11	3.56
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	3.33	3.56
Outcome depends on the skill and judgment of physician	3.44	3.67
Estimated risk of malpractice suit with poor outcome	3.22	3.78

RATIONALE:

New code 21046 describes a contemporary surgical approach for benign, but aggressive lesions of the mandible. The intra-oral approach is a more difficult and involved surgical approach when compared with older codes for a transoral approach. This new code more clearly describes the nature of the typical work for *aggressive* lesions and would include the complex nature of follow-up care. Treatment of these aggressive lesions usually involve surgical principles that are commonly used in the management of malignancies. This requires much greater dissection, greater margins, greater cognitive elements of treatment planning, and follow-up. The total time is somewhat greater than the reference procedure 21206. However, the time-intensity measures are less, as indicated by the survey respondents. We are recommending the survey median RVW of 13.00 for 21046, which is less than 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)?

21030-22	Excision of benign tumor or cyst of facial bone other than mandible
21041-22	Excision of benign cyst or tumor of mandible; complex
21299	Unlisted craniofacial and maxillofacial 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: maxillofacial surgery, plastic surgery, otolaryngology, oral 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: maxillofacial surgery, plastic surgery, otolaryngology, oral surgery — Frequency: 2,500-3,000 for all four new codes

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: maxillofacial surgery, plastic surgery, otolaryngology, oral surgery — Frequency: unknown percentage of national frequency

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

Many physicians would be able to perform this procedure.

CPT Code: 21047 (F5) **Global:** 090 **Recommended RVW:** 18.75

CPT Descriptor: Excision of benign tumor or cyst, mandible; with extra-oral osteotomy and partial mandibulectomy (eg, locally aggressive or destructive lesion)

Survey Vignette (Typical Patient)

A 17-year-old male presents with an abnormal radiodensity in the right mandible, extending from the ramus to the second premolar, from the superior to the inferior border, with displacement of the inferior alveolar nerve to the inferior border of the mandible. He has biopsy-proven juvenile ossifying fibroma. Recent imaging revealed perforation of the lingual and inferior cortices, and displacement of the nerve posteriorly and through the inferior border of the mandible. The lesion extended from the anterior ramus to the mental foramen and involved teeth #29 to #32. Four weeks prior, the teeth in the area were extracted. At operation, utilizing an extra-oral approach, the mandible is resected from the antegonial notch to the first premolar, with preservation of the nerve, application of a mandibular reconstruction plate, and immediate bone graft of the continuity defect using corticocancellous posterior iliac graft with platelet rich plasma. The patient is followed in the hospital/office, as necessary, through the 90-day global period. [When completing this survey please consider only the preservice work within 24 hours of the procedure, the procedure itself, and all work through the 90-day global period. You may continue to see the patient beyond the 90-day global period, but that work would be separately reportable.]

CLINICAL DESCRIPTION OF SERVICE:

PREOPERATIVE WORK:
- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up, with particular attention to cardiopulmonary risk assessment and cephalometrics
- Review planned incisions and procedure, with emphasis on closure cosmetics (preparation of PRP)
- Change into scrub clothes
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions and obtain informed consent
- Review length and type of anesthesia with anesthesiologist (ie, nasal as opposed to oral tube)
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Monitor patient positioning and draping, and assist with initial prone position for approach to the post ilium
- Scrub and gown

INTRA-SERVICE WORK:
Under general anesthesia, a corticocancellous posterior iliac graft with platelet rich plasma is harvested. After bone harvest, the wound is closed in multiple layers and a Jackson Pratte drain is placed. The wound is dressed and the patient is then turned to the supine position, prepped, and draped for the mandibular surgery. The surgeon and staff re-scrub, re-gown and re-glove prior to proceeding with the mandibular surgery. Utilizing an extra-oral approach, the mandible is resected from the antegonial notch to the first premolar, with preservation of the nerve. By means of sharp and blunt dissection, access is gained to the inferior border of the mandible allowing for this resection. Care is taken to identify and preserve the mandibular branch of the facial nerve. Soft tissue specimens are sent for frozen section to guarantee clear margins. After hemostasis and repositioning of the nerve, a mandibular reconstructive plate is applied and the previously harvested cortical cancellous graft is used to reconstruct the defect to give continuity to the mandible. During the surgery the PRP is prepared and used with the donor bone. The PPP is used in the multiple layer plastic closure.

POSTOPERATIVE WORK, IN HOSPITAL:
- Apply initial postoperative wound packing
- Assess blood loss in the drain at donor site
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Answer patient/family questions

- Dictate post-op report
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company
- Assess airway prior to discharge to determine the safety of breathing in an unmonitored setting
- Reassess postoperative oral intake before discharge
- Review instructions for post-discharge wound care and home care with patient and family including oral care and wound care
- Answer insurance staff questions
- Write orders for post-discharge medications
- Chart patient discharge notes

POSTOPERATIVE WORK, IN OFFICE:

- Examine and talk with patient
- Access neuralgic defect
- Remove staples/sutures/drains
- Monitory for swelling and mandible mobilization, integrity of neck incision, swelling of floor of mouth/airway and review gait
- Order and review radiographs to assess the osteotomy cuts and dental status compared with pre-operative films
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician
- Write orders for medications
- Discuss progress with patient/family
- Dictate patient progress notes for medical chart
- Dictate procedure outcome letter for referring physician, including plan for dental reconstruction

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SURVEY DATA

Presenter(s): Lanny Garvar, DMD

Specialty(s): American Association of Oral & Maxillofacial Surgeons/American Dental Association
American Society of Plastic Surgeons

CPT: 21047

Sample Size: 120 **Resp n:** 30 **Resp %:** 25%

Sample Type:

	Low	25th pctl	Median	75th pctl	High
Survey RVW	14.50	17.41	18.75	22.13	30.00
Pre-Service			90		
Intra-Service	180	210	240	330	500

Post-Service	**Total Min**	**CPT code / # of visits**
Day of Surgery:		
Immediate	40	
Other	19	99231x1
After Day of Surgery:		
Critical Care	0	
Other Hospital	19	99231x1
Dischg Day Mgmt	36	99238
Office Visits	114	99213x3 99212x3

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'02RVW	Glob
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft	17.15	090

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

	Svy CPT 21047	Ref CPT Hvd
TIME ESTIMATES (MEDIAN)		
Pre-service time	90	78
Intra-service time	240	95
Same Day Immediate Post-service time	40	30
Same Day Other Post-service time	19	59
Post Total critical care time (not same day)	0	
Post Total other hospital visit time (not same day)	19	
Discharge management time	36	
Total office visit time	114	105
Total Time	*558*	*367*
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	4.07	3.50
Intra-service	4.60	3.75
Post-service	4.07	3.25
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	4.19	3.56
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.94	3.63
Urgency of medical decision making	3.81	2.88
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	4.56	4.13
Physical effort required	4.56	3.94
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	4.50	3.88
Outcome depends on the skill and judgment of physician	4.50	4.13
Estimated risk of malpractice suit with poor outcome	4.19	4.44

RATIONALE:

New code 21047 describes a contemporary surgical approach for benign, but aggressive lesions of the mandible. The extra-oral approach is a more difficult and involved surgical approach when compared with older codes for a transoral approach. This new code more clearly describes the nature of the typical work for aggressive lesions and would include the complex nature of follow-up care.

Intraoperatively, code 210X2 requires significantly more time than 21193 because it typically includes immediate reconstruction with a bone graft. This involves two separate procedure and requires intraoperative repositioning, redraping and reprepping the patient, along with staff needing to scrub again and regown. We are recommending the survey median RVW of 18.75 for 21047, which is greater than the reference code, taking into account the additional intraoperative work (time/complexity).

FREQUENCY INFORMATION

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

21030-22	Excision of benign tumor or cyst of facial bone other than mandible
21041-22	Excision of benign cyst or tumor of mandible; complex
21299	Unlisted craniofacial and maxillofacial 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: maxillofacial surgery, plastic surgery, otolaryngology, oral 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: maxillofacial surgery, plastic surgery, otolaryngology, oral surgery Frequency: 2,500-3,000 for all four new codes

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: maxillofacial surgery, plastic surgery, otolaryngology, oral surgery Frequency: unknown percentage of national frequency

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

Many physicians would be able to perform this procedure.

CPT Code: **21048** (F6) **Global:** 090 **Recommended RVW:** 13.50

CPT Descriptor: Excision of benign tumor or cyst, maxilla; with intra-oral osteotomy (eg, locally aggressive or destructive lesion)

Survey Vignette (Typical Patient)

A 42-year-old female presents with a "soap bubble" lesion in the anterior maxilla located adjacent to the nasal cavity and the maxillary sinus. Odontogenic keratocyst was diagnosed by biopsy, and medical imaging has shown separation of the cystic lesion from the nasal cavity as well as the maxillary sinus. At operation, utilizing an intra-oral approach, a wide excision of the lesion is performed and a peripheral ostectomy and osteotomy are performed to remove the bone adjacent to the lesion with clear margins. The dead space is packed. The patient is followed in the hospital/office, as necessary, through the 90-day global period. [When completing this survey please consider only the preservice work within 24 hours of the procedure, the procedure itself, and all work through the 90-day global period. You may continue to see the patient beyond the 90-day global period, but that work would be separately reportable.]

CLINICAL DESCRIPTION OF SERVICE:

PREOPERATIVE WORK:
- Write pre-operative orders for peri-operative medications including antibiotics and steroids
- Review pre-operative work-up, including all radiographs and CT Scans
- Review planned incisions and procedure to avoid exposure of nasal cavity and maxillary sinuses
- 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 nature of odontogenic keratocyst and it's potential of recurrence
- Answer patient and family questions and obtain informed consent
- Review length and type of anesthesia with anesthesiologist (ie, nasal as opposed to oral tube)
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

INTRA-SERVICE WORK:
Under general anesthesia, a wide surgical excision is made utilizing an intra-oral approach. The excision consists of a peripheral ostectomy and osteotomy to remove the bone adjacent to the lesion in order to have clear margins. The infra-orbital nerve is identified and great care is necessary to avoid the roots of teeth. The integrity of the maxillary sinus must be maintained. The defect is packed with gauze and the flaps returned and sutured.

POSTOPERATIVE WORK, IN HOSPITAL:
- Write orders for post-op labs and medications, with emphasis on ensuring hemostasis to decrease the risk of a floor of mouth hematoma
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Answer patient/family questions
- Dictate post-op report
- Repack wound until discharge, as necessary
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company
- Assess airway prior to discharge to determine the safety of breathing in an unmonitored setting
- Reassess postoperative oral intake before discharge
- Review instructions for post-discharge wound care and home care with patient and family
- Answer insurance staff questions
- Write orders for post-discharge medications
- Chart patient discharge notes

POSTOPERATIVE WORK, IN OFFICE:

- Examine and talk with patient
- Check wounds and repack weekly – under local anesthesia, in the office - until the maxillary bone fills the defect
- Order and review radiographs to assess the osteotomy cuts and dental status compared with pre-operative films
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician
- Write orders for medications
- Discuss progress with patient/family – re-emphasize that the lesions have a tendency to recur and they need to be watched closely
- Dictate patient progress notes for medical chart
- Dictate procedure outcome letter for referring physician, including plan for dental reconstruction

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SURVEY DATA

Presenter(s): Lanny Garvar, DMD

Specialty(s): American Association of Oral & Maxillofacial Surgeons/American Dental Association
American Society of Plastic Surgeons

CPT: 21048

Sample Size: 120 **Resp n:** 33 **Resp %:** 28%

Sample Type: Random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	10.00	11.42	13.50	14.50	18.00
Pre-Service			75		
Intra-Service	60	75	120	120	300

Post-Service	**Total Min**	**CPT code / # of visits**
Day of Surgery:		
Immediate	30	
Other	19	99231x1
After Day of Surgery:		
Critical Care	0	
Other Hospital	0	
Dischg Day Mgmt	36	99238
Office Visits	114	99213x3 99212x3

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'02RVW	Glob
21206	Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)	14.10	090

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

	Svy CPT	Ref CPT
TIME ESTIMATES (MEDIAN)		
Pre-service time	75	75
Intra-service time	120	108
Same Day Immediate Post-service time	30	29
Same Day Other Post-service time	19	41
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	114	95
Total Time	*394*	*348*
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	3.29	3.44
Intra-service	3.24	3.61
Post-service	3.12	3.17
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3.56	3.22
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.28	3.56
Urgency of medical decision making	3.22	2.72
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	3.33	3.72
Physical effort required	3.17	3.61
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	3.44	3.67
Outcome depends on the skill and judgment of physician	3.67	3.78
Estimated risk of malpractice suit with poor outcome	3.56	3.83

RATIONALE:

New code 21048 is similar to 21046 in terms of pre/intra/post-operative times – varying by location of the lesion (mandible versus maxilla). As with 21046, the survey respondents chose 21026 as a reference, and although total time for the new code is higher, the median survey RVW was estimated lower, with lower time-intensity measures. That being said, the median RVW of 13.50 for 21048 is slightly higher than for 21046 at 13.00. This difference can be accounted for in the higher intensity with respect to maintaining the integrity of the maxillary sinus. The survey median RVW of 13.50 is recommended for 21048,

FREQUENCY INFORMATION

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

21030-22 Excision of benign tumor or cyst of facial bone other than mandible
21041-22 Excision of benign cyst or tumor of mandible; complex
21299 Unlisted craniofacial and maxillofacial 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: maxillofacial surgery, plastic surgery, otolaryngology, oral 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: maxillofacial surgery, plastic surgery, otolaryngology, oral surgery Frequency: 2,500-3,000 for all four new codes

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: maxillofacial surgery, plastic surgery, otolaryngology, oral surgery Frequency: unknown percentage of national frequency

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

Many physicians would be able to perform this procedure.

CPT Code: **21049** (F7) **Global:** 090 **Recommended RVW:** 18.00

CPT Descriptor: Excision of benign tumor or cyst, maxilla; with extra-oral osteotomy and partial maxillectomy (eg, locally aggressive or destructive lesion)

Survey Vignette (Typical Patient)

A 28-year-old male presents with an expansile lesion of the left maxilla with extension into the infraorbital region. He has biopsy-proven ameloblastic fibro-odontoma. Medical imaging has revealed an 8 x 6 cm radiopaque/radiolucent lesion that originates from the left 3rd molar region and extends into the maxillary sinus with disruption and distortion of the anterior maxillary wall extending above the infraorbital nerve foramen. At operation, surgical excision requires an extra-oral Weber-Ferguson approach to access the superior extent of the maxillary tumor. The lesion is resected with a left posterior maxillectomy and an anterior osteotomy, with clear margins. The large antral opening is packed, and the patient is fitted with a custom made surgical obturator to close the dead space. The patient is followed in the hospital/office, as necessary, through the 90-day global period. [When completing this survey please consider only the preservice work within 24 hours of the procedure, the procedure itself, and all work through the 90-day global period. You may continue to see the patient beyond the 90-day global period, but that work would be separately reportable.]

CLINICAL DESCRIPTION OF SERVICE:

PREOPERATIVE WORK:
- Write pre-operative orders for peri-operative medications
- Review pre-operative work-up, with particular attention to cardiopulmonary risk assessment and cephalometrics
- Review planned incisions and procedure
- Change into scrub clothes
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Answer patient and family questions and obtain informed consent
- Review length and type of anesthesia with anesthesiologist (ie, nasal as opposed to oral tube)
- Review planned procedure and positioning and draping of patient
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

INTRA-SERVICE WORK:
Under general anesthesia, utilizing an extraoral Weber-Ferguson approach to access the superior extent of the maxillary tumor, the lesion is resected with a left posterior maxillectomy and appropriate anterior osteotomy to obtain clear margins. Every attempt is made to preserve the infraorbital nerve and reconstruct the maxillary vestibule. A split thickness skin graft is taken from the lateral thigh, cut and placed in the defect. The pre-made temporary obturator is loaded with a thermo plastic compound and seated in the defect against the skin graft to customize the superior aspect of the obturator. The appliance is removed and the excess compound is removed. It is heated again and replaced for final contour and to support the skin graft against the surgical defect.

POSTOPERATIVE WORK, IN HOSPITAL:
- Write orders for post-op labs and medications
- Review recovery room care and medications with staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- Answer patient/family questions
- Dictate post-op report
- Repack wound until discharge, as necessary
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company
- Assess airway prior to discharge to determine the safety of breathing in an unmonitored setting

- Reassess postoperative oral intake before discharge
- Review instructions for post-discharge wound care and home care with patient and family
- Answer insurance staff questions
- Write orders for post-discharge medications
- Chart patient discharge notes

POSTOPERATIVE WORK, IN OFFICE:

- Examine and talk with patient
- Order and review radiographs to assess the osteotomy cuts and dental status compared with pre-operative films
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician
- Write orders for medications
- Discuss progress with patient/family
- Dictate patient progress notes for medical chart
- Dictate procedure outcome letter for referring physician, including plan for dental reconstruction

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SURVEY DATA

Presenter(s): Lanny Garvar, DMD

Specialty(s): American Association of Oral & Maxillofacial Surgeons/American Dental Association
American Society of Plastic Surgeons

CPT: 21049

Sample Size: 120 **Resp n:** 34 **Resp %:** 28%

Sample Type: Random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	13.75	15.50	18.00	20.00	30.00
Pre-Service			90		
Intra-Service	90	180	225	270	400

Post-Service	**Total Min**	**CPT code / # of visits**
Day of Surgery:		
Immediate	40	
Other	19	99231x1
After Day of Surgery:		
Critical Care	0	
Other Hospital	19	99231x1
Dischg Day Mgmt	36	99238
Office Visits	114	99213x3 99212x3

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'02RVW	Glob
21206	Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)	14.10	090

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

	Svy CPT	Ref CPT Hvd
TIME ESTIMATES (MEDIAN)		
Pre-service time	90	74
Intra-service time	225	108
Same Day Immediate Post-service time	40	29
Same Day Other Post-service time	19	41
Post Total critical care time (not same day)	0	
Post Total other hospital visit time (not same day)	19	
Discharge management time	36	
Total office visit time	114	95
Total Time	*543*	*348*
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	3.93	3.64
Intra-service	4.14	3.79
Post-service	3.57	3.36
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3.43	3.43
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.62	3.57
Urgency of medical decision making	3.43	2.79
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	3.93	3.79
Physical effort required	3.93	3.71
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	3.86	3.64
Outcome depends on the skill and judgment of physician	3.86	3.86
Estimated risk of malpractice suit with poor outcome	3.43	3.71

RATIONALE:

New code 21049 describes a contemporary surgical approach for benign, but aggressive lesions of the maxilla. The extra-oral approach is a more difficult and involved surgical approach when compared with older codes for a transoral approach. This new code more clearly describes the nature of the typical work for aggressive lesions and would include the complex nature of follow-up care.

Intraoperatively, code 21049 requires significantly more time than 21206 because it includes harvesting of a full thickness skin graft from a separate operative site and customizing of a temporary pre-made obturator. It requires less time than 21049, in that reposition is typically not necessary for harvesting and placing the donor graft. We are recommending the survey median RVW of 18.00 for 21049, which is greater than the reference code, taking into account the additional intraoperative work (time/complexity), and less than 21047, taking into account less 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)?

21030-22	Excision of benign tumor or cyst of facial bone other than mandible
21041-22	Excision of benign cyst or tumor of mandible; complex
21299	Unlisted craniofacial and maxillofacial 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: maxillofacial surgery, plastic surgery, otolaryngology, oral 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: maxillofacial surgery, plastic surgery, otolaryngology, oral surgery — Frequency: 2,500-3,000 for all four new codes

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: maxillofacial surgery, plastic surgery, otolaryngology, oral surgery — Frequency: unknown percentage of national frequency

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

Many physicians would be able to perform this procedure.

	A	B	C	D	E	F	G	H	I	J	K
1		CPT:		21046		21047		21048		21049	
2	Tab 21 PE Details (April 2002)	DESCRIPTOR:		Excision of benign tumor or cyst, mandible; with intra-oral osteotomy (eg, locally aggressive or destructive lesion)		Excision of benign tumor or cyst, mandible; with extra-oral osteotomy and partial mandibulectomy (eg, locally aggressive or destructive lesion)		Excision of benign tumor or cyst, maxilla, requiring intra-oral osteotomy (eg, locally aggressive or destructive lesion)		Excision of benign tumor or cyst maxilla; requiring extra-oral osteotomy and partial maxillectomy (eg, locally aggressive or destructive lesion)	
3		GLOBAL:		90		90		90		90	
4		CMS Code	CMS Desc	NonFac	Facility	NonFac	Facility	NonFac	Facility	NonFac	Facility
5	**PRE-service time**	130	RN/LPN/MA	--	60	--	60	--	60	--	60
6	**SERVICE time**	130	RN/LPN/MA	--	12	--	12	--	12	--	12
7	**POST-service time**	130	RN/LPN/MA	--	189	--	189	--	189	--	189
8	**PRE-SERVICE CLINICAL STAFF TIME**										
9	**BEGINS after consultation when a decision to perform surgery was made. (office / facility)**										
10	Complete pre-service diagnostic & referral forms (5/5)	130	RN/LPN/MA	--	5	--	5	--	5	--	5
11	Coordinate pre-surgery services, review test/exam results (10/20)	130	RN/LPN/MA	--	20	--	20	--	20	--	20
12	OV before surgery: Review test and exam results (0/0)	130	RN/LPN/MA	--	0	--	0	--	0	--	0
13	Schedule space and equipment in facility (0/8)	130	RN/LPN/MA	--	8	--	8	--	8	--	8
14	Provide pre-service education/obtain consent (10/20)	130	RN/LPN/MA	--	20	--	20	--	20	--	20
15	Follow-up phone calls & prescriptions (10/7)	130	RN/LPN/MA	--	7	--	7	--	7	--	7
16	**ENDS with admission to site of service**										
17	**SERVICE PERIOD CLINICAL STAFF TIME**	**CMS Code**	**CMS Desc**								
18	**BEGINS with admission to site of service**										
19	**Other Clinical Activity:**										
20	99238 discharge visit			--	1	--	1	--	1	--	1
21	***99238 discharge time***	130	RN/LPN/MA	--	12	--	12	--	12	--	12
22	**End: Patient leaves site of service**										
23	**POST-SERVICE PERIOD CLINICAL STAFF TIME**	**CMS Code**	**CMS Desc**								
24	**Start: Patient leaves site of service**										
25	99211 16 minutes			--	0	--	0	--	0	--	0
26	99212 27 minutes			--	3	--	3	--	3	--	3
27	99213 36 minutes			--	3	--	3	--	3	--	3
28	99214 53 minutes			--	0	--	0	--	0	--	0
29	99215 63 minutes			--	0	--	0	--	0	--	0
30	***Total Office Visit Time:***	130	RN/LPN/MA	--	189	--	189	--	189	--	189
31	**End: at completion of global period**										
32	**MEDICAL SUPPLIES - POST-OP OFFICE VISITS**	**CMS Code**	**CMS Desc**								
33	**Post-op Multispecialty Visit Package**	peac	pack	--	6	--	6	--	6	--	6
34	**Post-op Suture Care Kit:**	peac	pack	--	1	--	1	--	1	--	1
35	***Additional OFFICE VISIT Supplies (specify):***										
36	gown, staff, impervious, disposable	11304	item	--	6	--	0	--	6	--	0
37	mask, surgical	11306	item	--	6	--	0	--	6	--	0
38	protective eye wear	11309	pair	--	6	--	0	--	6	--	0
39	bite block	11512	item	--	2	--	0	--	2	--	0
40	stenle drape 22 in x 25 in	14001	item	--	6	--	0	--	6	--	0
41	gloves, stenle	14005	pair	--	6	--	0	--	6	--	0
42	sponge tipped applicator	31110	item	--	3	--	0	--	3	--	0
43	Gauze,Stenle 4 x 4	31505	item	--	24	--	0	--	24	--	0
44	gauze, 2x2	31506	item	--	24	--	0	--	24	--	0
45	xylocaine 2% with epinephrine	51509	ml	--	18	--	0	--	18	--	0
46	syringe, 10 cc or 12 cc	91407	item	--	3	--	0	--	3	--	0
47	syringe, 5 cc	91411	item	--	3	--	0	--	3	--	0
48	needle 30g	91427	item	--	6	--	0	--	6	--	0
49	Suction Canister, Disposable	93604	item	--	3	--	0	--	3	--	0
50	tubing, suction, 6' with yankauer tip	93606	foot	--	3	--	0	--	3	--	0
51	xylocaine, topical 4%	ENT-NEW	gm	--	18	--	0	--	18	--	0
52	Idoform Gauze 1" x 5yd	31524	item	--	4.5	--	0	--	4.5	--	0
53	**EQUIPMENT**	**CMS Code**									
54	fiberoptic exam light	E11006		--	1	--	1	--	1	--	1
55	reclining exam chair with headrest	E11011		--	1	--	1	--	1	--	1
56	light source	E13122		--	1	--	1	--	1	--	1
57	SMR unit with suction	ENT-NEW		--	1	--	1	--	1	--	1

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Minimally Invasive Repair of Pectus Excavetum

These codes were developed to describe a new minimally invasive technique in reconstructive repair of the pectus exacavatum or carinatum.

Because the specialty society was unable to provide adequate data in time for the April meeting, the RUC recommends that these codes be carrier priced until survey data is provided at the September RUC meeting.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲21740	AN1	Reconstructive repair of pectus excavatum or carinatum; open	090	16.50 (no change)
●21742	AN2	minimally invasive approach (Nuss procedure) without thoracoscopy	090	Carrier Priced
●21743	AN3	minimally invasive approach (Nuss procedure) with thoracoscopy	090	Carrier Priced

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Arthroscopic Rotator Cuff Repair

Editorial changes and a new code was created to fully capture the fact that arthroscopic rotator cuff repair has become the usual and preferred choice of surgeons performing this procedure.

Codes 23410 and 23412

The RUC reviewed the editorial changes to codes 23410, *Repair of ruptured musculotendinous cuff (eg rotator cuff) open; acute (for arthroscopic procedure, use 29727),* and 23412 *Repair of ruptured musculotendinous cuff (eg rotator cuff); chronic.* The RUC agreed that these changes were editorial in nature and do not affect the work value as these services always described the open technique. **Therefore, the RUC recommends a work relative value for 23410 of 12.45 and 23412 of 13.31.**

Code 29827

The RUC then examined the code 29827, *Arthroscopy, shoulder, surgical; with rotator cuff repair.* After some discussion about the new technology associated with this new code and its reference code, it was determined that the RUC should use code 29806 *Arthroscopy, shoulder, surgical; capsulorrhaphy* (RVU = 14.37) as an additional reference code for 29827. Code 29806 was previously reviewed by the RUC and has 55 minutes pre-service time, 100 minutes intra-service time, 30 minutes post service time, 0.5 discharge day and 5 office visits while code 29827, an outpatient procedure, should have 75 minute pre-service time, 120 minutes intra-service time, 40 minutes post-service time, 0.5 discharge day and 5 office visits. The RUC removed a 99231 hospital visit (0.64RVW) from the specialty society's recommended relative work value (16.00-0.64 = 15.36). **The RUC recommends a work relative value for 29827 of 15.36**

Practice Expenses

The RUC reviewed the practice expense inputs for codes 29827. **The RUC recommends the standard package for this 090-day global procedure.**

CPT Code (•New)	Track-ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲23410	AO1	Repair of ruptured musculotendinous cuff (eg rotator cuff) open; acute (For arthroscopic procedure, use 29827)	090	12.45 (no change)
▲23412		chronic	090	13.31 (no change)
●29827	AO2	Arthroscopy, shoulder, surgical; with rotator cuff repair (For open or mini-open rotator cuff repair, use 23412) (When arthroscopic subacromial decompression is performed at the same setting, use 29826 and append the modifier '-51') (When arthroscopic distal clavicle resection is performed at the same setting, use 29824 and append the modifier '-51')	090	15.36

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION **(Apr 2002)**

CPT Code: 29827 (AO2) **Global**: 090 **Recommended RVW**: ~~16.00~~
RUC Recommended RVW: 15.36

Descriptor: Arthroscopic, shoulder, surgical; with rotator cuff repair

Survey Vignette (Typical Patient)

Typical Patient/Service: A 40-year-old right-handed stockbroker is an avid tennis player on both weekends and weekdays. He develops insidious pain in the right shoulder, which gradually worsens. He is having problems sleeping on the shoulder and it awakens him if he rolls onto that side. He also complains of significant pain with lifting and overhead work. He visits his orthopedic surgeon is started on NSAIDs and physical therapy, which does not provide any relief. A subacromial injection provides short-term relief. A rotator cuff tear is suspected. Surgical intervention is recommended.

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
- Family and patient are apprised of the proposed surgery.
- Risks and complications associated with the surgery are discussed with the patient and family.
- Informed consent is obtained.
- Surgeon goes to the operating room and verifies that all appropriate equipment is available.
- Patient is brought to the operating room and placed on the operating table in the supine position. Patient is then placed in the lateral decubitus position.
- Patient's bony prominences are padded and an axillary roll is placed.
- Thermal regulation drapes are applied.
- Position of the extremities and head are checked and adjusted.
- An exam under anesthesia is performed.
- Patient's involved arm is prepped and draped.
- A sterile arm sleeve is placed and the arm is placed in a shoulder holder.
- All bony landmarks are palpated and marked with a sterile marker.

INTRA-SERVICE WORK: A posterior lateral incision is made for the insertion of the arthroscope. Once inserted the articular surfaces and all intra-articular structures are identified and examined. An anterior portal is created with an inside out technique or after needle localization. A probe is inserted through the anterior canula and any pathology is confirmed with a probe. Particular attention is noted of the subscapularis, the supraspinatus, and the infraspinatus and teres minor tendons. If any or all the above are torn they are identified and often marked by passing a needle through the anterior canula and passing a suture through the needle. The suture is grasped and held with a hemostat. A tissue resector is placed through the anterior canula and the degenerative portion of the tendon(s) is resected. Tendon retraction is addressed by aggressive release of the tethering adhesions. Any repair of the articular portion of the subscapularis is performed at this time. Generally, suture repair, which requires time consuming and difficult arthroscopic knot tying, are adequate for the subscapularis and rarely are bone anchors required. The arthroscope is then placed into the subacromial space where the tear is evaluated from superiorly. A lateral portal is created after needle localization and one or multiple sutures are placed in the tendon to assure an adequate release of the adhesions has been performed. Often a coracohumeral ligament release is required to allow the re-approximation of the supraspinatus tendon back to the greater humeral tuberosity. A fourth arthroscopic portal is needed just off the lateral acromial edge to allow a relatively perpendicular bone anchor placement into a shallow trough, which is created at the lateral humeral articular surface with a bone burr. Margin conversion, which converts an avulsion tear into a vertical tear with a smaller avulsion component, sutures are placed arthroscopically to recreate the normal anatomy of

the tendon and decrease the tendon surface area that is reattached to the bone. The bone anchors are placed and usually one to four are required. Each bone anchor has two sutures and the incredibly demanding part of the athroscopic repair is to pass and tie the sutures. The surgeon's ability to pass and tie arthroscopic sutures accurately and efficiently is the key to the procedure. For large tears ten or twelve sutures will be tied. Once the sutures are passed and firmly tied the cuff is reinspected. The arthroscope is removed and the portals are closed with sutures. The portals are injected with marcaine and a sterile dressing is applied. The patient is transferred to the post-op recovery room.

Postoperative work: in hospital

- Application of dressing and sling.
- 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.
- Patient's vital signs are checked.
- Circulation, sensation and motor function of the operated extremity are assessed.
- Evaluation and review of the postoperative medications.
- When the patient is awake and alert a mandatory review of the procedure and strict restrictions are discussed.

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 sling for evaluation of passive range of motion.
- Assessment of surgical wound.
- Redress wound.
- Order physical / occupational therapy and clarify all restrictions and suggestions.
- 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.
- Routinely the patient is seen at one, two and four weeks to monitor the wounds and insure progress in the passive range of motion.
- At six weeks attention is turned to monitoring active range of motion and strength.
- From six to twelve weeks returning to normal activity and the strength and motion required are evaluated.

SURVEY DATA

Presenter(s): David F. Martin, MD; William R. Beach, MD

Specialty(s): American Academy of Orthopaedic Surgeons

CPT: 29827

Sample Size: 50 **Resp n:** 32 **Resp %:** 64%

Sample Type: Panel

	Low	25th pctl	Median	75th pctl	High
Survey RVW	14.00	17.04	20.00	23.90	40.00
Pre-Service			75		
Intra-Service	60	113	120	128	180

Post-Service	Total Min	CPT code / # of visits
Day of Surgery:		
Immediate	40	
Other	0	
After Day of Surgery:		
Critical Care	0	
Other Hospital	~~19~~	~~99231x1~~
Dischg Day Mgmt	~~36~~ 18	99238x1~~-0.05~~
Office Visits	75	99212x5

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2002 RVW	Glob
23412	Repair of ruptured musculotendinous cuff (eg, rotator cuff); chronic	**13.31**	090

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

	Svy CPT	Ref CPT
TIME ESTIMATES (MEDIAN)	29827	23412 Harvard
Pre-service time	75	27
Intra-service time	120	93
Same Day Immediate Post-service time	40	84
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)	~~19~~	
Discharge management time	~~36~~ 18	
Total office visit time	75	56
INTENSITY/COMPLEXITY MEASURES (MEAN)		
TIME SEGMENTS		
Pre-service	3.77	3.75
Intra-service	4.86	4.04
Post-service	3.71	3.68
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3.79	3.61
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.93	3.75
Urgency of medical decision making	3.18	3.04
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	4.93	3.86
Physical effort required	4.71	3.68

PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	4.21	3.54
Outcome depends on the skill and judgment of physician	4.71	3.73
Estimated risk of malpractice suit with poor outcome	4.00	3.64

RATIONALE:

In comparison to open procedure, the arthroscopic procedure is a more difficult, technically challenging and mentally intense procedure for the following reasons:

- Included in the procedure is the complete arthroscopic evaluation of the shoulder joint.
- Inspection and manipulation of the tissue, although less traumatic, is more difficult.
- Creation of several portals to access the rotator cuff is more strategic and difficult than creating an open incision.
- Exact placement of the margin conversion sutures is a time consuming and demanding series of suture passes and arthroscopic knot tying.
- Accurate placement of the bone anchors into the humeral tuberosity requires greater visualization and technical skill to avoid injury to the articular surface and still secure the anchor.
- Management of the four suture arms extending from the anchors requires the utmost skill and patience. As many as four to six anchors, eight to twelve sutures and sixteen to twenty-four suture arms, for massive rotator cuff tears multiply the difficulty. Crossing the sutures will result in failure of that bone anchor in the re-approximation of the rotator cuff to the bone.

We therefore recommend that 29827 be given an RVW of 16.00.

FREQUENCY INFORMATION

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

23412 Repair of ruptured musculotendinous cuff (eg, rotator cuff); chronic (Medicare frequency = 11,254)

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** ~~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: 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: 4,000

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

This is a widely performed service among the members of the Arthroscopy Association of North America and the American Sports Medicine Society.

	A	B	C	D	E	F
1				29827		
2			HCFA MEDICAL SUPPLY CODE	Arthroscopy, shoulder, surgical, with rotator cuff repair		
3	LOCATION			In Office	Out Office	
4	GLOBAL PERIOD				90	
5	STAFF TYPE / CODE	RN/LPN/MA	1130	N/A		1130
6	TOTAL TIME					201
7	PRESERVICE TIME					60
8	INTRASERVICE TIME					6
9	POST-SERVICE TIME					135
10	PRE-SERVICE					
11	Start: Following visit when decision for surgery or procedure made					
12	Complete pre-service diagnostic & referral forms					5
13	Coordinate pre-surgery services					20
14	Schedule space and equipment in facility					8
15	Office visit before surgery/procedure Review test and exam results					0
16	Provide pre-service education/obtain consent					20
17	Follow-up phone calls & prescriptions					7
18	Other Clinical Activity (please specify)					
19	End:When patient enters office for surgery/procedure					
20	SERVICE PERIOD					
21	Start: When patient enters office for surgery/procedure					
22	Pre-service services					
23	Review charts					
24	Greet patient and provide gowning					
25	Obtain vital signs					
26	Provide pre-service education/obtain consent					
27	Prepare room, equipment supplies					
28	Prepare and position patient/ monitor patient/ set up IV					
29	Sedate/apply anesthesia					
30	Intra-service					
31	Assist physician in performing procedure					
32	Monitor pt following service/check tubes, monitors, drains					
33	Clean room/equipment by physician staff					
34	Complete diagnostic forms, lab & X-ray requisitions					
35	Review/read X-ray, lab, and pathology reports					
36	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions					
37	Other Clinical Activity (please specify)					
38	Discharge Day - 99238	12			0 5	6 0
39	End: Patient leaves office					
40	POST-SERVICE					
41	Start: Patient leaves office					
42	Conduct phone calls/call in prescriptions					
43	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, ccordinate home or outpatient are, conduct phone calls between office visits					
44	Other Activity (Phone calls)					
45	EM LEVEL / FREQUENCY	PEAC TIME				
46	99212	27			5.0	135 0
47	99213	36				0 0
48	99214	53				0 0
49	MEDICAL SUPPLIES					
50	Basic Post-Operative Incision Care Kit				1	
51	E/M Code Supply Package				5	
52	PROCEDURE SPECIFIC EQUIPMENT					
53	Power table	E11003			1	
54	Exam lamp	E30006			1	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Orthopedic Arthroscopy Procedures

Two Orthopaedic arthroscopy procedure codes were created to reflect new technology now being used in performing arthroscopy.

Codes 25320, 27425, 27730, 27732, 27734 and 27870
The RUC reviewed the editorial changes to codes **25320** *Capsulorrhaphy or reconstruction, wrist, open ~~any method~~ (eg, capsulodesis, ligament repair, tendon transfer or graft) (includes synovectomy, capsulotomy and open reduction) for carpal inst*ability and **27425** *Lateral retinacular release open ~~any method~~.* Additionally, the RUC reviewed the editorial changes to codes **27730,** *Arrest, epiphyseal (epihysiodesis), ~~any method~~ open; distal tibia,* **27732,** *Arrest, epiphyseal (epihysiodesis), ~~any method~~ open distal fibula* and **27734,** *Arrest, epiphyseal (epihysiodesis), ~~any method~~ open; distal tibia and fibula.* In addition, the RUC reviewed the editorial changes to code **27870** Arthrodesis, ankle, open ~~any method~~. The RUC agreed that these changes were editorial in nature and do not affect the work values as these services were all initially valued assuming an open technique was utilized. **The RUC recommends a work relative value for code 25320 of 10.77, for code 27425 of 5.22 and for code 27730 of 7.41. The RUC also recommends a work relative value for code 27732 of 5.32, for code 27734 of 8.48 and for code 27870 of 13.91.**

Code 29873
Code 29873, *Arthroscopy, knee, surgical; with lateral release* was created to reflect new technology. It was determined by the RUC after reviewing the reference code 27425, *Lateral retinacular release, any method* (work RVU= 5.22) that the surveyed code, 29873 was deemed more intense and took more time than the reference code. Therefore, the RUC accepted the specialty society's median value of their survey (work RVU = 6.00), which was minimally higher than the relative work value associated with the reference code. **The RUC recommends a work relative value of 6.00 for code 29873.**

Code 29899
CPT created code 29899 *Arthroscopy, ankle, (tibiotalar and fibulotaler joints) surgical; with ankle arthrodesis* to describe new technology. The RUC determined that the work of performing this procedure openly with code 27870, *Arthrodesis, ankle, any method* (RVU 13.91) is the same as performing the service arthroscopically. Therefore, the specialty society recommended the same relative work value for code 29899 as its reference code 27870. **The RUC recommends a work relative value of 13.91 for code 29899**

Practice Expense

The RUC reviewed the practice expense inputs for codes 29873 and 29899. These procedures are only performed in the facility setting only. **The RUC recommends the standard packages for the 090-day global procedures.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲25320	AP1	Capsulorrhaphy or reconstruction, wrist, open ~~any method~~ (eg, capsulodesis, ligament repair, tendon transfer or graft) (includes synovectomy, capsulotomy and open reduction) for carpal instability	090	10.77 (no change)
▲27425	AP7	Lateral retinacular release open ~~any method~~ (For arthroscopic lateral release, use 2987X3)	090	5.22 (no change)
▲27730		Arrest, epiphyseal (epihysiodesis), ~~any method~~ open; distal tibia		7.41 (no change)
▲27732		distal fibula		5.32 (no change)
▲27734		distal tibia and fibula		8.48 (no change)
▲27870	AP2	Arthrodesis, ankle, open ~~any method~~ (For arthroscopic ankle arthrodesis, see 2989X)	090	13.91 (no change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
29806	AP3	*Arthroscopy, shoulder, surgical; capsulorrhaphy*	090	14.37 (no change)
●29873	AP5	Arthroscopy, knee, surgical; with lateral release (For open lateral release, use 27425)	090	6.00
●29899	AP6	Arthroscopy, ankle, (tibiotalar and fibulotalar joints), surgical; with ankle arthrodesis (For open ankle arthrodesis, use 27870)	090	13.91

CPT Code: 29873 (AP5) **Global**: 090 **Recommended RVW**: 6.00

Descriptor: Arthroscopy, knee, surgical; with lateral release

Survey Vignette (Typical Patient)

A 16-year-old skeletally mature female returns to the office with persistent right knee pain. The knee pain has been persistent for 6 months despite aggressive quadriceps strengthening, hamstring stretching and activity modification. Physical exam reveals a contracted lateral patellar retinaculum and pain with bent knee and resisted extension exercises. Routine office radiographs reveal a laterally tilted patella. Surgical intervention, lateral release, is recommended.

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
- Family and patient are apprised of the proposed surgery.
- Risks and complications associated with the surgery are discussed with the patient and family.
- Informed consent is obtained.
- Surgeon goes to the operating room and verifies that all appropriate equipment is available
- Patient is brought to the operating room and placed on the operating table in the supine position.
- Patient's bony prominences are padded.
- Thermal regulation drapes are applied.
- Position of the extremities and head are checked and adjusted.
- Pre-operative portal site injections with marcaine maybe considered.
- Tourniquet is placed on the leg and the leg is exsanguinated with an esmarch.
- Patient's involved leg is prepped and draped.

INTRA-SERVICE WORK: The patient is taken to the operating room where an examination under anesthesia confirms a tight lateral patellar retinaculum. An anterior lateral portal is created. The comprehensive arthroscopic knee examination is performed. This includes evaluation and probing the patellar and trochlear articular surfaces, the medial and lateral compartment articular surfaces, the medial and lateral menisci, the anterior and posterior cruciate ligaments, the posterior medial and lateral compartments and the popliteus tendon and hiatus. Once this complete inspection is performed the the abnormally tight lateral patellar retinaculum is addressed. The tight lateral retinaculum causes the patella to tilt throughout the knee range of motion. The medial facet of the patella will not articulate with the trochlea until late in knee flexion if at all. The arthroscope is transferred to an anterior medial portal and an electrocautery device is introduced through the lateral portal. Care must be exercised to avoid injury to the trochlear and patellar articular cartilage because the tight retinaculum forces the patella against the trochlea. The lateral retinaculum is incised from the inferior edge of the vastus lateralis, but not to injure the lateral portion of the quadriceps tendon, to and slightly beyond the lateral portal. Hemostasis is insured with the electrocautery probe. The superior lateral geniculate artery often bleeds and causes a significant post-operative hemarthrosis. The incisions are closed and the knee and portals are injected with marcaine with epinephrine.

Postoperative work: in hospital

- Application of dressing and knee immobilizer or hinged knee brace.
- 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.
- Patient's vital signs are checked.
- Circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative prescriptions and medications are written and 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 knee immobilizer or hinged knee brace
- 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.
- The patient is routinely seen at weeks one, two, four, eight and twelve.
- Close monitoring of the postoperative effusion and pain dominates the early period and motion and strength then become the focus of post-op care.
- Gradual resumption of activities marks the end of the postoperative consultation period.

SURVEY DATA

Presenter(s): David F. Martin, MD; William R. Beach, MD

Specialty(s): American Academy of Orthopaedic Surgeons

CPT: 29873

Sample Size: 50 **Resp n: 30** **Resp %:** 60%

Sample Type: Panel

	Low	25th pctl	Median	75th pctl	High
Survey RVW	5.20	5.66	6.00	7.59	12.00
Pre-Service			75		
Intra-Service	25	40	45	45	90

Post-Service	Total Min	CPT code / # of visits
Day of Surgery:		
Immediate	30	
Other	0	
After Day of Surgery:		
Critical Care	0	
Other Hospital	0	
Dischg Day Mgmt	18	99238x 0.5
Office Visits	75	99212x5

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2002 RVW	Glob
27425	Lateral retinacular release (any method)	**5.22**	090

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

	Svy CPT	Ref CPT
TIME ESTIMATES (MEDIAN)	29873	27425 Harvard
Pre-service time	75	25
Intra-service time	45	37
Same Day Immediate Post-service time	30	35
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	~~36~~ 18	
Total office visit time	75	49
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	3.05	3.00
Intra-service	3.29	2.95
Post-service	3.00	3.00
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3.37	3.30
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.41	3.26
Urgency of medical decision making	2.70	2.65
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	3.41	3.15
Physical effort required	3.22	3.11
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	3.42	3.35
Outcome depends on the skill and judgment of physician	3.62	3.39
Estimated risk of malpractice suit with poor outcome	3.39	3.35

RATIONALE:

The work involved with the arthroscopic lateral retinacular release (29873) is greater than the open equivalent (27425) for the following reasons:

- The arthroscopic procedure includes a diagnostic examination of the entire knee joint requiring greater time and arthroscopic expertise.
- Positioning of the arthroscope and the arthroscopic electrocautery probe is critical. The articular surfaces must be avoided. Injury to these surrounding structures, not at risk with the open procedure, could produce several consequences.
- Arthroscopic cauterization of the superior lateral geniculate artery is important in avoiding postoperative hemarthrosis. This requires careful manipulation of the articular fluid pressure and visualization in the artery and vein.
- Care must be exercised in avoiding thermal injury to the skin and overlying structures via the arthroscopic procedure.
- Arthroscopic identification of the quadriceps tendon is also mandatory to avoid injury and to obtain a good clinical result.

We therefore recommend that 29873 be given an RVW of 6.00.

FREQUENCY INFORMATION

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

27425 Lateral retinacular release (any method) (Medicare frequency = 3405)

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** ~~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: orthopaedic surgery Frequency: 12,000

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: 3,400

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

This is performed widely across the country.

CPT Code: 29899 (AP6) **Global**: 090 **Recommended RVW**: 13.91

Descriptor: Arthroscopy, ankle, (tibiotalar and fibulotalar joints) surgical; with ankle arthrodesis

Survey Vignette (Typical Patient)

A 50-year old male develops severe ankle arthritis without associated deformity. He is treated with an Arthroscopic ankle arthrodesis.

CLINICAL DESCRIPTION OF SERVICE:

Preoperative work:

- Pre-procedural imaging studies are carefully reviewed including X-rays and CT scans.
- Pre-operative laboratory tests are reviewed.
- Consultation is completed with the referring physician and other health care professionals.
- Communication with the patient (and/or patient's family) to explain operative risks and benefits.
- Informed consent is obtained.
- Physician scrubs and verifies that all appropriate surgical instruments and supplies are available
- Arrangements for the use of portable intra-operative fluoroscopy are made.
- Under appropriate anesthesia, the patient is positioned
- A tourniquet is applied on the lower extremity
- Supervision of appropriate surgical prepping and draping of the patient follows
- The lower extremity is exsanguinated and the tourniquet is inflated to appropriate pressures.

INTRA-SERVICE WORK: To perform an arthroscopic ankle arthrodesis, visualization of the joint surfaces is important. The articular surfaces must be distracted to allow visualization, and an external fixator is applied to provide distraction of the joint surfaces. This involves insertion of bone pins into the tibia and calcaneus and construction of a distractor outrigger apparatus. Arthroscopic portals are then established over the anterior-medial and anterior-lateral aspects of the ankle. This will allow for insertion of the arthroscope and a high-speed arthroscopic abrader to remove the degenerative articular cartilage. After adequate visualization is established, the articular cartilage is removed from the distal tibia and the talus utilizing a high-speed burr and direct arthroscopic visualization to produce two concentric surfaces. After complete removal of the articular cartilage, the joint is thoroughly irrigated to remove any remaining debris. Fluoroscopic guidance is then utilized for positioning of the ankle and insertion of the compression fixation. The foot is positioned so that it will rest in a neutral plantigrade position with the heel in 5 to 10 degrees of valgus. Using fluoroscopic guidance, guide pins are inserted through small incisions over the tibia and fibula and advanced into the talus. After the position of the ankle and the guide pins is verified, compression screws are advanced over the guide wires, and the guide wires are removed. Final position of the ankle and hardware is verified both clinically and fluoroscopically. It is important to assess the fact that the foot is plantigrade, and that the heel is in 5 to 10 degrees of valgus. The tourniquet is deflated, and the wound is then closed in layers.

Postoperative work: in hospital

- Application of cast
- Monitoring patient stabilization in the recovery room
- Communication with health care professionals (including written and oral reports and orders)
- Monitoring neurovascular status
- Care and removal or drain
- Antibiotic and pain medication management
- Final examination of patient
- Preparation of discharge records

Postoperative work: in office

- Post-discharge office visits for this procedure for 90 days
- Removal of sutures
- Evaluation of periodic imaging to assess bony fusion and laboratory reports
- Antibiotic and pain medication management
- While awaiting fusion, the patient's ambulatory status is directed by the surgeon. The amount of weight bearing is dependent on the degree of healing that has occurred
- Once complete healing has occurred the surgeon directs the physical therapist in weaning the patient from external support (crutches or cane) to independent weight bearing.
- Proper footwear prescription is also necessary to achieve an optimal outcome.

SURVEY DATA

Presenter(s): David F. Martin, MD; Tye Ouzounian, MD

Specialty(s): American Academy of Orthopaedic Surgeons, American Orthopaedic Foot & Ankle Society

CPT: 29899

Sample Size: 50 **Resp n:** 30 **Resp %:** 60%

Sample Type: Panel

	Low	25th pctl	Median	75th pctl	High
Survey RVW	13.90	13.91	14.50	15.00	25.00
Pre-Service			75		
Intra-Service	80	115	120	145	180

Post-Service	**Total Min**	**CPT code / # of visits**
Day of Surgery:		
Immediate	30	
Other	0	
After Day of Surgery:		
Critical Care	0	
Other Hospital	38	99231x2
Dischg Day Mgmt	36	99238x1
Office Visits	92	99213x4

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2002 RVW	Glob
27870	Arthrodesis, ankle, any method	**13.91**	090

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

	Svy CPT	Ref CPT
TIME ESTIMATES (MEDIAN)	29899	27870 RUC
Pre-service time	75	60
Intra-service time	120	140
Same Day Immediate Post-service time	30	30
Same Day Other Post-service time	0	
Post Total critical care time (not same day)	0	0
Post Total other hospital visit time (not same day)	38	38
Discharge management time	36	36
Total office visit time	92	92
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	3.65	3.62
Intra-service	4.24	4.00
Post-service	3.35	3.39
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3.59	3.46
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.35	3.15
Urgency of medical decision making	2.71	2.62
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	4.53	4.00
Physical effort required	3.82	3.92
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	3.65	3.77
Outcome depends on the skill and judgment of physician	4.35	4.08
Estimated risk of malpractice suit with poor outcome	3.69	3.69

RATIONALE:

The work associated with an arthroscopic ankle arthrodesis is similar to the work associated with an open arthrodesis. The post-service work is identical for the two techniques. There is slightly more pre-service work required for the arthroscopic procedure, as more time is required for patient positioning and equipment preparation. The intra-service time for the arthroscopic arthrodesis is less than the open procedure, however the technical skill required is greater.

We therefore recommend that 29899 be given an RVW of 13.91. This is the 25th percentile and is equal to the current value of the open procedure 27870.

FREQUENCY INFORMATION

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

27870 Arthrodesis, ankle, any method (Medicare frequency = 2194)

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~~ ~~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: 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: orthopaedic surgery Frequency: 50

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

No. Limited to a few medical centers

	A	B	C	D	E	F	G	H	I
1				29873			29899		
2			HCFA MEDICAL SUPPLY CODE	Arthroscopy, knee, surgical, with lateral release			Arthroscopy, ankle, (tibiotalar and fibulotalar joints) surgical; with ankle arthrodesis		
3	LOCATION			In Office	Out Office		In Office	Out Office	
4	GLOBAL PERIOD				90			90	
5	STAFF TYPE / CODE	RN/LPN/MA	1130	N/A		1130	N/A		1130
6	TOTAL TIME					195			204
7	PRESERVICE TIME					60			60
8	INTRASERVICE TIME					0			0
9	POST-SERVICE TIME					135			144
10	PRE-SERVICE								
11	Start: Following visit when decision for surgery or procedure made								
12	Complete pre-service diagnostic & referral forms					5			5
13	Coordinate pre-surgery services					20			20
14	Schedule space and equipment in facility					8			8
15	Office visit before surgery/procedure Review test and exam results					0			0
16	Provide pre-service education/obtain consent					20			20
17	Follow-up phone calls & prescriptions					7			7
18	Other Clinical Activity (please specify)								
19	End:When patient enters office for surgery/procedure								
20	SERVICE PERIOD								
21	Start: When patient enters office for surgery/procedure								
22	Pre-service services								
23	Review charts								
24	Greet patient and provide gowning								
25	Obtain vital signs								
26	Provide pre-service education/obtain consent								
27	Prepare room, equipment,supplies								
28	Prepare and position patient/ monitor patient/ set up IV								
29	Sedate/apply anesthesia								
30	Intra-service								
31	Assist physician in performing procedure								
32	Monitor pt. following service/check tubes, monitors, drains								
33	Clean room/equipment by physician staff								
34	Complete diagnostic forms, lab & X-ray requisitions								
35	Review/read X-ray, lab, and pathology reports								
36	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions								
37	Other Clinical Activity (please specify)								
38	Discharge Day - 99238	PEAC Time 12			05	00		10	00
39	End: Patient leaves office								
40	POST-SERVICE								
41	Start: Patient leaves office								
42	Conduct phone calls/call in prescriptions								
43	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 or outpatient are, conduct phone calls between office visits								
44	Other Activity (Phone calls)								
45	EM LEVEL / FREQUENCY	PEAC TIME						–	
46	99212	27			50	1350			0.0
47	99213	36				00		40	144.0
48	99214	53				00			00
49	MEDICAL SUPPLIES								
50	Basic Post-Operative Incision Care Kit				1			1	
51	E/M Code Supply Package				5			4	
52	PROCEDURE SPECIFIC EQUIPMENT								
53	Power table	E11003			1			1	
54	Exam lamp	E30006			1			1	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Insertion Repositioning Venous Pacing Electrode for Biventricular Pacing

The CPT Editorial Panel created four new cardiac pacing codes edited two existing codes since current codes could not adequately reflect the entire procedure being performed with biventricular pacing. Originally, the CPT Editorial Panel established one new code to report the additional work of placing the left ventricular lead in the coronary sinus to achieve biventricular pacing and perform cardiac resynchronization therapy for patients with congestive heart failure. This service would be reported in addition to separately reported pacemaker or implantable cardioverter defibrillator insertion (ICD).

During the CPT Editorial Panel discussions, CMS raised the point that in approximately 10% of the cases, placing the left ventricular lead in the coronary sinus to achieve biventricular pacing is performed with an already existing pacemaker or ICD, thereby creating the need for the establishment of two codes to report this service, one as an add-on code for the initial implants, and one as a stand alone code for patients with an already established device.

Also during the CPT Editorial Panel discussions, CMS also requested the specialty to rewrite the pacemaker and ICD codes (36216 and 33217) which included the language "insertion or repositioning of a transvenous electrode..." due to a concern that in the outpatient prospective payment system, facilities were being reimbursed for the cost of a brand new lead in the case where a new lead was being repositioned and not replaced. According to CMS, this is not a physician work issue, it is simply a matter of fairness on the facility reporting side to separate out lead insertion from lead repositioning. Two new codes were created to eliminate the "insertion or repositioning language" that has been prevalent in the pacing/ICD section of the CPT book.

33215 (AQ 1)

This code is a separation of the previously listed code 33216 *Insertion or repositioning of a transvenous electrode (15 days or more after initial insertion); single chamber (one electrode) permanent pacemaker or single chamber pacing cardioverter-defibrillator* (work RVU = 5.39) from insertion or repositioning code to insertion only. The new code is for repositioning 33215. This code is a right atrial ventricular code only and as such represent a group different from codes 33224, 33225, and 33226. The value carried over of 5.39 RVW was felt to be appropriate for insertion but the work of repositioning was felt to be less work and therefore the code was devalued by half the difference between the parent and a code for catheter insertion. The specialty society indicated the difference in work between insertion and repositioning of the electrode involved vascular access (already present at time of repositioning). Therefore, to adjust for the difference in intra-service time between 33215 (60 minutes) and the parent insertion code, 33216 (90

minutes), two-thirds of the RVUs for code 36491 *Placement of central venous catheter (subclavian, jugular, or other vein) (eg, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); cutdown, over age 2* (Work RVU = 1.43) was subtracted from the parent Work RVU of 5.39. In addition, the RUC believed to maintain proper rank order between codes 33215 and code 33216 the RUC recommends a work RVU of 4.44 for 33215. **The RUC recommends a work RVW of 4.44 for 33215.**

33224 (AQ 4)
The RUC reviewed several similar procedures, and building block methodologies for this base code recommendation. The RUC believed that part of the work for this code was contained in code 33212 *Insertion or replacement of pacemaker pulse generator only; single chamber, atrial or ventricula* (Work RVU = 5.52) and code 33233 *Removal of permanent pacemaker pulse generator* (Work RVU = 3.29), and involved more work and intensity as the insertion of the pacing electrode is in the left ventricle rather than the right. The RUC discussed the code's global period and recommended a change from a 090 to a 000 day global code. The RUC believed a relative work value of 9.05 was the proper value based on subtracting out the value of the post-operative visits contained in the specialty's recommendation for a 090 day global period procedure with a the survey median work RVU of 11.00. **The RUC recommends a work RVU of 9.05 for code 33224, with the understanding that it be a 000 day global and the removal, insertion, and/or replacement of the generator be included in the physician work. This is a formal recommendation for a request for a CPT Editorial change.** The CPT Editorial Panel agreed in May 2002 with the CPT Executive Committee's decision to modify the descriptors of codes 33224 to include "*(including revision of pocket, removal, insertion and/or replacement of generator).*"

33225 (AQ 5)
The RUC reviewed and compared CPT code 33225 with codes 92973 *Percutaneous transluminal coronary thrombectomy (List separately in addition to code for primary procedure)* (work RVU = 3.28), 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)* (work RVU = 4.17), 22585 *Arthrodesis, anterior interbody technique, including minimal diskectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)* (work RVU= 5.53), and 22845 *Anterior instrumentation; 2 to 3 vertebral segments* (work RVU= 11.96).

The specialty society and the RUC agreed that code 33225 was similar to the intensity and work of 92981 (Work RVU=4.17). This is a ZZZ code and the society recommendation of 10.00 work RVUs were considered high. Code 92981 has a work time of 60 minutes and the survey median time for the considered code had a survey time of 120 minutes. Therefore, by doubling the work RVU of 92981 to obtain 8.34, it was felt to be appropriate considering the similarities in intensity and work involved. This is more than some ZZZ codes considered (eg 22585 *Arthrodesis, anterior interbody technique, including minimal diskectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)* (work RVU= 5.53); 92973 *Percutaneous transluminal coronary thrombectomy (List separately in addition to code for primary procedure)* (work

RVU=3.28) less than others (22845 *Anterior instrumentation; 2 to 3 vertebral segments* (work RVU= 11.96) and the calculated value was felt to appropriately represent the physician work. **The RUC recommends a relative work value for CPT code 33225 of 8.34.**

33226 (AQ 6)

The RUC reviewed several similar procedures, and building block methodologies for this base code recommendation. The RUC believed that part of the work for this code was contained in code 33212 *Insertion or replacement of pacemaker pulse generator only; single chamber, atrial or ventricula* (Work RVU = 5.52) and code 33233 *Removal of permanent pacemaker pulse generator* (Work RVU = 3.29), and involved more work and intensity as the insertion of the pacing electrode is in the left ventricle rather than the right. However, the generator must be removed to have access to this lead and the nature of the lead means that to be properly replaced it must be fully removed and the sheath placed for reinsertion. In essence it is very similar to the code 33224 *Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously-placed pacemaker or pacing cardioverter-defibrillator pulse generator* (RUC recommended work RVU = 9.05). The RUC discussed the code's global period and recommended a change from a 090 to a 000 day global code. The RUC believed the relative work value of 8.69 was the proper value based on the subtraction of the value of the post-operative visits contained therein from the survey median work RVU of 10.64. **The RUC recommends a work RVU of 8.69 with the understanding that it be a 000 day global and the removal, insertion, and/or replacement of the generator be included in the physician work. This is a formal recommendation for a CPT Editorial change.** The CPT Editorial Panel agreed in May 2002 with the CPT Executive Committee's decision to modify the descriptors of codes 33224 to include "*(including revision of pocket, removal, insertion and/or replacement of generator)*".

Practice Expense

The standard direct practice expense input packages for 090 day global codes has been applied to code 33215. Codes 33224 and 33226 as considered by the RUC were changed to a pre-service time of 35 minutes and 3 minutes for a follow up phone call, for these codes, consistent with the pre-service time for similar to cardiac catheterization codes (93508-93533) recently adopted by the PEAC/RUC. This change was made to reflect the change in global periods for these two codes from a 090 day global to a 000 day global, resulting in the deletion of the office visit time, supplies, and equipment. The RUC also recommends code 33225 have no practice expense inputs as it is an add-on code. All of these codes are considered by the RUC as to be performed in the facility setting and therefore no practice expense inputs are recommended in the non-facility setting.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●33215	AQ1	Repositioning of previously implanted transvenous pacemaker or pacing cardioverter-defibrillator (right atrial or right ventricular) electrode	090	4.44
▲33216	AQ2	Insertion ~~or repositioning~~ of a transvenous electrode; single chamber (one electrode) permanent pacemaker or single chamber pacing cardioverter-defibrillator	090	5.39 (no change)
▲33217	AQ3	dual chamber (two electrodes) permanent pacemaker or dual chamber pacing cardioverter-defibrillator	090	5.75 (no change)
●33224	AQ4	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously-placed pacemaker or pacing cardioverter-defibrillator pulse generator (including revision of pocket, removal, insertion and/or replacement of generator)	000	9.05
✚●33225	AQ5	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator (including upgrade to dual chamber system) (List separately in addition to code for primary procedure) (Use 33225 in conjunction with 33206, 33207, 33208, 33212, 33213, 33214, 33216, 33217, 33222, 33233, 33234, 33235, 33240, 33249)	ZZZ	8.34
●33226	AQ6	Repositioning of previously implanted cardiac venous system (left ventricular) electrode (including removal, insertion and/or replacement of generator)	000	8.69

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 33215 Tracking Number: AQ1 Global Period: 090 ~~**Recommended RVW: 5.37**~~
RUC Recommended RVW: 4.44

CPT Descriptor:
Repositioning of previously implanted transvenous pacemaker or pacing cardioverter-defibrillator (right atrial or right ventricular) electrode

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
A 65-year-old man experiences symptoms of near syncope 6 weeks after insertion of a pacemaker or pacemaker-defibrillator. Intermittent capture of the ventricle is noted on rhythm strip and pacemaker or pacemaker-defibrillator evaluation suggested lead dislodgement. The right ventricular lead is repositioned to achieve right ventricular capture.

Included in the procedure:
1) Local anesthetic injected into the existing generator pocket
2) Incision and blunt dissection to open the existing generator pocket and free up the existing pacemaker leads
3) Placing stylette in the lead and repositioning
4) Assessing sensing and pacing thresholds
5) Attach the lead to the generator
6) Suture closure and hemostasis monitoring of the generator pocket

Excluded from the procedure:
1) temporary lead placement (billed using CPT codes 33210 and 33211)

Description of Pre-Service Work:
The risks and benefits of the procedure are reviewed with the patient and their family. Pertinent laboratory tests including blood tests, chest x-ray, and pacemaker interrogation are reviewed.

Description of Intra-Service Work:
The patient is taken to the procedure room. After preparation and draping of the skin over the existing pulse generator pocket, local anesthetic is injected in the skin and subcutaneous tissues and the pulse generator pocket is entered. The electrode is inspected and evaluated for its pacing and sensing characteristics. The lead is disconnected from the pulse generator and manipulated into a different position in the right ventricle (or right atrium). Sensing and pacing thresholds are again evaluated and after being found satisfactory, the electrode is reconnected to the pulse generator. The pocket is closed after hemostasis is achieved.

Description of Post-Service Work:
Following the procedure, the incision is inspected and pacemaker programming is performed confirming acceptable function of the lead. Results are reviewed with the patient and family. The patient is discharged the following day. The patient is then seen post-operatively in the office setting for a wound check and visit related to the procedure. Reprogramming, which is separately billable, is not part of this E&M visit.

SURVEY DATA:

Presenter(s) James Maloney, MD, FACC and Anne Curtis, MD, FACC

Specialty(s): Cardiology/Electrophysiology

Sample Size: 75 Response Rate: (53%) 40 Median RVW: 5.39

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size:
Random members of the North American Society of Pacing and Electrophysiology (NASPE) were selected. In addition, two manufacturers provided current users of their products, most of whom were also NASPE members.

25th Percentile RVW: 5.37 75th Percentile RVW: 6 Low: 1.5 High: 9.00

Day before median pre-service time: 35 minutes
Median Pre-Service Time: 20 Median Intra-Service Time: 60

25th Percentile Intra-Svc Time: 45 75th Percentile Intra-Svc Time: 60 Low: 20 High: 120

Median Post-Service Time:	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	25	
Critical Care:	N/A	
Other Hospital Visits:	19	99231 (1)
Discharge Day Mgmt.:	36	99238 (1)
Office Visits:	15	99212 (1)

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
33216	Insertion or repositioning of a transvenous electrode (15 days or more after initial insertion); single chamber (one electrode) permanent pacemaker or single chamber pacing cardio-verter-defibrillator	090	5.39

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

TIME ESTIMATES (Median)	**New CPT Code 33215:**	**Key Reference CPT Code: 33216**
Median Pre-Time	20	60
Median Intra-Time	60	90
Median Immediate Post-service Time	25	90
Median of Aggregate Critical Care Times	N/A	N/A
Median of Aggregate Other Hospital Visit Times	19	1 visit
Median Discharge Day Management Time	36	N/A
Median of Aggregate Office Visit Times	15	2 visits 30 min. per RUC database

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	3.09	3.03
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.14	3.06
Urgency of medical decision making	3.56	3.39

Technical Skill/Physical Effort (Mean)

Technical skill required	3.50	3.39
Physical effort required	3.05	2.91

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.23	3.21
Outcome depends on the skill and judgement of physician	3.59	3.42
Estimated risk of malpractice suit with poor outcome	3.54	3.41

INTENSITY/COMPLEXITY MEASURES	CPT Code 33215	Reference Service 33216
Time Segments (Mean)		
Pre-Service intensity/complexity	3.14	3.12
Intra-Service intensity/complexity	3.31	3.28
Post-Service intensity/complexity	2.67	2.73

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. NASPE is represented on the ACC CVRUC.

Following the review of the survey data, the CVRUC recommends a work RVU of 5.37 which is the 25th percentile result. The reference procedure chosen most commonly was 33216. Although the intensity and complexity measurements were similar for both codes, the time results were lower so the CVRUC is recommending the 25th percentile. This recommendation places this code in proper rank order to the other pacemaker codes being surveyed for the April RUC and in proper rank order to all pacemaker and defibrillator implant codes.

FREQUENCY INFORMATION

How was this service previously reported? 33216 (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 specialt 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 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 Cardiology Frequency 1,600

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 33224 Tracking Number: AQ4 Global Period: ~~090~~ **000** ~~**Recommended RVW: 11**~~
RUC Recommended RVW: 9.05

CPT Descriptor:
Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously-placed pacemaker or pacing cardioverter-defibrillator pulse generator

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
A 54-year-old male presents with dilated cardiomyopathy, ejection fraction of 20%, and NYHA Class III congestive heart failure. His symptoms persist despite medical treatment with ACE inhibitors, beta blockers, and diuretic therapy. A left ventricular pacing lead is placed in the coronary sinus to allow biventricular pacing for cardiac resynchronization. The left ventricular pacing lead is then connected to an existing pacemaker or pacemaker-defibrillator generator.

Included in the procedure:

1) Local anesthetic injected into the existing generator pocket
2) Incision and blunt dissection to open the existing generator pocket and free up the existing pacemaker leads
3) Cannulation of the subclavian or cephalic vein
4) Coronary sinus cannulation
5) Coronary sinus venogram with interpretation
6) Placing guide wires, guiding sheath, and pacemaker lead in the coronary venous system
7) Assessment of sensing and pacing thresholds for the left ventricular lead
8) Removal of the guide wires and guiding sheath
9) Assessment of sensing and pacing thresholds for the left ventricular lead
10) Attach the left ventricular lead to the existing generator
11) Suture closure and hemostasis monitoring of the generator pocket

Excluded from the procedure: None

Description of Pre-Service Work:
The risks and benefits of the procedure are reviewed with the patient and their family. Pertinent laboratory tests including blood tests, chest x-ray, and pacemaker interrogation are reviewed.

Description of Intra-Service Work:
The procedure is performed under ECG, intra-arterial blood pressure, and pulse oximetry monitoring. The skin over the generator pocket is prepared and local anesthetic is injected into the insertion site. The generator pocket is opened and the generator and previously placed lead(s) are dissected free from the scar tissue. After achieving venous access, a guide wire is passed into the right atrium under fluoroscopic guidance. A 9-French peel-away sheath is passed over the wire, and a guide catheter is placed through the sheath and positioned into the right atrium under fluoroscopic guidance. A steerable catheter is placed within the guide catheter, and the coronary sinus is cannulated. Contrast is injected through the guide catheter to verify engagement of the coronary sinus, the steerable catheter is removed, and a balloon catheter is placed through the guide catheter into the coronary sinus. Contrast venography of the coronary sinus in RAO, LAO, and AP projections is performed. Following this, the balloon catheter is removed and a left ventricular pacing lead is advanced into the marginal branch of the coronary sinus. Adequate sensing and pacing thresholds is identified. Further manipulation of the lead may be required to attain an adequate location and thresholds. Once the left ventricular lead is in position, the guide catheter is removed. The electrode is then connected to the already placed pulse generator directly or with an adaptor. The pulse generator pocket is then closed.

Description of Post-Service Work:
Following the procedure, the incision is inspected and pacemaker programming is performed confirming acceptable function of the lead. Results are reviewed with the patient and family. The patient is discharged the following day. The patient is then seen post-operatively in the office setting for a wound check and visit related to the procedure. Reprogramming, which is separately billable, is not part of this E&M visit.

SURVEY DATA:

Presenter(s) James Maloney, MD, FACC and Anne Curtis, MD, FACC

Specialty(s): Cardiology/Electrophysiology

Sample Size: 75 Response Rate: (56%) 42 Median RVW: 11

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size:
Random members of the North American Society of Pacing and Electrophysiology (NASPE) were selected. In addition, two manufacturers provided current users of their products, most of whom were also NASPE members.

25th Percentile RVW: 9 75th Percentile RVW: 16.2 Low: 3 High: 35
Day before median pre-time: 50 minutes
Median Pre-Service Time: 20 Median Intra-Service Time: 135

25th Percentile Intra-Svc Time: 117.50 75th Percentile Intra-Svc Time: 180 Low: 60 High: 300

Median Post-Service Time:	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	30	
Critical Care:	N/A	
Other Hospital Visits:	~~30~~	~~99232 (1)~~
Discharge Day Mgmt.:	18	99238 (0.5)
Office Visits:	~~23~~	~~99213 (1)~~

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
33216	Insertion or repositioning of a transvenous electrode (15 days or more after initial insertion); single chamber (one electrode) permanent pacemaker or single chamber pacing cardio-verter-defibrillator	090	5.39

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

TIME ESTIMATES (Median)	New CPT Code 33224:	Key Reference CPT Code: 33216
Median Pre-Time	20	60
Median Intra-Time	135	90
Median Immediate Post-service Time	30	90
Median of Aggregate Critical Care Times	N/A	N/A
Median of Aggregate Other Hospital Visit Times	30	1 visit
Median Discharge Day Management Time	18	N/A
Median of Aggregate Office Visit Times		2 visits 30 min. per RUC database

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	4.17	2.91
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.42	3.09
Urgency of medical decision making	3.67	3.29

Technical Skill/Physical Effort (Mean)

Technical skill required	4.85	3.32
Physical effort required	4.65	2.94

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.33	3.41
Outcome depends on the skill and judgement of physician	4.82	3.65
Estimated risk of malpractice suit with poor outcome	3.97	3.41

INTENSITY/COMPLEXITY MEASURES	CPT Code 33224	Reference Service 33216

Time Segments (Mean)

Pre-Service intensity/complexity	3.96	3.18
Intra-Service intensity/complexity	4.90	3.47
Post-Service intensity/complexity	3.79	2.88

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. NASF is represented on the ACC CVRUC.

Following the review of the survey data, the CVRUC recommends a work RVU of 11 which is the median survey result. The reference procedure chosen most commonly was 33216 and code 33224 was ranked significantly higher in all categories for intensity and complexity of the procedure. This recommendation places this code in proper rank order to the other pacemaker codes being surveyed for the April RUC and in proper rank order to all pacemaker and defibrillator implant codes.

FREQUENCY INFORMATION

How was this service previously reported? 33999 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) (Frequency 1, 826 per RUC database)

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 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 Cardiology Frequency 2,000

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 33225 Tracking Number: AQ5 Global Period: ZZZ ~~**Recommended RVW: 10**~~

RUC Recommended RVW: 8.34

CPT Descriptor:
Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator (including upgrade to dual chamber system) (List separately in addition to code for primary procedure)

(Use 33225 in conjunction with 33206, 33207, 33208, 33212, 33213, 33214, 33216, 33217, 33222, 33233, 33234, 33235, 33240, 33249)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
A 54-year-old male presents with dilated cardiomyopathy, ejection fraction of 20%, and NYHA Class III congestive heart failure. His symptoms persist despite medical treatment with ACE inhibitors, beta blockers, and diuretic therapy. A left ventricular pacing lead is placed in the coronary sinus to allow biventricular pacing for cardiac resynchronization.

(Note: The placement of the pacemaker or pacemaker-defibrillator, right atrial pacing lead, and right ventricular pacing lead are coded separately).

Included in the procedure:

1) Cannulation of the subclavian or cephalic vein
2) Coronary sinus cannulation
3) Coronary sinus venogram with interpretation
4) Placing guide wires, guiding sheath, and pacemaker lead in the coronary venous system
5) Assessment of sensing and pacing thresholds for the left ventricular lead
6) Removal of the guide wires and guiding sheath
7) Assessment of sensing and pacing thresholds for the left ventricular lead

Excluded from the procedure: Physician work associated with primary procedure (see CPT descriptor).

Description of Intra-Service Work:
The procedure is performed under ECG, intra-arterial blood pressure, and pulse oximetry monitoring. The insertion site is prepped. Local anesthetic is injected into the insertion site. After achieving venous access, a guide wire is passed into the right atrium under fluoroscopic guidance. A 9-French peel-away sheath is passed over the wire, and a guide catheter is placed through the sheath and positioned into the right atrium under fluoroscopic guidance. A steerable catheter is placed within the guide catheter, and the coronary sinus is cannulated. Contrast is injected through the guide catheter to verify engagement of the coronary sinus, the steerable catheter is removed, and a balloon catheter is placed through the guide catheter into the coronary sinus. Contrast venography of the coronary sinus in RAO, LAO, and AP projections is performed. Following this, the balloon catheter is removed and a left ventricular pacing lead is advanced into the marginal branch of the coronary sinus. Adequate sensing and pacing thresholds is identified. Further manipulation of the lead may be required to attain an adequate location and thresholds. Once the left ventricular lead is in position, the guide catheter is removed.

SURVEY DATA:

Presenter(s) James Maloney, MD, FACC and Anne Curtis, MD, FACC

Specialty(s): Cardiology/Electrophysiology

Sample Size: 75 Response Rate: (59%) 44 Median RVW: 10

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size:
Random members of the North American Society of Pacing and Electrophysiology (NASPE) were selected. In addition, two manufacturers provided current users of their products, most of whom were also NASPE members

25th Percentile RVW: 7 75th Percentile RVW: 14.25 Low: 3 High: 40

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

25th Percentile Intra-Svc Time: 90 75th Percentile Intra-Svc Time: 157.5 Low: 60 High: 300

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

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
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)	ZZZ	4.17

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 CPT Code 33225:**	**Key Reference CPT Code: 92981**
Median Pre-Time	N/A	N/A
Median Intra-Time	120	60
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	4.15	3.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.30	4.00
Urgency of medical decision making	3.73	4.20

Technical Skill/Physical Effort (Mean)

Technical skill required	4.83	4.20
Physical effort required	4.57	3.40

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.33	4.60
Outcome depends on the skill and judgement of physician	4.74	4.60
Estimated risk of malpractice suit with poor outcome	3.90	4.20

INTENSITY/COMPLEXITY MEASURES	CPT Code 33225	Reference Service 92981
Time Segments (Mean)		
Pre-Service intensity/complexity	N/A	N/A
Intra-Service intensity/complexity	4.79	4.20
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. NASPE is represented on the ACC CVRUC.

Following the review of the survey data, the CVRUC recommends a work RVU of 10 which is the median survey result. This code is an add-on procedure to a pacemaker or defibrillator code and add-on code 92981 was chosen as the reference procedure chosen. Code 33225 took twice as much time and is higher in the majority of intensity and complexity measurements. The recommendation of 10 work RVUs places this code in proper rank order to the other pacemaker codes being surveyed for the April RUC and in proper rank order to all pacemaker and defibrillator implant codes.

FREQUENCY INFORMATION

How was this service previously reported? 33999 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) (Frequency 1,826 per RUC database)

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

Specialty _____ ____Commonly X Sometimes ____Rarely

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

Specialty _____ Frequency 28,000

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 _____ Frequency 14,000

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 33226 Tracking Number: AQ6 Global Period: ~~090~~ **000** ~~**Recommended RVW: 10.64**~~
RUC Recommended RVW: 8.69

CPT Descriptor:
Repositioning of previously implanted cardiac venous system (left ventricular) electrode

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
A 65-year-old man experiences symptoms of progressive heart failure 6 weeks after insertion of a left ventricular pacing electrode to achieve cardiac resynchronization by biventricular pacing. Intermittent capture of the left ventricle is noted on rhythm strip and pacemaker or pacemaker-defibrillator evaluation suggested lead dislodgement. The left ventricular pacing electrode is repositioned to achieve left ventricular capture.

Included in the procedure;

1) Local anesthetic injected into the existing generator pocket
2) Incision and blunt dissection to open the existing generator pocket and free up the existing pacemaker leads
3) Placing stylette or guide wire to reposition the pacemaker lead in the coronary venous system
4) Assessing sensing and pacing thresholds for the left ventricular lead
5) Removal of the stylette or guide wire
6) Assessing sensing and pacing thresholds for the left ventricular lead
7) Attach the left ventricular lead to the generator
8) Suture closure and hemostasis monitoring of the generator pocket

Excluded from the procedure: None

Description of Pre-Service Work:
The risks and benefits of the procedure are reviewed with the patient and their family. Pertinent laboratory tests including blood tests, chest x-ray, and pacemaker interrogation are reviewed.

Description of Intra-Service Work:
The patient was taken to the procedure room. After preparation and draping of the skin over the existing pulse generator pocket, local anesthetic was injected in the skin and subcutaneous tissues and the pulse generator pocket was entered. The electrode was inspected and evaluated for its pacing and sensing characteristics. The lead was disconnected from the pulse generator and manipulated into a different position in the coronary venous system. Sensing and pacing thresholds were again evaluated and after being found satisfactory, the electrode was reconnected to the pulse generator. The pocket was closed after hemostasis was achieved. The patient was returned to his room, and the next day, pacemaker reprogramming was performed and confirmed acceptable function of the left ventricular lead.

Description of Post-Service Work:
Following the procedure, the incision is inspected and pacemaker programming is performed confirming acceptable function of the lead. Results are reviewed with the patient and family. The patient is discharged the following day. The patient is then seen post-operatively in the office setting for a wound check and visit related to the procedure. Reprogramming, which is separately billable, is not part of this E&M visit.

SURVEY DATA:

Presenter(s) James Maloney, MD, FACC and Anne Curtis, MD, FACC

Specialty(s): Cardiology/Electrophysiology

Sample Size: 75 Response Rate: (56%) 42 Median RVW: 10.64

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size:
Random members of the North American Society of Pacing and Electrophysiology (NASPE) were selected. In addition, two manufacturers provided current users of their products, most of whom were also NASPE members.

25th Percentile RVW: 8.43 75th Percentile RVW: 15 Low: 3 High: 30
Day before median pre-time: 39 minutes
Median Pre-Service Time: 25 Median Intra-Service Time: 120

25th Percentile Intra-Svc Time: 90 75th Percentile Intra-Svc Time: 180 Low: 30 High: 240

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	25	
Critical Care:	N/A	
Other Hospital Visits:	~~30~~	~~99232 (1)~~
Discharge Day Mgmt.:	18	99238 (0.5)
~~Office Visits:~~	~~23~~	~~99213 (1)~~

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
33216	Insertion or repositioning of a transvenous electrode (15 days or more after initial insertion); single chamber (one electrode) permanent pacemaker or single chamber pacing cardio-verter-defibrillator	090	5.39

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

TIME ESTIMATES (Median)	New CPT Code 33226:	Key Reference CPT Code: 33216
Median Pre-Time	25	60
Median Intra-Time	120	90
Median Immediate Post-service Time	30	90
Median of Aggregate Critical Care Times	N/A	N/A
Median of Aggregate Other Hospital Visit Times	30	1 visit
Median Discharge Day Management Time	36	N/A
Median of Aggregate Office Visit Times	23	2 visits 30 min. per RUC database

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	3.99	3.02
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.06	3.02
Urgency of medical decision making	3.79	3.32

Technical Skill/Physical Effort (Mean)

Technical skill required	4.79	3.30
Physical effort required	4.49	3.02

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.44	3.25
Outcome depends on the skill and judgement of physician	4.73	3.41
Estimated risk of malpractice suit with poor outcome	3.95	3.23

INTENSITY/COMPLEXITY MEASURES	CPT Code 33226	Reference Service 33216
Time Segments (Mean)		
Pre-Service intensity/complexity	3.83	3.22
Intra-Service intensity/complexity	4.67	3.43
Post-Service intensity/complexity	3.59	2.6

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. NASPE is represented on the ACC CVRUC.

Following the review of the survey data, the CVRUC recommends a work RVU of 10.64 which is the median survey result. The reference procedure chosen most commonly was 33216 and code 33226 was ranked significantly higher in all categories for intensity and complexity of the procedure. This recommendation places this code in proper rank order to the other pacemaker codes being surveyed for the April RUC and in proper rank order to all pacemaker and defibrillator implant codes.

FREQUENCY INFORMATION

How was this service previously reported? 33999 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) (1,826 per RUC database) *New procedure

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 2,000

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 1,000

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

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

CPT Code: 33215 Tracking Number: AQ1

CPT Descriptor:
Repositioning of previously implanted transvenous pacemaker or pacing cardioverter-defibrillator (right atrial or right ventricular) electrode

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 was used. 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 direct inputs. NASPE is represented on the ACC CVRUC.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Completing forms, coordinating pre-surgery, scheduling space, providing education and obtaining consent, reviewing sults and followup work. (Standard package).

Intra-Service Clinical Labor Activities:

none

Post-Service Clinical Labor Activities:

For post service after procedure in hospital, there is no clinical labor time being reported. Office visit clinical staff time includes greeting the patient, providing gowning, obtaining interval history & vital signs, assembling previous test results, assisting physician during exam, assisting with wound care, preparing diagnosis tests and prescription forms, providing post service education and counseling, cleaning the room and checking supplies.

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 and Source
1130	RN/LPN/MTA	60	6	0	0	1	27	

*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. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies (note this is the basic standard supply package)	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
11107	Patient gown, disposable	1	Item	
11111	Exam table paper	7	Feet	
11112	Pillow case	1	Item	
11302	Gloves, non-sterile	2	Pair	
11509	Thermometer probe cover, disposable	1	Item	

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

HCFA's Equipment Code*	Medical Equipment	Minutes of use per procedure	Cost Estimate and Source (if applicable)
E11001	Examination table	27	

* From HCFA's Labor, Medical Supply, and Equipment List. 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 E&M Standard Package	**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/MTA
Coordinate pre-surgery services	20	RN/LPN/MTA
Schedule space and equipment in facility	8	RN/LPN/MTA
Office visit before surgery/procedure Review test and exam results	0	
ovide pre-service education/obtain consent	20	RN/LPN/MTA
Follow-up phone calls & prescriptions	7	RN/LPN/MTA
Other Activity (please specify) _____	0	
End: When patient enters hospital for surgery/procedure		
Service Period		
Start: Patient admitted to hospital for surgery/procedure		
Pre-service services		
Review charts	0	RN, LPN, MA, Other
Greet patient and provide gowning	0	RN, LPN, MA, Other
Obtain vital signs	0	RN, LPN, MA, Other
Provide pre-service education/obtain consent	0	RN, LPN, MA, Other
epare room, equipment, supplies	0	RN, LPN, MA, Other
Prepare and position patient/ monitor patient/ set up IV	0	RN, LPN, MA, Other

Sedate/apply anesthesia	0	RN, LPN, MA, Other
Intra-service		
Assist physician in performing surgery/procedure	0	RN, LPN, MA, Other
Post-service		
Monitor pt. following service/check tubes, monitors, drains	0	RN
Clean room/equipment by physician staff	0	RN, LPN, MA, Other
Assist with ICU or hospital visits	0	RN, LPN, MA, Other
Total Number of ICU visits	0	
Total Number of hospital visits	0	
Complete diagnostic forms, lab & X-ray requisitions	0	RN, LPN, MA, Other
Review/read X-ray, lab, and pathology reports	0	RN, LPN, MA, Other
Discharge day management services, check dressings & wound/ home care instructions/coordinate office visits/prescriptions	6	RN/LPN/MTA
Coordination of care by staff in office	0	RN, LPN, MA, Other_____
Other Activity (please specify) _____	0	RN, LPN, MA, Other _____

End: Patient discharge from hospital

Post-Service Period
Start: Patient discharge from hospital

Conduct phone calls/call in prescriptions

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	27	
Coordinate home or outpatient care		RN/LPN/MTA
List total number of office visits	1	
Total office visit time (A * B)	27	
Conduct phone calls between office visits	0	
Other Activity (please specify)		
End: With last office visit before end of global period		

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

CPT Code: 33224 Tracking Number: AQ4

CPT Descriptor:
Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously-placed pacemaker or pacing cardioverter-defibrillator pulse generator

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 was used. 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 direct inputs. NASPE is represented on the ACC CVRUC.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Completing forms, coordinating pre-surgery, scheduling space, providing education and obtaining consent, reviewing results and followup work. (Standard package).

Intra-Service Clinical Labor Activities:

none

Post-Service Clinical Labor Activities:

For post service after procedure in hospital, there is no clinical labor time being reported. Office visit clinical staff time includes greeting the patient, providing gowning, obtaining interval history & vital signs, assembling previous test results, assisting physician during exam, assisting with wound care, preparing diagnosis tests and prescription forms, providing post service education and counseling, cleaning the room and checking supplies.

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

CPT Code: 33224 Tracking Number: AQ4

CPT Descriptor:
Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously-placed pacemaker or pacing cardioverter-defibrillator pulse generator

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 was used. 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 direct inputs. NASPE is represented on the ACC CVRUC.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Completing forms, coordinating pre-surgery, scheduling space, providing education and obtaining consent, reviewing results and followup work. (Standard package).

ntra-Service Clinical Labor Activities:

none

Post-Service Clinical Labor Activities:

For post service after procedure in hospital, there is no clinical labor time being reported. Office visit clinical staff time includes greeting the patient, providing gowning, obtaining interval history & vital signs, assembling previous test results, assisting physician during exam, assisting with wound care, preparing diagnosis tests and prescription forms, providing post service education and counseling, cleaning the room and checking supplies.

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 I and S applic
1130	RN/LPN/MTA	35		0	3			

*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. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies (note this is the basic standard supply package)	Quantity of Supplies	Units Used for Purchase	Cost Estimate and (if applicable)
none	[illegible]			

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

HCFA's Equipment Code*	Medical Equipment	Minutes of use per procedure	Cost Estimate and Source (if applicable)
none			

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

TYPE OF SERVICE: Surgical Procedures
000 Global

SITE OF SERVICE: OUT-OF-OFFICE

Clinical Services E&M Standard Package	**Minutes**	**Staff Type – Circle**
Pre-Service Period		
Start: Following visit when decision for surgery or procedure made		
Complete pre-service diagnostic & referral forms	2	RN/LPN/MTA
Coordinate pre-surgery services	12	RN/LPN/MTA
Schedule space and equipment in facility	5	RN/LPN/MTA
Office visit before surgery/procedure Review test and exam results	0	RN
Provide pre-service education/obtain consent	12	RN/LPN/MTA
Follow-up phone calls & prescriptions	3	RN/LPN/MTA
Other Activity (please specify) _____	0	RN
End: When patient enters hospital for surgery/procedure		
Service Period		
Start: Patient admitted to hospital for surgery/procedure		
Pre-service services		
Review charts	0	RN, LPN, MA,Other_____
Greet patient and provide gowning	0	RN, LPN, MA, Other _____
Obtain vital signs	0	RN, LPN, MA, Other _____
Provide pre-service education/obtain consent	0	RN, LPN, MA, Other _____
Prepare room, equipment, supplies	0	RN, LPN, MA, Other _____
Prepare and position patient/ monitor patient/ set up IV	0	RN, LPN, MA, Other _____
Sedate/apply anesthesia	0	RN, LPN, MA, Other _____
Intra-service		
Assist physician in performing surgery/procedure	0	RN, LPN, MA, Other _____

Post-service

Monitor pt. following service/check tubes, monitors, drains	0	RN
Clean room/equipment by physician staff	0	RN, LPN, MA, Other
Assist with ICU or hospital visits	0	RN, LPN, MA, Other
Total Number of ICU visits	0	
Total Number of hospital visits	0	
Complete diagnostic forms, lab & X-ray requisitions	0	RN, LPN, MA, Other
Review/read X-ray, lab, and pathology reports	0	RN, LPN, MA, Other
Discharge day management services, check dressings & wound/ home care instructions/coordinate office visits/prescriptions	6	RN/LPN/MTA
Coordination of care by staff in office	0	RN, LPN, MA, Other
Other Activity (please specify) _____	0	RN, LPN, MA, Other _____

End: Patient discharge from hospital

Post-Service Period
Start: Patient discharge from hospital

Conduct phone calls/call in prescriptions	0	RN

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
List total number of office visits

Conduct phone calls between office visits	0	RN
Other Activity (please specify)		RN

End: With last office visit before end of global period

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

CPT Code: 33226 Tracking Number: AQ6

CPT Descriptor:
Repositioning of previously implanted cardiac venous system (left ventricular) electrode

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 was used. 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 direct inputs. NASPE is represented on the ACC CVRUC.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Completing forms, coordinating pre-surgery, scheduling space, providing education and obtaining consent, reviewing results and followup work. (Standard package).

Intra-Service Clinical Labor Activities:

none

Post-Service Clinical Labor Activities:

For post service after procedure in hospital, there is no clinical labor time being reported. Office visit clinical staff time includes greeting the patient, providing gowning, obtaining interval history & vital signs, assembling previous test results, assisting physician during exam, assisting with wound care, preparing diagnosis tests and prescription forms, providing post service education and counseling, cleaning the room and checking supplies.

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 and Sourc (if applicable
1130	RN/LPN/MTA	35		0	3			

*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. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies (note this is the basic standard supply package)	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
None				

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

HCFA's Equipment Code*	Medical Equipment	Minutes of use per procedure	Cost Estimate and Source (if applicable)
none	Examination table	36	

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

TYPE OF SERVICE: Surgical Procedures
010 and 090 Global Periods

Clinical Services E&M Standard Package	Minutes	Staff Type – Circle
Pre-Service Period		
Start: Following visit when decision for surgery or procedure made		
Complete pre-service diagnostic & referral forms	3	RN/LPN/MTA
Coordinate pre-surgery services	12	RN/LPN/MTA
Schedule space and equipment in facility	5	RN/LPN/MTA
Office visit before surgery/procedure Review test and exam results	0	RN
Provide pre-service education/obtain consent	12	RN/LPN/MTA
Follow-up phone calls & prescriptions	3	RN/LPN/MTA
Other Activity (please specify) _____	0	RN
End: When patient enters hospital for surgery/procedure		
Service Period		
Start: Patient admitted to hospital for surgery/procedure		
Pre-service services		
Review charts	0	RN, LPN, MA, Other
Greet patient and provide gowning	0	RN, LPN, MA, Other
Obtain vital signs	0	RN, LPN, MA, Other
Provide pre-service education/obtain consent	0	RN, LPN, MA, Other
Prepare room, equipment, supplies	0	RN, LPN, MA, Other
Prepare and position patient/ monitor patient/ set up IV	0	RN, LPN, MA, Other
Sedate/apply anesthesia	0	RN, LPN, MA, Other
Intra-service		
Assist physician in performing surgery/procedure	0	RN, LPN, MA, Other
Post-service		
Monitor pt. following service/check tubes, monitors, drains	0	RN

Clean room/equipment by physician staff	0	RN, LPN, MA, Other
Assist with ICU or hospital visits	0	RN, LPN, MA, Other
Total Number of ICU visits	0	
Total Number of hospital visits	0	
Complete diagnostic forms, lab & X-ray requisitions	0	RN, LPN, MA, Other
Review/read X-ray, lab, and pathology reports	0	RN, LPN, MA, Other
Discharge day management services, check dressings & wound/ home care instructions/coordinate office visits/prescriptions	6	RN/LPN/MTA
Coordination of care by staff in office	0	RN, LPN, MA, Other
Other Activity (please specify) _____	0	RN, LPN, MA, Other

End: Patient discharge from hospital

Post-Service Period
Start: Patient discharge from hospital

Conduct phone calls/call in prescriptions	0	RN

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
List total number of office visits

Total office visit time (A * B)

Conduct phone calls between office visits	0	
Other Activity (please specify)	0	RN

End: With last office visit before end of global period

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Minimally Invasive Vein Harvest for CABG Procedures

CPT created code 33508 *Endoscopy surgical, including video-assisted harvest of vein(s) for coronary artery bypass procedure* to recognize the new technology that allows the vein conduit used for coronary artery bypasses to be harvested using a minimally invasive approach. Currently, the open method of harvesting the veins is included in the coronary artery bypass procedures (33510-33536). This new technique represents a more complicated procedure requiring additional specialized training, and requires additional intra-operative time as compared to the open procurement of the vein conduits

33508

Code 33508 is an add on code that describes the incremental work of harvesting veins for coronary artery bypass using endoscopy. The presenters stated that the 10 minutes of intra-service time only includes the additional time related to the use of an endoscope to complete a saphenous vein harvest for a CABG. The RUC agreed with the specialty's approach of assigning .31 RVUs for this code, which corresponds to 10 minutes of time at the E/M intensity of 0.031. The RUC also compared this value to a number of other add on codessuch as 11001 *Debridement of extensive eczematous or infected skin; each additional 10% of the body surface (List separately in addition to code for primary procedure)*, with 10 minutes intra-service time and a work RVU = .30, and concluded that the .31 RVU recommendation seemed reasonable and placed the code in proper rank order.

The RUC recommends a work relative value of 0.31 for code 33508.

Practice Expense

The RUC assigned zero post service time, but the specialty requests to provide pre and intra-service time after GAO/OIG reports are issued regarding various aspects of the practice expense methodology and its implementation by CMS and also after consideration of ZZZ global definition by CMS. This procedure is only performed in the facility setting and the RUC recommends zero pre-servie clinical staff time.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
✚●33508	S1	**Endoscopy:** Surgical vascular endoscopy always includes diagnostic endoscopy Endoscopy surgical, including video-assisted harvest of vein(s) for coronary artery bypass procedure (List separately in addition to code for primary procedure) (Use 33508 in conjunction with code(s) 33510-33523, as appropriate) (For open procedure, use 35500)	ZZZ	0.31

CPT Code: 33508 **Global**: ZZZ **Recommended RVW**: 0.31

CPT Descriptor: Endoscopy, surgical, including video-assisted harvest of vein(s) for coronary artery bypass procedure (List separately in addition to code for primary procedure)
(Use 33508 in conjunction with code(s) 33510-33523 as appropriate)
(For open procedure, use 35500)

Survey Vignette (Typical Patient)

New code 3350X is meant to capture the difference in work between a CABG performed where the vein graph is harvested in an open fashion versus using an endoscope. The STS attempted to use a standard RUC survey and describe this in the vignette, asking for only the additional work for the new code. Very few surveys were returned because – we were told – that isolating use of an endoscope from the total procedure was too difficult (the CABG procedures have intraoperative times that range from 150 to 250+ minutes).

Because we wanted to determine what the difference in work was – we designed a simplified RUC survey (see attachment) to compare open vein harvest and endoscopic vein harvest. Surveyees were told that the vein harvest would be used for a CABG. The question posed to the surveyees was:

What is the relative skin-to-skin time for each of the two vein harvest approaches in your typical patient?	**OPEN Saphenous VEIN HARVEST**	**ENDOSCOPIC Saphenous VEIN HARVEST**
Procedure Skin-to-Skin time (incision to closure):	_____ **minutes**	_____ **minutes**

CLINICAL DESCRIPTION OF SERVICE:

Add-on work:

After the decision to perform a coronary artery bypass is made, the surgeon determines that the patient is a candidate for use of an endoscope to harvest the saphenous vein through review of past history and vascular studies. The surgeon must discuss the use of the endoscope as part of obtaining consent. In the operating room, the surgeon supervises the connection of the endoscope to the light source and the video camera. The surgeon confirms that the video camera is working properly, is in focus, and is oriented properly.

NOTE: The following description includes the work of harvesting the saphenous vein, however, only the use of the endoscope instead of utilizing an open harvest should be considered work assigned to this code. We cannot describe the use of the endoscope without describing the harvest procedure.

At operation, a small incision is made over the left saphenous vein at the level of the knee and the vein was identified. The endoscopic dissection system (trocar and camera) was introduced along the anterior surface of the vein. After dissecting the vein for several centimeters, the balloon trocar was introduced, the balloon inflated, and CO_2 insufflation begun at 15 torr. The saphenous vein was dissected towards the groin freeing it from surrounding soft tissue. The side branches were ligated. Once the thigh vein was completely dissected free the trocar and camera were removed and dissection initiated distally. The trocar was passed along the anterior surface of the vein for several centimeters, the port was introduced and the balloon inflated and CO_2 insufflation again instituted. The distal vein was dissected free of surrounding fatty tissue and side branches were isolated. The camera was removed and the dissection tip removed and replaced with bipolar scissors. The camera was reintroduced and the saphenous vein was carefully inspected. The side branches were ligated using the bipolar scissors beginning at the ankle and working proximally. Once the calf portion of the saphenous vein was free, the camera and the side port were removed from the knee incision and reinserted directed towards the groin. The camera was introduced and again the vein inspected and the side branches ligated using the bipolar scissors. The endoscopic equipment was then removed and small incisions made in the groin and ankle. The saphenous vein was ligated proximally and distally, the vein was divided and removed from the leg.

SURVEY DATA

Presenter(s): Sidney Levitsky, MD Keith Naunheim, MD Keith Horvath, MD
Specialty(s): Society of Thoracic Surgeons

Sample Size: 100 **Resp n:** 43 **Resp %:** %

Sample Type:

	Low	25th pctl	Median	75th pctl	High
Open Harvest Time	12	23	**35**	45	180
Endoscopic Harvest Time	30	45	**45**	70	240

Total Intra Service Time = 10 minutes (45 minutes – 35 minutes)

REFERENCE SERVICE(S): Codes with RUC data, total time less / equal to 15 minutes

CPT	Descriptor	2002 RVW	RUC Time
11101	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed (separate procedure); each separate/additional lesion (List separately in addition to code for primary procedure)	0.41	10
11201	Removal of skin tags, multiple fibrocutaneous tags, any area; each additional ten lesions (List separately in addition to code for primary procedure)	0.29	5
15351	Application of allograft, skin; each additional 100 sq cm (List separately in addition to code for primary procedure)	1.00	15
15401	Application of xenograft, skin; each additional 100 sq cm (List separately in addition to code for primary procedure)	1.00	15
17003	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions; second through 14	0.15	2
58611	Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)	1.45	13.5
64472	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)	1.29	15
93320	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete	0.38	15
93572	Intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; each additional vessel (List separately in addition	1.44	15

RELATIONSHIP OF CODES SURVEYED	Open	Endo
TIME ESTIMATES (MEDIAN)		
Total Time	35	45
INTENSITY/COMPLEXITY MEASURES (mean)		
Intra-service	2.65	4.17
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	2.28	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.05	2.41
Urgency of medical decision making	2.08	2.68
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	2.82	4.50
Physical effort required	2.55	4.00
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	2.90	3.08
Outcome depends on the skill and judgment of physician	3.23	4.18
Estimated risk of malpractice suit with poor outcome	2.67	3.00

ADDITIONAL RATIONALE

Reporting directions for the CABG procedure codes 33510-33523 specifically state that procurement of the saphenous vein graft is included in the description of the work. This new code 3350X describes only the additional work (time/intensity/complexity) related to the use of an endoscope to complete a saphenous vein harvest for a CABG. This add-on code – which itself is not a stand alone procedure – did not lend itself to a standard RUC survey as discussed in the "typical patient" section above. Our only available method to survey was to utilize a modified RUC survey to differentiate between an open vein harvest and an endoscopically harvested vein (see attached survey). Our survey results indicate a 10 minute difference, based on the responses of 43 cardiothoracic surgeons who reported performing a total of almost 4,700 open vein harvest procedures and 4,000 endoscopically harvested veins in the past 12 months. Additionally, the survey results show higher intensity/complexity values for all categories for the endoscopic harvest.

Although our survey was not standard, we have been able to show a difference in total time and a difference in intensity/complexity. Based on these data, the STS is recommending a value of 0.31 rvu's for this add-on code. This corresponds to 10 minutes of "evaluation and management intensity" at 0.031, which is an intensity assigned by CMS. Relative to other ZZZ-global codes that the RUC has approved (see list above), this recommendation appears reasonable.

FREQUENCY INFORMATION

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

New technology. No ability to code or possibly utilizing '-22' appended to the primary 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: 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: There are approximately 360,000 CABG procedures performed per year in the domestic United States. Of these approximately 80% (288,000) require the use of the saphenous vein for bypass. Approximately 25-40% of these procedures could utilize the endoscope, however, precise numbers are not predictable.

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: unknown

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

Only physicians trained to use the endoscope, but not limited to a few medical centers.

ATTACHMENT TO RUC SUMMARY FORM FOR 3350X (April 2002)

STS Survey to Compare Physician Work for Open versus Endoscopic Saphenous Vein Harvest *(for Coronary Bypass Surgery)*

Surgeon's Name (please print clearly): _____

Years Practicing Specialty: _____

Primary Geographic Practice Setting: ____Rural ____Suburban ____Urban

Primary Type of Practice:
____Solo Practice
____Single Specialty Group
____Multispecialty Group
____Medical School Faculty Practice Plan

QUESTION 1:

What is the relative skin-to-skin time for each of the two vein harvest approaches in your typical patient?	**OPEN Saphenous VEIN HARVEST**	**ENDOSCOPIC Saphenous VEIN HARVEST**
Procedure Skin-to-Skin time (incision to closure):	_____ **minutes**	_____ **minutes**

QUESTION 2:

For each of the two vein harvest approaches, rate the intensity for each component listed on a scale of 1 to 5, for each of the two vein harvest approaches in your typical patient.
(**Circle one: 1=low; 5=high**).

	OPEN Saphenous VEIN HARVEST	**ENDOSCOPIC Saphenous VEIN HARVEST**
INTRA-service complexity	1 2 3 4 5	1 2 3 4 5
Mental Effort and Judgment		
The number of possible diagnoses and/or the number of management options that must be considered	1 2 3 4 5	1 2 3 4 5
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained reviewed and analyzed	1 2 3 4 5	1 2 3 4 5
Urgency of medical decision making	1 2 3 4 5	1 2 3 4 5
Technical Skill/Physical Effort		
Technical skill required	1 2 3 4 5	1 2 3 4 5
Physical effort required	1 2 3 4 5	1 2 3 4 5
Psychological Stress		
The risk of significant complications, morbidity and/or mortality	1 2 3 4 5	1 2 3 4 5
Outcome depends on skill and judgment of physician	1 2 3 4 5	1 2 3 4 5
Estimated risk of malpractice suit with poor outcome	1 2 3 4 5	1 2 3 4 5

QUESTION 3:

For each of the two vein harvest approaches, indicate how many times you have performed each procedure in the past 12 months?	**OPEN Saphenous VEIN HARVEST**	**ENDOSCOPIC Saphenous VEIN HARVEST**
Procedure 12-month experience:	_____	_____

CPT Code: See Below
Specialty Society('s) STS

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

CPT Long Descriptor:

CPT	DESCRIPTION	GLOBAL
33508	Endoscopy, surgical, including video-assisted harvest of vein(s) for coronary artery bypass procedure	ZZZ

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. Also, after consideration of ZZZ global definition by CMS.

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. Also, after consideration of ZZZ global definition by CMS.

Post-service period clinical staff time: n/a

Supplies and equipment – postoperative office visits: n/a

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Open Iliac and Brachial Artery Exposure

Two new codes were developed to describe techniques involved in endovascular thoracic aortic aneurysm repair. The new CPT code 34833, *Open iliac artery exposure with creation of conduit for delivery of infrarenal aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral* includes the work of CPT code 34820, *Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral* (work RVU =9.75), plus the work involved in suturing a segment of large diameter synthetic conduit onto the iliac artery, and the work of subsequently terminating that conduit after completion of endograft deployment. The new CPT code 34834 is analogous to CPT code 34812, *Open femoral artery exposure for delivery of aortic endovascular prosthesis, by groin incision, unilateral* (work RVU= 6.75) and CPT code 34820.

34833

The RUC reviewed survey time data for the open iliac exposure and determined that the median survey value of 12.00 was appropriate when compared to the reference service 34820 (RVU=9.75). Thirty-three percent more intra-service time, plus 10 percent greater intra-service intensity readily justify the increment for the new code compared to the reference. Additionally, performance of an iliac conduit (34833) includes all the work of the reference service, CPT code 34820 (RVU=9.75), plus additional mobilization of the iliac artery, performance of an anastomosis of conduit to iliac artery, and termination of the conduit after it has been used for placement of the endograft. That means that the RVW of the new service would equal the entire work of the reference plus the additional work of conduit. Survey analysis demonstrated that the intra-service portion of the new service is 33% longer (100 min vs. 75 min) and 10% more complex than the reference. Pre-service time of new and reference services are essentially the same, but post-service time for the new procedure is 15 minutes longer. In sum, this readily accounts for the 2.25 RVU increment between established RVW of the reference service and the median survey value of the new service. The RUC agreed with the specialty societies' median work RVU and believed it was ranked appropriately with the reference service code 34820.

The RUC recommends a work relative value of 12.00 for 34833.

34834

The RUC reviewed survey time data for open brachial exposure and determined that the recommended RVU of 5.35 was appropriate when based on a comparison to key reference CPT code 34812, *Open femoral artery exposure for delivery of aortic endovascular prosthesis, by groin incision, unilateral* (work RVU =6.75). The society determined that when the pre- and the post-service work is subtracted from reference service code 34812 (work RVU=6.75), the intra-service work is approximately 3.75 RVUs. Using the survey data, the respondents indicated that the intensity in relation to the new services is 10 percent more than the reference service code 34812. In addition, survey respondents indicated that the amount of time required for the new procedure is about 33 percent less than that of the reference service. Considering these factors, when the intra-service work intensity for the RVUs is calculated, the recommended RVUs for the new service is about 2.76 RVUs. When the surveyed values for the pre- and post- service work is added to the intra-service work, recommended RVU is 5.35. An RVW of 5.35 is also justified by a building block IWPUT calculation. This value is less than the 25th percentile of survey responses.

Magnitude comparison to key reference service:

From a clinical perspective the new service, exposure of the brachial artery during endograft placement, is very similar to the key reference service CPT 34812, exposure of the femoral artery during endograft placement. The primary difference is that the brachial artery is smaller in caliber and therefore requires more painstaking dissection. In addition, the brachial artery is nearly surrounded by nerves, and extra care must be taken to avoid nerve injury during the dissection. This extra intensity is reflected in the intensity/complexity responses where intra-service intensity of the new service was rated as 4.21 compared with the key reference at 3.82.

The RUC reviewed the survey results and found that although the intensity of brachial exposure was rated 10% greater than that of femoral exposure, the survey respondents felt the intra-service time of new service was 15 minutes less than the reference, or 67% of the reference intra-time. The sum of pre- and post-service time was exactly equal for both, 105 minutes. Since this is a 0-day global, and since the pre- and post- service work in both services are similar, one may calculate the RVW of the new service based on intensity and time comparisons between new and reference services.

Reference service Intra-service work = 6.75 (RVW of reference) – 3.00 (pre + post work)
= 3.75 RVUs

Intra-service work of new service = intensity relationship (10% greater) x time relationship (33% less) x intra-service work of reference = 1.10 x 0.67 x 3.75 = 2.76 RVUs

Recommended RVW of new service = Pre + Post + Intra = 2.59 + 2.76 = 5.35

IWPUT Analysis of New Service Using Recommended RVW = 5.35

IWPUT Analysis				**Rec. RVW**
			34834	**5.35**
Pre-service:		**Time**	**Intensity**	(=time x intensity)
	Pre service	70	0.0224	**1.57**
Post-service:		**Time**	**Intensity**	
	Immediate post	17	0.0224	**0.38**
	Subsequent visits:	**Visit n**	**E/M RVU**	(=n x E/M RVU)
	ICU 99291	0.0	4.00	0.00
	99233	0.0	1.51	0.00
	99232	0.0	1.06	0.00
	99231	0.0	0.64	0.00
	Discharge 99238	0.5	1.28	0.64
Post-service total:				**1.02**
		Time	**IWPUT**	
Intra-service		30	**0.092**	**2.76**

The RUC recommends a work relative value of 5.35 for 34834.

Practice Expense

Both codes are typically performed in the facility setting and therefore have no practice expense inputs in the office setting. For codes 34833 and 34834 6 minutes of coordination of care was modified to the discharge day standard. The patient education booklet was also removed from the supply list. Attached to the recommendation are the details of the practice expense inputs.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•34833	AR1	Open iliac artery exposure with creation of conduit for delivery of infrarenal aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral (For bilateral procedure, use modifier '-50') (Do not report 34833 in addition to 34820)	000	12.00
•34834	AR2	Open brachial artery exposure to assist in the deployment of infrarenal aortic or iliac endovascular prosthesis, by arm incision, unilateral (For bilateral procedure, use modifier '-50')	000	5.35

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

Tracking AR1 April 2002

CPT Code: 34833 **Global**: 000 **Recommended RVW**: 12.00

CPT Descriptor: Open iliac artery exposure with creation of conduit for delivery of infrarenal aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral

(For bilateral procedure, use modifier '-50')

(Do not report 34833 in addition to 34820)

Survey Vignette (Typical Patient)

A 65-year-old female smoker with hypertension, COPD, and previous MI has a 7-cm. infrarenal aortic aneurysm. Her iliac arteries are very small in caliber and heavily calcified. Placement of an iliac conduit will be required to enable endovascular aortic aneurysm repair.

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:

Intra-service work of 34833 begins with skin incision. Access to the iliac artery is achieved via a transabdominal or retroperitoneal approach. All soft tissue, bowels, ureters, and veins are carefully mobilized as the iliac artery is approached. The artery is cleared for 5-6 cm, and vessel loops are passed around the vessel proximally and distally. Once adequate exposure is achieved and intravenous heparin anticoagulation administered, proximal and distal vascular clamps are applied. A longitudinal arteriotomy is made. The conduit (a large diameter tubular segment of synthetic bypass graft) is brought onto the field, tailored to appropriate size, and an anastomosis of conduit to iliac artery is sutured with fine polypropylene. The conduit is clamped and vascular clamps are removed from the iliac artery. The suture line is checked for hemostasis and additional sutures are applied as required.

Endovascular repair (separately reportable) is then undertaken with the prostheses introduced through the newly formed conduit.

Once endovascular repair is complete, closure of the conduit is achieved in one of two ways. The unattached distal end of the conduit may be sewn to the more distal external iliac artery, thereby leaving the conduit in place as a common to external iliac bypass graft. Alternatively, the conduit

can be transected close to the iliac artery and oversewn with polypropylene suture. Hemostasis is achieved. The wound is irrigated and closed in layers.

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital during the day of the procedure. 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
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.

SURVEY DATA

Presenter: Gary R. Seabrook, M.D.
Donna Mendes, M.D.
Robert Zwolak, M.D.

Specialty: American Association for Vascular Surgery

CPT: 34833

Sample Size: 150 **Resp n:** 32 **Resp %:** 21.3%

Sample Type:

	Low	25th pctl	Median	75th pctl	High
Survey RVW	9.75	11.00	12.00	15.00	25.00
Pre-Service			**75**		
Intra-Service	30	60	**100**	120	410
Immed Post-Svce			**27**		
Discharge		99238 x ½	**18**		

KEY REFERENCE SERVICE:

CPT	Descriptor	2002 RVW	Glob
34820	Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral	9.75	000

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE:

TIME ESTIMATES (MEDIAN)	Svy CPT 34833	Ref CPT 34820
Pre-service	75	80
Intra-service	100	75
Post-service	45	30
TOTAL TIME	*220*	*185*
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	3.88	3.73
Intra-service	4.21	3.82
Post-service	3.32	3.33
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3.88	3.70
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.97	3.82
Urgency of medical decision making	3.21	3.18
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	4.26	3.79
Physical effort required	4.18	3.79
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	4.21	3.88
Outcome depends on the skill and judgment of physician	4.38	4.00
Estimated risk of malpractice suit with poor outcome	3.82	3.67

ADDITIONAL RATIONALE

We recommend the median survey value of 12.00. This represents a 23% increment in RVW over the reference service RVW of 9.75. The increment is readily justified by 33% more intra-service time plus 10% greater intra-service intensity for the new code compared to reference. Additional justification for 12.00 is provided in an IWPUT analysis. Details are provided below.

Comparison with reference service:

Performance of an iliac conduit (34833) includes all the work of the reference service, CPT 34820 (iliac artery exposure), *plus* additional mobilization of the iliac artery, performance of an anastomosis of conduit to iliac artery, and termination of the conduit after it has been used for placement of the endograft. That means that the RVW of the new service = entire work of the reference *plus* the additional work of conduit. Survey analysis demonstrated that the intra-service portion of the new service is 33% longer (100 min vs. 75 min) *and* 10% more complex than the reference. Pre-service time of new and reference services are essentially the same, but post-service time for the new procedure is 15 minutes longer. Considered together this readily accounts for the 2.25 RVU increment between established RVW of the reference service and the median survey value of the new service.

IWPUT Analysis:

The following building block analysis reveals an IWPUT of 0.091, which we believe to be reasonable for vascular dissection and anastomosis of diseased iliac arteries deep in the pelvis.

IWPUT Analysis

			34833	**Rec. RVW 12.00**
Pre-service:		**Time**	**Intensity**	(=time x intensity)
	Pre service	75	0.0224	**1.68**
Post-service:		**Time**	**Intensity**	
	Immediate post	27	0.0224	**0.60**
	Subsequent visits:	**Visit n**	**E/M RVU**	(=n x E/M RVU)
	ICU 99291	0.0	4.00	0.00
	99233	0.0	1.51	0.00
	99232	0.0	1.06	0.00
	99231	0.0	0.64	0.00
	Discharge 99238	0.5	1.28	0.64
Post-service total:				**1.24**
		Time	**IWPUT**	
Intra-service		100	**0.091**	**9.08**

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 service that was previously reportable only with CPT 37799 unlisted vascular code

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: Vascular 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: Vascular Surgery **Frequency:** We estimate <500 per 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: Vascular Surgery **Frequency**: Estimate <450 per year

5. Do many physicians perform this service across the United States or is it limited to a few medical centers? No

6. Performed in Hospital: YES ASC: No Office: No

CPT: 34833 Iliac exposure with conduit
Specialty: AAVS

AMA/Specialty Society Update Process
RUC Summary of Recommendation
0-Day Global Out-Of-Office Direct Inputs [In-Office Not Applicable]

AAVS used a consensus panel approach to develop practice expense recommendations for code 34833. Our Government Relations Committee represents a diverse group of physicians who collaborate in describing what we believe to be typical clinical inputs.

Geographic Practice Setting %:

The panel members practice in all areas of the country. The group represented 67% urban, 24% suburban and 10% rural.

Type of Practice %:

The panel's composition is 66% academic and 34% private practice.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: Obtain all operative reports; obtain current labs; obtain pre-op cardiac evaluation; obtain cardiologist's current evaluation; review history; obtain current vital signs, meds, IV infusions; assess respiratory status; review microbiology reports; review x-rays; greet patient; provide pre-service education; obtain consent; prepare room; prepare equipment; position patient
Intra-Service Clinical Labor Activities: AAVS acknowledges that CMS does not reimburse for clinical staff time during the intra-service portion of 90-day global services. Thus, we have listed 'pending' for this section of the attached table. Nevertheless, the majority of AAVS members indicate that they bring their own clinical staff into the hospital primarily to provide specialty-related patient care and coordination of care that would not otherwise be provided by the hospital.
Post-Service Clinical Labor Activities - Office Visits Not Applicable for 0-day Global Service

	A	B	C	D	E	F	G	H	I	J	K	L
1	**Clinical Labor, Medical Supplies, and Procedure Equipment Practice Expense Data**									**CPT**	**34833**	**34833**
2										**Global**	**0-day**	**0-day**
3										**Number/Level of Post OV:**	**N/A**	**N/A**
4	**CLINICAL LABOR**						**Code**	**staff desc**		**Price**	**IN Off**	**OUT off**
5	**TOTAL TYPICAL TIME**						1130	RN/LPN/MA		$ 0.317	**0**	**25**
6	**PRE-service time**						1130	RN/LPN/MA		$ 0.317	**0**	**25**
7	**SERVICE time Coordination of Care**						1130	RN/LPN/MA		$ 0.317	**0**	**0**
8	**POST-service time**						1130	RN/LPN/MA		$ 0.317	**0**	**0**
9	**PRE-SERVICE**											
10	**BEGINS after procedure consult. (in off / out off)**										**Min**	**Min**
11	Complete pre-service diagnostic & referral forms (5/5)						1130	RN/LPN/MA		$ 0.317	**0**	**5**
12	Coord pre-proc services/review test/exam results (10/20)						1130	RN/LPN/MA		$ 0.317	**0**	**10**
13	Schedule space and equipment in facility (0/8)						1130	RN/LPN/MA		$ 0.317	**0**	**5**
14	OV before surgery/procedure - review test/exam results (0/0)						1130	RN/LPN/MA		$ 0.317	**0**	**0**
15	Provide pre-service education/obtain consent (10/20)						1130	RN/LPN/MA		$ 0.317	**0**	**5**
16	Follow-up phone calls & prescriptions (10/7)						1130	RN/LPN/MA		$ 0.317	**0**	**0**
17	**Other Pre-Service Activities (please specify):**											
18	none						1130	RN/LPN/MA		$ 0.317	**0**	**0**
19	**ENDS with admission to facility/office**											
20	**SERVICE PERIOD**											
21	**Starts with admission to facility/office**										**Min**	**Min**
22	Discharge Day						1130	RN/LPN/MA		$ 0.317	**0**	**6**
23	**Ends with discharge from facility/office**											
24	**POST-SERVICE**											
25	**Begins after discharge from facility/office**										**Min**	**Min**
26	**Postop OV total time (E/M standards)**	-211 (16)	-212 (27)	-213 (36)	-214 (53)	-215 (63)	1130	RN/LPN/MA		$ 0.317	**0**	**0**
38	**Other Activities (please specify):**											
39	Coordinate care for evaluation of endoleaks						1130	RN/LPN/MA		$ 0.317	**0**	**0**
40	**ENDS after 90 days from day of procedure.**											
41	**MEDICAL SUPPLIES**						**Code**	**Unit Size**	**Unit Cnt**	**Price**	**Out Off**	**Out Off**
42											**QTY**	**QTY**
43	**0-Day Global, no post-op supplies**										**N/A**	**N/A**
44												
45												
46												
47												
48												
49	**Add'l per visit supplies:**											
50	patient education booklet						11115	item	1	$ 0.920	**0**	**0**
51							**Code**	**Unit Size**	**Unit Cnt**	**Price**	**Out Off**	**Out Off**
52	**Postop incision care supplies:**										**QTY**	**QTY**
53											**N/A**	**N/A**
54												
55												
56												
57												
58												
59												
60	**PROCEDURE SPECIFIC EQUIPMENT**											
61											**N/A**	**N/A**
62												
63												

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

April 2002

CPT Code: 34834 **Global**: 000 **RUC Recommended RVW**: ~~5.76~~5.35

CPT Descriptor: Open brachial artery exposure to assist in the deployment of infrarenal aortic or iliac endovascular prosthesis, by arm incision, unilateral

(For bilateral procedure, use modifier '-50')

Survey Vignette (Typical Patient)

A 65-year-old female smoker with hypertension, COPD, and previous MI has a 7-cm. infrarenal aortic aneurysm. Her iliac arteries are tortuous. Exposure of the brachial artery is performed to insert a guide to enable endovascular aortic aneurysm repair.

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:

The intra-service work of 34834 begins with skin incision. Access to the brachial artery is achieved via an upper arm incision. All soft tissue, nerves and veins are carefully mobilized as the brachial artery is approached. The artery is cleared for 5-6 cm, and soft vessel loops are passed around the artery proximally and distally. Once adequate exposure is achieved and intravenous heparin anticoagulation administered, proximal and distal vascular clamps are applied/removed as required for subsequent introduction of wires, sheaths, and catheters.

The endovascular procedure is performed (separately reported)

Upon completion of endovascular procedure, vascular clamps are reapplied. The large hole in brachial artery is irrigated, edges trimmed as needed, and closed with fine polypropylene sutures. The suture line is checked for hemostasis and additional sutures are applied as required. The wound is irrigated and closed in layers.

Description of Post-Service Work:

Post-service work includes immediate postoperative care starting after skin closure plus all related subsequent in-hospital during the day of the procedure. 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
- Discharge preparation, communication with PCP, referring MD, rehab, PT, etc.

SURVEY DATA

Presenters: Gary R. Seabrook, M.D.
Donna Mendes, M.D.
Robert Zwolak, M.D.

Specialty: American Association for Vascular Surgery

CPT: 34834
Sample Size: 200 **Resp n:** 39 **Response** 19.5%
Sample Type:

	Low	25th pctl	Median	75th pctl	High
Survey RVW	5.00	6.00	**6.75**	7.00	11.00
Pre-Service			**70**		
Intra-Service	10	30	**30**	50	180
Immed Post-Svce			**17**		
Discharge		99238 x ½	**18**		

KEY REFERENCE SERVICE:

CPT	Descriptor	2002 RVW	Glob
34812	Open femoral artery exposure for delivery of aortic endovascular prosthesis, by groin incision, unilateral	**6.75**	000

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

TIME ESTIMATES (MEDIAN)	Svy CPT 34834	Ref CPT 34812
Pre-service	70	75
Intra-service	30	45
Post-service	35	30
TOTAL TIME	*135*	*150*

INTENSITY/COMPLEXITY MEASURES (mean)

TIME SEGMENTS		
Pre-service	3.28	3.10
Intra-service	3.44	3.18
Post-service	3.00	2.90
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3.46	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.38	3.11
Urgency of medical decision making	2.95	2.84
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	3.56	3.36
Physical effort required	3.03	3.13
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	3.74	3.46
Outcome depends on the skill and judgment of physician	3.90	3.46
Estimated risk of malpractice suit with poor outcome	3.72	3.23

ADDITIONAL RATIONALE

Based on a comparison to key reference CPT 34812 the new service has 33% less intra-service time but 10% more intra-service intensity. A mathematical extrapolation of this relationship leads us to recommend an RVW of 5.76. An RVW of 5.76 is also justified by building block IWPUT calculation. This value is < the 25th percentile of survey responses.

Magnitude comparison to key reference service:

From a clinical perspective the new service, exposure of the brachial artery during endograft placement, is very similar to the key reference service CPT 34812, exposure of the femoral artery during endograft placement. The primary difference is that the brachial artery is smaller in caliber and therefore requires more painstaking dissection. In addition, the brachial artery is nearly surrounded by nerves, and extra care must be taken to avoid nerve injury during the dissection. This extra intensity is reflected in the intensity/complexity responses where intra-service intensity of the new service was rated as 4.21 compared with the key reference at 3.82.

Although the intensity of brachial exposure was rated 10% greater than that of femoral exposure, the survey respondents felt the intra-service time of new service was 15 minutes less than the reference, or 67% of the reference intra-time. The sum of pre- and post-service time was exactly equal for both, 105 minutes. Since this is a 0-day global, and since there is 3 RVUs of pre + post service work in both services, one may calculate the RVW of the new service based on intensity and time comparisons between new and reference services.

Reference service Intra-service work = 6.75 (RVW of reference) – 3.00 (pre + post work)
= 3.75 RVUs

Intra-service work of new service = intensity relationship (10% greater) x time relationship (33% less) x intra-service work of reference = 1.10 x 0.67 x 3.75 = 2.76 RVUs

Recommended RVW of new service = Pre + Post + Intra = ~~3.00~~ 2.59+ 2.76 = 5.76

IWPUT Analysis of New Service Using Recommended RVW = 5.35

IWPUT Analysis				**Rec. RVW**
			34834	~~5.76~~ 5.35
Pre-service:		**Time**	**Intensity**	(=time x intensity)
	Pre service	70	0.0224	**2.02**
Post-service:		**Time**	**Intensity**	
	Immediate post	17	0.0224	**0.38**
	Subsequent visits:	**Visit n**	**E/M RVU**	(=n x E/M RVU)
	ICU 99291	0.0	4.00	0.00
	99233	0.0	1.51	0.00
	99232	0.0	1.06	0.00
	99231	0.0	0.64	0.00
	Discharge 99238	0.5	1.28	0.64
Post-service total:				**1.02**
		Time	**IWPUT**	
Intra-service		30	**~~0.091~~ 0.092**	**~~2.72~~ 2.76**

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 service that was previously reportable only with CPT 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:** We estimate <500 per 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: Vascular Surgery **Frequency:** Estimate <450 per year

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 U.S. in a limited number of medical centers.

6. Performed in Hospital: Yes ASC: No Office: No

CPT: 34834 Brachial artery exposure
Specialty: AAVS

AMA/Specialty Society Update Process
RUC Summary of Recommendation
0-Day Global Out-Of-Office Direct Inputs [In-Office Not Applicable]

AAVS used a consensus panel approach to develop practice expense recommendations for code 34834. Our Government Relations Committee represents a diverse group of physicians who collaborate in describing representative clinical inputs

Geographic Practice Setting %:

The panel members practice in all areas of the country. The group represented 67% urban, 24% suburban and 10% rural.

Type of Practice %:

The panel's composition is 66% academic and 34% private practice.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: Obtain all operative reports; obtain current labs; obtain pre-op cardiac evaluation; obtain cardiologist's current evaluation; review history; obtain current vital signs, meds, IV infusions; assess respiratory status; review microbiology reports; review x-rays; greet patient; provide pre-service education; obtain consent; prepare room; prepare equipment; position patient
Intra-Service Clinical Labor Activities: AAVS acknowledges that CMS does not reimburse for clinical staff time during the intra-service portion of 90-day global services. Thus, we have listed 'pending' for this section of the attached table. Nevertheless, the majority of AAVS members indicate that they bring their own clinical staff into the hospital primarily to provide specialty-related patient care and coordination of care that would not otherwise be provided by the hospital.
Post-Service Clinical Labor Activities - Office Visits Not Applicable for 0-day Global Service

	A	B	C	D	E	F	G	H	I	J	K	L
1	**Clinical Labor, Medical Supplies, and Procedure Equipment Practice Expense Data**									**CPT**	**34834**	**34834**
2										**Global**	**0-day**	**0-day**
3										**Number/Level of Post OV:**	**N/A**	**N/A**
4	**CLINICAL LABOR**						**Code**	**staff desc**		**Price**	**IN Off**	**OUT off**
5	**TOTAL TYPICAL TIME**						1130	RN/LPN/MA		$ 0.370	**0**	**25**
6	**PRE-service time**						1130	RN/LPN/MA		$ 0.370	**0**	**25**
7	**SERVICE time Coordination of Care**						1130	RN/LPN/MA		$ 0.370	**0**	**0**
8	**POST-service time**						1130	RN/LPN/MA		$ 0.370	**0**	**0**
9	**PRE-SERVICE**											
10	**BEGINS after procedure consult. (in off / out off)**										**Min**	**Min**
11	Complete pre-service diagnostic & referral forms (5/5)						1130	RN/LPN/MA		$ 0.370	**0**	**5**
12	Coord pre-proc services/review test/exam results (10/20)						1130	RN/LPN/MA		$ 0.370	**0**	**10**
13	Schedule space and equipment in facility (0/8)						1130	RN/LPN/MA		$ 0.370	**0**	**5**
14	OV before surgery/procedure - review test/exam results (0/0)						1130	RN/LPN/MA		$ 0.370	**0**	**0**
15	Provide pre-service education/discuss informed consent						1130	RN/LPN/MA		$ 0.370	**0**	**5**
16	Follow-up phone calls & prescriptions (10/7)						1130	RN/LPN/MA		$ 0.370	**0**	**0**
17	**Other Pre-Service Activities (please specify):**											
18	none						1130	RN/LPN/MA		$ 0.370	**0**	**0**
19	**ENDS with admission to facility/office**											
20	**SERVICE PERIOD**											
21	**Starts with admission to facility/office**										**Min**	**Min**
22	Discharge Day						1130	RN/LPN/MA		$ 0.370	**0**	**6**
23	**Ends with discharge from facility/office**											
24	**POST-SERVICE**											
25	**Begins after discharge from facility/office**										**Min**	**Min**
26	**Postop OV total time (E/M standards)**	-211 (16)	-212 (27)	-213 (36)	-214 (53)	-215 (63)	1130	RN/LPN/MA		$ 0.370	**0**	**0**
38	**Other Activities (please specify):**											
39							1130	RN/LPN/MA		$ 0.370	**0**	**0**
40	**ENDS after 90 days from day of procedure.**											
41	**MEDICAL SUPPLIES**						**Code**	**Unit Size**	**Unit Cnt**	**Price**	**Out Off**	**Out Off**
42											**QTY**	**QTY**
43											**N/A**	**N/A**
44												
45												
46												
47												
48												
49	**Add'l per visit supplies:**											
50	patient education booklet						11115	item	1	$ 0.920	**0**	**0**
51											**Out Off**	**Out Off**
52	**Postop incision care supplies:**						**Code**	**Unit Size**	**Unit Cnt**	**Price**	**QTY**	**QTY**
53											**N/A**	**N/A**
54												
55												
56												
57												
58												
59												
60	**PROCEDURE SPECIFIC EQUIPMENT**											
61											**N/A**	**N/A**
62												
63	*Note: NDC=national drug code. Price shown is AWP (average wholesale price per unit)											

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Endovascular Repair of Iliac Artery Aneurysm

The existing codes for direct iliac artery aneurysm repairs do not reflect the approach or techniques involved in endovascular graft placement. For these reasons, two new codes were created and one code was revised to describe endovascular graft placement techniques and supervision and interpretation of the graft placement.

34900

The RUC reviewed the survey data and determined that an RVW of 16.38, which is midway between the two commonly chosen reference services, CPT code 34800 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis* (RVW 20.75) and CPT code 34825 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic aneurysm; initial vessel* (RVW 12.00) represented the proper range value for these codes. The median physician time results are very closely aligned with 34800 while the intensity values fall between 34800 and 34825. Both key reference services are 90-day globals. While a mathematical method to simultaneously account for the bimodal key reference service choice and the specialty-based distribution of survey data was not possible; the RUC agreed that a midpoint between the RVW of 34800 (20.75) and the RVW of 34825 (12.00) is the most reasonable clinical magnitude estimate for this service. The mathematical mean of these two key reference services, an RVW of 16.38. This value is less than the 25th percentile of survey responses, and it is well justified by an IWPUT analysis.

The RUC recommends a work relative value of 16.38 for 34900.

75954

The RUC reviewed the recommendations from vascular surgery and interventional radiology. The RUC understands that a different physician (i.e. radiologist) almost always performs this service while the vascular surgeon performs the services described in 34900. Two reference services, CPT code 75952 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation* (RVU= 4.50) and CPT code 75953 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic aneurysm, radiological supervision and interpretation*, (RVU=1.36) were commonly chosen by survey respondents. The RUC agreed with the rationale that was also used for code 34900. The most reasonable clinical magnitude estimate for this service lies between the two reference services. The value of 2.93 is very close to the 25th percentile of survey responses of 2.56.

The RUC recommends a work relative value of 2.93 for 75954.

Practice Expense

The practice expense inputs were accepted as submitted. The practice expense inputs are attached to the recommendations.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Code 34900 represents a procedure to report introduction, positioning, and deployment of an endovascular graft for treatment of aneurysm, pseudoaneurysm, or dissection of the iliac artery (common, hypogastric, external). All balloon angioplasty and/or stent deployments within the target treatment zone for the endoprosthesis, either before or after endograft deployment, are included in the work of 34900 and are not separately reportable. Open femoral or iliac artery exposure (eg, 34812, 34820, introduction of guidewires and catheters (eg, 36200, 36215-36218), and extensive repair or replacement of an artery (eg 35206-35286) should be additionally reported. For fluoroscopic guidance in conjunction with endovascular iliac aneurysm repair, see codes 75954. Code 75954 includes angiography of the aorta and iliac arteries for diagnostic imaging prior to deployment of the endovascular device (including all routine components), fluoroscopic guidance in the delivery of the endovascular components, and intraprocedural arterial angiography to confirm appropriate position of the graft, detect endoleaks, and evaluate the status of the runoff vessels (eg, evaluation for dissection, stenosis, thrombosis, distal embolization, or iatrogenic injury). Other interventional procedures performed at the time of endovascular aortic aneurysm repair should be additionally reported (eg, transluminal angioplasty outside the aneurysm target zone, arterial embolization, intravascular ultrasound)				
▲34812		Open femoral artery exposure for delivery of aortic endovascular prosthesis, by groin incision, unilateral	000	6.75 (no change)
▲34825		Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic aneurysm; initial vessel	090	12.00 (no change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲34826		Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic aneurysm; each additional vessel (List separately in addition to code for primary procedure)	ZZZ	4.13 (no change)
•34900	AS1	Endovascular graft placement for repair of iliac artery (eg, aneurysm, pseudoaneurysm, arteriovenous malformation, trauma) (For radiological supervision and interpretation, use 75954) (For placement of extension prosthesis during endovascular iliac artery repair, use 34825) (For bilateral procedure, use modifier '–50')	090	16.38
•75954	AS2	Endovascular repair of iliac artery aneurysm, pseudoaneurysm, arteriovenous malformation, or trauma, radiological supervision and interpretation (For implantation of endovascular graft, see 34900)	XXX	2.93

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲75953		Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal aortic or iliac artery aneurysm, pseudoaneurysm, or dissection, radiological supervision and interpretation *(For implantation of endovascular extension prostheses, see 34825, 34826)*	XXX	1.36 (no change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

April 2002

CPT Code: 34900 **Global Period**: 090 **Recommended RVW**: 16.38

CPT Descriptor: Endovascular graft placement for repair of iliac artery (eg, aneurysm, pseudoaneurysm, arteriovenous malformation, trauma)

(For radiological supervision and interpretation use 75954)
(For placement of extension prosthesis during endovascular iliac artery repair, use 34825)
(For bilateral procedure, use modifier '-50')

Typical Patient (*Survey Vignette*): A 67-year-old male with coronary artery disease s/p MI plus chronic obstructive pulmonary disease has a 5 cm diameter iliac artery aneurysm. Imaging studies indicate the aneurysm is suitable for endovascular repair.

CLINICAL DESCRIPTION OF SERVICE:

Description of Pre-Service Work: Pre-service work begins after the decision to operate, from the day before the operation until the skin incision. This activity includes obtaining and reviewing the previous work-up, with special attention to cardiovascular risks. In addition, an extensive and detailed review of the preoperative imaging studies (some combination of CT scan, CT angiogram, CT with 3-D reconstructions, MRI, contrast angiograms) is required to determine the exact measurements of the aneurysm. This is necessary because an accurate preoperative choice of component diameters and lengths is one of the primary determinants of whether the endovascular procedure will be successful. In this regard endovascular repair differs substantially from open surgical iliac aneurysm repair. Although imaging studies are carefully reviewed prior to open repair, the painstaking diameter and length measurements are uniquely important for the endovascular procedure.

Informed consent is obtained from the patient following a discussion of surgical risks and benefits with patient and family. Other pre-service work includes changing into OR garb, supervising patient positioning, scrubbing, waiting for the anesthetic to become effective, prepping, and draping the patient. Unique to endovascular IAA repair is the pre-service work of ensuring that all required endovascular components and all potential backup components are immediately available.

Description of Intra-Service Work begins after achieving arterial exposure (e.g. 34812) and after initial catheter and guidewire placements (typically reported by codes 36200, 36245-8). These services are separately reportable and subject to multiple procedure payment reduction rules.

Intra-service work for 34900 begins as the endovascular device is loaded onto the guidewire and advanced into the patient. Depending on the device chosen, this may or may not be done through a large introducer sheath. The device is carefully manipulated through adjacent arteries towards the deployment target. It is carefully positioned such that the proximal edge lies in normal caliber vessel proximal to the beginning of the aneurysm. Position is confirmed exactly by fluoroscopy, often with injection of contrast. The device is then deployed under exacting fluoroscopic guidance. Fine adjustments in position are made during the deployment to assure accurate deployment. In some patients the mean arterial pressure is transiently reduced by the anesthesiologist to decrease the chance that pressure from flowing blood will push the endograft distally during deployment. After deployment the arterial pressure is normalized. The introducer portion of the main device is removed over the guidewire, leaving the endograft in position.

Some devices require balloon dilatation at the proximal and distal landing zones to help assure proper seating and hemostatic seal with the arterial wall. If this is the case, a large diameter balloon is advanced over the wire, and using fluoroscopic guidance the balloon is positioned and inflated. This same balloon may be repositioned to fully expand and seat the remainder of the endoprosthesis.

Once the complete endograft is in place, a pigtail catheter or multi-sidehole catheter is repositioned over one of the guidewire, and placed just above the proximal endograft for a final angiographic evaluation. If the graft is in good position and free of endoleaks, the catheters and guidewires are removed.

Closure of the arteriotomy(s) and arterial exposure site(s) is included in the work of the exposure codes.

Post-service work begins after skin closure. Tasks include apply dressings, transfer patient to stretcher, accompany patient to recovery area, write orders, dictate operative note, communicate with the patient's family, communicate with referring and consulting physicians, and participate with the anesthesiologist in the recovery area to ensure smooth emergence from anesthesia. Depending on the preexisting comorbidities and operative course the patient may require admission to the intensive care unit. Results of the procedure are discussed with the patient once he or she is fully awake. The patient is transferred to the acute care ward when criteria are met. The physician makes daily visits, takes interval history, performs physical exam, makes assessment and plan, writes orders & notes, communicates with patient, family, nurses, and other care givers. Discharge day management includes communicating with all support services such as visiting nurse, meals on wheels, etc., communicating with referring physician, providing activity advice and warnings to patient and family, and arranging office follow-up for wound checks, suture/staple removal, etc. The post-service work of 34900 includes all in-hospital and post-discharge care related to the endovascular iliac repair for 90 days following the procedure.

Not included in this Procedure (Separately reportable using component coding and multiple procedure payment reduction rules)

- Open femoral, iliac or brachial artery exposure (code 34812, 34820, 34834),
- Catheter placement (codes 36200, or 36245-36248),
- Fluoroscopic guidance of device and catheters (code 75954),
- Angiography and other imaging required for the procedure, including imaging for "mapping" and detection of endoleaks (code 75954), and IVUS if required (code 37250, 37251, 75945, 75946)
- Placement of extensions or cuffs (codes 34825, 34826, and 75953),
- Removal of guidewires and catheters (included in initial 36200 or 36245-8),
- Closure of arteriotomy and application of sterile dressing (included in codes 34812, 34820, 34834)

SURVEY DATA

Presenters: Gary Seabrook, M.D.
Donna Mendes, M.D.
Robert Vogelzang, M.D.
Bibb Allen Jr., M.D.

Specialty(s): American Association for Vascular Surgery
Society for Cardiovascular and Interventional Radiology
American College of Radiology

CPT: 34900
Sample Size: 200 **Resp n:** 51 **Resp %:** 25%
Sample Type:

	Low	25th pctl	Median	75th pctl	High
Survey RVW	12.00	18.00	**19.00**	20.75	30.00
Pre-Service			**105**		
Intra-Service	60	90	**120**	150	210

Post-Service	**Total Min**	**CPT code / # of visits**
Day of Surgery:		
Immediate Same Day	**30**	
Other Same Day	**19**	99231
After Day of Surgery:		
Critical Care	**0**	
Other Hospital	**0**	
Dischg Day Mgmt	**36**	99238
Office Visits	**38**	99213x1 99212x1

KEY REFERENCE SERVICES:

CPT	Descriptor	2002 RVW	Glob
34800	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis	20.75	90
34825	Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic aneurysm; initial vessel	12.00	90

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE:

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 34900	Ref CPT 34800	Ref CPT 34825
Pre-service	105	130	80
Intra-service	120	120	60
Same Day Immediate Post-service	30	40	30
Same Day Other Post-service	19	49	49
Post Total critical care (not same day)	0		
Post Total other hospital visit (not same day)	0		
Discharge management	36	36	36
Total office visit	38	38	38
TOTAL TIME	*348*	*413*	*293*

INTENSITY/COMPLEXITY MEASURES (mean)

TIME SEGMENTS			
Pre-service	4.03	4.36	3.90
Intra-service	4.09	4.48	3.80
Post-service	3.44	3.64	3.20
MENTAL EFFORT AND JUDGMENT			
The number of possible diagnosis and/or the number of management options that must be considered	4.09	4.29	3.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.29	4.35	4.10
Urgency of medical decision making	3.47	3.50	3.70
TECHNICAL SKILL/PHYSICAL EFFORT			
Technical skill required	4.35	4.47	3.60
Physical effort required	3.53	3.62	3.50
PSYCHOLOGICAL STRESS			
The risk of significant complications, morbidity and/or mortality	4.26	4.41	3.70
Outcome depends on the skill and judgment of physician	4.47	4.50	4.00
Estimated risk of malpractice suit with poor outcome	3.94	3.97	3.90

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

We recommend an RVW midway between the two commonly chosen reference services, CPT 34800 (RVW 20.75) and CPT 34825 (RVW 12.00) = 16.38. This value is < the 25th percentile of survey responses, and it is well justified by an IWPUT analysis.

The survey data for this service was challenging to analyze because it represented a bimodal distribution between a larger number of respondents who felt CPT 34800 (Endovascular AAA repair) was the best reference service, vs. a smaller number who felt CPT 34825 (Placement of extension prosthesis) was best reference. For the most part, those who chose 34800 felt RVW of new service should be < RVW of 34800 while those who chose 34825 felt RVW of new service should be > 34825. The median physician time results are very closely aligned with 34800 while the intensity values fall between 34800 and 34825. Both key reference services are 90-day globals.

The data analysis was not straightforward for another reason. A large number of surgeons submitted responses compared to radiologists and interventional radiologists. Since this is a new service we have no way to predict the proportion of these that will eventually be performed by physicians from each specialty. It is therefore impossible to gauge how the specialty-based variations in survey responses should be weighted in calculation of the final RVW.

During an extended conference call including representatives from AAVS, SCVIR and ACR, we agreed that there is no reasonable mathematical method to simultaneously account for the bimodal key reference service choice and the specialty-based distribution of survey data. We agreed that the most reasonable clinical magnitude estimate for this service lies midway between the RVW of 34800 (20.75) and the RVW of 34825 (12.00). We recommend the mathematical mean of these two key reference services, an RVW of 16.38.

Additional Rationale - IWPUT Calculation

Reverse Building Block to calculate IWPUT based on Recommended RVW of 16.38 results in a reasonable IWPUT of 0.086 for this service.

IWPUT Analysis

			34900	Rec. RVW 16.38
Pre-service:		**Time**	**Intensity**	(=time x intensity)
	Pre service	105	0.0224	**2.35**
Post-service:		**Time**	**Intensity**	
	Immediate post	30	0.0224	**0.67**
	Subsequent visits:	**Visit n**	**E/M RVU**	(=n x E/M RVU)
	ICU 99291	0.0	4.00	0.00
	99233	0.0	1.51	0.00
	99232	0.0	1.06	0.00
	99231	1.0	0.64	0.64
	Discharge 99238	1.0	1.28	1.28
	99215	0.0	1.73	0.00
	99214	0.0	1.08	0.00
	99213	1.0	0.65	0.65
	99212	1.0	0.43	0.43
	99211	0.0	0.17	0.00
Post-service total:				**3.67**
		Time	**IWPUT**	
Intra-service		120	**0.086**	**10.36**

Additional Rationale - Description of Typical "Total Package" Coding Example

At prior RUC meetings questions have arisen regarding the "total package" of codes used to describe procedures reported with more than one CPT code. This section is included in anticipation of that question. For a typical iliac artery aneurysm repaired using current endovascular techniques, the ipsilateral femoral artery would be exposed using open surgical techniques (CPT 34812). A guidewire would be inserted from that exposure into the aorta, and a second guidewire would be inserted percutaneously through the opposite groin and advanced into the aorta. This contralateral wire serves to protect the lumen and maintain access to the contralateral iliac artery in case it is compressed, dissected, or injured during manipulation of devices on the ipsilateral side. Advancing catheters into the aorta from both sides is reported as CPT 32600-50. Deployment of the iliac endograft is reported as CPT 34900. The single S&I for all this work, including roadmapping arteriogram, is 75954.

Medicare multiple procedure payment reduction rules indicate full payment for the primary operation and 50% for others. XXX globals such as S&Is are exempt from multiple procedure rules. Thus the total RVW for the 90-day global procedure described herein, assuming our proposed RVWs, would be:

359X1 endo repair iliac artery (proposed RVW)	16.38
34812 open femoral exposure 6.75 x ½ (established RVW)	3.38
36200-50 catheter in aorta, bilateral 4.51rvus x ½ (established RVW)	2.26
75954 endo repair iliac artery S&I (proposed)	2.93
Total Iliac Endovascular Package RVW:	**24.95**

For comparison, the current RVW for an analogous endovascular repair of an abdominal aortic aneurysm, using all currently established MD Work RVUs is:

34802 Endo repair infrarenal AAA modular bifurcated prosthesis	23.00
34812 open femoral exposure 6.75 x ½	3.38
36200-50 catheter in aorta, bilateral 4.51rvus x ½	2.26
75952 endo repair iliac artery S&I	4.50
Total Aortic Endovascular Package RVW:	**33.14**

FREQUENCY INFORMATION

How was this service previously reported? 37799

How often do physicians in your specialty perform this service?
SVS, SCVIR & ACR Sometimes

Estimate the number of times this service might be provided nationally in a one-year period?
Specialty: SVS, SCVIR & ACR each: National Frequency: 500 Medicare Frequency: 400

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

Performed in Hospitals: Yes **ASC:** No **Office:** No

CPT: 34900 Endovascular graft placement iliac artery
Specialty: AAVS, SCVIR, ACR

AMA/Specialty Society Update Process
RUC Summary of Recommendation
Out-Of-Office Direct Inputs [In-Office Not Applicable]

Our combined specialties used a consensus panel approach to develop practice expense recommendations for code 34900. Recommendations were finalized via email negotiations.

Geographic Practice Setting %:

The panel members practice in all areas of the country. The group represented 67% urban, 24% suburban and 10% rural.

Type of Practice %:

The panel's composition is 66% academic and 34% private practice.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: Obtain all operative reports; obtain current labs; obtain pre-op cardiac evaluation; obtain cardiologist's current evaluation; review history; obtain current vital signs, meds, IV infusions; assess respiratory status; review microbiology reports; review x-rays; greet patient; provide pre-service education; review details of informed consent; prepare room; prepare equipment; position patient
Intra-Service Clinical Labor Activities: Coordination of Care
Post-Service Clinical Labor Activities - Office Visits Greet patient - escort to room; provide gowning; interval history/vital signs; assemble lab reports; assist physician during exam; assist with dressing, wound care, suture removal; prepare prescriptions; education/counseling; clean room, check supplies; coordinate out-patient care; calls with patient between office visits; coordinate visiting nurse/physical therapy. In addition to the typical clinical staff activities for E/M services described above, additional time is needed for coordination of care with the imaging services to arrange evaluation for endoleaks between office visits (1 phone call, 5 minutes). This time is listed under "Other Activities."

	A	B	C	D	E	F	G	H	I	J	K	L
1	**Clinical Labor, Medical Supplies, and Procedure Equipment Practice Expense Data**									**CPT**	**34900**	**34900**
2										**Global**	**090**	**090**
3								**Number/Level of Post OV:**			**N/A**	**99213x1 99212x1**
4	**CLINICAL LABOR**						**Code**	**staff desc**		**Price**	**IN Off**	**OUT off**
5	**TOTAL TYPICAL TIME**						1130	RN/LPN/MA		$ 0.370	**0**	**140**
6	**PRE-service time**						1130	RN/LPN/MA		$ 0.370	**0**	**60**
7	**SERVICE time Coordination of Care**						1130	RN/LPN/MA		$ 0.370	**0**	**12**
8	**POST-service time**						1130	RN/LPN/MA		$ 0 370	**0**	**68**
9	**PRE-SERVICE**											
10	**BEGINS after procedure consult (in off / out off)**										**Min**	**Min**
11	Complete pre-service diagnostic & referral forms (5/5)						1130	RN/LPN/MA		$ 0.370	**0**	**5**
12	Coord pre-proc services/review test/exam results (10/20)						1130	RN/LPN/MA		$ 0.370	**0**	**20**
13	Schedule space and equipment in facility (0/8)						1130	RN/LPN/MA		$ 0.370	**0**	**8**
14	OV before surgery/procedure - review test/exam results (0/0)						1130	RN/LPN/MA		$ 0.370	**0**	**0**
15	Provide pre-service education/obtain consent (10/20)						1130	RN/LPN/MA		$ 0.370	**0**	**20**
16	Follow-up phone calls & prescriptions (10/7)						1130	RN/LPN/MA		$ 0.370	**0**	**7**
17	**Other Pre-Service Activities (please specify):**											
18	none						1130	RN/LPN/MA		$ 0.370	**0**	**0**
19	**ENDS with admission to facility/office**											
20	**SERVICE PERIOD**											
21	**Starts with admission to facility/office**										**Min**	**Min**
22	Discharge Day						1130	RN/LPN/MA		$ 0.370	**0**	**12**
23	**Ends with discharge from facility/office**											
24	**POST-SERVICE**											
25	**Begins after discharge from facility/office**										**Min**	**Min**
26	**Postop OV total time (E/M standards)**	-211 (16)	-212 (27)	-213 (36)	-214 (53)	-215 (63)	1130	RN/LPN/MA		$ 0.370	**0**	**63**
38	**Other Activities (please specify):**											
39	Coordinate care for evaluation of endoleaks						1130	RN/LPN/MA		$ 0.370	**0**	**5**
40	**ENDS after 90 days from day of procedure.**											
41	**MEDICAL SUPPLIES**						**Code**	**Unit Size**	**Unit Cnt**	**Price**	**Out Off**	**Out Off**
42											**QTY**	**QTY**
43	**PEAC Minimum visit package (multi-specialty):**						**PEAC**	**PKG**	**1**	**$ 1.310**	**0**	**2**
44	exam table paper (7 ft)						11111	foot	1	$ 0.015		
45	gloves, non-sterile (2 pair)						11302	pair	1	$ 0.120		
46	patient gown, disposable						11107	item	1	$ 0.570		
47	pillow case, disposable						11112	item	1	$ 0.320		
48	thermometer probe cover, disposable						11509	item	1	$ 0 069		
49	**Add'l per visit supplies:**									-		
50	patient education booklet						11115	item	1	$ 0.920	**0**	**0**
51											**Out Off**	**Out Off**
52	**Postop incision care supplies:**						**Code**	**Unit Size**	**Unit Cnt**	**Price**	**QTY**	**QTY**
53	**PEAC Post-op Incisional Care Kit**										**0**	**1**
54	Gloves, sterile						14005	1 pair			**0**	**1**
55	Swab, alcohol						31101	2 item			**0**	**2**
56	Steri-strips						31513	2 packs			**0**	**2**
57	Tape 12 inches						31514	2 increments			**0**	**2**
58	Staple remover kit						31702	1 item			**0**	**1**
59	Betadine						52301	10 ml			**0**	**2**
60	Gauze, sterile 4x4						31505	2 items			**0**	**2**
61	Tincture benzoin swab						52308	1 item			**0**	**1**
62	**PROCEDURE SPECIFIC EQUIPMENT**											
63	Power Table						E11003	1		$ 6,939	**0**	**1**
64	Light source						E13122	1		$ 1,700	**0**	**0**
65												

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

April 2002

CPT Code: 75954 **Global Period:** XXX **Recommended RVW:** 2.9

CPT Descriptor: Endovascular graft placement for repair of iliac artery (e.g. aneurysm, pseudoaneurysm, arteriovenous malformation, trauma) radiological supervision and interpretation

(For implantation of endovascular graft see 34900)

Typical Patient (*Survey Vignette*): A 67-year-old male with coronary artery disease s/p MI plus chronic obstructive pulmonary disease has a 5 cm diameter iliac artery aneurysm. Imaging studies indicate the aneurysm is suitable for endovascular repair.

CLINICAL DESCRIPTION OF SERVICE

Pre-service work includes:
- Donning lead apparel
- Supervision of patient positioning for proper fluoroscopy function
- Supervision of selection of equipment (check fluoro function, ensure patient data is correct, select imaging technique, etc.)
- Supervision of the set-up up x-ray equipment and organizing the technologic personnel for appropriate imaging during the procedure

Intra-service work includes:
- Angiographic "road-mapping" of iliac anatomy
- Fluoroscopic guidance of guidewires, catheters, and endovascular prosthesis
- Fluoroscopic confirmation of appropriate placement of prosthesis, with or without contrast.
- Fluoroscopic guidance of intra-prosthesis balloon dilatation, if necessary
- Supervision and interpretation of post-deployment aortogram for graft position, patency of appropriate branches (e.g. hypogastrics), presence or absence of endoleaks
- Interpretation of films and fluoroscopic imaging.
- Balloon dilatation and/or intra-device stenting to ensure proper seating, to fully open the graft, and/or to treat endoleak (if present)

Post-service work:
- Dictation of permanent report
- Communication with referring and consulting physicians

Not included in this Procedure (Separately Reportable)
- Deployment of endovascular prosthesis, extensions, S&I for extensions, occlusion device
- Open artery exposure (codes 34812, 34820, 34834)
- Catheter placement (codes 36200-36245)
- Closure of arteriotomy and application of sterile dressing (included in codes 34812, 34820, 34834)
- IVUS, if performed

SURVEY DATA

Presenters: Gary Seabrook, M.D.
Donna Mendes, M.D.
Robert Vogelzang, M.D.
Bibb Allen Jr., M.D.

Specialty(s): American Association for Vascular Surgery
Society for Cardiovascular and Interventional Radiology
American College of Radiology

CPT: 75954

Sample Size: 200 **Resp n:** 43 **Resp %:** 21.5%

Sample Type:

	Low	25th pctl	Median	75th pctl	High
Survey RVW	1.00	2.56	**4.00**	4.50	19.50
Pre-Service			**20**		
Intra-Service	20	30	**45**	60	150
Post-Service			**20**		

KEY REFERENCE SERVICE:

CPT	Descriptor	2002 RVW	Glob
75952-26	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation	4.50	XXX

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE:

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 75954	Ref CPT 75952-26
Pre-service	20	20
Intra-service	45	60
Post-service	20	15
TOTAL TIME	*85*	*95*

INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	3.40	3.72
Intra-service	4.04	4.32
Post-service	3.08	3.12
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3.68	3.88
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.64	3.68
Urgency of medical decision making	3.44	3.52
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	4.00	4.12
Physical effort required	3.24	3.36
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	4.04	4.24
Outcome depends on the skill and judgment of physician	4.32	4.52
Estimated risk of malpractice suit with poor outcome	3.92	4.00

ADDITIONAL RATIONALE

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

We recommend an RVW midway between the two commonly chosen reference services, CPT 75952 (RVW 4.50) and CPT 75953 (RVW 1.36) = 2.93. This value is just above the 25th percentile of survey responses, and the rationale is identical to that used for the companion code 34900.

Unlike many of the other radiological S&I codes, 75954 includes all routine supervision and interpretation of the endovascular iliac graft placement procedure with the only exception being that 75953 is added if an extension prosthesis is required. This more inclusive approach makes 75954 very similar in concept to the inclusive S&I for endovascular aortic aneurysm repair CPT 75952. In fact, 75952 (RVW 4.50) was the reference service chosen most often by respondents. In general, however, those who chose 75952 felt that the new code deserved an RVW less than the reference. Consistent with that relationship they estimated an intra-service time 15 minutes (25%) less than 75952.

A second group of respondents chose CPT 75953 (S&I for placement of extension prosthesis) as the key reference service. 75953 has an RVW of 1.36. Almost everyone who chose 75953 as reference felt the RVW of the new service should be greater than that of 75953.

The data analysis was not straightforward for another reason. A relatively large number of surgeons submitted responses compared to radiologists and interventional radiologists. Since this is a new service we have no way to predict the proportion of these that will eventually be performed by physicians from each specialty. It is impossible, therefore, to gauge how the specialty-based variation in survey number should be analyzed in calculation of the final RVW.

During a conference call including representatives from AAVS, SCVIR and ACR, we agreed that there is no reasonable mathematical method to simultaneously account for the bimodal reference service choice and the specialty-based distribution of survey submission. This is the same issue encountered with the companion code 34900, and we decided to use identical rationale in reaching a recommendation. We agreed that the most reasonable clinical magnitude estimate for this service lies midway between the RVW of 75952 (4.50) and the RVW of 75953 (1.36). We recommend the mathematical mean of these two key reference services, 2.93. This value falls very close to the 25th percentile survey response of 2.56.

Additional Rationale - Description of Typical "Total Package" Coding Example

At prior RUC meetings questions have arisen regarding the "total package" of codes used to describe procedures reported with more than one CPT code. This section is included in anticipation of that question. For a typical iliac artery aneurysm repaired using current endovascular techniques, the ipsilateral femoral artery would be exposed using open surgical techniques (CPT 34812). A guidewire would be inserted from that exposure into the aorta, and a second guidewire would be inserted percutaneously through the opposite groin and advanced into the aorta. This contralateral wire serves to protect the lumen and maintain access to the contralateral iliac artery in case it is compressed, dissected, or injured during manipulation of devices on the ipsilateral side. Advancing catheters into the aorta from both sides is reported as CPT 32600-50. Deployment of the iliac endograft is reported as CPT 34900. The single S&I for all this work, including roadmapping arteriogram, is 75954.

Medicare multiple procedure payment reduction rules indicate full payment for the primary operation and 50% for others. XXX globals such as S&Is are exempt from multiple procedure rules. Thus the total RVW for the 90-day global procedure described herein, assuming our proposed RVWs, would be:

34900 endo repair iliac artery (proposed RVW)	16.38
34812 open femoral exposure 6.75 x ½ (established RVW)	3.38
36200-50 catheter in aorta, bilateral 4.51rvus x ½ (established RVW)	2.26
75954 endo repair iliac artery S&I (proposed)	2.93
Total Iliac Endovascular Package RVW:	**24.95**

For comparison, the current RVW for a typical endovascular repair of an abdominal aortic aneurysm, using currently established MD Work RVUs is:

34802 Endo repair infrarenal AAA modular bifurcated prosthesis	23.00
34812 open femoral exposure 6.75 x ½	3.38
36200-50 catheter in aorta, bilateral 4.51rvus x ½	2.26
75952 endo repair iliac artery S&I	4.50
Total Aortic Endovascular Package RVW:	**33.14**

FREQUENCY INFORMATION

How was this service previously reported? This is an entirely new code representing a new service. If these services were reported previously they may have been included in the surgical coding or as some combination of 75625, 75960, 75962, or 76499.

How often do physicians in your specialty perform this service?
Specialty: AAVS, SCVIR & ACR: Sometimes

Estimate the number of times this service might be provided nationally in one-year?
Specialty: AAVS, SCVIR, ACR each: National Frequency: 500, Medicare Frequency: 400

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

Performed in Hospital: Yes **ASC:** No **Office:** No

CPT: 75954 Endovascular repair iliac aneurysm
Specialty: AAVS, SCVIR, ACR

AMA/Specialty Society Update Process
RUC Summary of Recommendation
XXX Global Out-Of-Office Direct Inputs [In-Office Not Applicable]

AAVS, SCVIR and ACR used a consensus panel approach to develop practice expense recommendations for code 75954. Recommendations were finalized via email negotiations.

Geographic Practice Setting %:

The panel members practice in all areas of the country. The group represented 67% urban, 24% suburban and 10% rural.

Type of Practice %:

The panel's composition is 66% academic and 34% private practice.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: XXX Global S&I out-of-office = 0 Clinical Labor
Intra-Service Clinical Labor Activities: XXX Global S&I out-of-office = 0 Clinical Labor
Post-Service Clinical Labor Activities - Office Visits Not Applicable for XXX Global Service

	A	B	C	D	E	F	G	H	I	J	K	L
1	**Clinical Labor, Medical Supplies, and Procedure Equipment Practice Expense Data**									**CPT**	**75954**	**75954**
2										**Global**	**XXX**	**XXX**
3										**Number/Level of Post OV:**	**N/A**	**N/A**
4	**CLINICAL LABOR**						**Code**	**staff desc**		**Price**	**IN Off**	**OUT off**
5	**TOTAL TYPICAL TIME**						1130	RN/LPN/MA		$ 0.317	**0**	**0**
6	**PRE-service time**						1130	RN/LPN/MA		$ 0.317	**0**	**0**
7	**SERVICE time Coordination of Care**						1130	RN/LPN/MA		$ 0.317	**0**	**0**
8	**POST-service time**						1130	RN/LPN/MA		$ 0.317	**0**	**0**
9	**PRE-SERVICE**											
10	**BEGINS after procedure consult. (in off / out off)**										**Min**	**Min**
11	Complete pre-service diagnostic & referral forms (5/5)						1130	RN/LPN/MA		$ 0.317	**0**	**0**
12	Coord pre-proc services/review test/exam results (10/20)						1130	RN/LPN/MA		$ 0.317	**0**	**0**
13	Schedule space and equipment in facility (0/8)						1130	RN/LPN/MA		$ 0.317	**0**	**0**
14	OV before surgery/procedure - review test/exam results (0/0)						1130	RN/LPN/MA		$ 0.317	**0**	**0**
15	Provide pre-service education/obtain consent (10/20)						1130	RN/LPN/MA		$ 0.317	**0**	**0**
16	Follow-up phone calls & prescriptions (10/7)						1130	RN/LPN/MA		$ 0.317	**0**	**0**
17	**Other Pre-Service Activities (please specify):**											
18	none						1130	RN/LPN/MA		$ 0.317	**0**	**0**
19	**ENDS with admission to facility/office**											
20	**SERVICE PERIOD**											
21	**Starts with admission to facility/office**										**Min**	**Min**
22	Coordination of care						1130	RN/LPN/MA		$ 0.317	**0**	**0**
23	**Ends with discharge from facility/office**											
24	**POST-SERVICE**											
25	**Begins after discharge from facility/office**										**Min**	**Min**
26	**Postop OV total time (E/M standards)**	-211 (16)	-212 (27)	-213 (36)	-214 (53)	-215 (63)	1130	RN/LPN/MA		$ 0.317	**0**	**0**
38	**Other Activities (please specify):**											
39	Coordinate care for evaluation of endoleaks						1130	RN/LPN/MA		$ 0.317	**0**	**0**
40	**ENDS after 90 days from day of procedure.**											
41	**MEDICAL SUPPLIES**						**Code**	**Unit Size**	**Unit Cnt**	**Price**	**Out Off**	**Out Off**
42											**QTY**	**QTY**
43											**none**	**none**
44												
45												
46												
47												
48												
49												
50												
51												
52												
53												
54												
55												
56												
57												
58												
59												
60	**PROCEDURE SPECIFIC EQUIPMENT**											
61											**none**	**none**
62												
63	*Note: NDC=national drug code. Price shown is AWP (average wholesale price per unit)											

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Harvest of Femoropopliteal Vein Segment

One new code was created for the harvest of one segment of the femoropopliteal vein, for use as a conduit during vascular reconstruction. Although CPT created three new codes for the harvest of distant site for use as a bypass conduit (35500, 35682, and 35683), none of these describes the anatomical site or encompasses the physician work involved in harvesting the femoraopopliteal vein.

35572

The RUC determined that specialty society recommended a value based on the inclusion of pre- and post- service work, but CMS has not yet approved the addition of pre- and post- service work in high level ZZZ codes. Therefore, the RUC developed a recommendation by comparing the specialty recommendation of 7.20 work RVUs for CPT code 35572 to other vein harvest procedures, such as:

- 35500 Harvest of the upper extremity vein, one segment, for lower extremity or coronary artery bypass procedure (List separately in addition to cod for primary procedure) (6.45 RVU) intra-service time of 60 minutes

- 35682 Bypass graft; autogenous composite, two segments of veins from two locations (List separately in addition to code for primary procedure) (7.20 RVU) intra-service time 60 minutes

- 35683 Bypass graft; autogenous composite, three or more segments of vein from two or more locations (List separately in addition to code for primary procedure) (8.50 RVU) intra service time of 90 minutes.

The RUC examined the code as a ZZZ global period with no pre-service or post-service time and determined that the intensity of the deep vein harvest procedure for the lower extremity is greater as compared to the intensity for the superficial vein harvest in the upper extremity. In order to maintain rank order, the code should be valued above CPT code 35500 (work RVU = 6.45). The RUC, however, believed that the code should be valued below the more time consuming bypass graft codes 35682 (work RVU =7.20), and 35683 (work RVU =8.50). The RUC determined that the value of 6.82 places the code in appropriate rank order with the above reference service codes.

The RUC recommends a work relative value of 6.82 for code 35572.

Practice Expense

As this is a code with a ZZZ global period, there are no practice expense inputs.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Procurement of the saphenous vein graft is included in the description of the work for 35501-35587 and should not be reported as a separate service or co-surgery. To report harvesting of an upper extremity vein, use 35500 in addition to the bypass procedure. To report harvesting of a femoropopliteal vein segment, use 35572 in addition to the bypass procedure. To report harvesting and construction of an autogenous composite graft of two segments from two distant locations, report 35682 in addition to the bypass procedure, for autogenous composite of three or more segments from distant sites report 35683.				
✚● 35572	AT1	Harvest of femoropopliteal vein, one segment, for vascular reconstruction procedure (eg, aortic, vena caval, coronary, peripheral artery) (List separately in addition to code for primary procedure) (Use 35572 in conjunction with codes 33510 – 33516, 33517 – 33523, 33533 – 33536, 34502, 34520, 35001-35002, 35011-35022, 35102-35103, 35121-35152, 35231-35256, 35501-35587, 35901-35907)	ZZZ	6.82

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

Tracking AT1 April 2002

CPT Code: 35572 **Global Period:** ZZZ **RUC Recommended RVW:** ~~7.20~~ 6.82

CPT Descriptor: Harvest of femoropopliteal vein, one segment, for use as conduit during vascular reconstruction.

(List separately in addition to code for primary procedure)

(Use 355721 in conjunction with codes 34502, 34520, 35001-35002, 35011-35022, 35102-35103, 35121-35152, 35231-35256, 35501-35587, 35901-35907)

Typical Patient (*Survey Vignette*): A 70-year-old male has comorbidities including tobacco abuse, COPD, CAD, & MI, and he is s/p revascularization surgeries including CABG using autogenous vein, bilateral lower extremity bypass grafts using autogenous vein, and a synthetic femoral-femoral bypass graft, the latter as treatment for an occluded left iliac artery. He returned to medical attention with complaints of fever, chills, malaise, and a small skin pore in his left groin that is releasing purulent drainage. Diagnostic work-up revealed infection of the femoral-femoral graft, requiring surgical removal and extensive debridement. As a result he has severe left leg ischemia, and a new graft must be placed to save his leg. Extensive duplex vein search reveals that he has no remaining autogenous superficial vein suitable for conduit on either lower or upper extremity. Synthetic revascularization is contraindicated due to open groin wounds and significant local infection. Femoral-femoral bypass using vein conduit is recommended (separately reportable as CPT 35558). Autogenous femoropopliteal vein is harvested for use as conduit.

CLINICAL DESCRIPTION OF SERVICE:

Pre-Service Work: The incremental pre-service work associated with femoropopliteal vein harvest relates to review of duplex ultrasound or other imaging studies that have been performed to assess the suitability of removing the deep femoropopliteal vein from a lower extremity. These studies must reveal that the deep vein is patent and free of any thrombus. In addition it must be proven that the superficial venous system is patent and will be able to carry the increased returning venous blood once the deep system has been harvested. Additional pre-service work specifically associated with fem-pop vein harvest is the extra prep time associated with finding a leg holder, scrubbing, prepping, and draping the leg.

Intra-Service Work: Intra-service work begins with the skin incision. An incision is extended from the groin along the anterior aspect of the thigh. Soft tissue is dissected with electrocautery. The lateral border of the sartorius muscle is identified and reflected medially to expose the adductor canal. The femoral vein (FV) is identified next to the femoral artery. The branches of the FV are carefully doubly ligated and divided without injuring the vein wall. The dissection is continued distally as the vein and artery travel deep in the thigh. The adductor hiatus is opened by dividing the tendinous insertion of the adductor magnus muscle. The dissection is usually tedious in the distal adductor canal region where there are often multiple large branches that must be carefully ligated, and where the vein is usually in very close apposition to the artery and the aponeurosis of

the addutor magnus. At the upper end of the popliteal space the name of the deep vein becomes the popliteal vein. Initial dissection of the popliteal vein follows the same incision and planes as the femoral had, but a separate incision is required to harvest the most distant segment of popliteal vein. When the vein is completely exposed it is ligated proximally and distally, and divided. The vein segment is removed from the thigh and measured to determine that adequate length has been obtained. Vein valves are disrupted using a valvulotome. Flow through the new conduit is tested by injection of heparinized saline. Any missed branches or rents in the conduit are repaired under loupe magnification using very fine polypropylene suture.

Once the conduit is proven adequate it is used in the separately reportable bypass procedure. After completion of the bypass, the vein harvest site is irrigated copiously, and hemostasis is achieved with electrocautery and suture ligation as required. The harvest site wound is closed in multiple layers. Drains are inserted as required.

Post-service work: Although this is a ZZZ add-on service the survey respondents indicated that the magnitude of this femoropopliteal dissection results in extra hospital days and extra outpatient visits. The recent action by the RUC indicated that, when justified, the RVW of ZZZ services could reflect post-service work that would not otherwise be required.

Important Notes Regarding Work Evaluation of This Service

The primary procedure bypass grafts listed in the parenthetical above are all procedures performed "with vein". That is, each primary procedure already has work RVUs built into it for harvest of the greater saphenous vein, which is the standard autogenous conduit used for bypass operations. In the RUC work survey for this new procedure we instructed respondents to value only the "incremental work" associated with harvesting the femoropopliteal vein that lies deep within the thigh and behind the knee in the popliteal space. The following note was on first page of RUC work survey for this code, and the message was repeated several times throughout the survey:

> "Please Note: This survey asks you to estimate only the additional physician time, intensity, and work required to harvest the femoropopliteal vein in excess of that involved in routine harvest a saphenous vein."

At the February 2002 RUC meeting the motion was passed that ZZZ add-on services may potentially have pre-service and post-service physician work. According to our survey respondents, harvest of the deep femoropopliteal vein is a procedure of sufficient magnitude to merit additional pre and post-service RVUs.

SURVEY DATA

Presenters: Gary Seabrook, M.D.
Donna Mendes, M.D.
Bob Zwolak, M.D.

Specialty: American Association for Vascular Surgery

CPT: 35572

Sample Size: 150 **Resp n:** 32 **Resp %:** 23%

Sample Type:

	Low	25th pctl	Median	75th pctl	High
Survey RVW	6.00	7.20	**8.13**	10.00	25.00
Incremental Pre-time					
Incremental Intra-Time	25	45	**60**	60	120
Incremental Immed-Post					
Incremental Other Hosp				~~99231 x 1~~	
Incremental Office-Time				~~99212 x 1~~	

KEY REFERENCE SERVICE:

CPT	Descriptor	2002 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:

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 35572	Ref CPT 35500
Pre-service	0	0
Intra-service	60	60
Post-service	0	0
TOTAL TIME	*60*	*60*

INTENSITY/COMPLEXITY MEASURES (mean)

TIME SEGMENTS		
Intra-service	3.54	2.54
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3.21	2.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.07	2.50
Urgency of medical decision making	2.57	2.36
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	3.57	2.71
Physical effort required	3.43	2.64
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	3.64	2.64
Outcome depends on the skill and judgment of physician	3.43	2.93
Estimated risk of malpractice suit with poor outcome	3.36	2.79

ADDITIONAL RATIONALE

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

FREQUENCY INFORMATION

How was this service previously reported?

37799

How often do physicians in your specialty perform this service?

Specialty: AAVS Sometimes

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

Specialty: AAVS National Frequency: 500 Medicare Frequency: 400

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

Performed in Hospital: Yes **ASC:** No **Office:** No

CPT: 35572 Harvest Femoropopliteal Vein
Specialty: AAVS

AMA/Specialty Society Update Process
RUC Summary of Recommendation
ZZZ Global Out-Of-Office Direct Inputs [In-Office Not Applicable]

AAVS used a consensus panel approach to develop practice expense recommendations for code 35572. Recommendations were finalized via email negotiations.

Geographic Practice Setting %:

The panel members practice in all areas of the country. The group represented 67% urban, 24% suburban and 10% rural.

Type of Practice %:

The panel's composition is 66% academic and 34% private practice.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: RN/LPN/MA provides additional pre-service education regarding expectations for, and care of, a lower extremity that has undergone harvest of the deep femoropopliteal vein, specifically addressing issues of chronic leg swelling, need for elevation and compression, proper skin care in limb predisposed to venous hypertension due to absence of deep venous system, DVT precautions
Intra-Service Clinical Labor Activities: N/A
Post-Service Clinical Labor Activities - Office Visits The magnitude of deep femoropopliteal vein harvest is such that survey respondents agreed that one extra 99212 office visit is required for these patients. Post-service clinical labor corresponds to that additional visit.

	A	B	C	D	E	F	G	H	I	J	K	L
1	**Clinical Labor, Medical Supplies, and Procedure**									**CPT**	**35572**	**35572**
2	**Equipment Practice Expense Data**									**Global**	**ZZZ**	**ZZZ**
3								**Number/Level of Post OV:**			**N/A**	**N/A**
4	**CLINICAL LABOR**						**Code**	**staff desc**		**Price**	**IN Off**	**OUT off**
5	**TOTAL TYPICAL TIME**						1130	RN/LPN/MA		$ 0.370	0	0
6	**PRE-service time**						1130	RN/LPN/MA		$ 0.370	0	0
7	**SERVICE time Coordination of Care**						1130	RN/LPN/MA		$ 0.370	0	0
8	**POST-service time**						1130	RN/LPN/MA		$ 0.370	0	0
9	**PRE-SERVICE**											
10	**BEGINS after procedure consult. (in off / out off)**										**Min**	**Min**
11	Complete pre-service diagnostic & referral forms (5/5)						1130	RN/LPN/MA		$ 0.370	0	0
12	Coord pre-proc services/review test/exam results (10/20)						1130	RN/LPN/MA		$ 0.370	0	0
13	Schedule space and equipment in facility (0/8)						1130	RN/LPN/MA		$ 0.370	0	0
14	OV before surgery/procedure - review test/exam results (0/0)						1130	RN/LPN/MA		$ 0.370	0	0
15	Provide pre-service education/obtain consent (10/20)						1130	RN/LPN/MA		$ 0.370	0	0
16	Follow-up phone calls & prescriptions (10/7)						1130	RN/LPN/MA		$ 0.370	0	0
17	**Other Pre-Service Activities (please specify):**											
18	none						1130	RN/LPN/MA		$ 0.370	0	0
19	**ENDS with admission to facility/office**											
20	**SERVICE PERIOD**											
21	**Starts with admission to facility/office**										**Min**	**Min**
22	Coordination of care						1130	RN/LPN/MA		$ 0.370	0	0
23	**Ends with discharge from facility/office**											
24	**POST-SERVICE**											
25	**Begins after discharge from facility/office**										**Min**	**Min**
26	**Postop OV total time (E/M standards)**	-211 (16)	-212 (27)	-213 (36)	-214 (53)	-215 (63)	1130	RN/LPN/MA		$ 0.370	0	0
38	**Other Activities (please specify):**											
39							1130	RN/LPN/MA		$ 0.370	0	0
40	**ENDS after 90 days from day of procedure.**											
41											Out Off	Out Off
42	**MEDICAL SUPPLIES**						**Code**	**Unit Size**	**Unit Cnt**	**Price**	**QTY**	**QTY**
43	**PEAC Minimum visit package (multi-specialty):**						**PEAC**	**PKG**	**1**	**$ 1.310**	0	0
44	exam table paper (7 ft)						11111	foot	1	$ 0.015		
45	gloves, non-sterile (2 pair)						11302	pair	1	$ 0.120		
46	patient gown, disposable						11107	item	1	$ 0.570		
47	pillow case, disposable						11112	item	1	$ 0.320		
48	thermometer probe cover, disposable						11509	item	1	$ 0.069		
49	**Add'l per visit supplies:**											
50	patient education booklet						11115	item	1	$ 0.920	0	0
51											Out Off	Out Off
52	**Postop incision care supplies:**						**Code**	**Unit Size**	**Unit Cnt**	**Price**	**QTY**	**QTY**
53	**Post-op Incisional Care Kit - one additional required**										0	0
54	Gloves, sterile						14005	1 pair			0	0
55	Swab, alcohol						31101	2 item			0	0
56	Steri-strips						31513	2 packs			0	0
57	Tape 12 inches						31514	2 increments			0	0
58	Staple remover kit						31702	1 item			0	0
59	Betadine						52301	10 ml			0	0
60	Gauze, sterile 4x4						31505	2 items			0	0
61	Tincture benzoin swab						52308	1 item			0	0
62	**Other required material for fempop vein harvest**											
63	Ace wrap 6"						31503	each			0	0
64	Ace Wrap 4"						31515	1 item			0	0
65	Kerlix roll 4"						32013	each			0	0
66												
67	**PROCEDURE SPECIFIC EQUIPMENT**											
68	Power Table						E11003	1		$ 6,939	0	0
69	Light source						E13122	1		$ 1,700	0	0
70												

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Venipuncture *(G Code Transition to CPT)*

Doctor Dickey of the Endocrine Society requested additional time to refine the practice expense recommendations for the venipuncture codes. The recommendation from the specialty society for these codes is for practice expense only, since there is no physician work. The presenter suggested that the family of codes should be expanded to include the codes that are scheduled to be presented to the PEAC. Since additional venipuncture codes (36400, 36410, 36405, 36406) are currently scheduled to be presented to the PEAC in September, 2002, the RUC agreed that it would be beneficial to review the practice expense inputs for all of these codes at the same time. However, since these codes new codes are transitioning to CPT, they need to be reviewed by April 2002. The RUC therefore directed the specialties that will be involved in the venipuncture presentation to the PEAC do review the codes at the March meeting as opposed to the September meeting, and present inputs for the venipuncture G codes that are transitioning to CPT at that time. Codes 36415, 3641X, and 36540 should therefore be added to the PEAC March agenda.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲36415	T1	~~Routine venipuncture of finger/heel/ear stick for collection of specimen(s)~~Collection of capillary blood specimen (eg, finger, heel, ear stick	XXX	0.00
G0001		~~Routine venipuncture for collection of specimen(s)~~	XXX	N/A

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●3641X	T2	Collection of venous blood by venipuncture (Do not report 36540 in conjunction with 36415, 3641X)	XXX	0.00
▲36540	T3	Collection of blood specimen from a ~~partially or~~ completely implantable venous access device (For collection of capillary blood specimen, use 36415) (For collection of venous blood specimen by venipuncture, use 3641X)	XXX	0.00

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Therapeutic Apheresis

The CPT codes 36511-36514 replace code 36520 *Therapeutic apheresis; plasma and/or cell exchange* (Work RVU = 1.74), and CPT codes 36515 and 36516 replace code 35521 *Therapeutic apheresis; with extracorporeal affinity column adsorption and plasma reinfusion* (Work RVU = 1.74) to allow reporting for the different types of therapeutic apheresis that are now performed. This provides a more accurate coding for the actual work and procedure since the different types of apheresis involve different amounts of work and technique. This also allows for better recording of the frequency of the different therapeutic apheresis procedures. Previously reported codes 36520 and 36521 were too vague to code for all the different apheresis procedures now in existence.

The specialty has tried to coordinate its survey efforts with subspecialty organizations and other specialties (eg, nephrology and rheumatology), however it has been unable to conduct a survey of the work relative values for these services. American Society of Hematology (ASH) is also in contact with the manufacturer associated with the supplies and equipment for this service to best determine the institutions that are currently performing this service. ASH will utilize this list in conducting their survey this summer.

While ASH works to complete the survey, the **RUC recommends interim values of 1.74 for each of the therapeutic apheresis services, which is the value crosswalked from current codes 36521 and 36520**. The RUC recommends that survey data be presented at the September 2002 RUC meeting. The interim values serve as a place-holder until the specialty has the opportunity to collect better data and coordinate with other relevant specialties. If data is not presented, the interim RUC recommendations will be considered "not validated."

Practice Expense Inputs:
The specialty had determined these services are performed more than 95% in the facility setting and the RUC agreed that they should not be priced in the non-facility setting at this time. The RUC and the specialty agreed that for these services there wouldn't be any practice expense inputs, and therefore recommends no practice expense inputs in either the facility or non-facility settings.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Rec.
●36511	U1	Therapeutic apheresis; for white blood cells	000	1.74 (Interim)
●36512	U2	for red blood cells	000	1.74 (Interim)
●36513	U3	for platelets	000	1.74 (Interim)
●36514	U4	for plasma pheresis	000	1.74 (Interim)
●36515	U5	with extracorporeal immunoadsorption and plasma reinfusion	000	1.74 (Interim)
●36516	U6	with extracorporeal selective adsorption or selective filtration and plasma reinfusion	000	1.74 (Interim)
36520(D)		~~Therapeutic apheresis; plasma and/or cell exchange~~ (36520 has been deleted. To report use 36511-36512)	000	N/A
36521(D)		~~with extracorporeal affinity column adsorption and plasma reinfusion~~ (36521 has been deleted. To report, use 36515 or 36516)	000	N/A

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2002

Fibrin Sheath/Intraluminal Mechanical Removal of Obstruction for Central Venous Devices

Four new codes were presented to the RUC to describe the physician work associated with the maintenance of central venous devices. While CPT currently contains codes for introducing, revising, and removing central venous access devices, the work associated with the maintenance of the devices is not represented. The options for maintenance include striping the fibrin sheath from/about the existing catheter or clearing obstructive material with a mechanical device under imaging guidance. The RUC discussed in detail the use of these codes and focused on identifying any possible overlap in physician work between the procedure codes and the related supervision and interpretation code.

The RUC felt that the specialty recommendation for CPT code 36536 (V1) value of 4.83, overstated the physician work, and was not supported by the survey data. Therefore, the RUC looked at two different methods of developing RVUs including assigning the IWPUT values to the survey time, and comparing the survey time with the time for existing codes. The RUC felt that the pre-service work had an IWPUT similar to evaluation and management codes, and an intra-service IWPUT similar to there codes in the family. As a result, the RUC agreed to the following value:

36536 (V1)
Intra .06 x 45 = 2.7
Pre .03 x 30 = .9
Total 3.6 RVW

In addition to devising a work RVU using IWPUT values, the RUC also examined CPT code 36536 in relation to the reference service CPT code 37203 *Transcatheter retrieval, percutaneous, of intravascular foreign body (e.g., fractured venous or arterial catheter)* (work RVU = 5.03). CPT code 36536 had a lower pre-service time and intra-service time in comparison to code 37203, therefore the RUC felt that a reduction of approximately 30% from the reference service value of 5.03 would be warranted, thereby resulting in an approximate work value of 3.60. Given the various methodologies producing similar results, the RUC agreed that a work value of 3.60 is appropriate and placed the code in proper rank order. **The RUC recommends 3.60 work RVUs for CPT code 36536.**

36537 (V2)
The RUC examined a number of comparable codes such as code 51600 *Injection procedure for cystography or voiding urethrocystography* (work RVU = 0.88) and code 23350 I*njection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography* (work RVU =1.00). In comparison to reference code 50394 *Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter* (RVW = 0.76), the work is similar. The RUC felt that CPT code 36537 should be valued less than codes 51600 and 23350, and about the same as code 50394. The intra-service time for 36537 was reduced from 10 minutes to 9 minutes, to account for overlap between the procedure and the supervision and interpretation services **The RUC recommends a work RVU of 0.75 for CPT code 36537.**

75901 (V3)
In comparison to the reference code 75978 *Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation* (RVW =0.54), the work was slightly lower. The RUC agreed that code 75900 *Exchange of a previously placed arterial catheter during thrombolytic therapy with contrast monitoring, radiological supervision and interpretation* (work RVU =0.49) was a comparable service and 75901 should involve the same amount of work. The intra-service time was reduced from 15 minutes to 9 minutes. **The RUC recommends a work RVU of 0.49 for CPT code 75901.**

75902 (V4)
The reference code 75820 *Venography, extremity, unilateral, radiological supervision and interpretation* (RVW = 0.70) has a higher total Harvard time that is less than code 75902. In addition, in relation to code 75901, CPT code 75902 is about the same in terms of overall time. To maintain the relativity between the supervision and interpretation codes in this code family, the RUC wanted to retain the original specialty recommended differential between 75901 and 75902. Therefore the RUC agreed that 75902 should be valued at 80% of 75901. **The RUC recommends a work RVU of 0.39 for CPT code 75902.**

Practice Expenses
The RUC made a number of changes to the practice expense staff inputs. Primarily the RUC reduced phone calls to the 3-minute standard and deleted post service time in the facility setting, except for one 3-minute phone call. In addition, the specialty deleted a number of supplies.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 36536	V1	Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access (Do not report 36550 in addition to 36536) (For venous catheterization, see 36010-36012) (For radiological supervision and interpretation, use 75901)	000	3.60
● 36537	V2	Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen (Do not report 36550 in addition to 36537) (For venous catheterization, see 36010-36012) (For radiological supervision and interpretation , use 75902)	000	0.75

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 75901	V3	**Radiology** **Transcatheter Procedures** Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access radiologic supervision and interpretation (For procedure, use 36536) (For venous catheterization, see 36010-36012)	XXX	0.49
● 75902	V4	Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen radiologic supervision and interpretation (For procedure, use 36537) (For venous catheterization, see 36010-36012)	XXX	0.39

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:	36536	Tracking Number:	V1	Global Period:	000	RUC Recommended RVW:	3.60

CPT Descriptor: Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access (Do not report 36550 in addition to 36536) (For venous catheterization, see 36010-36012) (For radiological supervision and interpretation, use 75901)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 68-year-old male with gastric cancer and a subcutaneous port presents with a poorly functioning port. Infusion/injection can be made but blood cannot be aspirated.

For purposes of this survey, the physician work associated with removal of obstructive material commences after the catheter has been introduced and manipulated into target vein. Do not include the physician work attributed to access and catheterization since it is separately billable as codes 36010-36012.

Description of Pre-Service Work:

The pre-service period includes physician services provided from the day before the operative procedure until the time of the operative procedure and may include the following:

- Hospital admission work-up.
- The pre-operative evaluation may include the procedural work-up, review of records, and/or prior imaging studies, communicating with other professionals, patient and family, and obtaining consent.
- Other pre-operative work may include dressing, scrubbing, and waiting before the operative procedure, preparing patient and needed equipment for the operative procedure, positioning the patient, examination of chest and port site, and other non "skin-to-skin" work in the OR.

The following services are not included:

- Consultation or evaluation at which the decision to provide the procedure was made (reported with modifier -57).
- Distinct evaluation and management services provided in addition to the procedure (reported with modifier -25).
- Mandated services (reported with modifier –32).

Description of Intra-Service Work:

The intra-service period includes all "skin-to-skin" work that is a necessary part of the procedure.
Do NOT consider imaging services (e.g., fluoroscopic check of device/catheter position, post procedure imaging) or catheterization/access services related to this procedure as they are separately reportable.

- After venous access (work of access is separately billable and not included in code (36536), a vascular snare is placed in the cava through the catheter, and the tip of the central venous catheter is engaged with the snare.
- The fibrin sheath and thrombus are stripped from the catheter.

Description of Post-Service Work:

The post-service period includes services provided on the day of the procedure if the global period is 000, post-service period may include the following:

- Day of Procedure: Post-operative care on day of the procedure, includes non "skin-to-skin" work in the OR, patie stabilization in the recovery room or special unit, communicating with the patient and other professionals (includin written and telephone reports and orders), and patient visits on the day of the operative procedure. Post-procedural observation of the patient.

The following services are not included:

- Unrelated evaluation and management service provided during the postoperative period (reported with modifier -24)
- Return to the operating room for a related procedure during the postoperative period (reported with modifier -78)
- Unrelated procedure or service performed by the same physician during the postoperative period (reported with modifier -79)

SURVEY DATA:

Presenter(s) Robert Vogelzang, M.D., SCVIR RUC advisor; Bibb Allen, Jr., M.D., ACR RUC advisor

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

Sample Size: 212 Response Rate: (%): 38 (17.9%) Median RVW: 4.83

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

25th Percentile RVW: 4.23 75th Percentile RVW: 5.05 Low: 2.70 High: 8.00

Median Pre-Service Time: 30.00 Median Intra-Service Time: 45.00

25th Percentile Intra-Service Time: 30.00 75th Percentile Intra-Svc Time: 60.00 Low: 15.00 High: 120.00

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	15.00	
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
37203	Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter)	5.03

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)	**New/Revis. CPT Code: 36536**	**Key Reference CPT Code: 37203**
Median Pre-Time	30.00	
Median Intra-Time	45.00	
Median Immediate Post-service Time	15.00	
Median of Aggregate Critical Care Times	N/A	
Median of Aggregate Other Hospital Visit Times	N/A	
Median Discharge Day Management Time	N/A	
Median of Aggregate Office Visit Times	N/A	
Total Time (* Harvard Time)		141 min *
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	2.74	2.78
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.50	2.50
Urgency of medical decision making	2.66	3.41
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.55	3.88
Physical effort required	3.00	3.13
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.74	3.16
Outcome depends on the skill and judgement of physician	3.63	3.81
Estimated risk of malpractice suit with poor outcome	2.24	3.23

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.56	2.68
Intra-Service intensity/complexity	3.31	3.81
Post-Service intensity/complexity	2.19	2.13

ADDITIONAL RATIONALE

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

The ACR and SCVIR have reviewed the survey data and recommend the median RVU of 4.83. We believe that the RVU of 4.83 accurately reflects the physician work involved in this procedure.

FREQUENCY INFORMATION

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

37203 (Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter) or 36534 (Revision of implantable venous access device, and/or subcutaneous reservoir

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	Interventional Radiology				X	
Specialty	Radiology		X			

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 Interventional Radiology Frequency 1,600**

Specialty Radiology 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 Interventional Radiology Frequency 800 *

Specialty Radiology Frequency 3,000*

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

*: These numbers are based on 1999 BMAD data for CPT code 37203.
**: In order to estimate the number of times the service is provided nationally, we used a multiplier of 2 for the Medicare frequency rate.

CPT Code: 36536
Specialty Societies: American College of Radiology
Society of Cardiovascular & Interventional Radiology

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

CPT Long Descriptor: Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access

(Do not report 36550 in addition to 36536)
(For venous catheterization, see 36010-36012)
(For radiological supervision and interpretation, use 75901)

Sample Size: consensus Response Rate: (%): N/A Global Period: 0-days

Tracking Number: V1 Reference Code 1 36870 Reference Code 2 37203

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 serves as the Society's Practice Expense Committee developed preliminary direct input recommendations. The Economics Committee's 26 members exhibit the geographic and practice type distribution as detailed above. Physicians representing both ACR and SCVIR reviewed these preliminary recommendations and consensus was achieved.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic & referral forms
- Follow-up phone calls & prescriptions

Intra-Service Clinical Labor Activities:

- Review charts
- Greet patient and provide gowning
- Obtain vital signs
- Provide pre-service education/obtain consent
- Prepare room, equipment, supplies
- Prepare and position patient/monitor patient
- Intra-procedure monitoring of patient
- Monitor patient following service
- Check dressing & wound/ home care instructions/coordinate office visits/prescriptions
- Follow-up phone calls
- Instruct patient about port malfunction and proper flushing technique

Total Staff Time In Office: 103 minutes Visits in Global Period: None

CMS' Staff Type Code*	Clinical Labor - Description	Pre-Service Time	Service Period (Day of service)	Cost Estimate and Source (if applicable)
1130	RN/LPN/MA	10 minutes	93 minutes	

* 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)
93816	Hydrophilic wire	1	Item @ 30.30	
	Microvera loop snare	1.5	Item @ 565.00 ea	Per Supplier

* 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 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)

* 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
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	5	**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	5	**RN, LPN, MA**, Other _____
Other Clinical Activity (please specify)		
_____	_____	RN, LPN, MA, Other _____
End: When patient enters office for surgery/procedure		
Service Period		
Start: When patient enters office for surgery/procedure		
Pre-service services		
Review charts	5	**RN, LPN, MA**, Other _____
Greet patient and provide gowning	3	**RN, LPN, MA**, Other _____
Obtain vital signs	3	**RN, LPN, MA**, Other _____
Provide pre-service education/obtain consent	5	**RN, LPN, MA**, Other _____
Prepare room, equipment, supplies	5	**RN, LPN, MA**, Other _____
Prepare and position patient/ monitor patient/ set up IV	3	**RN, LPN, MA**, Other _____
Sedate/apply anesthesia	_____	RN, LPN, MA, Other _____
Intra-service		
Intra-procedure monitoring of patient (monitoring pt's vital signs)	45	**RN, LPN, MA**, Other _____

Monitor pt. following service/check tubes, monitors, drains	15	**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	3	**RN, LPN, MA,** Other _____
Other Clinical Activity (please specify)		
Follow-up phone calls (e.g., with patient, call in prescriptions)	3	**RN, LPN, MA,** Other _____
Other Clinical Activity (please specify)		
Instruct patient about port malfunction and proper flushing technique	3	**RN, LPN, MA,** Other _____

End: Patient leaves facility

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:	36537	Tracking Number:	V2	Global Period:	000	RUC Recommended RVW:	0.75

CPT Descriptor: Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen (Do not report 36550 in addition to 36537) (For venous catheterization, see 36010-36012) (For radiological supervision and interpretation, use 75902)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 68-year-old male with gastric cancer and a subcutaneous port presents with a poorly functioning port. Infusion/injection can be made but blood cannot be aspirated.

For purposes of this survey, the physician work associated with removal of obstructive material commences after the catheter has been introduced and manipulated into target vein. Do not include the physician work attributed to access and catheterization since it is separately billable as codes 36010-36012.

Description of Pre-Service Work:

The pre-service period includes physician services provided from the day before the operative procedure until the time of the operative procedure and may include the following:

- Hospital admission work-up.
- The pre-operative evaluation may include the procedural work-up, review of records, and/or prior imaging studies, communicating with other professionals, patient and family, and obtaining consent.
- Other pre-operative work may include dressing, scrubbing, and waiting before the operative procedure, preparing patient and needed equipment for the operative procedure, positioning the patient, examination of chest and port site, and other non "skin-to-skin" work in the OR.

The following services are not included:

- Consultation or evaluation at which the decision to provide the procedure was made (reported with modifier -57).
- Distinct evaluation and management services provided in addition to the procedure (reported with modifier -25).
- Mandated services (reported with modifier –32).

Description of Intra-Service Work:

The intra-service period includes all "skin-to-skin" work that is a necessary part of the procedure.
Do NOT consider imaging services (e.g., fluoroscopic check of device/catheter position, post procedure imaging) or catheterization/access services related to this procedure as they are separately reportable.

- A ureteral brush is inserted into the catheter lumen and pushed toward the distal tip of the catheter, through the distal end hole, and then retracted into the catheter.
- The maneuver is repeated several times to "brush" the multiple side holes and the distal end hole.
- The ureteral brush is removed.
- The catheter is flushed with appropriate amounts of saline and Heparin and the ports are clamped.
- A sterile dressing is reapplied on the chest wall at the catheter entry site.

Description of Post-Service Work:

The post-service period includes services provided on the day of the procedure if the global period is 000, post-service period may include the following:

- Day of Procedure: Post-operative care on day of the procedure, includes non "skin-to-skin" work in the OR, patient stabilization in the recovery room or special unit, communicating with the patient and other professionals (including written and telephone reports and orders), and patient visits on the day of the operative procedure. Post-procedural observation of the patient.

The following services are not included:

- Unrelated evaluation and management service provided during the postoperative period (reported with modifier -24)
- Return to the operating room for a related procedure during the postoperative period (reported with modifier -78)
- Unrelated procedure or service performed by the same physician during the postoperative period (reported with modifier -79)

SURVEY DATA:

Presenter(s) Robert Vogelzang, M.D., SCVIR RUC advisor; Bibb Allen, Jr., M.D., ACR RUC advisor

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

Sample Size: 212 Response Rate: (%): 32 (15.1%) Median RVW: 2.00

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

25th Percentile RVW: 1.00 75th Percentile RVW: 2.81 Low: 0.70 High: 8.50

Median Pre-Service Time: 23.00 Median Intra-Service Time: 9

25th Percentile Intra-Service Time: 15.00 75th Percentile Intra-Svc Time: 31.25 Low: 10.00 High: 80.00

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	5.00	
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
50394	Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter	0.76

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)	**New/Revis. CPT Code: 36537**	**Key Reference CPT Code: 50394**
Median Pre-Time (*25th percentile)	23.00	
Median Intra-Time (*25th percentile)	9.00	
Median Immediate Post-service Time (*25th percentile)	5.00	
Median of Aggregate Critical Care Times	N/A	
Median of Aggregate Other Hospital Visit Times	N/A	
Median Discharge Day Management Time	N/A	
Median of Aggregate Office Visit Times	N/A	
Total Time (* Harvard Time)		48 min *
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	2.25	1.29
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.38	1.57
Urgency of medical decision making	2.22	1.86
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.38	1.43
Physical effort required	2.16	1.43
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.06	1.43
Outcome depends on the skill and judgement of physician	2.44	1.29
Estimated risk of malpractice suit with poor outcome	1.84	1.14

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.19	1.00
Intra-Service intensity/complexity	2.48	1.33
Post-Service intensity/complexity	2.18	1.33

ADDITIONAL RATIONALE

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

The ACR and SCVIR have reviewed the survey data and recommend the 25th percentile for RVU (1.00) as well as the time. We believe that the 25th percentile data is the most appropriate values for this procedure as it accurately reflects the physician work involved.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 35476 (Transluminal balloon angioplasty, percutaneous; venous

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 Radiology	___	Commonly	X	Sometimes	___	Rarely
Specialty	Radiology	___	Commonly	X	Sometimes	___	Rarely

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

Specialty Interventional Radiology Frequency 26,000**

Specialty Radiology Frequency 114,000**

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 Interventional Radiology Frequency 13,000*

Specialty Radiology Frequency 57,000*

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

*: These numbers are based on 1999 BMAD data for CPT code 35476.

**: In order to estimate the number of times the service is provided nationally, we used a multiplier of 2 for the Medicare frequency rate.

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

CPT Long Descriptor: Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen

(Do not report 36550 in addition to 36537)
(For venous catheterization, see 36010-36012)
(For radiological supervision and interpretation , use 75902)

Sample Size: consensus Response Rate: (%): N/A Global Period: 0-days

Tracking Number: V2 Reference Code 1 37203 Reference Code 2 50394

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 serves as the Society's Practice Expense Committee developed preliminary direct input recommendations. The Economics Committee's 26 members exhibit the geographic and practice type distribution as detailed above. Physicians representing both ACR and SCVIR reviewed these preliminary recommendations and consensus was achieved.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic & referral forms
- Follow-up phone calls & prescriptions

Intra-Service Clinical Labor Activities:

- Review charts
- Greet patient and provide gowning
- Obtain vital signs
- Provide pre-service education/obtain consent
- Prepare room, equipment, supplies
- Prepare and position patient/monitor patient
- Intra-procedure monitoring of patient
- Check dressing & wound/ home care instructions/coordinate office visits/prescriptions
- Follow-up phone calls
- Instruct patient about port malfunction and proper flushing technique

Total Staff Time In Office: 58 minutes Visits in Global Period: None

HCFA's Staff Type Code*	Clinical Labor - Description	Pre-Service Time	Service Period (Day of service)	Cost Estimate and Source (if applicable)
1130	RN/LPN/MA	10 minutes	48 minutes	

* 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)
14005	Gloves, sterile	3	Item @ .89 ea	
91406	Syringe, 3cc, 20-25 gauge needle	1	Item @ .14 ea	
91409	Syringe, 20 cc	1	Item @ .62 ea	
53007	Heparin, 1000 ups	5	Units @ 1.60	
11107	Gown, pt disposable	1	Item @ .57	
14008	Sterile surgical gown	2	Item @ 4.45	
51502	lidocaine	1	30 ml @ 1.68	
Not Listed	Ureteral brush	1	Item @ 116.00	116.00 (per supplier Boston Scientific)
A4550	Surgical Tray	1		Separately reportable

* 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 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)

* 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
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	5	**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	5	**RN, LPN, MA,** Other _____
Other Clinical Activity (please specify)		
_____	_____	RN, LPN, MA, Other _____
End: When patient enters office for surgery/procedure		
Service Period		
Start: When patient enters office for surgery/procedure		
Pre-service services		
Review charts	5	**RN, LPN, MA,** Other _____
Greet patient and provide gowning	3	**RN, LPN, MA,** Other _____
Obtain vital signs	3	**RN, LPN, MA,** Other _____
Provide pre-service education/obtain consent	5	**RN, LPN, MA,** Other _____
Prepare room, equipment, supplies	5	**RN, LPN, MA,** Other _____
Prepare and position patient/ monitor patient/ set up IV	3	**RN, LPN, MA,** Other _____
Sedate/apply anesthesia	_____	RN, LPN, MA, Other _____
Intra-service		
Assist physician in performing procedure	15	**RN, LPN, MA,** Other _____

Monitor pt. following service/check tubes, monitors, drains	_____	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	3	**RN, LPN, MA,** Other _____
Other Clinical Activity (please specify)		
Follow-up phone calls (e.g., with patient, call in prescriptions)	3	**RN, LPN, MA,** Other _____
Other Clinical Activity (please specify)		
Instruct patient about port malfunction and proper flushing technique	3	**RN, LPN, MA,** Other _____

End: Patient leaves facility

CPT Code: 36537
Specialty Societies: American College of Radiology
Society of Cardiovascular & Interventional Radiology

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

CPT Long Descriptor: Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen

(Do not report 36550 in addition to 36537)
(For venous catheterization, see 36010-36012)
(For radiological supervision and interpretation , use 75902)

Sample Size: consensus Response Rate: (%): N/A Global Period: 0-days

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

ease 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 serves as the Society's Practice Expense Committee developed preliminary direct input recommendations. The Economics Committee's 26 members exhibit the geographic and practice type distribution as detailed above. Physicians representing both ACR and SCVIR reviewed these preliminary recommendations and consensus was achieved.

Staff Time: Our recommended staff time of 36 minutes takes into account the non-physician clinician (RN/LPN/MA) time spent (either in the office and/or the hospital) with the patient prior to the procedure, preparing the necessary clinical paperwork, scheduling, post-procedural care instructions, and post-procedure follow-up.

Supplies: None. Supplies would be incurred by the hospital.

Equipment: None. Equipment would be provided by the hospital.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- **Obtain medical records**
- **Schedule space and equipment in facility**

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

- **Coordinates care with referring physician**
- **Follow-up phone calls & prescriptions**
- **Instruct patient about port malfunction and proper flushing technique**

Total Staff Time Out of Office: 18 minutes Visits in Global Period: None

HCFA's Staff Type Code**	Clinical Labor	Pre-Service Time	Service Period	Coordination of Care*	Post-Service Time
1130	RN/LPN/MA	15 minutes	0 minutes	0 minutes	3 minutes

*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 sour

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.

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	_____	**RN/LPN/MA**
Coordinate pre-surgery services	**10 minutes**	**RN/LPN/MA**
Schedule space and equipment in facility	**5 minutes**	**RN/LPN/MA**
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 _____
ther Clinical 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 _____

Monitor patient following service/check tubes, monitors, drains	_____	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	_____	RN, LPN, MA, Other _____
Coordination of care by staff in office	**0 minutes**	**RN/LPN/MA**
Other Clinical Activity (please specify)		
Follow-up phone calls (e.g., with patient, call in prescriptions)	**3 minutes**	**RN/LPN/MA**
Other Clinical Activity (please specify)		
Instruct patient about port malfunction and proper flushing technique	**0 minutes**	**RN/LPN/MA**

End: Patient leaves facility

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:	75901	Tracking Number:	V3	Global Period:	XXX	RUC Recommended RVW:	0.49

CPT Descriptor: Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access, radiologic supervision and interpretation (For procedure, use 36536) (For venous catheterization, see 36010-36012)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
A 68-year-old male with gastric cancer and a subcutaneous port presents with a poorly functioning port. Infusion/injection can be made but blood cannot be aspirated.

Description of Pre-Service Work:
- Review of any previous imaging studies
- Confirmation of patient position and imaging setup
- Determine need for intravascular contrast

Description of Intra-Service Work:
- Fluoroscopy check is performed to ascertain catheter position and condition
- Imaging necessary during the removal of fibrin sheath or pericatheter obstructive material from central venous device (the actual removal of fibrin sheath or pericatheter obstructive material is separately reportable as code 36536)
- Post-contrast imaging to visualize free flow with no residual abnormalities is performed

Description of Post-Service Work:
- Imaging report is dictated and read.

CPT Code: 75901

SURVEY DATA:

Presenter(s) Robert Vogelzang, M.D., SCVIR RUC advisor; Bibb Allen, Jr., M.D., ACR RUC advisor

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

Sample Size: 212 Response Rate: (%): 30 (14.2%) Median RVW: 1.15

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

25th Percentile RVW: 0.75 75th Percentile RVW: 1.50 Low: 0.40 High: 4.50

Median Pre-Service Time: 4.00 Median Intra-Service Time: 9.00

25th Percentile Intra-Service Time: 15.00 75th Percentile Intra-Svc Time: 45.00 Low: 5.00 High: 120.00

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	5.00	
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
75978	Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation	0.54

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)	New/Revis. CPT Code: 75901	Key Reference CPT Code: 75978
Median Pre-Time (*25th percentile)	4.00	
Median Intra-Time (*25th percentile)	9.00	
Median Immediate Post-service Time (*25th percentile)	5.00	
Median of Aggregate Critical Care Times	N/A	
Median of Aggregate Other Hospital Visit Times	N/A	
Median Discharge Day Management Time	N/A	
Median of Aggregate Office Visit Times	N/A	
Total Time (* Harvard Time)		12 min *
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	2.60	2.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.33	2.60
Urgency of medical decision making	2.50	2.60
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.29	3.00
Physical effort required	2.73	2.60
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.47	3.20
Outcome depends on the skill and judgement of physician	3.30	4.00
Estimated risk of malpractice suit with poor outcome	2.17	2.60

CPT Code: 75901

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.47	2.80
Intra-Service intensity/complexity	2.93	3.00
Post-Service intensity/complexity	2.17	2.40

ADDITIONAL RATIONALE

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

The ACR and SCVIR have reviewed the survey data and recommend the 25th percentile for RVU (0.75) as well as the time. We believe that the 25th percentile data is the most appropriate values for this procedure as it accurately reflects the physician work involved.

FREQUENCY INFORMATION

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

75961 (Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), radiological supervision or 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		Commonly		Sometimes		Rarely
Specialty	Interventional Radiology				X	
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 Interventional Radiology Frequency 6**

Specialty Radiology Frequency 42**

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 Interventional Radiology Frequency 3*

Specialty Radiology Frequency 21*

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

*: These numbers are based on 1999 BMAD data for CPT code 75961.
**: In order to estimate the number of times the service is provided nationally, we used a multiplier of 2 for the Medicare frequency rate.

CPT Code: 75901
Specialty Societies: American College of Radiology
Society of Cardiovascular & Interventional Radiology

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

CPT Long Descriptor: Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access radiologic supervision and interpretation

(For procedure, use 36536)
(For venous catheterization, see 36010-36012)

Sample Size: consensus Response Rate: (%): N/A Global Period: 0-days

Tracking Number: V3 Reference Code 75961 Reference Code 2 75978

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 serves as the Society's Practice Expense Committee developed preliminary direct input recommendations. The Economics Committee's 26 members exhibit the geographic and practice type distribution as detailed above. Physicians representing both ACR and SCVIR reviewed these preliminary recommendations and consensus was achieved.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

- Prep and position patient
- Assist physician during exam
- Clean room/equipment
- Develop films taken during procedure

Post-Service Clinical Labor Activities:

CPT Code: 75901

Specialty Societies: American College of Radiology
Society of Cardiovascular & Interventional Radiology

Total Staff Time In Office: 68 minutes Visits in Global Period: None

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)
	Registered Technologist		68 minutes		

* 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)
14001	Sterile drapes	3	Item @ .50 ea	
73402	Film 14x17	3	Item @ 3.61 ea	
73405	Film jacket	1	Item @ .34 ea	

* 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)
E51005	Radiographic/fluoroscopic room (1.404 per min)	1	45	40	

CPT Code: 75901
Specialty Societies: American College of Radiology
Society of Cardiovascular & Interventional Radiology

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	12	RN, LPN, MA, **Other** Registered Technologist
Prepare room, equipment, supplies	3	RN, LPN, MA, Other _____
Assist physician during exam	45	RN, LPN, MA, **Other** Registered Technologist
Education/instruction/ counseling	_____	RN, LPN, MA, Other _____
Coordinate home or outpatient care	_____	RN, LPN, MA, Other _____
Clean room/equipment	3	RN, LPN, MA, **Other** Registered Technologist
Other Clinical Activity (please specify)		
Develop films taken during procedure	5	RN, LPN, MA, **Other** Registered Technologist
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:	75902	Tracking Number:	V4	Global Period:	XXX	RUC Recommended RVW:	0.39

CPT Descriptor: Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen supervision and interpretation (For procedure, use 36537) (For venous catheterization, see 36010-36012)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
A 68-year-old male with gastric cancer and a subcutaneous port presents with a poorly functioning port. Infusion/injection can be made but blood cannot be aspirated.

Description of Pre-Service Work:
- Review of any previous imaging studies
- Confirmation of patient position and imaging setup
- Determine need for intravascular contrast

Description of Intra-Service Work:
- Fluoroscopy check is performed to ascertain catheter position and condition
- Imaging services are provided while the separately reportable (as 36537) procedure of mechanical removal of intraluminal obstruction from central venous device is performed
- Post-contrast imaging to visualize free flow with no residual abnormalities is performed

Description of Post-Service Work:
- Imaging report is dictated and read.

CPT Code: 75902

SURVEY DATA:

Presenter(s) Robert Vogelzang, M.D., SCVIR RUC advisor; Bibb Allen, Jr., M.D., ACR RUC advisor

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

Sample Size: 212 Response Rate: (%): 28 (13.2%) Median RVW: 0.78

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

25th Percentile RVW: 0.60 75th Percentile RVW: 1.11 Low: 0.35 High: 4.85

Median Pre-Service Time: 5.00 Median Intra-Service Time: 10.00

25th Percentile Intra-Service Time: 10.00 75th Percentile Intra-Svc Time: 30.00 Low: 7.50 High: 80.00

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	5.00	
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
75820	Venography, extremity, unilateral, radiological supervision and interpretation	0.70

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)	**New/Revis. CPT Code: 75902**	**Key Reference CPT Code: 75820**
Median Pre-Time (*25th percentile)	5.00	
Median Intra-Time (*25th percentile)	10.00	
Median Immediate Post-service Time (*25th percentile)	5.00	
Median of Aggregate Critical Care Times	N/A	
Median of Aggregate Other Hospital Visit Times	N/A	
Median Discharge Day Management Time	N/A	
Median of Aggregate Office Visit Times	N/A	
Total Time (* Harvard Time)		14 min *
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	2.11	2.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.11	2.00
Urgency of medical decision making	1.96	2.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.29	2.40
Physical effort required	2.21	2.20
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.07	2.00
Outcome depends on the skill and judgement of physician	2.50	2.40
Estimated risk of malpractice suit with poor outcome	1.82	2.40

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.11	2.00
Intra-Service intensity/complexity	2.41	2.50
Post-Service intensity/complexity	1.93	2.00

ADDITIONAL RATIONALE

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

The ACR and SCVIR have reviewed the survey data and recommend the 25th percentile for RVU (0.60) as well as the time. We believe that the 25th percentile data is the most appropriate values for this procedure as it accurately reflects the physician work involved.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 75978 ((Transluminal balloon angioplasty, venous (eg, subclavian stenosis), 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	Interventional Radiology	___	Commonly	___	Sometimes	X	Rarely
Specialty	Radiology	___	Commonly	X	Sometimes	___	Rarely

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

Specialty Interventional Radiology Frequency 1,200 **

Specialty Radiology 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 Interventional Radiology Frequency 600 *

Specialty Radiology Frequency 2,000 *

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

*: These numbers are based on 1999 BMAD data for CPT code 75978.

**: In order to estimate the number of times the service is provided nationally, we used a multiplier of 2 for the Medicare frequency rate.

CPT Code: 75902
Specialty Societies: American College of Radiology
Society of Cardiovascular & Interventional Radiology

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

CPT Long Descriptor: Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen radiologic supervision and interpretation

(For procedure, use 36537)
(For venous catheterization, see 36010-36012)

Sample Size: consensus Response Rate: (%): N/A Global Period: 0-days

Tracking Number: V4 Reference Code 75820

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 serves as the Society's Practice Expense Committee developed preliminary direct input recommendations. The Economics Committee's 26 members exhibit the geographic and practice type distribution as detailed above. Physicians representing both ACR and SCVIR reviewed these preliminary recommendations and consensus was achieved.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

- Prep and position patient
- Assist physician during exam
- Clean room/equipment
- Develop films taken during procedure

Post-Service Clinical Labor Activities:

Total Staff Time In Office: 23 minutes Visits in Global Period: None

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)
	Registered Technologist		23 minutes		

* 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)
14001	Sterile drapes	3	Item @ .50 ea	
73402	Film, 14x17	3	Item @ 3.61 ea	
73405	Film jacket	1	Item @ .34 ea	

* 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)
E51005	Radiographic/fluoroscopic room (1.404 per min)	1	10	40	

CPT Code: 75902
Specialty Societies: American College of Radiology
Society of Cardiovascular & Interventional Radiology

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	3	RN, LPN, MA, **Other** Registered Technologist
Prepare room, equipment, supplies	3	RN, LPN, MA, Other _____
Assist physician during exam	9	RN, LPN, MA, **Other** Registered Technol...
Education/instruction/ counseling	_____	RN, LPN, MA, Other _____
Coordinate home or outpatient care	_____	RN, LPN, MA, Other _____
Clean room/equipment	3	RN, LPN, MA, **Other** Registered Technologist
Other Clinical Activity (please specify)		
Develop films taken during procedure	5	RN, LPN, MA, **Other** Registered Technologist
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 COMMITTEE
SUMMARY OF RECOMMENDATIONS
February 2002

Transjugular Intrahepatic Portosystemic Shunt(s) (TIPS)

Four new codes were added to CPT to describe Transjugular Intrahepatic Portosystemic Shunt insertion and revision procedures.

37182 W1
The committee examined the IWPUT (based on specialty recommended RVUs of 22 and 12.25) for these two procedures and concluded that they were too high when compared to other codes such as venous anastomosis procedures. In particular the committee compared code 37182 to the following codes:

37140 *Venous anastomosis; portocaval* (RVU = 23.60);
37145 *Venous anastomosis; renoportal* (RVU = 24.61);
37160 *Venous anastomosis; caval-mesenteric* (RVU =21.60); and
38180 *Venous anastomosis; splenorenal, proximal* (RVU=24.61)

The RUC determined that a value of 17.00 would create a proper rank order. The committee examined the reference code 34800 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis* (RVU 20.75) as well as other codes with similar intra-service work. The committee felt that an IWPUT of .095 is appropriate for this intense and complicated procedure. Using an IWPUT of .095, the resulting RVU is 17.00. Although the reference service had a higher IWPUT, the committee felt that this was due to inaccurate Harvard physician time.

The RUC recommends a work RVU of 17.00 for 37182 (W1).

37183 W2
The committee reviewed the survey results and determined that the survey respondents felt that W2 was valued at about half of W1. To maintain this relativity, the committee concluded that a value of 8.00 was appropriate, which is approximately half of the recommended value of W1. Additionally the value of 8.00 results in an IWPUT of .077 with also relative to the IWPUT of 0.095 for CPT code 37183.

The RUC recommends a work RVU of 8.00 for 37183 W2.

Practice Expense

A specialty society consensus panel developed the direct practice expenses. The society used code 34800 as a reference service to determine appropriate direct inputs. No supplies or equipment were required. The RUC decreased the clinical staff time for these services. The RUC recommended staff time of 18 minutes takes into account the non-physician clinician (RN/LPN/MA) time spent (either in the office and/or the hospital) with the patient prior to the procedure, preparing the necessary clinical paperwork, scheduling, post-procedural care instructions, and post-procedure follow-up. The revised direct PE inputs are attached to this recommendation.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲37140		Venous anastomosis; portocaval	090	23.60 (no change)
▲37181		Venous anastomosis; splenorenal, distal (selective decompression of esophagogastric varices, any technique)	090	26.68 (no change)
●37182	W1	**Surgery** **Cardiovascular Procedures** **Portal Decompression Procedures** Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation) (Do not report 75885 or 75887 in conjunction with codes 37182)	000	17.00

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●37183	W2	Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanalization/dilatation, stent placement and all associated imaging guidance and documentation) (Do not report 75885 or 75887 in conjunction with codes 37183)	000	8.00

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 37182 Tracking Number: W1 Global Period: 000 **RUC Recommended RVW: 17.00**

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

(Do not report, 75885 or 75887 in conjunction with codes 37182)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
A 57-year-old male with cirrhosis is admitted with his third episode of bleeding esophageal varices in 14 days, having twice failed endoscopic sclerotherapy. The patient is referred for TIPS.

For purposes of this survey, TIPS includes access, all procedural imaging, tract recanalization, tract dilatation, and tract stenting. Additionally, when the physician work of the initial venography and/or portography (including imaging and access) confirms the need for TIPS and TIPS is performed, code 37182 is inclusive of these services. If TIPS is not indicated then the appropriate codes for venography and/or portography would be reported in lieu of code 37182.

Description of Pre-Service Work:
Prior imaging studies and other test results are reviewed by the physician. The procedure is discussed with the patient, family, and referring physician, and informed consent is obtained. The physician confirms room and equipment set up, including sterile preps and drapes, and proper patient positioning. Appropriate supplies such as catheters, sheaths, and guidewires are selected. Staff is directed to prepare for the procedure.

Description of Intra-Service Work:
Following anesthesia, the skin is prepared with appropriate antiseptic. Under sterile technique, the right internal jugular vein is entered and a guidewire advanced into the superior vena cava. A large sheath is placed. A curved catheter is used to cannulate the hepatic vein and hepatic venography performed to assess the adequacy of the vein for TIPS placement. The catheter is advanced deeply into the distal hepatic vein and wedged hepatic venography with carbon dioxide is then performed to assess the position and size of the portal vein. The diagnostic catheter is withdrawn and a sheathed cannula is placed into the hepatic vein over a heavy-duty guidewire. The cannula is positioned in the central portion of the hepatic vein and brought into contact with the inferior wall of the vein. A sharp stylet is advanced into the hepatic parenchyma in the direction of the portal vein and withdrawn slowly until blood return is seen. Contrast is injected to confirm intraportal position and a guidewire is carefully threaded into the portal vein. A pigtail catheter is placed over the wire into the portal vein and portal venous pressures and IVC/Right atrial pressures obtained. A diagnostic portogram is performed and filmed.

After confirming the adequacy of the puncture site into the portal vein for TIPS placement, the hepatic parenchymal tract between the hepatic vein and portal vein is dilated. A balloon angioplasty catheter is placed over the wire and the tract created with serial balloon inflations. A large sheath is advanced into the portal vein.

Stent placement is carried out. Following tract dilation, a self-expanding stent (usually 10-12 mm diameter) is positioned in the tract and deployed under careful fluoroscopic control to place appropriate amounts of stent both within the portal and hepatic veins. The stent is fully expanded with a second balloon dilation and a portogram performed to check adequacy of the result. A second stent may need to be deployed to ensure adequate coverage of the tract and/or the portal or hepatic veins. Portal pressures are remeasured and compared with pre-TIPS values.

Following repeat intra-operative portography with or without additional hemodynamics , the stent delivery cathe' and sheath are withdrawn. Hemostatis is achieved. Patient is sent to the ICU or recovery room.

Description of Post-Service Work:
The procedure report is dictated and reviewed. The outcome of the procedure is discussed with the patient's family and the referring physician is apprised of procedure outcome.

SURVEY DATA:

Presenter(s): **Robert L. Vogelzang, MD**
Specialty(s): **SCVIR**

Presenter(s): **Bibb Allen, Jr., MD**
Specialty(s): **ACR**

Sample Size: **212** Response Rate: (%): **(n=33) 16%** Median RVW: **22.00**

Type of Sample (Circle One): random, **panel**, convenience.
Explanation of sample size: Participants included members of ACR and SCVIR Economics and RUC Committees plus physicians having published articles on TIPS.

25th Percentile RVW: **20.0** 75th Percentile RVW: **25.0** Low: **3.0** High: **36.0**

Median Pre-Service Day Preceding Time: **60 min**

Median Pre-Service Time Day of Procedure: **30 min**

Median Intra-Service Time: **150 min**

25th Percentile Intra-Svc Time: **120 min** 75th Percentile Intra-Svc Time: **180 min**

Low: **24 min** High: **250 min**

	Median Total Time	Level of Serviee by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	**30 min**	
Critical Care:	**N/A**	**0-day global period**
Other Hospital Visits:	**N/A**	**0-day global period**
Discharge Day Mgmt.:	**N/A**	**0-day global period**
Office Visits:	**N/A**	**0-day global period**

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
34800	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis	20.75

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: 37182**	**Key Reference CPT Code: 34800**
Median Day Preceding Pre-Time	60 min	
Median Day of Procedure Pre-Time	35 min	
Total Pre-Time	95 min	130 min
Median Intra-Time	150 min	120 min
Median Immediate Post-service Time	30 min	40 min
Median of Aggregate Critical Care Times	N/A	
Median of Aggregate Other Hospital Visit Times	N/A	49 min
Median Discharge Day Management Time	N/A	36 min
Median of Aggregate Office Visit Times	N/A	38 min

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	4.46	3.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.46	4.17
Urgency of medical decision making	4.69	4.08

Technical Skill/Physical Effort (Mean)	**New/Revis. CPT Code: 37182**	**Key Reference CPT Code: 34800**
Technical skill required	5.00	4.67

Physical effort required	4.69	4.33

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.85	4.42
Outcome depends on the skill and judgement of physician	4.77	4.58
Estimated risk of malpractice suit with poor outcome	4.23	4.25

INTENSITY/COMPLEXITY MEASURES

Time Segments (Mean)

Pre-Service intensity/complexity	4.62	4.54
Intra-Service intensity/complexity	5.00	4.85
Post-Service intensity/complexity	4.38	4.08

ADDITIONAL RATIONALE

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

A conference call was convened with representatives from both SCVIR and the ACR. The survey data were reviewed. The recommended RVW is the median RVW (22.0) from the pooled data from ACR and SCVIR.

FREQUENCY INFORMATION

How was this service previously reported? 37205, 35476, 36481, 36012, 75960, 75978, 75889, 75887

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 Radiology _____Commonly __X__Sometimes _____Rarely

Specialty Radiology _____Commonly __X__Sometimes _____Rarely

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

Specialty: Radiology & Interventional Radiology Combined Frequency: estimated to be less than 3500

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 & Interventional Radiology Combined Frequency estimated to be less than 1400

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

CPT Code: 37182
Specialty Societies: American College of Radiology
Society of Cardiovascular & Interventional Radiology

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

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

Sample Size: consensus Response Rate: (%): N/A Global Period: 0-days

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 serves as the Society's Practice Expense Committee developed preliminary direct input recommendations. The Economics Committee's 26 members exhibit the geographic and practice type distribution as detailed above. Physicians representing both ACR and SCVIR reviewed these preliminary recommendations and consensus was achieved.

Staff Time: Our recommended staff time of 33 minutes takes into account the non-physician clinician (RN/LPN/MA) time spent (either in the office and/or the hospital) with the patient prior to the procedure, preparing the necessary clinical paperwork, scheduling, post-procedural care instructions, and post-procedure follow-up.

Supplies: None. Supplies would be incurred by the hospital.

Equipment: None. Equipment would be provided by the hospital.

'ease describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- **Complete pre-service diagnostic and referral forms**
- **Obtain medical records**
- **Coordinate pre-surgery services and scheduling**

Intra-Service Clinical Labor Activities:

- **Coordinates care with referring physician**

Post-Service Clinical Labor Activities:

- **Follow-up phone calls & prescriptions**

Total Staff Time Out of Office: 18 minutes Visits in Global Period: None

HCFA's Staff Type Code**	Clinical Labor	Pre-Service Time	Service Period	Coordination of Care*	Post-Service Time
1130	RN/LPN/MA	15 minutes	0 minutes	3 minutes	0 minutes

*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.

,CFA'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.

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	**5 minutes**	**RN/LPN/MA**
Coordinate pre-surgery services	**10 minutes**	**RN/LPN/MA**
Schedule space and equipment in facility	**0 minutes**	**RN/LPN/MA**
Office visit before surgery/procedure Review test and exam results	_____	RN, LPN, MA, Other _____
Provide pre-service education/obtain consent	_____	RN, LPN, MA, Other _____
Follow-up phone calls & prescriptions	_____	RN, LPN, MA, Other _____
Other Clinical Activity (please specify)		
_____	_____	RN, LPN, MA, Other _____
End: When patient enters 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 _____

Monitor patient following service/check tubes, monitors, drains	_____	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	_____	RN, LPN, MA, Other _____
Coordination of care by staff in office	**3 minutes**	**RN/LPN/MA**
Other Clinical Activity (please specify)		
Follow-up phone calls (e.g., with patient, call in prescriptions)	**0 minutes**	**RN/LPN/MA**

End: Patient leaves facility

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 37183 Tracking Number: W2 Global Period: 000 **RUC Recommended RVW: 8.00**

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

(Do not report, 75885 or 75887 in conjunction with code 37183)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
A 62-year-old male with alcoholic cirrhosis who had TIPS performed six months ago for treatment of variceal hemorrhage presents with a recurrent GI bleeding. Endoscopy confirms the presence of gastric varices and TIPS stenosis or occlusion is suspected. The patient is referred for TIPS revision.

For purposes of this survey, TIPS revision includes access, all procedural imaging, tract recanalization, tract dilatation, and tract stenting. Additionally, when the physician work of the initial venography and/or portography (including imaging and access) confirms the need for TIPS revision and TIPS revision is performed, code 37183 is inclusive of these services. If TIPS revision is not indicated then the appropriate codes for venography and/or portography would be reported in lieu of code 37183.

Description of Pre-Service Work:
Prior imaging studies and other test results are reviewed by the physician. The procedure is discussed with the patient, family, and referring physician and informed consent is obtained. The physician confirms room and equipment set up, including sterile preps and drapes, and proper patient positioning. Appropriate supplies such as catheters, sheaths, and guidewires are selected. Staff is directed to prepare for the procedure.

Description of Intra-Service Work:
Following anesthesia, the skin is prepared with appropriate antiseptic. Under sterile technique, the right internal jugular vein is entered and a guidewire advanced into the superior vena cava. A large sheath is placed. A curved catheter is used to cannulate the hepatic vein and hepatic venography is performed. The TIPS shunt is catheterized and a wire and catheter advanced into the portal vein. A portogram and shunt study of the TIPS tract are performed along with portal pressure measurements.

If thrombus in the TIPS tract or portal vein clot is present either pharmacological and/or mechanical removal of the thrombus is performed and the tract and portal vein restudied. If TIPS tract stenosis is present, angioplasty and/or repeat stenting of the tract is performed to re-establish a widely patent tract and normalize pressures.

A portogram is performed to check adequacy of the result. Portal pressures are remeasured and compared with pre-revision values. The catheter and sheath is removed from the puncture site and hemostasis is achieved. Patient is sent to the ICU or recovery room.

Description of Post-Service Work:
The procedure report is dictated and reviewed. The outcome of the procedure is discussed with the patient's family and the referring physician is apprised of procedure outcome.

SURVEY DATA:

Presenter(s): **Robert L. Vogelzang, MD**
Specialty(s): **SCVIR**

Presenter(s): **Bibb Allen, Jr., MD**
Specialty(s): **ACR**

Sample Size: **212** Response Rate: (%): **(n=32) 15%** Median RVW: **12.25**

Type of Sample (Circle One): random, **panel**, convenience.
Explanation of sample size: Participants included members of ACR and SCVIR Economics and RUC Committees plus physicians having published articles on TIPS.

25th Percentile RVW: **10.05** 75th Percentile RVW: **15.63** Low: **8.0** High: **21.0**

Median Pre-Service Day Preceding Time: **30 min**

Median Pre-Service Day of Procedure Time: **27.5 min**

Median Intra-Service Time: **77.5 min**

25th Percentile Intra-Svc Time: **60 min** 75th Percentile Intra-Svc Time: **97.5 min**

Low: **40 min** High: **180 min**

	Median Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	**30 min**	
Critical Care:	**N/A**	**0-day global period**
Other Hospital Visits:	**N/A**	**0-day global period**
Discharge Day Mgmt.:	**N/A**	**0-day global period**
Office Visits:	**N/A**	**0-day global period**

CPT Code: _____

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
35471	**Transluminal balloon angioplasty, percutaneous; renal or visceral artery**	**10.07**

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: 37183**	**Key Reference CPT Code: 35471**
Median Day Preceding Pre-Time	**30 min**	
Median Day of Procedure Pre-Time	**27.5 min**	
Total Pre-Time	**57.5 min**	
Median Intra-Time	**77.5 min**	
Median Immediate Post-service Time	**30 min**	
Median of Aggregate Critical Care Times	**N/A**	
Median of Aggregate Other Hospital Visit Times	**N/A**	
Median Discharge Day Management Time	**N/A**	
Total Time (*Harvard Time)		**230 min***

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	**3.58**	**3.83**
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	**3.75**	**3.75**
Urgency of medical decision making	**4.08**	**3.83**

Technical Skill/Physical Effort (Mean)	**New/Revis. CPT Code: 37183**	**Key Reference CPT Code: 35471**
Technical skill required	**3.50**	**4.08**

Physical effort required	4.42	4.33

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.17	3.92
Outcome depends on the skill and judgement of physician	3.67	4.50
Estimated risk of malpractice suit with poor outcome	4.58	4.50

INTENSITY/COMPLEXITY MEASURES

Time Segments (Mean)

Pre-Service intensity/complexity	3.75	3.66
Intra-Service intensity/complexity	4.22	3.97
Post-Service intensity/complexity	3.59	3.44

ADDITIONAL RATIONALE

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

A conference call was convened with representatives from both SCVIR and the ACR. The survey data was reviewed. The recommended RVW is the median RVW (12.25) from the pool survey data from ACR and SCVIR.

FREQUENCY INFORMATION

How was this service previously reported?

TIPS revision was reported previously using codes for: catheterization (36012, 36481), therapeutic intervention(s) [e.g. venous angioplasty (35476, 75978), stenting (37205, 757960), mechanical thrombectomy (37799)] as indicated, and imaging (75887, 75889).

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

Specialty Interventional Radiology _____Commonly __X__Sometimes _____Rarely

Specialty Radiology _____ Commonly __X__Sometimes _____Rarely

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

Specialty: Radiology & Interventional Radiology Combined Frequency: estimated to be less than 1,050

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 & Interventional Radiology Combined Frequency estimated to be less than 420

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

CPT Code: 37183
Specialty Societies: American College of Radiology
Society of Cardiovascular & Interventional Radiology

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

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

Sample Size: consensus Response Rate: (%): N/A Global Period: 0-days

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 serves as the Society's Practice Expense Committee developed preliminary direct input recommendations. The Economics Committee's 26 members exhibit the geographic and practice type distribution as detailed above. Physicians representing both ACR and SCVIR reviewed these preliminary recommendations and consensus was achieved.

Staff Time: Our recommended staff time of 33 minutes takes into account the non-physician clinician (RN/LPN/MA) time spent (either in the office and/or the hospital) with the patient prior to the procedure, preparing the necessary clinical paperwork, scheduling, post-procedural care instructions, and post-procedure follow-up.

Supplies: None. Supplies would be incurred by the hospital.

Equipment: None. Equipment would be provided by the hospital.

CPT Code: 37183
Specialty Societies: American College of Radiology
Society of Cardiovascular & Interventional Radiology

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- **Complete pre-service diagnostic and referral forms**
- **Obtain medical records**
- **Coordinate pre-surgery services and scheduling**

Intra-Service Clinical Labor Activities:

- **Coordinates care with referring physician**

Post-Service Clinical Labor Activities:

- **Follow-up phone calls & prescriptions**

Total Staff Time Out of Office: 18 minutes Visits in Global Period: None

HCFA's Staff Type Code**	Clinical Labor	Pre-Service Time	Service Period	Coordination of Care*	Post-Service Time
1130	RN/LPN/MA	15 minutes	0 minutes	3 minutes	0 minutes

*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 sou

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.

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	**5 minutes**	**RN/LPN/MA**
Coordinate pre-surgery services	**10 minutes**	**RN/LPN/MA**
Schedule space and equipment in facility	**0 minutes**	**RN/LPN/MA**
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 _____
ther Clinical 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 _____

Monitor patient following service/check tubes, monitors, drains	_____	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	_____	RN, LPN, MA, Other _____
Coordination of care by staff in office	**3 minutes**	**RN/LPN/MA**
Other Clinical Activity (please specify)		
Follow-up phone calls (e.g., with patient, call in prescriptions)	**0 minutes**	**RN/LPN/MA**

End: Patient leaves facility

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Endoscopic Ligation Subfascial Perforator Veins (SEPS)

One new code was developed and one existing code was revised to accurately describe what is becoming the most common method to perform subfascial perforator ligation. The endoscopic technique is completely different from the only existing code for open subfascial perforator ligation, CPT code 37760 *Ligation of perforators, subfascial, radical (Linton type), with or without skin graft*, (work RVU=10.47).

37500
The RUC determined that the pre-service time was excessive compared to the services for the following codes:

- 37600 Ligation; external carotid artery (11.25 RVU) with a 55-minute pre-service time.
- 37650 Ligation of femoral vein (7.80 RVU) with a 60-minute pre-service time (Harvard time)
- 37660 Ligation of common iliac (21.00 RVU) with a 60-minute pre-service time

The RUC considered the work of 37500 (AU1), and determined that work was more than the 37650, yet less than 37650 and 37660. The specialty and the RUC agreed that the pre-service time was excessive when compared to these services, and believed that the median pre-service time should be decreased to 60 from 90 minutes. In addition, the RUC believed that the 25th percentile of the survey respondents represented the work involved for the typical patient. The RUC also reviewed similar codes for their IWPUT calculations and it was determined that they were consistent. The survey median and the initial specialty recommendation was for a work value of 12.00, the 25th percentile survey results and the recommendation of the RUC is for a relative value of 11.00, with a pre-service time of 60 minutes.

The RUC recommends a work relative value of 11.00 for code 37500.

Practice Expense
This procedure is only performed out-of-the-office. The practice expense inputs were approved with minor modifications. The 6 minutes for coordination of care was modified to the discharge day standards. In addition, the patient education book was removed. Details of the practice expense are attached to the recommendation.

CPT Code (•New)	Track-ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
●37500	AU1	Surgical vascular endoscopy always includes diagnostic endoscopy. Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS) (For open procedure, use 37760)	090	11.00
37501		Unlisted vascular endoscopy procedure	YYY	N/A
▲37760		Ligation of perforator veins, subfascial, radical (Linton type), with or without skin graft, open (For endoscopic procedure, use 37500)	090	10.47 (no change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

AU1 April 2002

CPT Code: 37500 **Global Period**: 090**RUC Recommended RVW**: ~~12.00~~ 11.00

CPT Descriptor: Vascular endoscopy, surgical with ligation of perforator veins, subfascial (SEPS)

Typical Patient (*Survey Vignette*): A 70-year old patient presents with stasis dermatitis and ulceration of the right lower extremity. Duplex scan of his veins corroborates the clinical diagnosis of perforator vein valvular insufficiency with identification of several large incompetent perforating veins and many smaller ones. To limit skin deterioration and help prevent recurrent ulcers, subfascial endoscopic perforator surgery (SEPS) is performed.

CLINICAL DESCRIPTION OF SERVICE:

Pre-Service Work: Pre-service work begins after the decision to operate is made, from the day before the operation until the skin incision. This activity includes obtaining and reviewing the previous work-up, with special attention to potential cardiovascular risk factors. The peripheral vascular exam and the preoperative duplex study are reviewed. Informed consent is obtained from the patient following a discussion of surgical risks and benefits. Discussion is also held with the anesthesiologist to determine the anesthetic of choice. Additional pre-service work includes ensuring that all endoscopic equipment is available and functional. Finally, preoperative work also includes change into surgical scrubs, supervise patient positioning, surgical hand scrub, prep and drape patient, and wait for the anesthetic to become effective.

Intra-Service Work: Intra-service work begins with the skin incision. The first incision is made over the medial compartment, through the subcutaneous tissue and through the fascia for introduction of the "space maker" balloon. This device is introduced to the subfascial compartment, expanded with saline, then insufflated with CO2 in order to develop the subfascial work area. Two additional incisions are made for port entry. Dissection and identification of perforators is carried out one at a time. CO2 re-insufflation is performed as necessary. As each suspected perforator is identified it is cleared of soft tissue, absolutely identified as a vein, then clipped and divided with endoscopic instrumentation. A thorough search is made to identify and divide all perforators. The endoscopic spoon dissector is introduced through the port to identify difficult-to-find perforators. Additional incisions and scope insertions are performed as necessary to find and divide all perforators. Once completed the endoscopic equipment is removed.

Very low perforators not amenable to endoscopic visualization are approached through separate small skin incisions. They are identified, ligated and divided under direct vision. All incisions are irrigated with saline and closed with sutures or steri-strips.

Post-service work begins after skin closure and includes application of gauze dressings plus external elastic support bandages. Patient is transported to the recovery area. Additional post-service work includes writing postoperative orders, assuring patient is positioned with legs elevated and compressed, communicating with family and referring physicians, dictating operative note. The physician discusses operative findings with patient when he/she emerges from anesthesia. Additional post-operative visits are performed as required. Discharge planning and wound care instructions are completed. Follow-up appointments are scheduled. All related post-discharge care for the next 90-days is included in the global service.

SURVEY DATA

Presenters: Gary Seabrook, M.D.
Donna Mendes, M.D.
Bob Zwolak, M.D.

Specialty(s): American Association for Vascular Surgery

CPT: 37500
Sample Size: 150 **Resp n:** 32 **Resp %:** 21%
Sample Type:

	Low	25th pctl	Median	75th pctl	High
Survey RVW	8.70	**11.00**	12.00	15.00	27.00
Pre-Service			60		
Intra-Service	45	**60**	90	120	210

Post-Service	**Total Min**	**CPT code / # of visits**
Day of Surgery:		
Immediate Same Day	**30**	
Other Same Day	**18**	99238 x 0.5
After Day of Surgery:		
Critical Care	**0**	
Other Hospital	**0**	
Dischg Day Mgmt	**0**	
Office Visits	**61**	99213x2 99212x1

KEY REFERENCE SERVICES:

CPT	Descriptor	2002 RVW	Glob
34203	Embolectomy or thrombectomy, with or without catheter, popliteal-tibio-peroneal artery, by leg incision	16.50	90

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE:

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 37500	Ref CPT 34203
Pre-service	60	75
Intra-service	90	108
Same Day Immediate Post-service	30	30
Same Day Other Post-service	0	87
Post Total critical care (not same day)	0	
Post Total other hospital visit (not same day)	0	
Discharge management	18	36
Total office visit	61	61
TOTAL TIME	~~289~~259	397

INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	3.00	4.00
Intra-service	3.67	3.60
Post-service	2.33	3.20
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3.00	3.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.67	3.40
Urgency of medical decision making	2.60	4.40
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	3.50	3.80
Physical effort required	3.17	3.20
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	2.67	4.20
Outcome depends on the skill and judgment of physician	3.50	4.20
Estimated risk of malpractice suit with poor outcome	3.00	3.80

ADDITIONAL RATIONALE

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

We recommend the median survey value of 12.00 RVUs based on comparison to the reference service with further justification provided by an IWPUT/Building Block calculation. The new service has 18 minutes (17%) less intra-service time, but it has 2% greater intra-service intensity than the key reference. The new service has 4 less hospital days but same office visits as reference. Reference service has RVW of 16.50, less 1.28 RVUs for intra-service discrepancy, less 3.62 RVUs for the hospital days, results in a comparison RVW of 11.60, very close to median survey of 12.00. IWPUT for new service is a reasonable at 0.077.

The details of reference service comparison are as follows. The new service has an intra-service time 18 minutes less than the reference code, but an intra-service intensity 2% greater than reference. The reference code 34203 was thoroughly evaluated in the recently completed 10-year review, and based on that analysis it has an intra-service RVU of 8.53. If we adjust for time (90/108 minutes) and for intensity (3.67/3.60) based on survey respondent data noted above, the intra-service work of new code is 8.53 x (90/108) x (3.67/3.60) = 7.25, or 1.28 RVUs less than reference. We then calculated the three hospital days and half a discharge day less for new service (3 x 99231=1.92 plus 1 x 99232=1.06 plus ½ x 99238 = 0.64 = 3.62). The adjusted RVW for new service may be estimated as 16.50 *less* 1.28 (intra-adjustment) *less* 3.62 (hospital visit adjustment) = 11.60. This is remarkably close to the median survey value of 12.00.

IWPUT Calculation

The IWPUT for this service is calculated from the median RVW of 12.00 and turns out to be 0.077, an acceptable value for this high-tech endoscopic procedure.

Building Block Analysis

				Rec. RVW
			37500	**12.00**
Pre-service:		**Time**	**Intensity**	(=time x intensity)
	Pre service	90	0.0224	**2.02**
Post-service:		**Time**	**Intensity**	
	Immediate post	30	0.0224	**0.67**
	Subsequent visits:	**Visit n**	**E/M RVU**	(=n x E/M RVU)
	ICU 99291	0.0	4.00	0.00
	99233	0.0	1.51	0.00
	99232	0.0	1.06	0.00
	99231	0.0	0.64	0.00
	Discharge 99238	0.5	1.28	0.64
	99215	0.0	1.73	0.00
	99214	0.0	1.08	0.00
	99213	2.0	0.65	1.30
	99212	1.0	0.43	0.43
	99211	0.0	0.17	0.00
Post-service total:				**3.04**
		Time	**IWPUT**	
Intra-service		90	**0.077**	**6.94**

FREQUENCY INFORMATION

How was this service previously reported? 37799

How often do physicians in your specialty perform this service?

Specialty: AAVS - Sometimes

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

Specialty: AAVS National Frequency: 500 Medicare Frequency: 400

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

Performed in Hospital: yes **ASC:** yes **Office:** no

CPT: 37500 SEPS
Specialty: AAVS

AMA/Specialty Society Update Process
RUC Summary of Recommendation
90-Day Global Out-Of-Office Direct Inputs [In-Office Not Applicable]

AAVS used a consensus panel approach to develop practice expense recommendations for code 37500. Our Government Relations Committee is composed of members representing all aspects of the vascular surgical community. We worked together to develop "typical" clinical inputs for this code.

Geographic Practice Setting %:

The panel members practice in all areas of the country. The group represented 67% urban, 24% suburban and 10% rural.

Type of Practice %:

The panel's composition is 66% academic and 34% private practice.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: Obtain all operative reports; obtain current labs; obtain pre-op cardiac evaluation; obtain cardiologist's current evaluation; review history; obtain current vital signs, meds, IV infusions; assess respiratory status; review microbiology reports; review x-rays; greet patient; provide pre-service education; obtain consent; prepare room; prepare equipment; position patient
Intra-Service Clinical Labor Activities: AAVS acknowledges that CMS does not reimburse for clinical staff time during the intra-service portion of 90-day global services. Thus, we have listed 'pending' for this section of the attached table. Nevertheless, the majority of AAVS members indicate that they bring their own clinical staff into the hospital primarily to provide specialty-related patient care and coordination of care that would not otherwise be provided by the hospital.
Post-Service Clinical Labor Activities - Office Visits Greet patient - escort to room; provide gowning; interval history/vital signs; assemble lab reports; assist physician during exam; assist with dressing, wound care, suture removal; prepare prescriptions; education/counseling; clean room, check supplies; coordinate out-patient care; calls with patient between office visits; coordinate visiting nurse/physical therapy.

	A	B	C	D	E	F	G	H	I	J	K	L
1	**Clinical Labor, Medical Supplies, and Procedure Equipment Practice Expense Data**									**CPT**	**37500**	**37500**
2										**Global**	**090**	**090**
3								**Number/Level of Post OV:**			**N/A**	**99213x2 99212x1**
4	**CLINICAL LABOR**						**Code**	**staff desc**		**Price**	**IN Off**	**OUT off**
5	**TOTAL TYPICAL TIME**						1130	RN/LPN/MA		$ 0.317	**0**	**165**
6	**PRE-service time**						1130	RN/LPN/MA		$ 0.370	**0**	**60**
7	**SERVICE time Coordination of Care**						1130	RN/LPN/MA		$ 0.370	**0**	**6**
8	**POST-service time**						1130	RN/LPN/MA		$ 0.370	**0**	**99**
9	**PRE-SERVICE**											
10	**BEGINS after procedure consult. (in off / out off)**										**Min**	**Min**
11	Complete pre-service diagnostic & referral forms (5/5)						1130	RN/LPN/MA		$ 0.370	**0**	**5**
12	Coord pre-proc services/review test/exam results (10/20)						1130	RN/LPN/MA		$ 0.370	**0**	**20**
13	Schedule space and equipment in facility (0/8)						1130	RN/LPN/MA		$ 0.370	**0**	**8**
14	OV before surgery/procedure - review test/exam results (0/0)						1130	RN/LPN/MA		$ 0.370	**0**	**0**
15	Provide pre-service education/obtain consent (10/20)						1130	RN/LPN/MA		$ 0.370	**0**	**20**
16	Follow-up phone calls & prescriptions (10/7)						1130	RN/LPN/MA		$ 0.370	**0**	**7**
17	**Other Pre-Service Activities (please specify):**											
18	none						1130	RN/LPN/MA		$ 0.370	**0**	**0**
19	**ENDS with admission to facility/office**											
20	**SERVICE PERIOD**											
21	**Starts with admission to facility/office**										**Min**	**Min**
22	Discharge Day						1130	RN/LPN/MA		$ 0.370	**0**	**6**
23	**Ends with discharge from facility/office**											
24	**POST-SERVICE**											
25	**Begins after discharge from facility/office**										**Min**	**Min**
26	**Postop OV total time (E/M standards)**	-211 (16)	-212 (27)	-213 (36)	-214 (53)	-215 (63)	1130	RN/LPN/MA		$ 0.370	**0**	**99**
38	**Other Activities (please specify):**											
39							1130	RN/LPN/MA		$ 0.370	**0**	**0**
40	**ENDS after 90 days from day of procedure.**											
41	**MEDICAL SUPPLIES**						**Code**	**Unit Size**	**Unit Cnt**	**Price**	**Out Off**	**Out Off**
42											**QTY**	**QTY**
43	**PEAC Minimum visit package (multi-specialty):**						**PEAC**	**PKG**	**1**	**$ 1.310**	**0**	**3**
44	exam table paper (7 ft)						11111	foot	1	$ 0.015		
45	gloves, non-sterile (2 pair)						11302	pair	1	$ 0.120		
46	patient gown, disposable						11107	item	1	$ 0.570		
47	pillow case, disposable						11112	item	1	$ 0.320		
48	thermometer probe cover, disposable						11509	item	1	$ 0.069		
49	**Add'l per visit supplies:**											
50	patient education booklet						11115	item	1	$ 0.920	**0**	**1-0**
51											**Out Off**	**Out Off**
52	**Postop incision care supplies:**						**Code**	**Unit Size**	**Unit Cnt**	**Price**	**QTY**	**QTY**
53	**Post-op Incisional Care Kit**										**0**	**1**
54	Gloves, sterile						14005	1 pair		-	**0**	**1**
55	Swab, alcohol						31101	2 item			**0**	**2**
56	Steri-strips						31513	2 packs			**0**	**2**
57	Tape 12 inches						31514	2 increments			**0**	**2**
58	Staple remover kit						31702	1 item			**0**	**1**
59	Betadine						52301	10 ml			**0**	**2**
60	Gauze, sterile 4x4						31505	2 items			**0**	**2**
61	Tincture benzoin swab						52308	1 item			**0**	**1**
62	**Other required material for prevention of post-operative venous ulceration in leg with severe venous insufficiency**											
63	Adaptic dressing 5" x 9" (NDC: 56091-0020-19) one per visit						see NDC*	each	1	$ 1.750		**3**
4	Ace wrap 4" one per visit						31515	each	1			**3**
55	Ace wrap 6" one per visit						31503	each	1			**3**
66	**PROCEDURE SPECIFIC EQUIPMENT**											
67	Power Table						E11003	1		$ 6,939	**0**	**1**
68												
69	*Note: NDC=national drug code. Price shown is AWP (average wholesale price per unit)											

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Bone Marrow Procedures

Thirteen new CPT codes were added and two were deleted to provide greater granularity to code accurately the specific procedures performed for each patient. The newer techniques used in a transplant laboratory under physician supervision are now captured in these new CPT codes. CPT codes 38204-382046 replace codes 38231 *Blood-derived peripheral stem cell harvesting for transplantation, per collection* (Work RVU = 1.50) and 86915 *Bone marrow or peripheral stem cell harvest, modification or treatment to eliminate cell type(s) (eg, T-cells, metastatic carcinoma)* (Work RVU = 0.00) to allow for different types, work, and techniques now used for different types of cell harvesting and also transplant preparation as well as the critical work and techniques involved in stem cell processing prior to a Bone Marrow Transplant. Present codes 38231 and 86915 were not designed for modern procedures in Bone Marrow transplant and have virtually no relevance to the present stem cell harvesting and processing work and procedures. The RUC understands that these services are more commonly performed on the Medicare population and very few centers perform these services (50 centers), therefore a small sample size of 22 is expected.

38204 ***Management of recipient hematopoietic proginator cell donor search and cell acquisition***
The RUC reviewed the survey results and the similarities in physician work of the reference code, 80502 *Clinical pathology consultation; comprehensive, for complex diagnostic problem, with review of patient's history and medical records* (Work RVU=1.33). The RUC believed that this service was more intense than 80502 as there was zero tolerance for error. The RUC understands that this newly reported service would be billed one time per recipient. The RUC also compared this service to CPT code 99204 *Office or other outpatient visit for the evaluation and management of a new patient ...* a level 4 new patient office visit representing 45 minutes of physician time (work RVU = 2.00). The RUC agreed that the time spent on this type of per patient management reflected the specialty's recommended 25th percentile surveyed intra-service time. **The RUC recommends a relative work value of 2.00 for CPT code 38204.**

→ The RUC agrees that there is no pre- or post-service time

38205 ***Blood derived hematopoietic proginator cell harvest for future transplantation per collection; allogeneic***
38206 ***Blood derived hematopoietic proginator cell harvest for future transplantation per collection; autologous***
These two codes were previously billed as code 38231 *Blood derived peripheral stem cell harvesting for transplantation, per collection* (Work RVU = 1.50). The specialty society recommended a value of 2.0 stating code 38231 had been undervalued. The

RUC however found no compelling evidence to increase the value, and believed it had been appropriately valued by the RUC when reviewed in 1995. **The RUC recommends a relative work value of 1.50 for CPT codes 38205 and 38206.**

38210 & 38207 – 38215

The RUC reviewed CPT code 38210 *Transplantation preparation of hematopoietic progenitor cells; cryopreservation and storage; specific cell depletion within harvest, T-cell depletion* as an anchor code for family 38205 through 38215. The RUC first recognized that the vignette did not reflect an accurate description of the service of 38210, however the RUC did believe that the work involved in code 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Work RVU = 0.94) was similar. The RUC also reviewed the codes in comparison the work of evaluation and management services. The RUC was concerned regarding the accuracy of the survey data for these services. However, the RUC agreed that a repeated survey would not be appropriate as it would have to be circulated to the same physicians/centers. The RUC recommends that a consensus panel of physicians, with the participation of one or more RUC members, review these codes again for the September 2002 RUC meeting. The RUC however, felt strongly, that these services require physician work and recommends interim work values to be assigned for 38207-38215. The RUC emphasized that these interim values should not be viewed as a "ceiling" for the future review, but serve as the best alternative until future review is completed. **Considering the similarities in work of code 86077 and 38210, the RUC recommends an interim value of 0.94 for code 38210.**

The RUC compared similarities in work and intensity of codes 86077 and 38210, and then agreed with the rank order established by the specialty society for the family of codes 38207 through 38215. The RUC agreed with the specialty society's recommended rank order for the family, but also understood that the values being established were interim pending future RUC review and consideration at the September 2002 meeting. **The RUC recommends the following interim work relative values for CPT codes 38207-38215:**

38207	**0.47**
38208	**0.56**
38209	**0.24**
38210	**0.94**
38211	**0.71**
38212	**0.47**
38213	**0.24**
38214	**0.24**
38215	**0.55**

38242 ***Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic donor lymphocyte infusions***
The specialty presented a typical patient that is severely ill and in great risk. Approximately 25% of these procedures are complicated by life threatening reactions to the infusion. The RUC agreed with the specialties description of the intensity of intra-service work and 25th percentile time of 30 minutes.

The RUC also understood that this service could be compared to several other intense procedures including critical care code 99292 *Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)* (work RVU = 2.0), however, the work for this code was not quite as intense, and could be more appropriately aligned with code 99357 *Prolonged physician service in the inpatient setting, requiring direct (face-to-face) patient contact beyond the usual service (eg, maternal fetal monitoring for high risk delivery or other physiological monitoring, prolonged care of an acutely ill inpatient); each additional 30 minutes (List separately in addition to code for prolonged physician service* (work RVU= 1.71) for its time and intensity. The RUC in addition, believed code 38242 was less intense than the reference code 38240 *Bone marrow or blood-derived peripheral stem cell transplantation; allogenic* (work RVU = 2.24, Harvard total time 53). **The RUC recommends a relative work value of 1.71 for code 38242,** which has the approval of the specialty society.

Practice Expense: The RUC and the specialty society agreed that these procedures do not have any practice expense inputs and are performed exclusively in the facility setting.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•38204	AV1	Management of recipient hematopoietic progenitor cell donor search and cell acquisition	XXX	2.0
•38205	X1	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogenic	000	1.50
•38206	X2	autologous	000	1.50
•38207	X3	Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage (For diagnostic cryopreservation and storage, see 88240)	XXX	0.47 (Interim)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 38208	X4	thawing of previously frozen harvest (For diagnostic thawing and expansion of frozen cells, see 88241)	XXX	0.56 (Interim)
● 38209	X5	washing of harvest	XXX	0.24 (Interim)
● 38210	X6	specific cell depletion within harvest, T-cell depletion	XXX	0.94 (Interim)
● 38211	X7	tumor cell depletion	XXX	0.71 (Interim)
● 38212	X8	red blood cell removal	XXX	0.47 (Interim)
● 38213	X9	platelet depletion	XXX	0.24 (Interim)
● 38214	X10	plasma (volume) depletion	XXX	0.24 (Interim)
● 38215	X11	cell concentration in plasma, mononuclear, or buffy coat layer	XXX	0.55 (Interim)
~~38231~~		~~Blood-derived peripheral stem cell harvesting for transplantation, per collection~~ (38231 has been deleted. To report, use 38205-38206)	XXX	N/A

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
• 38242	X12	Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic donor lymphocyte infusions	XXX	1.71
~~86915~~		~~Bone marrow or peripheral stem cell harvest, modification or treatment to eliminate cell type(s) (eg, T-cells, metastatic carcinoma)~~ (86915 has been deleted. To report, use 38210-38213)	XXX	N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38204 Tracking Number: AV1 Global Period: XXX **Recommended RVW:** 2.0

CPT Descriptor: Management of recipient hematopoietic proginator cell donor search and cell acquisition

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient is a 35 year old female with acute leukemia who lacks an HLA identical sibling. Because of the need for treatment of the leukemia, a search for an unrelated donor is required. The patient's acute leukemia is in relapse.
The unrelated donor registry has 30 potential donors who are AB matched and 5 who are AB DR matched but are molecular subtype mismatched. It is necessary to select potential donors for further HLA typing, review the HLA typing to determine which donor is the best possible match and select that donor as the potential donor. While a search coordinator orders the testing, the review of which prospective donors are tested and ultimate selection of a prospective donor is done by a physician. Criteria are the patient's age, the donor's age, the patient's CMV status, the donor's CMV status, and the patient's HLA typing and sub-typing. The urgency of transplantation determines how closely the donor must match the recipient to be acceptable and how long the search continues. Once a potential unrelated donor is identified, requests are made for information from the unrelated donor registry to help decide whether to acquire unrelated bone marrow or stem cells from a prospective donor. The donor size, HLA match, and status of patient's leukemia (i.e., in remission or relapse) are used to make this decision. If the source of hematopoietic progenitors is an umbilical cord blood, the ordering physician reviews how many cells are in the umbilical cord and if possible how many CD34(+) cells, before madding a decision to order that particular cord blood. The physician managing the unrelated donor search then write a prescription requesting that hematopoietic progenitor cells be collected from the prospective donor and by either a bone marrow harvest or a blood-derived peripheral blood progenitor cell collection. The requesting physician requests that the progenitor cells be collec[redacted] to meet the recipient's needs. The bone marrow, stem cells or umbilical cord blood is collected, local to the do[redacted]
The physician responsible for the donor's collection then informs the physician ordering the hematopoietic progenitor what the donor is capable of donating. The recipient's physician determines if this is acceptable to meet the needs of the patient or if the search needs to continue to find a donor able to meet the recipient's needs. The donor's physician tries to balance all donor safety needs with recipient needs for the product. The risk for patient care is high.

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 71% Median RVW: 2.4

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

25th Percentile RVW: 1.5 75th Percentile RVW: 3.25 Low: 1 High: 5

Median Pre-Service Time: 20 Median Intra-Service Time: 100

25th Percentile Intra-Svc Time: 52.5 75th Percentile Intra-Svc Time: 120 Low: 0 High: 300

CPT Code: 38204

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	0	

The consensus panel recommends that there be no pre- or post- service time for this CPT code.

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
80502	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	XXX	1.33

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including 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:**
Median Pre-Time	20 0	No RUC data
Median Intra-Time	52.50	No RUC data
Median Immediate Post-service Time	0	No RUC data
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	4.67	4.13
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.67	3.80
Urgency of medical decision making	4.47	3.73

Technical Skill/Physical Effort (Mean)

Technical skill required	4.40	3.71
Physical effort required	1.67	2.21

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.73	3.86

Outcome depends on the skill and judgement of physician	4.80	3.79
Estimated risk of malpractice suit with poor outcome	3.73	2.93

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.25	3.25
Intra-Service intensity/complexity	3.92	3.38
Post-Service intensity/complexity	3.57	2.57

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data and felt that the median time values were too high. The panel felt that the 25th percentile values were more reflective of the time physicians spend performing 38204.

FREQUENCY INFORMATION

How was this service previously reported? Not previously paid (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_____ _____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 a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty _____ Frequency: No Medicare Data on code

Specialty _____ Frequency_____

CPT Code: 38204

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

CPT Code: 38205

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38205 Tracking Number: X 1 Global Period: 000 ~~**Recommended RVW: 2.0**~~

RUC Recommended RVW:

CPT Descriptor: Blood derived hematopoietic proginator cell harvest for future transplantation per collection; allogeneic

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient has AML in first relapse with an HLA identical sibling. Allogeneic bone marrow/stem cell transplant is the only curative procedure.
First, the physician evaluates whether the donor is a good donor, Hepatitis types (if any), HLA type of the donor, transmissible diseases, and donor size versus recipient size to make a decision about using an allogeneic stem cell harvest. Then the actual peripheral mononuclear stem cells are harvested from the allogeneic donor using an FDA approved apheresis device. Prior to starting the procedure that day the physician checks donor electrolytes, creatinine, CBC, and ECG. The physcian monitors the amount of RBC's removed by the machine continuously if donor and recipient are ABO mismatched. The physcian continuously monitors donor safety by evaluating blood pressure, pulse, and replaces electrolytes, especially calcium as determined by patient symptoms and ECG monitoring. Post procedure the donor CBC is checked if platelets need to be added from the product. Quality assessment of the collection procedure is performed by the physician using cell counts, cell differentials, flow cytometry, infection control cultures, etc.

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 71% Median RVW: 2.70

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

25th Percentile RVW: 2.38 75th Percentile RVW: 4.0 Low: 2.0 High: 5.0

Median Pre-Service Time: 38 Median Intra-Service Time: 60

25th Percentile Intra-Svc Time: 45 75th Percentile Intra-Svc Time: 120 Low: 10 High: 300

Median Post-Service Time:	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	30	

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
90937	Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription	000	2.11

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:**
Median Pre-Time	38	0
Median Intra-Time	45	55
Median Immediate Post-service Time	30	0
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	3.87	3.93
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.20	4.07
Urgency of medical decision making	4.20	4.13

Technical Skill/Physical Effort (Mean)

Technical skill required	4.40	4.13
Physical effort required	2.73	2.80

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.27	3.80
Outcome depends on the skill and judgement of physician	4.47	3.80
Estimated risk of malpractice suit with poor outcome	4.40	3.80

CPT Code: 38205

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.90	3.90
Intra-Service intensity/complexity	3.93	3.73
Post-Service intensity/complexity	3.33	3.00

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data and felt that the median time values were too high. The panel felt that the 25th percentile values were more reflective of the time physicians spend performing 38205.

FREQUENCY INFORMATION

How was this service previously reported? 38231 (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_____ _____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: No Medicare Data on code

Specialty _____ Frequency_____

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

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CPT Code: 38206

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38206 Tracking Number: X 2 Global Period: 000 ~~**Recommended RVW: 2.0**~~

RUC Recommended RVW: 1.50

CPT Descriptor: Blood derived hematopoietic proginator cell harvest for future transplantation per collection; autologous

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient is a 35 year old female with Hodgkin's disease in second relapse with no marrow involvement. BMT is curative. Autologous peripheral stem cell collection is treatment of choice. Recipient needs to be assessed for risk of myelodysplasia.
First, the patient's bone marrow cellularity is assessed. The hematopoietic progenitor cells are assessed for any cytogenetic defects and for any blood transmissible diseases. Blood-derived hematopoietic progenitor cells are harvested. Prior to starting the procedure that day the physcian checks patient electrolytes, creatinine, CBC, and ECG. The physcian continuously monitors patient safety by evaluating blood pressure, pulse, and replaces electrolytes, especially calcium as determined by patient symptoms and ECG monitoring. Post procedure the donor CBC is checked if platelets need to be added from the product. Quality assessment of the collection procedure is performed by the physician using cell counts, cell differentials, flow cytometry, infection control cultures, etc.

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 71% Median RVW: 3.0

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

25th Percentile RVW: 2.0 75th Percentile RVW: 4.0 Low: 2.0 High: 6.0

Median Pre-Service Time: 40 Median Intra-Service Time: 60

25th Percentile Intra-Svc Time: 35 75th Percentile Intra-Svc Time: 120 Low: 15 High: 300

Median Post-Service Time:	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	20	

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	XXX	4.0

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/Revis. CPT Code:**	**Key Reference CPT Code:**
Median Pre-Time	40	15
Median Intra-Time	35	45
Median Immediate Post-service Time	20	15
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.00	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.53	4.27
Urgency of medical decision making	4.40	4.20

Technical Skill/Physical Effort (Mean)

Technical skill required	4.47	4.20
Physical effort required	3.13	3.27

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.60	4.13
Outcome depends on the skill and judgement of physician	4.53	4.00
Estimated risk of malpractice suit with poor outcome	4.20	3.87

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.40	4.00
Intra-Service intensity/complexity	4.07	4.07
Post-Service intensity/complexity	3.67	3.00

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data and felt that the median time values were too high. The panel felt that the 25th percentile values were more reflective of the time physicians spend performing 38206.

FREQUENCY INFORMATION

How was this service previously reported? 38231 (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_____ ____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: No Medicare Data on code

Specialty _____ Frequency_____

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

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38207 Tracking Number: X3 Global Period: XXX ~~**Recommended RVW: 1.0**~~

RUC Recommended RVW:

CPT Descriptor: Cryopreservation and storage

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Peripheral blood stem cells or bone marrow have been collected. These cells are to be cryopreserved for later use as part of an autologous transplant where hematopoietic progenitor cells have to first be cryopreserved for a later autologous hematopoietic progenitor cell transplant. In many cases, the bone marrow or peripheral blood progenitor cells are also cryopreserved for allogeneic transplants. This ensures that the cells are ready and available when the patient needs them. The physcian writes separate prescriptions for cryropreservation and thawing of the product. A physcian supervises both cryropreservation and thawing of the product and in an emergency does these procedure himself/herself as a patient life is in jeopardy.
The cryopreservation process is begun. It is important to make sure the freezing process is performed correctly to ensure that the cells have been frozen in a safe manner to be acceptable for transplantation. This requires following validated standard operating procedures. Cryopreservation data are reviewed and quality assessment of the procedure is performed. Cells are stored at a low temperature under controlled monitored conditions until needed for transplant. The physcian may do this procedure in an emergency. The quality of the cryropreserved transplantation product (bone marrow, blood-derived, or umbilical cord blood-derived hematopoietic progenitor cells, allogeneic t-lymphocytes) must be assessed prior to release of product. Examples of quality assurance are nucleated cell count, differential, viability, sterility and/or immunophenotyping by flow cytometry for cd34(+) progenitor cells, T-lymphocytes, or tumor cells. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physcian then judges if this product remains suitable for transplantation or if new product needs to be collected.

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 66% Median RVW: 1.42

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

25th Percentile RVW: 1.23 75th Percentile RVW: 1.88 Low: 1.00 High: 8.00

Median Pre-Service Time: 2.5 Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 20 75th Percentile Intra-Svc Time: 56.25 Low: 10 High: 420

Median Post-Service Time: Level of Service by CPT Code

CPT Code: 38207

Total Time (List CPT Code & # of Visits)

Immediate Post Service Time: 12.5

The consensus panel recommends that there be no pre- or post- service time for this CPT code.

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
80502	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	XXX	1.33

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including 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:**
Median Pre-Time	2.5	No RUC data
Median Intra-Time	20	No RUC data
Median Immediate Post-service Time	12.5	No RUC data
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	3.64	3.85
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.93	3.54
Urgency of medical decision making	4.14	3.92

Technical Skill/Physical Effort (Mean)

Technical skill required	4.29	3.62
Physical effort required	2.43	2.08

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.36	4.00

Outcome depends on the skill and judgement of physician	4.21	4.15
Estimated risk of malpractice suit with poor outcome	4.43	4.38

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.13	2.63
Intra-Service intensity/complexity	3.62	3.08
Post-Service intensity/complexity	3.22	2.63

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data and felt that the median time values were too high. The panel felt that the 25th percentile values were more reflective of the time physicians spend performing 38207.

FREQUENCY INFORMATION

How was this service previously reported? 86915 (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_____ _____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 a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty _____ Frequency: No Medicare Data on code

Specialty _____ Frequency_____

CPT Code: 38207

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

CPT Code: 38208

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38208 Tracking Number: X4 Global Period: XXX ~~**Recommended RVW: 1.2**~~

RUC Recommended RVW:

CPT Descriptor: Thawing of previously frozen harvest

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The previously cryopreserved marrow and stem cells are thawed in a heated water bath. A sample is obtained for post-thaw quality assessment such as nucleated cell count and viability. Cells are infused immediately post-thaw. The physician may do this procedure in an emergency. The quality of the thawed transplantation product (bone marrow, blood-derived, or umbilical cord blood-derived hematopoietic progenitor cells, allogeneic t-lymphocytes) must be assessed prior to release of product. Examples of quality assurance are nucleated cell count, differential, viability, sterility and/or immunophenotyping by flow cytometry for cd34(+) progenitor cells, T-lymphocytes, or tumor cells. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physcian then judges if this product remains suitable for transplantation or if new product needs to be collected.

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 76% Median RVW: 1.42

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

25th Percentile RVW: 1.00 75th Percentile RVW: 2.58 Low: 0.37 High: 5

Median Pre-Service Time: 5 Median Intra-Service Time: 45

25th Percentile Intra-Svc Time: 24 75th Percentile Intra-Svc Time: 60 Low: 5 High: 150

Median Post-Service Time:	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	5	

The consensus panel recommends that there be no pre- or post- service time for this CPT code.

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
80502	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	XXX	1.33

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including 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:**
Median Pre-Time	5	No RUC data
Median Intra-Time	24	No RUC data
Median Immediate Post-service Time	5	No RUC data
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.63	3.44
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.31	3.19
Urgency of medical decision making	4.19	3.06

Technical Skill/Physical Effort (Mean)

Technical skill required	3.88	3.19
Physical effort required	2.56	2.25

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.06	3.19
Outcome depends on the skill and judgement of physician	3.75	3.38
Estimated risk of malpractice suit with poor outcome	4.00	3.31

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.10	2.50
Intra-Service intensity/complexity	3.75	3.13
Post-Service intensity/complexity	3.20	2.50

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data and felt that the median time values were too high. The panel felt that the 25th percentile values were more reflective of the time physicians spend performing 38208.

FREQUENCY INFORMATION

How was this service previously reported? 86915 (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_____ _____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: No Medicare Data on code

Specialty _____ Frequency_____

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

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CPT Code: 38209

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38209 Tracking Number: X5 Global Period: XXX ~~**Recommended RVW: 0.5**~~

RUC Recommended RVW: 0.24

CPT Descriptor: Washing of harvest

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Blood derived hematopoietic progenitor cells have been harvested but the patient mobilizes very poorly with few stem cells. Thus, it is necessary to freeze them in multiple aliquots. Such harvest material contains a significant number of neutrophils or mature granulocytes, which are not capable of restoring hematopoiesis. Only the primitive cells are able to do this. DMSO is necessary for the cyropreservation. Because the cells have been frozen in multiple aliquots (multiple bags of these products were frozen over many days and then thawed later), the total content of DMSO is large and the patient gets a large exposure to DMSO. Such large amounts of DMSO in the transplant can potentially cause projectile vomiting and other injury to the patient. Thus it is necessary to wash the harvest cells to minimize the DMSO content] A physcian writes a prescription for this procedure based on the review of the cryropreserved product and whether recipient needs to maximize cell dose or minimize DMSO toxicity. The physcian may do this procedure n an emergency.
The thawed cells are washed using an automated cell washer. During the wash process, cells are concentrated and resuspended in infusible grade solutions such as saline/albumin. The physcian may do this procedure in an emergency. Quality assessment of the washed product is performed. The quality of the thawed transplantation product (bone marrow, blood-derived, or umbilical cord blood-derived hematopoietic progenitor cells) must be assessed prior to release of product. Examples of quality assurance are nucleated cell count, differential, viability, sterility and/or immunophenotyping by flow cytometry for cd34(+) progenitor cells, T-lymphocytes, or tumor cells. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physcian then judges if this product remains suitable for transplantation or if new or additional product needs to be collected.

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 57% Median RVW: 1.25

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

25th Percentile RVW: 0.99 75th Percentile RVW: 2.20 Low: 0.50 High: 4.00

Median Pre-Service Time: 5 Median Intra-Service Time: 37.5

25th Percentile Intra-Svc Time: 25 75th Percentile Intra-Svc Time: 60 Low: 0 High: 240

Median Post-Service Time: Level of Service by CPT Code

CPT Code: 38209

Total Time (List CPT Code & # of Visits)

Immediate Post Service Time: 10

The consensus panel recommends that there be no pre- or post- service time for this CPT code.

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
85097	Bone marrow, smear interpretation	XXX	0.94

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:**
Median Pre-Time	5	No RUC data
Median Intra-Time	25	No RUC data
Median Immediate Post-service Time	10	No RUC data
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	3.50	3.27
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.33	2.82
Urgency of medical decision making	4.00	3.09

Technical Skill/Physical Effort (Mean)

Technical skill required	3.92	3.09
Physical effort required	2.42	2.18

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.08	3.36
Outcome depends on the skill and judgement of physician	3.50	3.18

Estimated risk of malpractice suit with poor outcome	3.83	3.27

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.33	3.20
Intra-Service intensity/complexity	3.55	2.90
Post-Service intensity/complexity	3.43	3.17

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data and felt that the median time values were too high. The panel felt that the 25th percentile values were more reflective of the time physicians spend performing 38209.

FREQUENCY INFORMATION

How was this service previously reported? 86915 (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_____ _____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: No Medicare Data on code

Specialty _____ Frequency_____

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38210 Tracking Number: X6 Global Period: XXX ~~**Recommended RVW: 2.0**~~
RUC Recommended RVW:

CPT Descriptor: Specific cell depletion within harvest; T-cell depletion

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient is a 10 year old boy with DiGeorge's Syndrome who needs a bone marrow/peripheral blood progenitor stem cell transplant from his father. The marrow has to be T-cell depleted for this allogeneic graft to reduce the risk of graft versus host disease. The physcian writes a prescription ordering this procedure based on recipient needs and the degree of HLA mismatching with the donor. In an emergency the physcian may do this procedure.
T-cell depletion is performed using various methods such as the Baxter Isolex device. This instrument enriches the stem cells (CD34+) and passively removes unwanted cells such as T-cells. In an emergency the physcian may do this procedure. Quality assessment of the product is performed. . The quality of the T-lymphocyte depleted hematopoietic progenitor cell product (bone marrow or blood-derived) must be assessed prior to release of product. Examples of quality assurance are nucleated cell count, differential, viability, sterility and/or immunophenotyping by flow cytometry for cd34(+) progenitor cells and T-lymphocytes. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physcian then judges if this product remains suitable for transplantation or if new product needs to be collected.

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood-and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 71% Median RVW: 2.50

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

25th Percentile RVW: 1.50 75th Percentile RVW: 3.25 Low: 1.08 High: 10

Median Pre-Service Time: 10 Median Intra-Service Time: 60

25th Percentile Intra-Svc Time: 23 75th Percentile Intra-Svc Time: 210 Low: 0 High: 600

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	20	

The consensus panel recommends that there be no pre- or post- service time for this CPT code.

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
80502	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	XXX	1.33

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including 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:**
Median Pre-Time	10	No RUC data
Median Intra-Time	23	No RUC data
Median Immediate Post-service Time	20	No RUC data
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	4.13	3.93
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.40	3.47
Urgency of medical decision making	4.40	3.47

Technical Skill/Physical Effort (Mean)

Technical skill required	4.60	4.14
Physical effort required	2.67	2.21

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.73	3.93
Outcome depends on the skill and judgement of physician	4.47	3.79
Estimated risk of malpractice suit with poor outcome	4.27	3.79

CPT Code: 38210

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.20	2.89
Intra-Service intensity/complexity	4.21	3.47
Post-Service intensity/complexity	3.70	2.80

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data and felt that the median time values were too high. The panel felt that the 25th percentile values were more reflective of the time physicians spend performing 38210.

FREQUENCY INFORMATION

How was this service previously reported? 86915 (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_____ _____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: No Medicare Data on code

Specialty _____ Frequency_____

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

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CPT Code: 38211

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38211 Tracking Number: X 7 Global Period: XXX ~~**Recommended RVW: 1.5**~~

RUC Recommended RVW: 0.71

CPT Descriptor: Tumor Cell Depletion

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient is a 25 year old male with B-cell lymphoma or breast cancer metastatic to the bone marrow. The patient needs an autologous peripheral blood stem cell harvest with later transplant but there is known tumor contamination in the bone marrow. A physcian writes a prescription for this procedure based on review of the patient's disease and risk of tumor contamination. In an emergency, a physcian may do this procedure.

Tumor cell depletion is performed using various methods such as the Baxter Isolex device, which has been FDA approved for tumor depletion. The instrument enriches for stem cells (CD34+) and passively removes unwanted cells such as tumor cells. Quality assessment of the product is performed. In an emergency a physcian may do this procedure. The quality of the tumor cell depleted hematopoietic progenitor cell product (bone marrow or blood-derived hematopoietic progenitor cells) must be assessed prior to release of product. Examples of quality assurance are nucleated cell count, differential, viability, sterility and/or immunophenotyping by flow cytometry for cd34(+) progenitor cells and or tumor cells. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physcian then judges if this product remains suitable for transplantation or if new product needs to be collected.

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 71% Median RVW: 2.27

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

25th Percentile RVW: 1.63 75th Percentile RVW: 2.75 Low: 1.00 High: 6.00

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

25th Percentile Intra-Svc Time: 25 75th Percentile Intra-Svc Time: 105 Low: 0 High: 360

Median Post-Service Time:	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	10	

The consensus panel recommends that there be no pre- or post- service time for this CPT code.

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
80502	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	XXX	1.33

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including 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:
Median Pre-Time	5	No RUC data
Median Intra-Time	25	No RUC data
Median Immediate Post-service Time	10	No RUC data
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	3.80	3.86
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.07	3.36
Urgency of medical decision making	4.07	3.21

Technical Skill/Physical Effort (Mean)

Technical skill required	4.57	4.00
Physical effort required	2.57	2.15

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.13	3.86
Outcome depends on the skill and judgement of physician	3.93	3.57
Estimated risk of malpractice suit with poor outcome	3.80	3.79

CPT Code: 38211

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.90	2.60
Intra-Service intensity/complexity	4.14	3.47
Post-Service intensity/complexity	3.50	2.80

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data and felt that the median time values were too high. The panel felt that the 25th percentile values were more reflective of the time physicians spend performing 38211.

FREQUENCY INFORMATION

How was this service previously reported? 86915 (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_____ ____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: No Medicare Data on code

Specialty _____ Frequency_____

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

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CPT Code: 38212

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38212 Tracking Number: X 8 Global Period: XXX ~~**Recommended RVW: 1.0**~~

RUC Recommended RVW: t

CPT Descriptor: Red blood cell removal

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old female with leukemia is blood type O and requires a peripheral blood stem cell transplant. The donor is blood type A. With such a stem cell harvest, ABO blood group barriers are routinely crossed. If fresh bone marrow containing Type A red blood cells is given to the patient, those type A cells will be immediately hemolyzed. This would cause renal failure and ultimately death to the patient because they could not receive post transplant immunosuppression therapy. Because of the different blood types, red blood cell depletion is required from the harvest. The stem cell harvest is then performed. A physcian writes an order for this procedure and supervises it. In an emergency, a physcian may do this procedure.
The red cell depletion can be done by various methods such as mononuclear cell concentration using an FDA approved apheresis device, mononuclear cell enrichment using density gradient solution, hydroxyethel starch which is FDA approved as an infusible solution. In an emergency a physcian may do this procedure. Quality assessment of the product is performed. The quality of the hematopoietic progenitor cells (bone marrow, blood-derived, or umbilical cord blood-derived hematopoietic progenitor cells) must be assessed prior to release of product. Examples of quality assurance are hematocrit, red cell count, nucleated cell count, differential, viability, sterility and/or immunophenotyping by flow cytometry for cd34(+) progenitor cells. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physcian then judges if this product remains suitable for transplantation or if new product needs to be collected.

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 71% Median RVW: 1.50

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

25th Percentile RVW: 1.00 75th Percentile RVW: 2.10 Low: 0.50 High: 3.00

Median Pre-Service Time: 5 Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 12.5 75th Percentile Intra-Svc Time: 120 Low: 0 High: 150

Median Post-Service Time:	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	15	

The consensus panel recommends that there be no pre- or post- service time for this CPT code.

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
90935	Hemodialysis procedure with single physician evaluation	000	1.22

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:**
Median Pre-Time	5	0
Median Intra-Time	**12.5**	21
Median Immediate Post-service Time	15	0
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	3.33	3.53
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.20	3.00
Urgency of medical decision making	3.60	3.20

Technical Skill/Physical Effort (Mean)

Technical skill required	3.80	3.53
Physical effort required	2.27	2.40

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.07	4.07
Outcome depends on the skill and judgement of physician	3.80	3.67
Estimated risk of malpractice suit with poor outcome	4.33	3.47

CPT Code: 38212

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.70	2.70
Intra-Service intensity/complexity	3.50	3.27
Post-Service intensity/complexity	3.40	2.80

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data and felt that the median time values were too high. The panel felt that the 25th percentile values were more reflective of the time physicians spend performing 38212.

FREQUENCY INFORMATION

How was this service previously reported? 86915 (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_____ _____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: No Medicare Data on code

Specialty _____ Frequency_____

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

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38213 Tracking Number: X 9 Global Period: XXX ~~**Recommended RVW: 0.5**~~

RUC Recommended RVW: 0.24

CPT Descriptor: Platelet depletion

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient is a 35 year old female with leukemia who requires an allogeneic peripheral blood stem cell transplant. The donor is much smaller than the intended recipient, thus requiring multiple days of harvesting. Because multiple successive days of stem cell collection causes the donor's platelets to become severely depleted, prior platelet depletion of the donor is required. The physcian assesses both donor needs and recipient needs as this procedure will deplete some of the hematopoietic progenitors collected. A physcian writes a prescription for a platelet addback to be obtained and separated from the blood-derived hematopoietic progenitor cell product. A physcian supervises this procedure. In an emergency a physcian does this procedure.
The collected apheresis product is depleted of platelets using a centrifugation method. The separated platelets are infused back to the donor and the stem cells are used for transplantation for the patient. In an emergency a physcian does this procedure. Quality assessment on both products is performed. It is critical to be sure that the donor is not harmed by an excessively low platelet count as part of the transplant process. The physician has to ascertain whether there is a quality platelet product obtained from the donor with minimal risk to the transplant product. . The quality of the platelets (bone marrow or blood-derived) must be assessed prior to release of product. Examples of quality assurance are platelet count, hematocrit,nucleated cell count, viability, and sterility. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physcian then judges if this product is suitable for infusion.

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 52% Median RVW: 1.20

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

25th Percentile RVW: 1.00 75th Percentile RVW: 1.75 Low: 0.80 High: 3.50

Median Pre-Service Time: 10 Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 20 75th Percentile Intra-Svc Time: 67.5 Low: 0 High: 180

Median Post-Service Time:	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	10	

The consensus panel recommends that there be no pre- or post- service time for this CPT code.

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
80502	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	XXX	1.33

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including 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:**
Median Pre-Time	10	No RUC data
Median Intra-Time	20	No RUC data
Median Immediate Post-service Time	10	No RUC data
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	3.27	3.55
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.18	3.73
Urgency of medical decision making	3.91	3.73

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	3.82
Physical effort required	2.55	2.82

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.00	3.82
Outcome depends on the skill and judgement of physician	3.55	3.73
Estimated risk of malpractice suit with poor outcome	4.00	3.45

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.33	3.17
Intra-Service intensity/complexity	3.30	3.45
Post-Service intensity/complexity	3.33	3.00

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data and felt that the median time values were too high. The panel felt that the 25th percentile values were more reflective of the time physicians spend performing 38213.

FREQUENCY INFORMATION

How was this service previously reported? 86915 (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_____ _____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: No Medicare Data on code

Specialty _____ Frequency_____

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

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CPT Code: 38214

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38214 Tracking Number: X 10 Global Period: XXX ~~**Recommended RVW: 0.50**~~
RUC Recommended RVW: 1

CPT Descriptor: Plasma (volume) depletion

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient is a 35 year old female with leukemia who is type A and requires a bone marrow transplant. The only available donor is type O. The donor's type O plasma has sufficient anti-A that it may cause hemolysis with infusion of the marrow product. The plasma needs to be depleted from this product so that there can be a safe transplant. A physcian writes a prescription for and supervises this procedure. In an emergency a physcian does this procedure.
Plasma/volume depletion can be done by various methods (i.e. centrifugation or nucleated cell concentration using an FDA approved apheresis device. In this process, stem cells are concentrated and plasma/excess volume are removed. In an emergency a physcian does this procedure. Quality assessment of the product is performed. The quality of the plasma depleted hematopoietic progenitor cell transplantation product (bone marrow-derived hematopoietic progenitor cells) must be assessed prior to release of product. Examples of quality assurance are nucleated cell count, differential, viability, sterility and/or immunophenotyping by flow cytometry for cd34(+) progenitor cells or T-lymphocytes. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physcian then judges if this product remains suitable for transplantation or if the procedure needs to be repeated.

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 71% Median RVW: 1.30

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

25th Percentile RVW: 1.00 75th Percentile RVW: 1.66 Low: 0.50 High: 2.80

Median Pre-Service Time: 5 Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 10 75th Percentile Intra-Svc Time: 60 Low: 0 High: 120

Median Post-Service Time:	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	5	

The consensus panel recommends that there be no pre- or post- service time for this CPT code.

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
80502	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	XXX	1.33

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including 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:**
Median Pre-Time	5	No RUC data
Median Intra-Time	10	No RUC data
Median Immediate Post-service Time	5	No RUC data
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	3.27	3.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.47	3.13
Urgency of medical decision making	3.73	3.07

Technical Skill/Physical Effort (Mean)

Technical skill required	3.80	3.67
Physical effort required	2.20	2.27

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.13	3.93
Outcome depends on the skill and judgement of physician	3.67	3.60
Estimated risk of malpractice suit with poor outcome	4.07	3.60

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.70	2.60
Intra-Service intensity/complexity	3.36	3.27
Post-Service intensity/complexity	3.22	2.78

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data and felt that the median time values were too high. The panel felt that the 25th percentile values were more reflective of the time physicians spend performing 38214.

FREQUENCY INFORMATION

How was this service previously reported? 86915 (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_____ _____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: No Medicare Data on code

Specialty _____ Frequency_____

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

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38215 Tracking Number: X 11 Global Period: XXX ~~**Recommended RVW: 1.18**~~
RUC Recommended RVW: 0.55

CPT Descriptor: Cell concentration in plasma, mononuclear, or buffy coat layer

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient is a 35 year old female with leukemia who is type B and requires a peripheral blood stem cell transplant. The only available donor is type A. Thus, to prevent transplant problems, a purified hematopoietic progenitor cell population (with minimal red cell and plasma contamination) is needed for the graft. A physcian writes an order for this procedure and supervises. In an emergency a physcian may do this procedure.
In this scenario, to avoid hemolytic transfusion reaction, both the RBCs and plasma must be removed. This can be achieved by various methods such as mononuclear cell concentration using an FDA approved apheresis device or density gradients solutions. In this process, stem cells are concentrated and plasma/excess volumes are removed. In an emergency a physcian may do this procedure. Quality assessment of the product is performed. The quality of the mononuclear cell preparation of the hematopoietic progenitor cell transplantation product (bone marrow, blood-derived, or umbilical cord blood-derived hematopoietic progenitor cells) must be assessed prior to release of product. Examples of quality assurance are hematocrit,nucleated cell count, differential, viability, sterility and/or immunophenotyping by flow cytometry for cd34(+) progenitor cells and T-lymphocytes. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physcian then judges if this product remains suitable for transplantation or if the procedure needs to be repeated or if new product needs to be collected.

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 71% Median RVW: 1.50

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

25th Percentile RVW: 1.18 75th Percentile RVW: 1.99 Low: 0.50 High: 3.60

Median Pre-Service Time: 5 Median Intra-Service Time: 40

25th Percentile Intra-Svc Time: 25 75th Percentile Intra-Svc Time: 110 Low: 0 High: 150

Median Post-Service Time:	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	15	

The consensus panel recommends that there be no pre- or post- service time for this CPT code.

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
80502	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	XXX	1.33

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including 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:**
Median Pre-Time	5	No RUC data
Median Intra-Time	25	No RUC data
Median Immediate Post-service Time	15	No RUC data
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.47	3.47
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.73	3.27
Urgency of medical decision making	4.00	3.53

Technical Skill/Physical Effort (Mean)

Technical skill required	4.20	3.80
Physical effort required	2.53	2.27

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.40	4.33
Outcome depends on the skill and judgement of physician	4.20	3.93
Estimated risk of malpractice suit with poor outcome	4.20	3.93

CPT Code: 38215

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.70	2.60
Intra-Service intensity/complexity	3.64	3.20
Post-Service intensity/complexity	3.20	2.60

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data and felt that the median time values were too high. The panel felt that the 25th percentile values were more reflective of the time physicians spend performing 38215.

FREQUENCY INFORMATION

How was this service previously reported? 86915 (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_____ ____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: No Medicare Data on code

Specialty _____ Frequency_____

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

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 38242 Tracking Number: X 12 Global Period: XXX ~~**Recommended RVW: 2.0**~~

RUC Recommended RVW:

CPT Descriptor: Allogeneic donor lymphacyte infusion

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The typical patient is a 35 year old female who has previously received an allogeneic bone marrow transplant for chronic myelogenous leukemia. Post-transplant, the patient relapses with the return of the Philadelphia chromosome positive cells. A lymphocyte infusion transplant procedure is recommended because of this relapse. An allogeneic donor is found for the lymphocyte infusion and the donor has undergone one day of pheresis to produce the transplant material.
Allogeneic lymphocytes are collected using FDA approved apheresis devices. The T-cell content of the product is determined by flow cytometry. The precise dose of T-cells depends on the type of donor and whether the patient is being treated for infection or relapsed malignancy. Quality assessment of the product is performed.

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA:

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 71% Median RVW: 2.3

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

25th Percentile RVW: 2.2 75th Percentile RVW: 3.0 Low: 1.5 High: 9.0

Median Pre-Service Time: 30 Median Intra-Service Time: 60

25th Percentile Intra-Svc Time: 30 75th Percentile Intra-Svc Time: 60 Low: 10 High: 150

Median Post-Service Time:	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	20	

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
38240	Bone marrow or blood-derived peripheral stem cell transplantation; allogenic	XXX	2.24

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:**
Median Pre-Time	30	No RUC Data
Median Intra-Time	30	No RUC Data
Median Immediate Post-service Time	20	No RUC Data
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	3.73	3.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.07	3.87
Urgency of medical decision making	4.20	3.87

Technical Skill/Physical Effort (Mean)

Technical skill required	3.73	3.60
Physical effort required	2.60	2.67

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.47	3.67
Outcome depends on the skill and judgement of physician	4.47	3.80
Estimated risk of malpractice suit with poor outcome	3.53	2.87

CPT Code: 38242

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.90	3.90
Intra-Service intensity/complexity	3.67	3.40
Post-Service intensity/complexity	3.50	3.10

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.
A panel of physicians from various related societies reviewed the data and felt that the median time values were too high. The panel felt that the 25th percentile values were more reflective of the time physicians spend performing 38242.

FREQUENCY INFORMATION

How was this service previously reported? 38231 (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_____ _____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: No Medicare Data on code

Specialty _____ Frequency_____

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

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AMA/Specialty Society RVS Update Committee
Summary of Recommendations
April 2002

Endoscopic Injections and Balloon Dilation of Intestinal Strictures

The specialty society initially presented its survey data to a pre-facilitation committee at the RUC. After extensive discussion with this small group, the specialty decided to revise its recommendations. The revised physician time and work relative values are listed below. The RUC reviewed this rationale and agreed that it was appropriate.

GI Endoscopic Injection Procedure Codes								
					Revised Gastro Work RVU	**Incremental Work Over Base Code**	**Incremental Intra Time Over Base Code**	**Conscious sedation Included?**
	CPT Code	**Total Pre**	**Total Intra**	**Total Post**				
Base	43200	12	15	27.5	1.59			
Bx	43202	12	22	27.5	1.89			
Esoph Inj	43201	12	25	27.5	**2.09**	**0.5**	**10**	Yes
Base	43235	16	25	26.5	2.39			
Bx	43239	27	34	23.5	2.87			
EGD Inj	43236	27	35	23.5	**2.92**	**0.53**	**10**	Yes
Base	45330	7	15	7	0.96			
Bx	45331	7	18	10	1.15			
Flex Sig Inj	45335	7	23	10	**1.46**	**0.5**	**8**	No
Base	45378	20	39	31.5	3.7			
Bx	45380	45	51.5	22	4.44			
Colon Inj	45381	45	49	22	**4.30**	**0.60***	**10**	Yes

*An increase in the increment is appropriate as an injection into the colon is more technically difficult.

GI Endoscopic Dilation Procedure Codes								
	CPT Code	Total Pre	Total Intra	Total Post	Revised Gastro Work Total RVU	Incremental Work Over Base Code	Incremental Intra Time Over Base Code	Conscious sedation Included?
Base	43235	16	25	26.5	2.39			
Bx	43239	27	34	23.5	2.87			
EGD Dilation	43245	27	40	23.5	**3.18**	**0.79**	**15**	Yes
Base	45330	7	15	7	0.96			
Bx	45331	7	18	10	1.15			
Flex Sig Dilation	45340	17	25	16	**1.96**	**1.00***	**10**	Yes
Base	45378	20	39	31.5	3.7			
Bx	45380	45	51.5	22	4.44			
Colon Dilation	45386	45	54	22	**4.58**	**0.88**	**15**	Yes

*An increase in the increment is necessary because the base does not include conscious sedation.

The physician pre and post service time for both the injection and the dilation codes were adjusted to be consistent with the biopsy codes for each family.

Practice Expense Inputs

Minor revisions were made to the practice expense inputs as presented by the specialty societies to standardize the conscious sedation inputs. The clinical staff pre-time for these services, when performed in a facility setting, was made consistent with other gastrointestinal endoscopy services presented in the past to the PEAC/RUC. The revised practice expense inputs are attached to the recommendations for these services.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●43201	G1	Esophagoscopy, rigid or flexible; with directed submucosal injection(s), any substance (For injection sclerosis of esophageal varices, use 43204)	000	2.09
43235		Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate;	000	2.39 (no change)
●43236	G2	with directed submucosal injection(s), any substance (For injection sclerosis of esophageal and/or gastric varices, use 43243)	000	2.92
▲43245		with dilation of gastric outlet for obstruction ~~any method~~ (eg, balloon, guide wire, bougie) (Do not report 43245 in conjunction with 43256)	000	3.18
●45335	G3	Sigmoidoscopy, flexible; with directed submucosal injection(s) any substance	000	1.46
●45340	G4	with dilation by balloon, one or more strictures (Do not report 45340 in conjunction with 45345)	000	1.96
●45381	G5	Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection(s), any substance	000	4.30
●45386	G6	with dilation by balloon, one or more strictures (Do not report 45386 in conjunction with 45387)	000	4.58

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 43201 **Global Period:** 000 **Recommended RVW:** ~~2.35~~ 2.09

CPT Descriptor: Esophagoscopy, rigid or flexible; with directed submucosal injection(s), any substance.

CLINICAL DESCRIPTION OF SERVICE

Vignette Used in Survey: A 75-year-old man with a history of radiation therapy for lung cancer has difficulty swallowing. Following endoscopic dilatation, steroid solution was injected into several sites in the esophageal stricture. The physician monitors the stricture site for signs of bleeding. If stable, the endoscope is then carefully withdrawn. The physician records a post-procedure note prepares post-procedure orders, dictates a note to the referring physician, assesses the patient's post-procedure vital signs and status, and discusses the findings with the family.

Description of Pre-Service Work:
On the day of the procedure you review with the patient his symptoms and ascertain the severity of his dysphagia to identify if technical problems may arise when using the gastroscope to traverse the esophagus. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. Available laboratory studies which may indicate a risk for bleeding are reviewed. A pre-anesthetic exam with airway assessment and cardiopulmonary evaluation is performed. You are provided with the patient's x-rays and have an opportunity to review these imaging studies. You discuss the risks of the procedure with the patient including bleeding, perforation,infection and medication reaction including cardiopulmonary compromise.

Description of Intra-Service Work:
Conscious sedation is provided to the patient by you while continuously monitoring pulse oximetry and sequential non-invasive blood pressure measurements. A standard video gastroscope is advanced into the esophagus to allow an endoscopic assessment of the lesion. Documentation of the exam findings including measurements of the lesion, labelin the identified structures and magnified images of the abnormality are obtained and sent to a hard copy device. Steroid solution is injected into several sites in the esophageal stricture. The physician monitors the stricture site for signs of bleeding. If stable, the endoscope is then carefully withdrawn.

Description of Post-Service Work:
The images generated during the exam are reviewed and a report is dictated. After the patient has recovered from the procedure and prior to departure, the patient is assessed by you to determine if any complications have occurred. The findings of the exam are reviewed with the patient and their family. Appropriate follow up is discussed with the patient and family.

SURVEY DATA

Presenters: Maurits Wiersema, MD, Joel Brill, MD, Thomas Browning, MD

Specialties: American Society for Gastrointestinal Endoscopy, American Gastroenterological Association

Sample Size: 83 **Response Rate:** (%): 24 (29%) **Median RVW:**

Type of Sample: Panel
Explanation of sample size: Panel consists of participants from an ASGE survey group from July 2000 and two AGA committees.

	Low	25th %	Median	75 %	High
Survey RVW	1.89	2.09	2.35	2.59	3.39
Pre-Service Time	12	16.75	~~17~~ 12	22	32
Intra-Service Time	20	23	25	26.25	35
Post-Service Time	27.5	30.25	~~32.5~~27.5	37.5	42.5

KEY REFERENCE SERVICE:

CPT Code: 43200 **RVW:** 1.59

CPT Descriptor: Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)

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

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

TIME ESTIMATES (Median)	New/Revis. CPT Code:	Key Reference CPT Code:
Median Pre-Time	~~17~~ 12	12
Median Intra-Time	25	15
Median Immediate Post-service Time	~~32.5~~ 27.5	27.5

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	2.5
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.8	2.6
Urgency of medical decision making	3.4	2.5

Technical Skill/Physical Effort (Mean)

Technical skill required	3.8	2.5
Physical effort required	3.3	2.4

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.6	2.4
Outcome depends on the skill and judgement of physician	3.7	2.6
Estimated risk of malpractice suit with poor outcome	3.7	2.6

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.3	2.4
Intra-Service intensity/complexity	3.8	2.5
Post-Service intensity/complexity	3.2	2.3

ADDITIONAL RATIONALE

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

Our RUC recommendations are based on survey responses from gastroenterologists located across the country, including gastroenterologists from single-specialty, multi-specialty and academic practices. Once responses are compiled, a panel of gastroenterologists comprised of a representative sample of the above described group convenes to examine the data associated with each code and determine the final RUC recommendations. The survey results reflect an assessment of the work increment from the base code resulting in an additional time of 5, 10 and 5 minutes for pre, intra and post service work, respectively. The proposed increment is 0.76 above the base code 43200 (1.59 RVW).

FREQUENCY INFORMATION

How was this service previously reported? **43200 - 22**

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

Specialty: **Gastroenterology** **Rarely**

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

Specialty: **Gastroenterology** Frequency: **500**

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

Specialty: **Gastroenterology** Frequency: **250**

Do many physicians perform this service across the United States? **YES**

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 43236 **Global Period:** 000 **Recommended RVW:** ~~3.19~~ 2.92

CPT Descriptor: Upper GI endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection.

CLINICAL DESCRIPTION OF SERVICE

Vignette Used in Survey: A 75-year-old female with weight loss and difficulty swallowing is referred for evaluation after her primary physician ordered a barium swallow and upper GI x-ray that revealed a markedly dilated esophagus with a "bird's beak" tapering near the gastroesophageal junction consistent with a diagnosis of achalasia. After discussion with the patient, the decision was made to proceed withesophagogastroduodenoscopy. After inspecting the remainder of the stomach and proximal duodenum to confirm the absence of any co-existing mucosal abnormality, Botulinum Toxin type A was injected utilizing a sclerotherapy needle into the lower esophageal sphincter area. After observation to confirm the absence of bleeding, the endoscope is then withdrawn. The physician records a post procedure note, assesses the patient's post procedure vital signs and status, prepares post procedure orders, dictates a note to the referring physician, and discusses the findings with the family.

Description of Pre-Service Work:
On the day of the procedure you review with the patient her symptoms and ascertain the severity of the dysphagia. A review of the patient's allergies and medications is done specifically noting usage ofantiplatelet or anticoagulation medications. Available laboratory studies which may indicate a risk for bleeding are reviewed. A pre-anesthetic exam with airway assessment and cardiopulmonary evaluation is performed. You are provided with the patient's x-rays and have an opportunity to review these imaging studies. You discuss the risks o procedure with the patient including bleeding, perforation, infection and medication reaction including cardiopulmonary compromise.

Description of Intra-Service Work:
Conscious sedation is provided to the patient by you while continuously monitoring pulse oximetry and sequential non-invasive blood pressure measurements. A standard video gastroscope is advanced into the esophagus to allow an endoscopic assessment. After inspecting the remainder of the stomach and proximal duodenum to confirm the absence of any co-existing mucosal abnormality, Botulinum Toxin type A was injected utilizing a sclerotherapy needle into the lower esophageal sphincter area. After observation to confirm the absence of bleeding, the endoscope is then withdrawn. Documentation of the exam findings including measurements of the lesion, labeling of the identified structures and magnified images of the abnormality are obtained and sent to a hard copy device.

Description of Post-Service Work:
The physician records a post procedure note, assesses the patient's post procedure vital signs and status, prepares post procedure orders, dictates a note to the referring physician, and discusses the findings with the family. Appropriate follow up is discussed with the patient and family.

SURVEY DATA

Presenters: Maurits Wiersema, MD, Joel Brill, MD, Thomas Browning, MD

Specialties: American Society for Gastrointestinal Endoscopy, American Gastroenterological Association

Sample Size: 83 **Response Rate:** 26 (31%) **Median RVW:** 3.19

Type of Sample: Panel
Explanation of sample size: Panel consists of participants from an ASGE survey group from July 2000 and two AGA committees.

	Low	25th %	Median	75 %	High
Survey RVW	2.69	3.0	3.19	3.39	4.39
Pre-Service Time	16	21	~~26~~ 27	26	41
Intra-Service Time	30	35	35	40	55
Post-Service Time	26.5	30.5	~~31.5~~ 23.5	36.5	46.5

KEY REFERENCE SERVICE:

CPT Code: 43235 **RVW:** 2.39

CPT Descriptor: Upper GI endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimens (separate procedure)

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

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

TIME ESTIMATES (Median)	New/Revis. CPT Code:	Key Reference CPT Code:
Median Pre-Time	26	16
Median Intra-Time	35	25
Median Immediate Post-service Time	31.5	26.5

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.0	2.8
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.0	2.7
Urgency of medical decision making	3.4	2.7

Technical Skill/Physical Effort (Mean)

Technical skill required	3.9	2.7
Physical effort required	3.4	2.6

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.6	2.5
Outcome depends on the skill and judgement of physician	3.9	2.7

Estimated risk of malpractice suit with poor outcome	3.7	2.8

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.7	2.7
Intra-Service intensity/complexity	4.0	2.7
Post-Service intensity/complexity	3.4	2.5

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

Our RUC recommendations are based on survey responses from gastroenterologists located across the country, including gastroenterologists from single-specialty, multi-specialty and academic practices. Once responses are compiled, a panel of gastroenterologists comprised of a representative sample of the above described group convenes to examine the data associated with each code and determine the final RUC recommendations. The survey results reflect an assessment of the work increment from the base code resulting in an additional time of 10, 10 and 5 minutes for pre, intra and post service work, respectively. After reviewing the survey results, the pre service time was felt to be higher than anticipated for the procedure and a value of 5 minutes was used. The proposed increment is 0.80 above the base code 43235 (2.39 RVW).

FREQUENCY INFORMATION

How was this service previously reported? **43235 - 22**

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

Specialty: **Gastroenterology** **Rarely**

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

Specialty: **Gastroenterology** Frequency: **1000**

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

Specialty: **Gastroenterology** Frequency: **500**

Do many physicians perform this service across the United States? **YES**

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 43245 **Global Period:** 000 **Recommended RVW:** ~~3.64~~ 3.18

CPT Descriptor: Upper GI endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with dilation

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CLINICAL DESCRIPTION OF SERVICE

Vignette Used in Survey: A 67-year-old man with a history of duodenal ulcer disease has developed progressive early satiety with nausea and vomiting. A barium upper GI demonstrates narrowing at the apex of the duodenum. The patient has significant co-morbid conditions including end-stage renal disease on hemodialysis and congestive heart failure. For these co-morbidity reasons, and after consultation with the surgical service, the primary physician has requested that an endoscopic approach be undertaken in an attempt to relieve the obstruction without resorting to surgery. A video gastroscope is advanced into the stomach and retained liquid is removed with suction. At the apex of the duodenum narrowing with scarring and superficial ulceration is seen. A 12 mm thru-the-scope balloon is advanced through the biopsy channel and placed directly across the strictured segment of the duodenum apex. The stricture is dilated under direct visualization. The balloon is deflated and no evidence of perforation is identified. The physician records a post-procedure note, assesses the patient's post-procedure vital signs and status, prepares post-procedure orders, dictates a note to the referring physician, and discusses the findings and expected treatment with the family. The patient is re-examined after awakening to assess for the development of complications such as perforation.

Description of Pre-Service Work:
On the day of the procedure you review with the patient his symptoms. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. Available laboratory studies which may indicate a risk for bleeding are reviewed. A pre-anesthetic exam with airway assessment and cardiopulmonary evaluation is performed. You are provided with the patient's x-rays and have an opportunity to review these imaging studies. You discuss the risks of the procedure with the patient including bleeding, perforation, infection and medication reaction including cardiopulmonary compromise. The heightened risk of perforation is detailed to the patient.

Description of Intra-Service Work:
A video gastroscope is advanced into the stomach and retained liquid is removed with suction. At the apex of the duodenum narrowing with scarring and superficial ulceration is seen. A 12 mm thru-the-scope balloon is advanced through the biopsy channel and placed directly across the strictured segment of the duodenum apex. The stricture is dilated under direct visualization. The balloon is deflated and no evidence of perforation is identified.

Description of Post-Service Work:
The physician records a post-procedure note, assesses the patient's post-procedure vital signs and status, prepares post-procedure orders, dictates a note to the referring physician, and discusses the findings and expected treatment with the family. The patient is re-examined after awakening to assess for the development of complications such as perforation.

SURVEY DATA

Presenters: Maurits Wiersema, MD, Joel Brill, MD, Thomas Browning, MD

Specialties: American Society for Gastrointestinal Endoscopy, American Gastroenterological Association

Sample Size: 83 **Response Rate:** 26 (31%) **Median RVW:** 3.64

Type of Sample: Panel
Explanation of sample size: Panel consists of participants from an ASGE survey group from July 2000 and two AGA committees.

	Low	25th %	Median	75 %	High
Survey RVW	2.99	3.24	3.64	3.89	4.49
Pre-Service Time	20	22	~~26~~ 27	31	46
Intra-Service Time	26	35	40	45	55
Post-Service Time	27.5	31.5	~~36.5~~ 23.5	41.5	46.5

CPT Code: 43245

KEY REFERENCE SERVICE:

CPT Code: 43235 **RVW:** 2.39

CPT Descriptor: Upper GI endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimens (separate procedure)

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

TIME ESTIMATES (Median)	New/Revis. CPT Code:	Key Reference CPT Code:
Median Pre-Time	~~26~~ 27	16
Median Intra-Time	40	25
Median Immediate Post-service Time	~~36.5~~ 23.5	26.5

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.1	2.7
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.1	2.7 -
Urgency of medical decision making	4.0	2.7

Technical Skill/Physical Effort (Mean)

Technical skill required	4.4	2.7
Physical effort required	4.1	2.6

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.6	2.5
Outcome depends on the skill and judgement of physician	4.5	2.7

Estimated risk of malpractice suit with poor outcome	4.5	2.8

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.9	2.6
Intra-Service intensity/complexity	4.6	2.7
Post-Service intensity/complexity	3.8	2.5

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

Our RUC recommendations are based on survey responses from gastroenterologists located across the country, including gastroenterologists from single-specialty, multi-specialty and academic practices. Once responses are compiled, a panel of gastroenterologists comprised of a representative sample of the above described group convenes to examine the data associated with each code and determine the final RUC recommendations. The survey results reflect an assessment of the work increment from the base code resulting in an additional time of 10, 15 and 10 minutes for pre, intra and post service work, respectively. The proposed increment is 1.25 RVW above the base code 43235 (2.39 RVW). The code was previously valued at 3.39 RVW (increment of 1.0 RVW from base code) and had survey data of 18, 39 and 27 minutes of pre, intra and post service time reflecting an increment of 2, 14, and 1 minutes from the base code. The increased complexity of the pre and post evaluation warrant the higher increments in time as supported by the survey results.

FREQUENCY INFORMATION

How was this service previously reported? **43245 (This code has undergone a CPT edit)**

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

Specialty: **Gastroenterology** **Rarely**

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

Specialty: **Gastroenterology** Frequency: **1000**

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

Specialty: **Gastroenterology** Frequency: **500**

Do many physicians perform this service across the United States? **YES**

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 45335 **Global Period:** 000 **Recommended RVW:** ~~1.53~~ 1.46

CPT Descriptor: Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance.

CLINICAL DESCRIPTION OF SERVICE

Vignette Used in Survey: A 68-year-old gentleman had a large sessile polyp endoscopically removed from the mid-sigmoid colon that was shown to contain adenocarcinoma. Flexible sigmoidoscopy is now performed to inject sterile India Ink utilizing a sclerotherapy needle into the scar to allow identification of the site by the surgeon. The sclerotherapy needle is withdrawn, and the physician observes the site for signs of bleeding. The flexible sigmoidoscope instrument is then withdrawn. The physician records a post-procedure note, assess the patient's post-procedure vital signs and status, prepares post-procedure orders, dictates a note to the referring physician, and discusses the findings with the family.

Description of Pre-service work:
On the day of the procedure you review with the patient his symptoms. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. Available laboratory studies which may indicate a risk for bleeding are reviewed. You discuss the risks of the procedure with the patient including bleeding, perforation, infection and cardiopulmonary compromise.

Description of Intra-service work:
Digital rectal exam is performed. Flexible sigmoidoscopy is now performed to inject sterile India Ink utilizing a sclerotherapy needle into the scar to allow identification of the site by the surgeon. The sclerotherapy needle is withdrawn, and the physician observes the site for signs of bleeding. The flexible sigmoidoscope instrumen then withdrawn. Documentation of the exam findings including measurements of the lesion(s), labeling of the identified structures and magnified images of the abnormality are obtained and sent to a hard copy device.

Description of Post -service work:
After the patient has recovered from the procedure and prior to departure, the patient is assessed by you to determine if any complications have occurred including perforation. The findings of the exam are reviewed with the patient and their family. Appropriate follow up is discussed with the patient and family.

SURVEY DATA

Presenters: Maurits Wiersema, MD, Joel Brill, MD, Thomas Browning, MD

Specialties: American Society for Gastrointestinal Endoscopy, American Gastroenterological Association

Sample Size: 83 **Response Rate:** 26 (31%) **Median RVW:** 1.53

Type of Sample: Panel
Explanation of sample size: Panel consists of participants from an ASGE survey group from July 2000 and two AGA committees.

	Low	25th %	Median	75 %	Hi
Survey RVW	1.16	1.37	1.53	1.84	2.2
Pre-Service Time	7	10	~~12~~ 7	12	32
Intra-Service Time	20	22	23	25	30
Post-Service Time	7	9	~~11~~ 10	12	17

KEY REFERENCE SERVICE

CPT Code: 45330 **RVW:** 0.96

CPT Descriptor: Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)

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

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

TIME ESTIMATES (Median)	New/Revis. CPT Code:	Key Reference CPT Code:
Median Pre-Time	~~12~~ 7	7
Median Intra-Time	23	15
Median Immediate Post-service Time	~~11~~ 10	7

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	3.1	2.2
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.1	2.0
Urgency of medical decision making	2.8	2.1
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.4	2.1
Physical effort required	3.0	2.1
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.0	2.0
Outcome depends on the skill and judgement of physician	3.3	2.2
Estimated risk of malpractice suit with poor outcome	3.4	2.5

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.8	2.0
Intra-Service intensity/complexity	3.4	2.1
Post-Service intensity/complexity	2.7	2.0

ADDITIONAL RATIONALE

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

Our RUC recommendations are based on survey responses from gastroenterologists located across the country, including gastroenterologists from single-specialty, multi-specialty and academic practices. Once responses are compiled, a panel of gastroenterologists comprised of a representative sample of the above described group convenes to examine the data associated with each code and determine the final RUC recommendations. The survey results reflect an assessment of the work increment from the base code resulting in an additional time of 5, 8, and 4 minutes for pre, intra and post service work, respectively. After reviewing the survey results, the pre service time was felt to be higher than anticipated for the procedure and an increment time of 3 minutes was used. The proposed increment is 0.57 above the base code 45330 (0.96 RVW).

FREQUENCY INFORMATION

How was this service previously reported? **45300- 22**

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

Specialty: **Gastroenterology** **Rarely**

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

Specialty: **Gastroenterology** Frequency: **500**

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

Specialty: **Gastroenterology** Frequency: **250**

Do many physicians perform this service across the United States? **YES**

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 45340 **Global Period:** 000 **Recommended RVW:** 1.96

CPT Descriptor: Sigmoidoscopy, flexible; with dilation by balloon, one or more strictures

CLINICAL DESCRIPTION OF SERVICE

Vignette Used in Survey: A 72-year-old gentleman previously underwent a low anterior resection for a rectal adenocarcinoma. He had developed symptoms of constipation. The flexible sigmoidoscope is passed to 10cm where an anastomotic stricture is identified. A 15-mm thru-the-scope balloon is passed by the physician through the flexible sigmoidoscope channel and placed across the strictured segment. The stricture is dilated under direct visualization. The balloon is deflated and is removed from the endoscope. No evidence of perforation is identified. The physician records a post-procedure note, assesses the patient's post-procedure vital signs and status, prepares post-procedure orders, dictates a note to the referring physician, and discusses the findings and expected treatment with the family. The patient is re-examined after awakening to assess for the development of complications such as perforation.

Description of Pre-service work:
On the day of the procedure you review with the patient his symptoms. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. Available laboratory studies which may indicate a risk for bleeding are reviewed. You discuss the risks of the procedure with the patient including bleeding, perforation, infection and cardiopulmonary compromise. A pre-anesthetic exam with airway assessment and cardiopulmonary evaluation is performed.

Description of Intra-service work:
Digital rectal exam is performed. The flexible sigmoidoscope is passed to 10cm where an anastomotic stricture is identified. A 15-mm thru-the-scope balloon is passed by the physician through the flexible sigmoidoscope channel and placed across the strictured segment. The stricture is dilated under direct visualization. The balloon is deflated and is removed from the endoscope. No evidence of perforation is identified. Documentation of the exam findings including measurements of the lesion(s), labeling of the identified structures and magnified images of the abnormality are obtained and sent to a hard copy device.

Description of Post -service work:
The physician records a post-procedure note, assesses the patient's post-procedure vital signs and status, prepares post-procedure orders, dictates a note to the referring physician, and discusses the findings and expected treatment with the family. The patient is re-examined after awakening to assess for the development of complications such as perforation. Appropriate follow up is discussed with the patient and family.

SURVEY DATA

Presenters: Maurits Wiersema, MD, Joel Brill, MD, Thomas Browning, MD

Specialties: American Society for Gastrointestinal Endoscopy, American Gastroenterological Association

Sample Size: 83 **Response Rate:** 25 (30%) **Median RVW:** 1.96

Type of Sample: Panel
Explanation of sample size: Panel consists of participants from an ASGE survey group from July 2000 and two AGA committees.

	Low	25th %	Median	75 %	High
Survey RVW	1.36	1.74	1.96	2.46	3.16
Pre-Service Time	10	12	17	17.5	37
Intra-Service Time	20	25	25	30	45
Post-Service Time	9	12	16	17	37

KEY REFERENCE SERVICE:

CPT Code: 45330 **RVW:** 0.96

CPT Descriptor: Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)

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

TIME ESTIMATES (Median)	New/Revis. CPT Code:	Key Reference CPT Code:
Median Pre-Time	17	7
Median Intra-Time	25	15
Median Immediate Post-service Time	16	7

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.8	2.0
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.6	1.8
Urgency of medical decision making	3.5	2.0

Technical Skill/Physical Effort (Mean)

Technical skill required	4.0	2.1
Physical effort required	3.6	2.1

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.1	2.0
Outcome depends on the skill and judgement of physician	4.2	2.2

Estimated risk of malpractice suit with poor outcome	4.1	2.5

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.5	2.0
Intra-Service intensity/complexity	4.1	2.1
Post-Service intensity/complexity	3.5	2.1

ADDITIONAL RATIONALE

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

Our RUC recommendations are based on survey responses from gastroenterologists located across the country, including gastroenterologists from single-specialty, multi-specialty and academic practices. Once responses are compiled, a panel of gastroenterologists comprised of a representative sample of the above described group convenes to examine the data associated with each code and determine the final RUC recommendations. The proposed increment is 1.0 above the base code 45330 (0.96 RVW).

FREQUENCY INFORMATION

How was this service previously reported? **45300- 22**

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

Specialty: **Gastroenterology** **Rarely**

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

Specialty: **Gastroenterology** Frequency: **500**

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

Specialty: **Gastroenterology** Frequency: **250**

Do many physicians perform this service across the United States? **YES**

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 45381 **Global Period:** 000 **Recommended RVW:** 4.30

CPT Descriptor: Colonoscopy, flexible, proximal to the splenic flexure; with directed submucosal injection(s), any substance

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CLINICAL DESCRIPTION OF SERVICE

Vignette Used in Survey: A 68-year-old male had previously undergone a colonoscopy for evaluation of occult blood-positive stool, where a 2cm adenomatous sessile polyp in the transverse colon was identified and removed. Pathologic examination showed evidence of adenocarcinoma extending to the line of resection. Colonoscopy is now performed to inject sterile India ink into the site of the previous polyp resection of allow the surgeon to identify the site for surgical resection. The physician records a post-procedure note, assesses the patient's post-procedure vital signs and status, prepares post-procedure orders, dictates a note to the referring physician, and discusses the findings with the family.

Description of Pre-service work:
On the day of the procedure you review with the patient his symptoms. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. Available laboratory studies which may indicate a risk for bleeding are reviewed. You discuss the risks of the procedure with the patient including bleeding, perforation, infection and cardiopulmonary compromise. A pre-anesthetic exam with airway assessment and cardiopulmonary evaluation is performed.

Description of Intra-service work:
Digital rectal exam is performed. Colonoscopy is now performed to inject sterile India ink into the site of the previous polyp resection of allow the surgeon to identify the site for surgical resection. The sclerotherapy needle is withdrawn, and the physician observes the site for signs of bleeding. The colonoscope is then withdrawn. Documentation of the exam findings including measurements of the lesion(s), labeling of the identified structures and magnified images of the abnormality are obtained and sent to a hard copy device.

Description of Post -service work:
The physician records a post-procedure note, assesses the patient's post-procedure vital signs and status, prepares post-procedure orders, dictates a note to the referring physician, and discusses the findings with the family. Appropriate follow up is discussed with the patient and family.

SURVEY DATA

Presenters: Maurits Wiersema, MD, Joel Brill, MD, Thomas Browning, MD

Specialties: American Society for Gastrointestinal Endoscopy, American Gastroenterological Association

Sample Size: 83 **Response Rate:** 25 (30%) **Median RVW:** 4.62

Type of Sample: Panel
Explanation of sample size: Panel consists of participants from an ASGE survey group from July 2000 and two AGA committees.

	Low	25th %	Median	75 %	High
Survey RVW	4.0	4.3	4.6	4.78	5.2
Pre-Service Time	20	23	~~25~~ 45	30	45
Intra-Service Time	44	48	49	49	54
Post-Service Time	31.5	33.5	~~36.5~~ 22	36.5	46.5

KEY REFERENCE SERVICE:

CPT Code: 45378 **RVW:** 3.70

CPT Descriptor: Colonoscopy, flexible, proximal to the splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)

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

TIME ESTIMATES (Median)	New/Revis. CPT Code:	Key Reference CPT Code:
Median Pre-Time	~~25~~ 45	20
Median Intra-Time	49	39
Median Immediate Post-service Time	~~36.5~~ 22	31.5

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.6	2.8
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.6	2.7
Urgency of medical decision making	3.3	2.7

Technical Skill/Physical Effort (Mean)

Technical skill required	4.0	3.0
Physical effort required	3.8	3.1

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.8	3.0
Outcome depends on the skill and judgement of physician	4.0	3.2
Estimated risk of malpractice suit with poor outcome	4.0	3.3

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.6	2.9
Intra-Service intensity/complexity	4.0	3.1
Post-Service intensity/complexity	3.4	2.7

ADDITIONAL RATIONALE

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

Our RUC recommendations are based on survey responses from gastroenterologists located across the country, including gastroenterologists from single-specialty, multi-specialty and academic practices. Once responses are compiled, a panel of gastroenterologists comprised of a representative sample of the above described group convenes to examine the data associated with each code and determine the final RUC recommendations. Although the recommended RVW is lower than the median survey value, this proposed increment from the base code avoids rank order anomalies and is consistent with the work effort described by the vignette. The proposed increment is 0.6 above base code 45378 (3.70RVW).

FREQUENCY INFORMATION

How was this service previously reported? **45378- 22**

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

Specialty: **Gastroenterology** **Rarely**

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

Specialty: **Gastroenterology** Frequency: **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: **Gastroenterology** Frequency: **500**

Do many physicians perform this service across the United States? **YES**

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 45386 **Global Period:** 000 **Recommended RVW:** ~~4.95~~ 4.58

CPT Descriptor: Colonoscopy, flexible, proximal to the splenic flexure; with dilation by balloon, one or more strictures.

CLINICAL DESCRIPTION OF SERVICE

Vignette Used in Survey: A 65-year-old female with crampy abdominal pain and a past history of a colon resection undergoes a barium enema, which reveals a transverse colon stricture at the site of the previous colonic anastomosis. A colonoscope is passed to the area of the stricture. A 15mm thru-the-scope dilating balloon is passed through the colonoscope and positioned across the area of narrowing. The stricture is dilated, the balloon is deflated, and the colonoscope is then passed to the cecum. The colonoscope is then withdrawn. The physician then records a post-procedure note, assesses the patient's post-procedure vital signs and status, prepares post-procedure orders, dictates a note to the referring physician, and discusses the findings and expected treatment with the family. The patient is re-examined after awakening to assess for the development of complications such as perforation.

Description of Pre-service work:
On the day of the procedure you review with the patient his symptoms. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. Available laboratory studies which may indicate a risk for bleeding are reviewed. You discuss the risks of the procedure with the patient including bleeding, perforation, infection and cardiopulmonary compromise. A pre-anesthetic exam with airway assessment and cardiopulmonary evaluation is performed.

Description of Intra-service work:
Digital rectal exam is performed. A colonoscope is passed to the area of the stricture. A 15mm thru-the-scope dilating balloon is passed through the colonoscope and positioned across the area of narrowing. The stricture is dilated, the balloon is deflated, and the colonoscope is then passed to the cecum. The colonoscope is then withdrawn. Documentation of the exam findings including measurements of the lesion(s), labeling of the identified structures and magnified images of the abnormality are obtained and sent to a hard copy device.

Description of Post -service work:
The physician then records a post-procedure note, assesses the patient's post-procedure vital signs and status, prepares post-procedure orders, dictates a note to the referring physician, and discusses the findings and expected treatment with the family. The patient is re-examined after awakening to assess for the development of complications such as perforation.

SURVEY DATA

Presenters: Maurits Wiersema, MD, Joel Brill, MD, Thomas Browning, MD

Specialties: American Society for Gastrointestinal Endoscopy, American Gastroenterological Association

Sample Size: 83 **Response Rate:** 21 (25%) **Median RVW:** 5.2

Type of Sample: Panel
Explanation of sample size: Panel consists of participants from an ASGE survey group from July 2000 and two AGA committees.

	Low	25th %	Median	75 %	High
Survey RVW	4.2	4.55	5.2	5.2	5.9
Pre-Service Time	23	25	~~30~~ 45	30	50
Intra-Service Time	44	49	54	54	69
Post-Service Time	33.5	36.5	~~41.5~~ 22	41.5	61.5

KEY REFERENCE SERVICE:

CPT Code: 45378 **RVW:** 3.70

CPT Descriptor: Colonoscopy, flexible, proximal to the splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)

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

TIME ESTIMATES (Median)	New/Revis. CPT Code:	Key Reference CPT Code:
Median Pre-Time	~~30~~ 45	20
Median Intra-Time	54	39
Median Immediate Post-service Time	~~41.5~~ 22	31.5

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.9	2.9
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.7	2.6
Urgency of medical decision making	3.7	2.7

Technical Skill/Physical Effort (Mean)

Technical skill required	4.4	3.1
Physical effort required	4.4	3.2

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.4	3.0
Outcome depends on the skill and judgement of physician	4.5	3.2
Estimated risk of malpractice suit with poor outcome	4.3	3.3

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.8	2.9
Intra-Service intensity/complexity	4.4	3.2
Post-Service intensity/complexity	3.8	2.9

ADDITIONAL RATIONALE

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

Our RUC recommendations are based on survey responses from gastroenterologists located across the country, including gastroenterologists from single-specialty, multi-specialty and academic practices. Once responses are compiled, a panel of gastroenterologists comprised of a representative sample of the above described group convenes to examine the data associated with each code and determine the final RUC recommendations. They felt that the 25th percentile for the pre, and post work times, which are 25 and 36.5 minutes, were most consistent with the work involved and therefore these values were used to determine the final RVW. Although the recommended RVW is lower than the median survey value, this proposed increment from the base code avoids rank order anomalies and is consistent with the work effort describe by the vignette. The proposed increment is 1.25 above the base code 45378 (3.70RVW).

FREQUENCY INFORMATION

How was this service previously reported? **45378- 22**

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

Specialty: **Gastroenterology** **Rarely**

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

Specialty: **Gastroenterology** Frequency: **1000**

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

Specialty: **Gastroenterology** Frequency: **500**

Do many physicians perform this service across the United States? **YES**

Endoscopic Injections and Balloon Dilation of Intestinal Strictures		CPT:	43201		43236		43245		45335		45340	
		DESCRIPTOR:	Esophagoscopy, rigid or flex; with directed submucosal injection(s), any substance		UGE including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any		UGE including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with dilation		SIG flexible; with directed submucosal injection(s) any substance		SIG, flex; with dilation by balloon, each stricture	
		GLOBAL:	0		0		0		0		0	
	CMS Code	CMS Desc	NonFac	Facility	NonFac	Facility	NonFac	Facility	NonFac	Facility	NonFac	Facility
PRE-service time	130	RN/LPN/MA	9	19	9	19	9	19	9	19	9	19
SERVICE time	130	RN/LPN/MA	43	6	49	6	53	6	41	6	43	6
SERVICE time	033	RN	40	0	50	0	55	0	38	0	40	0
POST-service time	130	RN/LPN/MA	3	3	3	3	3	3	3	3	3	3
PRE-SERVICE CLINICAL STAFF TIME												
BEGINS after consultation when a decision to perform surgery was made. (90-day office / facility)												
Complete pre-service diagnostic & referral forms (5/5)	130	RN/LPN/MA	3	3	3	3	3	3	3	3	3	3
Coord. pre-surgery services, review test/exam results (10/20)	130	RN/LPN/MA	3	3	3	3	3	3	3	3	3	3
OV before surgery: Review test and exam results (0/0)	130	RN/LPN/MA	0	2	0	2	0	2	0	2	0	2
Schedule space and equipment in facility (0/8)	130	RN/LPN/MA	0	3	0	3	0	3	0	3	0	3
Provide pre-service education/obtain consent (10/20)	130	RN/LPN/MA	0	5	0	5	0	5	0	5	0	5
Follow-up phone calls & prescriptions (10/7)	130	RN/LPN/MA	3	3	3	3	3	3	3	3	3	3
ENDS with admission to site of service												
SERVICE PERIOD CLINICAL STAFF TIME	CMS Code	CMS Desc										
BEGINS with admission to site of service												
Pre-procedure (in office)												
Assemble/review X-ray, lab, pathology reports (99213=2)	130	RN/LPN/MA	2	0	2	0	2	0	2	0	2	0
Greet patient and provide gowning (peac std=3)	130	RN/LPN/MA	3	0	3	0	3	0	3	0	3	0
Obtain vital signs (Vitals 0=0; 1-3=3; 4-6=5)	130	RN/LPN/MA	3	0	3	0	3	0	3	0	3	0
Review history, systems, and medications (99213=6)	130	RN/LPN/MA	3	0	3	0	3	0	3	0	3	0
Provide pre-service education/obtain consent	130	RN/LPN/MA	5	0	5	0	5	0	5	0	5	0
Prepare room, equipment,supplies (99213=2)	130	RN/LPN/MA	2	0	2	0	2	0	2	0	2	0
Procedure												
FirstAssist physician in performing procedure	033	RN	25	0	35	0	40	0	23	0	25	0
SecondAssist physician in performing procedure	130	RN/LPN/MA	17	0	23	0	27	0	15	0	17	0
Post-procedure (in-office)												
Monitor pt. following service/check tubes, monitors, drains	033	RN	15	0	15	0	15	0	15	0	15	0
Clean room/equipment by physician staff (99213=3)	130	RN/LPN/MA	3	0	3	0	3	0	3	0	3	0
Complete postop diagnostic forms, lab & X-ray requisitions	130	RN/LPN/MA	2	0	2	0	2	0	2	0	2	0
home care instructions /coord. off vis / Rx	130	RN/LPN/MA	3	0	3	0	3	0	3	0	3	0
Other Clinical Activity:												
99238 discharge visit			0	0.5	0	0.5	0	0.5	0	0.5	0	0.5
99238 discharge time	130	RN/LPN/MA	0	6	0	6	0	6	0	6	0	6
End: Patient leaves site of service												
POST-SERVICE PERIOD CLINICAL STAFF TIME	CMS Code	CMS Desc										
Start: Patient leaves site of service												
Followup phone call to patient - same day	130	RN/LPN/MA	3	3	3	3	3	3	3	3	3	3
End: midnight - same day												

Endoscopic Injections and Balloon Dilation of Intestinal Strictures	CPT:		43201		43236		43245		45335		45340	
	DESCRIPTOR:		Esophagoscopy, rigid or flex; with directed submucosal injection(s), any substance		UGE including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any		UGE including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with dilation		SIG flexible; with directed submucosal injection(s) any substance		SIG, flex; with dilation by balloon, each stricture	
	GLOBAL:		0		0		0		0		0	
	CMS Code	CMS Desc	NonFac	Facility	NonFac	Facility	NonFac	Facility	NonFac	Facility	NonFac	Facility
MEDICAL SUPPLIES - DAY OF PROCEDURE	CMS Code	CMS Desc										
SUPPLIES, DAY OF PROCEDURE:												
Multispecialty Visit Package	PEAC	PACK	1	0	1	0	1	0	1	0	1	0
scrub brush (impregnated)	11119	item	3	0	3	0	3	0	3	0	3	0
surgical cap	11305	item	3	0	3	0	3	0	3	0	3	0
surgical mask, with face shield	11301	item	3	0	3	0	3	0	3	0	3	0
gown, staff, impervious, disposable	11304	item	3	0	3	0	3	0	3	0	3	0
gloves, non-sterile	11302	pair	3	0	3	0	3	0	3	0	3	0
shoe covers	11307	pair	3	0	3	0	3	0	3	0	3	0
angiocatheter 20 to 25g	91106	item	1	0	1	0	1	0	1	0	1	0
ECG Electrodes Disposable	71006	lead	1	0	1	0	1	0	1	0	1	0
electrode pads	71011	pad	3	0	3	0	3	0	3	0	3	0
emesis basin	11506	item	1	0	1	0	1	0	1	0	1	0
gauze, 2x2	31506	item	2	0	2	0	2	0	2	0	2	0
needle free injection system	new	item	1	0	1	0	1	0	1	0	1	0
iv extension tube	91109	item	1	0	1	0	1	0	1	0	1	0
nasal cannula	93803	item	1	0	1	0	1	0	1	0	1	0
oxygen, 1 ltr	53014	liter	1	0	1	0	1	0	1	0	1	0
pulse oximeter probe	new	item	1	0	1	0	1	0	1	0	1	0
rubber tourniquet	91417	item	1	0	1	0	1	0	1	0	1	0
swab, alcohol	31101	item	1	0	1	0	1	0	1	0	1	0
syringe, 5 cc	91411	item	3	0	3	0	2	0	3	0	2	0
tape	31514	inch	3	0	3	0	3	0	3	0	3	0
cleaning brush	92020	item	1	0	1	0	1	0	1	0	1	0
Balloon dilator, 14-28 FR (Boston Scientific)	new	item	0	0	0	0	1	0	0	0	1	0
Suction Canister, Disposable	93604	item	1	0	1	0	1	0	1	0	1	0
tubing, suction, 6' with yankauer tip	93606	foot	1	0	1	0	1	0	1	0	1	0
bite block	11512	item	1	0	1	0	1	0	1	0	1	0
irrigation basin	new	item	1	0	1	0	1	0	1	0	1	0
KY jelly, single use foil pack, 5 grams	31105	item	2	0	2	0	2	0	2	0	2	0
Variceal injection needle	new	item	1	0	1	0	0	0	1	0	0	0
Equipment - day of procedure	CMS Code											
Power Table	E11003		1	0	1	0	1	0	1	0	1	0
endoscopy stretcher	E11005		1	0	1	0	1	0	1	0	1	0
surgical lamp	E30009		1	0	1	0	1	0	1	0	1	0
sigmoidoscopic equipment cart	E13103		0	0	0	0	0	0	1	0	1	0
sigmoidoscope, flexible	NEW		0	0	0	0	0	0	1	0	1	0
gastroscope video	E13106		1	0	1	0	1	0	1	0	1	0
colonoscope, video	E13110		0	0	0	0	0	0	0	0	0	0
3 channel ECG/BP monitor	E55005		1	0	1	0	1	0	1	0	1	0

Endoscopic Injections and Balloon Dilation of Intestinal Strictures	CPT:		45381		45386	
	DESCRIPTOR:		COL, flex, proximal to splenic flexure; with directed submucosal injection(s), any substance		COL, flex, proximal to splenic flexure; with dilation by balloon, each stricture	
	GLOBAL:		0		0	
	CMS Code	CMS Desc	NonFac	Facility	NonFac	Facility
PRE-service time	130	RN/LPN/MA	9	19	9	19
SERVICE time	130	RN/LPN/MA	59	6	62	6
SERVICE time	033	RN	64	0	69	0
POST-service time	130	RN/LPN/MA	3	3	3	3
PRE-SERVICE CLINICAL STAFF TIME						
BEGINS after consultation when a decision to perform surgery was made. (90-day office / facility)						
Complete pre-service diagnostic & referral forms (5/5)	130	RN/LPN/MA	3	3	3	3
Coord. pre-surgery services, review test/exam results (10/20)	130	RN/LPN/MA	3	3	3	3
OV before surgery: Review test and exam results (0/0)	130	RN/LPN/MA	0	2	0	2
Schedule space and equipment in facility (0/8)	130	RN/LPN/MA	0	3	0	3
Provide pre-service education/obtain consent (10/20)	130	RN/LPN/MA	0	5	0	5
Follow-up phone calls & prescriptions (10/7)	130	RN/LPN/MA	3	3	3	3
ENDS with admission to site of service						
SERVICE PERIOD CLINICAL STAFF TIME	**CMS Code**	**CMS Desc**				
BEGINS with admission to site of service						
Pre-procedure (in office)						
Assemble/review X-ray, lab, pathology reports (99213=2)	130	RN/LPN/MA	2	0	2	0
Greet patient and provide gowning (peac std=3)	130	RN/LPN/MA	3	0	3	0
Obtain vital signs (Vitals 0=0; 1-3=3; 4-6=5)	130	RN/LPN/MA	3	0	3	0
Review history, systems, and medications (99213=6)	130	RN/LPN/MA	3	0	3	0
Provide pre-service education/obtain consent	130	RN/LPN/MA	5	0	5	0
Prepare room, equipment,supplies (99213=2)	130	RN/LPN/MA	2	0	2	0
Procedure						
FirstAssist physician in performing procedure	033	RN	49	0	54	0
SecondAssist physician in performing procedure	130	RN/LPN/MA	33	0	36	0
Post-procedure (in-office)						
Monitor pt. following service/check tubes, monitors, drains	033	RN	15	0	15	0
Clean room/equipment by physician staff (99213=3)	130	RN/LPN/MA	3	0	3	0
Complete postop diagnostic forms, lab & X-ray requisitions	130	RN/LPN/MA	2	0	2	0
home care instructions /coord. off vis / Rx	130	RN/LPN/MA	3	0	3	0
Other Clinical Activity:						
99238 discharge visit			0	0.5	0	0.5
99238 discharge time	130	RN/LPN/MA	0	6	0	6
End: Patient leaves site of service						
POST-SERVICE PERIOD CLINICAL STAFF TIME	**CMS Code**	**CMS Desc**				
Start: Patient leaves site of service						
Followup phone call to patient - same day	130	RN/LPN/MA	3	3	3	3
End: midnight - same day						

Endoscopic Injections and Balloon Dilation of Intestinal Strictures	CPT:		45381		45386	
	DESCRIPTOR:		COL, flex, proximal to splenic flexure; with directed submucosal injection(s), any substance		COL, flex, proximal to splenic flexure; with dilation by balloon, each stricture	
	GLOBAL:		0		0	
	CMS Code	CMS Desc	NonFac	Facility	NonFac	Facility
MEDICAL SUPPLIES - DAY OF PROCEDURE	CMS Code	CMS Desc				
SUPPLIES, DAY OF PROCEDURE:						
Multispecialty Visit Package	PEAC	PACK	1	0	1	0
scrub brush (impregnated)	11119	item	3	0	3	0
surgical cap	11305	item	3	0	3	0
surgical mask, with face shield	11301	item	3	0	3	0
gown, staff, impervious, disposable	11304	item	3	0	3	0
gloves, non-sterile	11302	pair	3	0	3	0
shoe covers	11307	pair	3	0	3	0
angiocatheter 20 to 25g	91106	item	1	0	1	0
ECG Electrodes Disposable	71006	lead	1	0	1	0
electrode pads	71011	pad	3	0	3	0
emesis basin	11506	item	1	0	1	0
gauze, 2x2	31506	item	2	0	2	0
needle free injection system	new	item	1	0	1	0
iv extension tube	91109	item	1	0	1	0
nasal cannula	93803	item	1	0	1	0
oxygen, 1 ltr	53014	liter	1	0	1	0
pulse oximeter probe	new	item	1	0	1	0
rubber tourniquet	91417	item	1	0	1	0
swab, alcohol	31101	item	1	0	1	0
syringe, 5 cc	91411	item	3	0	2	0
tape	31514	inch	3	0	3	0
cleaning brush	92020	item	1	0	1	0
Balloon dilator, 14-28 FR (Boston Scientific)	new	item	0	0	1	0
Suction Canister, Disposable	93604	item	1	0	1	0
tubing, suction, 6' with yankauer tip	93606	foot	1	0	1	0
bite block	11512	item	1	0	1	0
irrigation basin	new	item	1	0	1	0
KY jelly, single use foil pack, 5 grams	31105	item	2	0	2	0
Variceal injection needle	new	item	1	0	0	0
Equipment - day of procedure	CMS Code					
Power Table	E11003		1	0	1	0
endoscopy stretcher	E11005		1	0	1	0
surgical lamp	E30009		1	0	1	0
sigmoidoscopic equipment cart	E13103		1	0	1	0
sigmoidoscope, flexible	NEW		0	0	0	0
gastroscope video	E13106		1	0	1	0
colonoscope, video	E13110		1	0	1	0
3 channel ECG/BP monitor	E55005		1	0	1	0

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Laproscopic Colectomy Procedures

Six new laproscopic colectomy procedure codes were created to provide the level of specificity that CPT has established for the open colectomy codes.

44206 – 44212
The RUC reviewed these new surgical laproscopy codes independently and as a family and believed that the median survey results reflected the proper relative work values. The RUC understood that the entire family of codes displayed a tight, well surveyed group that presented itself in the proper rank order. The reference code 44204 *Laparoscopy, surgical; colectomy, partial, with anastomosis* (Work RVU = 25.08) had been recently surveyed by the RUC and served as an anchor to be used across the entire family. The RUC also compared the family across specialties by reviewing code 50545 *Laparoscopy, surgical; radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy)* (Work RVU=24.00), and believed the work was similar, however these new procedures required more pre and post service time physician work. After considering the survey results and code comparisons, the RUC regarded the values presented by the specialty were reasonable given the intensity and work involved. **The RUC recommends the following work relative values for codes 44206 - 44212.**

44206	**27.00**
44207	**30.00**
44208	**32.00**
44210	**28.00**
44211	**35.00**
44212	**32.50**

Practice Expense
The RUC reviewed the practice expense inputs for this family of codes and believed at a minimum the PEAC standard 60 minutes of pre-service time was appropriate and that for some codes 44208, 44210, 44211, and 44212 additional time for stoma education and counseling was necessary. The RUC also agreed with the presenters that code 44206 was emergent and that the pre-service time should be only 15 minutes. The RUC agreed with the remaining practice expense components, and they are attached to the recommendations for these codes.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●44206	AW1	Laproscopy, surgical; colectomy, partial, with end colostomy and closure of distal segment (Hartmann type procedure) (For open procedure, use 44143)	090	27.00
●44207	AW2	colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) (For open procedure, use 44145)	090	30.00
●44208	AW3	colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) with colostomy (For open procedure, use 44146)	090	32.00
●44210	AW4	colectomy, total, abdominal, without proctectomy, with ileostomy or ileoproctostomy (For open procedure, use 44150)	090	28.00
●44211	AW5	colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), with loop ileostomy, with or without rectal mucosectomy. (For open procedure, see 44152-44153)	090	35.00
●44212	AW6	colectomy, total, abdominal, with proctectomy, with ileostomy (For open procedure, use 44155)	090	32.50

New CPT Code: 44206 (AW1) **Global:** 090 **Recommended RVW:** ~~27.46~~
RUC Recommended RVW: 27.00

CPT Descriptor: Laparoscopy, surgical; colectomy, partial, with end colostomy and closure of distal segment (Hartmann type procedure)

Survey Vignette (Typical Patient)

A 56-year-old female presents to the emergency room with a 24-hour history of severe abdominal pain. Evaluation revealed rebound tenderness throughout the entire abdomen, fever to 39°C, and WBC elevation to 24,000. A CT scan of the abdomen was suggestive of perforated diverticulitis. The patient undergoes a laparoscopic evaluation of the abdomen with plans to proceed with a laparoscopic-aided sigmoid colectomy and colostomy, if necessary.

CLINICAL DESCRIPTION OF SERVICE:

Pre-operative work:
Complete history and physical performed with emphasis on any abdominal operations that might make the laparoscopic approach more difficult. Write pre-operative orders for peri-operative medications. Review pre-operative work-up, with particular attention to pathology reports and films. Review planned incisions and procedure - a potential site for the stoma is marked.. Confirm OR start time –notify patient and family. Arrange for surgical asst. Verify blood and/or x-match is available. Change into scrub clothes. The procedure and the differential diagnosis are reviewed with the patient and family as well as the different possible outcomes of surgery and potential complications depending on the findings at the time of surgery. Answer patient and family questions and obtain informed consent arrange where to meet post op. Review length and type of anesthesia with anesthesiologist. Review planned procedure and positioning and draping of patient. Verify that all necessary surgical instruments and supplies are readily available in the operative suite. Monitor patient positioning (supine with her legs in hydraulic stirrups) and draping, and assist with positioning as needed. All extremities are checked for proper positioning and padding to avoid neuropathy. Scrub and gown.

INTRA-OPERATIVE WORK:
At operation, under general anesthesia, the initial 10 mm trocar is inserted using open technique and pneumoperitoneum is established at 12 mm Hg. Additional trocars are placed under direct vision in the right lower quadrant, right upper quadrant and then in the left lower quadrant at the same site chosen for the colostomy. Laparoscopic evaluation of the abdomen indicates perforated diverticulitis with considerable free purulence. A single loop of small bowel is adhered to the inflammatory phlegmon and has to be mobilized out of the pelvis. The considerable adhesions between the sigmoid colon and the pelvic sidewall are meticulously taken down and the sigmoid colon mobilized by incising the lateral peritoneal attachments. The distal resection margin is chosen at the rectosigmoid junction and the bowel divided here using an endoscopic linear stapler/cutter. The mesosigmoid is divided with a combination of clips and harmonic scalpel. The left colon is further mobilized to allow enough length of bowel to exteriorize. Because of the peritonitis, it is elected to perform a colostomy rather than an anastomosis. The abdominal cavity is thoroughly irrigated. A stoma site is prepared at the left lower quadrant trocar site and the divided end of the sigmoid colon delivered up through the stoma site. All trocars are removed and the fascia closed at these sites. The proximal resection site is chosen and the bowel divided and a colostomy matured.

Post-operative work, in hospital:
Sterile dressings and a colostomy appliance are placed. Sign OR forms, indicating pre and post-op diagnosis and operation performed, and any pathology forms. Write orders for post-op labs, films, medications, diet, and patient activity. Review recovery room care and medications with staff. Discuss procedure outcome with family. Discuss procedure outcome with patient after emergence from anesthesia. Dictate post-op report. Dictate

procedure outcome and expected recovery letter for primary care physician and / or insurance company. Discharge patient from recovery to ICU for a minimum of two day stay before transfer to non-ICU floor. The patient is evaluated for sepsis, bowel function, cardiorespiratory function and analgesia initially post operatively then on a daily basis - documented in the medical record. Revisit patient to assess progress, pulmonary, cardiac, renal function and status of abdominal dressings. Write and summarize orders for floor nurse. Write discharge order to floor unless done by anesthesiologist. Examine patient, check wounds and patient progress daily as necessary. Check 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 labs, films, medications, diet, and patient activity. Chart patient progress notes. The patient is discharged when there is return of bowel function and adequate pain control with oral analgesics. Prior to discharge the pathology is reviewed with the patient. The wound and stoma are examined. Home restrictions (ie, diet, activity, bathing, return visits) are discussed with the patient and family members. All appropriate medical records are completed, including day of discharge progress notes, discharge summary, and discharge instructions, prescriptions, and insurance forms.

Post-operative work, in office:
At the first post op visit, sutures/drains are removed. At each post-op visit, the patient is examined and the wound and colostomy are assessed. Post discharge labs/films are ordered and reviewed. The patient is assessed for adequacy of pain control. (Note multiple visits are necessary because stoma). All patient and family questions are answered, including repetitive questions about the stoma. Discuss any additional or adjuvant treatment that may be required and referrals. Evaluation and management components are recorded and pertinent information forwarded to the primary care physician.

SURVEY DATA

Presenter(s): Anthony Senagore, MD
David Margolin, MD

Specialty(s): American Society of Colon and Rectal Surgeons
American Society of General Surgeons

Sample Size: 50 **Resp n:** 29 **Resp %:** 58%

Sample Type: Random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	24.00	26.25	27.00	29.50	33.50
Pre-Service			70		
Intra-Service	150	168	180	180	300

Post-Service	**Total Min**	**CPT code / # of visits**
Day of Surgery:		
Immediate	35	
Other	41	99233* x 1
After Day of Surgery:		
Critical Care		
Other Hospital	150	99233* x2 99232x1 99231x2
Dischg Day Mgmt	36	99238
Office Visits	76	99214x1 99213x1 99212x1

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'02 RVW	Glob
44204	Laparoscopy, surgical; colectomy, partial, with anastomosis	25.08	90

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

	Svy CPT	Ref CPT
TIME ESTIMATES (MEDIAN)	AW1	44204
Pre-service time	70	45
Intra-service time	180	180
Same Day Immediate Post-service time	35	30
Same Day Other Post-service time	41	87
Post Total critical care time (not same day)	0	
Post Total other hospital visit time (not same day)	150	
Discharge management time	36	36
Total office visit time	76	61
TOTAL TIME	*588*	*439*
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	3.27	3.18
Intra-service	4.45	4.09
Post-service	3.00	3.09
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3.91	3.45
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.64
Urgency of medical decision making	4.91	4.00
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	4.36	3.64
Physical effort required	4.45	4.00
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	4.27	4.20
Outcome depends on the skill and judgment of physician	4.27	4.20
Estimated risk of malpractice suit with poor outcome	3.91	4.00

RATIONALE:

In 2001, CMS increased the family of colectomy codes by 14% to bring them into line with five year review changes recommended by the RUC - and approved by CMS - for general surgery, vascular surgery, and cardiothoracic surgery codes. In 2001, CMS also assigned a value for new code 44204 that included the 14% increase in the open colectomy codes and accounted for the 19.43% difference accepted by the RUC between 44204 (Laparoscopic, colectomy, partial, with anastomosis) and 44140 (open, colectomy, partial, with anastomosis).

Federal Register: Volume 66, Number 111, June 8, 2001

The RUC recommended no change in the work RVUs for this family of codes based on lack of compelling evidence for changing the RVUs of the fully surveyed code 44140 (Partial colectomy). Moreover, the intraservice time for code 44140 had not changed since the last 5-year review. Additionally, the RUC compared code 44140 to code 32480 (Removal of lung, other than total pneumonectomy; single lobe (lobectomy)) and code 50230 (Nephrectomy, including partial ureterectomy, any approach including rib resection; radical, with regional lymphadenectomy and/or vena caval thrombectomy) that have similar work RVUs to 44140 and were believed to be longer, more intense procedures with more postoperative

care. We disagree with this recommendation. If the RVUs for procedures in this family are not changed, the procedures will be significantly undervalued compared to other general surgery codes (Family 5 and Family 7) and vascular surgery codes. As an example, we note that the RUC-recommended work RVU for code 44153 Colectomy, total, abdominal, without proctectomy; with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loop, will significantly undervalue this code compared to code 45113, Proctectomy, partial, with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with our without loop ileostomy, thus creating a rank-order anomaly.

We compared code 44140 to code 32480 for which the RUC is recommending a work RVU increase to 23.75. These procedures have similar intraservice times, and the postoperative visits show that although the initial care required for code 32480 is more intense, the length of stay for code 44140 is frequently longer. We also compared code 44140 to codes 37617, Ligation, major artery (eg post-traumatic, rupture); abdomen, and 35221, Repair blood vessel, direct; intra-abdominal. Code 37617, for which the RUC recommended work RVUs of 22.06, is an emergency operation with a slightly shorter intraservice time and shorter hospital stay. Code 35221, which has RUC-recommended work RVUs of 24.39, is also an emergency operation with an intraservice time and length of stay identical to code 44140. Based on these comparisons, we believe that the survey's 25th percentile work RVUs of 21.00 are appropriate and correctly rank code 44140 to the comparison procedures. This increase is 14 percent greater than the current work RVUs and, with the exception of the two codes discussed below, applying this 14 percent increase to the other codes in this family will place them in proper relationship to other comparable procedures.

Federal Register: Vol. 66, No. 212 / Thursday, November 1, 2001

Laparoscopy, Surgical; Colectomy, Partial With Anastomosis (CPT Code 44204) and Laparoscopy, Surgical; Colectomy, Partial, With Removal of Terminal Ileum With Ileocecostomy (CPT Code 44205)

The RUC recommended 22.00 RVUs for CPT code 44204 and 19.50 RVUs for CPT Code 44205 based on the reference code 44140 (*Colectomy, partial; with anastomosis*) which, at the time of the recommendation, had a work RVU of 18.35. We increased the work RVU of CPT Code 44140 to 21 as part of the 5- year review of physician work. In order to prevent rank order anomalies we are assigning work RVUs of 25.08 and 22.23 to CPT Codes 44204 and 44205, respectively. These work RVUs represent a 14 percent increase over the RUC recommendation and are consistent with our valuation of CPT Code 44140.

Althought the survey median RVWs for the new codes has ranked the procedures correctly vis-à-vis their open counterparts, we are recommending an RVW that is equal to 19.43% higher than the comparable open procedures for AW1-AW4 and AW6 (44143, 44145, 44146, 44150, and 44155). For new code AW5, we are recommending an RVW that is equal to 19.43% higher than the average of its comparable open procedures (44152 and 44153). The table below presents the current RVW for the open procedure codes, the median survey RVW for the new laparoscopic codes and the recommended RVW for each code.

Open Proc.	2002 RVW		Lap. Proc	Svy med RVW	RVW RECOMMADATION (19.43% increase over open procedure)
44140	21.00		44204		25.08 (2002 RVW)
44143	22.99		**44206 AW1**	27.00	**27.46**
44145	26.42		**442X2 AW2**	30.00	**31.55**
44146	27.54		**442XX2 AW3**	32.00	**32.89**
44150	23.95		**442X3 AW4**	28.00	**28.60**
44152	27.83	29.21 (avg)	**442X4 AW5**	35.00	**34.89**
44153	30.59				
44155	27.86		**442X6 AW6**	32.50	**33.27**

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

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: Colon & Rectal Surgery; 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: Colon & Rectal Surgery; General Surgery Frequency: estimated 6% of total

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: Colon & Rectal Surgery; General Surgery Frequency: estimated 6% of total

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

Physicians trained to use the laparoscope. Not limited to a few medical centers.

New CPT Code: 44207 (AW2) **Global:** 090 **Recommended RVW:** ~~31.55~~
RUC Recommended RVW: 30.00

CPT Descriptor: Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis)

Survey Vignette (Typical Patient)

A 62-year-old male presents with a rectal cancer in the upper rectum. Colonoscopy revealed no other abnormality and CT scan was normal. The patient undergoes a laparoscopic resection of the rectosigmoid with a coloproctostomy.

CLINICAL DESCRIPTION OF SERVICE:

Pre-operative work:
The CT scan, lab work including blood bank, pathology and colonoscopic findings are reviewed. Complete history and physical exam are performed with emphasis on any abdominal operations that might make the laparoscopic approach more difficult. The records from the radiotherapist and medical oncologist are reviewed. The procedure is reviewed with the patient and family as well as the potential complications. All questions answered. Informed consent is obtained. Medication and bowl prep instructions are reviewed. The OR time is confirmed and the patient and family are notified. Review length and type of anesthesia with anesthesiologist. Review planned procedure and positioning and draping of patient. Verify that all necessary surgical instruments and supplies are readily available in the operative suite. Monitor patient positioning (supine with her legs in hydraulic stirrups) and draping, and assist with positioning as needed. All extremities are checked for proper positioning and padding to avoid neuropathy. Scrub and gown.

INTRA-OPERATIVE WORK:
At operation, the initial 10 mm trocar is inserted using open technique and pneumoperitoneum is established at 12 mm Hg. Additional trocars are placed under direct vision in the right lower quadrant, right upper quadrant and then in the left lower quadrant at the same site chosen for the colostomy. Laparoscopic evaluation of the abdomen indicates a mass in the upper rectum. The liver appears normal. The sigmoid colon is mobilized by incising the lateral peritoneal attachments. The superior rectal vessels are identified, dissected up off of the sacral promontory, and then divided using a combination of clips and electrocautery. The rectum is then mobilized by incising along the lateral edges of the mesorectum and entering the presacral space and dissecting distally to the mid- to distal rectum. Special care is taken to identify and preserve both ureters and the presacral sympathetic chain. The distal resection margin is chosen at five centimeters distal to the mass. The bowel is divided here using a reticulating endoscopic linear stapler/cutter. The mesorectum is divided with a combination of clips and harmonic scalpel. The left colon is further mobilized to allow enough length of bowel to exteriorize. The abdominal cavity is thoroughly irrigated. The left lower quadrant trocar site is enlarged and the divided end of the rectosigmoid colon delivered up through the stoma site. The proximal resection site is chosen and the bowel divided and a purse-string suture placed around the end of the bowel. A 31 mm anvil is placed in the end of the bowel and then the bowel placed back within the abdominal cavity. The left lower quadrant site is closed in layers. An EEA stapler is passed transanally and the spike advanced out through the rectal stump. The anvil and the stapler are mated and then fired to form an end-to-end anastomosis. The anastomosis is then air-tested under water. All the remaining trocars are removed and all 10 mm and larger trocar sites are closed at the fascial level. The skin is closed with a subcuticular stitch.

Post-operative work, in hospital:
Sterile dressings are applied. Write an op note in the patient's record. Sign OR forms, indicating pre and post-op diagnosis and operation performed, and any pathology forms. Write orders for post-op labs, films, medications, diet, and patient activity. Review recovery room care and medications with staff. Discuss procedure outcome with family. Discuss procedure outcome with patient after emergence from anesthesia.

Dictate post-op report. Dictate procedure outcome and expected recovery letter for primary care physician and / or insurance company. The patient is evaluated for sepsis, bowel function, cardiorespiratory function and analgesia initially post operatively then on a daily basis and documented in the medical record. Revisit patient to assess progress, pulmonary, cardiac, renal function and status of abdominal dressings. Write and summarize orders for floor nurse. Write discharge order to floor unless done by anesthesiologist. Examine patient, check wounds and patient progress daily as necessary. Check 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 labs, films, medications, diet, and patient activity. Chart patient progress notes. The patient is discharged when there is return of bowel function and adequate pain control with oral analgesics. Prior to discharge the pathology is reviewed with the patient. Home restrictions (i.e.; diet, activity, bathing, return visits) are discussed with the patient and family members. All appropriate medical records are completed, including day of discharge progress notes, discharge summary, and discharge instructions, prescriptions, and insurance forms.

Post-operative work, in office:
At the first post op visit, sutures/drains are removed. At each post-op visit, the patient is examined and the wound assessed. Post discharge labs/films are ordered and reviewed. The patient is assessed for adequacy of pain control. All patient and family questions are answered. Discuss any additional or adjuvant treatment that may be required and referrals. Evaluation and management components are recorded and pertinent information forwarded to the primary care physician.

SURVEY DATA

Presenter(s): Anthony Senagore, MD
David Margolin, MD

Specialty(s): American Society of Colon and Rectal Surgeons
American Society of General Surgeons

Sample Size: 50 **Resp n:** 29 **Resp %:** 58%

Sample Type: Random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	27.00	29.00	30.00	31.00	36.42
Pre-Service			75		
Intra-Service	135	180	195	210	240

Post-Service	**Total Min**	**CPT code / # of visits**
Day of Surgery:		
Immediate	35	
Other	41	99233
After Day of Surgery:		
Critical Care	0	
Other Hospital	79	99232X2 99231X1
Dischg Day Mgmt	36	99238
Office Visits	61	99213X2 99212X1

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'02 RVW	Glob
44204	Laparoscopy, surgical; colectomy, partial, with anastomosis	25.08	90

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

	Svy CPT	Ref CPT
TIME ESTIMATES (MEDIAN)	AW2	44204
Pre-service time	75	45
Intra-service time	195	180
Same Day Immediate Post-service time	35	30
Same Day Other Post-service time	41	87
Post Total critical care time (not same day)	0	
Post Total other hospital visit time (not same day)	117	
Discharge management time	36	36
Total office visit time	61	61
TOTAL TIME	*560*	*439*

INTENSITY/COMPLEXITY MEASURES (mean)

TIME SEGMENTS

Pre-service	3.73	3.27
Intra-service	4.82	4.09
Post-service	4.09	3.18

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.45	3.55
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.55	3.73
Urgency of medical decision making	4.00	4.00

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.73	3.73
Physical effort required	4.73	4.09

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.55	4.30
Outcome depends on the skill and judgment of physician	4.82	4.30
Estimated risk of malpractice suit with poor outcome	4.36	4.20

RATIONALE:

In 2001, CMS increased the family of colectomy codes by 14% to bring them into line with five year review changes recommended by the RUC - and approved by CMS - for general surgery, vascular surgery, and cardiothoracic surgery codes. In 2001, CMS also assigned a value for new code 44204 that included the 14% increase in the open colectomy codes and accounted for the 19.43% difference accepted by the RUC between 44204 (Laparoscopic, colectomy, partial, with anastomosis) and 44140 (open, colectomy, partial, with anastomosis).

Federal Register: Volume 66, Number 111, June 8, 2001

The RUC recommended no change in the work RVUs for this family of codes based on lack of compelling evidence for changing the RVUs of the fully surveyed code 44140 (Partial colectomy). Moreover, the intraservice time for code 44140 had not changed since the last 5-year review. Additionally, the RUC compared code 44140 to code 32480 (Removal of lung, other than total pneumonectomy; single lobe (lobectomy)) and code 50230 (Nephrectomy, including partial ureterectomy, any approach including rib resection; radical, with regional lymphadenectomy and/or vena caval thrombectomy) that have similar work RVUs to 44140 and were believed to be longer, more intense procedures with more postoperative

care. We disagree with this recommendation. If the RVUs for procedures in this family are not changed, the procedures will be significantly undervalued compared to other general surgery codes (Family 5 and Family 7) and vascular surgery codes. As an example, we note that the RUC-recommended work RVU for code 44153 Colectomy, total, abdominal, without proctectomy; with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loop, will significantly undervalue this code compared to code 45113, Proctectomy, partial, with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with our without loop ileostomy, thus creating a rank-order anomaly.

We compared code 44140 to code 32480 for which the RUC is recommending a work RVU increase to 23.75. These procedures have similar intraservice times, and the postoperative visits show that although the initial care required for code 32480 is more intense, the length of stay for code 44140 is frequently longer. We also compared code 44140 to codes 37617, Ligation, major artery (eg post-traumatic, rupture); abdomen, and 35221, Repair blood vessel, direct; intra-abdominal. Code 37617, for which the RUC recommended work RVUs of 22.06, is an emergency operation with a slightly shorter intraservice time and shorter hospital stay. Code 35221, which has RUC-recommended work RVUs of 24.39, is also an emergency operation with an intraservice time and length of stay identical to code 44140. Based on these comparisons, we believe that the survey's 25th percentile work RVUs of 21.00 are appropriate and correctly rank code 44140 to the comparison procedures. This increase is 14 percent greater than the current work RVUs and, with the exception of the two codes discussed below, applying this 14 percent increase to the other codes in this family will place them in proper relationship to other comparable procedures.

Federal Register: Vol. 66, No. 212 / Thursday, November 1, 2001

Laparoscopy, Surgical; Colectomy, Partial With Anastomosis (CPT Code 44204) and Laparoscopy, Surgical; Colectomy, Partial, With Removal of Terminal Ileum With Ileocecostomy (CPT Code 44205)

The RUC recommended 22.00 RVUs for CPT code 44204 and 19.50 RVUs for CPT Code 44205 based on the reference code 44140 (*Colectomy, partial; with anastomosis*) which, at the time of the recommendation, had a work RVU of 18.35. We increased the work RVU of CPT Code 44140 to 21 as part of the 5- year review of physician work. In order to prevent rank order anomalies we are assigning work RVUs of 25.08 and 22.23 to CPT Codes 44204 and 44205, respectively. These work RVUs represent a 14 percent increase over the RUC recommendation and are consistent with our valuation of CPT Code 44140.

Althought the survey median RVWs for the new codes has ranked the procedures correctly vis-à-vis their open counterparts, we are recommending an RVW that is equal to 19.43% higher than the comparable open procedures for AW1-AW4 and AW6 (44143, 44145, 44146, 44150, and 44155). For new code AW5, we are recommending an RVW that is equal to 19.43% higher than the average of its comparable open procedures (44152 and 44153). The table below presents the current RVW for the open procedure codes, the median survey RVW for the new laparoscopic codes and the recommended RVW for each code.

Open Proc.	2002 RVW		Lap. Proc	Svy med RVW	RVW RECOMMADATION (19.43% increase over open procedure)
44140	21.00		44204		25.08 (2002 RVW)
44143	22.99		**442X1 AW1**	27.00	**27.46**
44145	26.42		**44207 AW2**	30.00	**31.55**
44146	27.54		**442XX2 AW3**	32.00	**32.89**
44150	23.95		**442X3 AW4**	28.00	**28.60**
44152	27.83	29.21 (avg)	**442X4 AW5**	35.00	**34.89**
44153	30.59				
44155	27.86		**442X6 AW6**	32.50	**33.27**

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

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: Colon & Rectal Surgery; 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: Colon & Rectal Surgery; General Surgery Frequency: estimated 6% of total

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: Colon & Rectal Surgery; General Surgery Frequency: estimated 6% of total

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

Physicians trained to use the laparoscope. Not limited to a few medical centers.

New CPT Code: 44208 (AW3) **Global:** 090 **Recommended RVW:** ~~32.89~~
RUC Recommended RVW: 32.00

CPT Descriptor: Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) with colostomy

Survey Vignette (Typical Patient)

A 62-year-old male presents with a large, fixed rectal cancer in the upper rectum. Colonoscopy revealed no other abnormality and CT scan was normal. Following adjuvant radiochemotherapy (reported separately by another physician), the patient undergoes a laparoscopic resection of the rectosigmoid with a coloproctostomy.

CLINICAL DESCRIPTION OF SERVICE:

Pre-operative work:
The CT scan, lab work including blood bank, pathology and colonoscopic findings are reviewed. Complete history and physical exam are performed with emphasis on any abdominal operations that might make the laparoscopic approach more difficult. The records from the radiotherapist and medical oncologist are reviewed. The procedure is reviewed with the patient and family as well as the potential complications. All questions answered. Informed consent is obtained. Medication and bowl prep instructions are reviewed. The OR time is confirmed and the patient and family are notified. Review length and type of anesthesia with anesthesiologist. Review planned procedure and positioning and draping of patient. Potential stoma sites are identified and marked. Verify that all necessary surgical instruments and supplies are readily available in the operative suite. Monitor patient positioning (supine with her legs in hydraulic stirrups) and draping, and assist with positioning as needed. All extremities are checked for proper positioning and padding to avoid neuropathy. Scrub and gown.

INTRA-OPERATIVE WORK:
At operation, the initial 10 mm trocar is inserted using open technique and pneumoperitoneum is established at 12 mm Hg. Additional trocars are placed under direct vision in the right lower quadrant, right upper quadrant and then in the left lower quadrant at the same site chosen for the colostomy. Laparoscopic evaluation of the abdomen indicates a mass in the upper rectum. The liver appears normal. The sigmoid colon is mobilized by incising the lateral peritoneal attachments. The superior rectal vessels are identified, dissected up off of the sacral promontory, and then divided using a combination of clips and electrocautery. The rectum is then mobilized by incising along the lateral edges of the mesorectum and entering the presacral space and dissecting distally to the mid- to distal rectum. Special care is taken to identify and preserve both ureters and the presacral sympathetic chain. The distal resection margin is chosen at five centimeters distal to the mass. The bowel is divided here using a reticulating endoscopic linear stapler/cutter. The mesorectum is divided with a combination of clips and harmonic scalpel. The left colon is further mobilized to allow enough length of bowel to exteriorize. The abdominal cavity is thoroughly irrigated. The left lower quadrant trocar site is enlarged and the divided end of the rectosigmoid colon delivered up through the stoma site. The proximal resection site is chosen and the bowel divided and a purse-string suture placed around the end of the bowel. A 31 mm anvil is placed in the end of the bowel and then the bowel placed back within the abdominal cavity. The left lower quadrant site is closed in layers. An EEA stapler is passed transanally and the spike advanced out through the rectal stump. The anvil and the stapler are mated and then fired to form an end-to-end anastomosis. The anastomosis is then air-tested under water. At the time of testing a small air leak is identified at the anterior border of the anastomosis. This is repaired with interrupted Lembert sutures. Because of the air leak and the previous radiotherapy, a diverting ileostomy is placed. The ileostomy site developed in the right lower quadrant. The ileum is then brought up out through the ileostomy site. All the remaining trocars are removed and all 10 mm and larger trocar sites are closed at the fascial level. The skin is closed with a subcuticular stitch

Post-operative work, in hospital:
Sterile dressings and a colostomy appliance are placed. Sign OR forms, indicating pre and post-op diagnosis and operation performed, and any pathology forms. Write orders for post-op labs, films, medications, diet, and patient activity. Review recovery room care and medications with staff. Discuss procedure outcome with family. Discuss procedure outcome with patient after emergence from anesthesia. Dictate post-op report. Dictate procedure outcome and expected recovery letter for primary care physician and / or insurance company. The patient is evaluated for sepsis, bowel function, cardiorespiratory function and analgesia initially post operatively then on a daily basis and documented in the medical record. Revisit patient to assess progress, pulmonary, cardiac, renal function and status of abdominal dressings. Write and summarize orders for floor nurse. Write discharge order to floor unless done by anesthesiologist. Examine patient, check wounds and patient progress daily as necessary. Check 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 labs, films, medications, diet, and patient activity. Chart patient progress notes. The patient is discharged when there is return of bowel function and adequate pain control with oral analgesics. Prior to discharge the pathology is reviewed with the patient. The wound and stoma are examined. Home restrictions I(.e.; diet, activity, bathing, return visits) are discussed with the patient and family members. All appropriate medical records are completed, including day of discharge progress notes, discharge summary, and discharge instructions, prescriptions, and insurance forms.

Post-operative work, in office:
At the first post op visit, sutures/drains are removed. At each post-op visit, the patient is examined and the wound and colostomy are assessed. Post discharge labs/films are ordered and reviewed. The patient is assessed for adequacy of pain control. (Note multiple visits are necessary because stoma). All patient and family questions are answered, including repetitive questions about the stoma. Discuss any additional or adjuvant treatment that may be required and referrals. Evaluation and management components are recorded and pertinent information forwarded to the primary care physician.

SURVEY DATA

Presenter(s): Anthony Senagore, MD
David Margolin, MD

Specialty(s): American Society of Colon and Rectal Surgeons
American Society of General Surgeons

Sample Size: 50 **Resp n:** 29 **Resp %:** 58%

Sample Type: Random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	27.00	30.50	32.00	33.00	39.00
Pre-Service			75		
Intra-Service	180	195	205	224	400

Post-Service	**Total Min**	**CPT code / # of visits**
Day of Surgery:		
Immediate	35	
Other	30	99232
After Day of Surgery:		
Critical Care	0	
Other Hospital	117	99232X2 99231X3
Dischg Day Mgmt	36	99238
Office Visits	61	99213X2 99212X1

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'02 RVW	Glob
44204	Laparoscopy, surgical; colectomy, partial, with anastomosis	25.08	90

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

	Svy CPT	Ref CPT
TIME ESTIMATES (MEDIAN)	AW3	44204
Pre-service time	75	45
Intra-service time	205	180
Same Day Immediate Post-service time	35	30
Same Day Other Post-service time	30	87
Post Total critical care time (not same day)	0	
Post Total other hospital visit time (not same day)	117	
Discharge management time	36	36
Total office visit time	61	61
TOTAL TIME	*559*	*439*
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	3.36	3.36
Intra-service	4.55	4.18
Post-service	3.18	3.18
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3.36	3.64
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.55	3.82
Urgency of medical decision making	3.91	3.91
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	4.45	3.73
Physical effort required	5.00	4.09
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	4.45	4.40
Outcome depends on the skill and judgment of physician	5.00	4.30
Estimated risk of malpractice suit with poor outcome	4.18	4.20

RATIONALE:

In 2001, CMS increased the family of colectomy codes by 14% to bring them into line with five year review changes recommended by the RUC - and approved by CMS - for general surgery, vascular surgery, and cardiothoracic surgery codes. In 2001, CMS also assigned a value for new code 44204 that included the 14% increase in the open colectomy codes and accounted for the 19.43% difference accepted by the RUC between 44204 (Laparoscopic, colectomy, partial, with anastomosis) and 44140 (open, colectomy, partial, with anastomosis).

Federal Register: Volume 66, Number 111, June 8, 2001

The RUC recommended no change in the work RVUs for this family of codes based on lack of compelling evidence for changing the RVUs of the fully surveyed code 44140 (Partial colectomy). Moreover, the intraservice time for code 44140 had not changed since the last 5-year review. Additionally, the RUC compared code 44140 to code 32480 (Removal of lung, other than total pneumonectomy; single lobe (lobectomy)) and code 50230 (Nephrectomy, including partial ureterectomy, any approach including rib resection; radical, with regional lymphadenectomy and/or vena caval thrombectomy) that have similar work RVUs to 44140 and were believed to be longer, more intense procedures with more postoperative

care. We disagree with this recommendation. If the RVUs for procedures in this family are not changed, the procedures will be significantly undervalued compared to other general surgery codes (Family 5 and Family 7) and vascular surgery codes. As an example, we note that the RUC-recommended work RVU for code 44153 Colectomy, total, abdominal, without proctectomy; with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loop, will significantly undervalue this code compared to code 45113, Proctectomy, partial, with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with our without loop ileostomy, thus creating a rank-order anomaly.

We compared code 44140 to code 32480 for which the RUC is recommending a work RVU increase to 23.75. These procedures have similar intraservice times, and the postoperative visits show that although the initial care required for code 32480 is more intense, the length of stay for code 44140 is frequently longer. We also compared code 44140 to codes 37617, Ligation, major artery (eg post-traumatic, rupture); abdomen, and 35221, Repair blood vessel, direct; intra-abdominal. Code 37617, for which the RUC recommended work RVUs of 22.06, is an emergency operation with a slightly shorter intraservice time and shorter hospital stay. Code 35221, which has RUC-recommended work RVUs of 24.39, is also an emergency operation with an intraservice time and length of stay identical to code 44140. Based on these comparisons, we believe that the survey's 25th percentile work RVUs of 21.00 are appropriate and correctly rank code 44140 to the comparison procedures. This increase is 14 percent greater than the current work RVUs and, with the exception of the two codes discussed below, applying this 14 percent increase to the other codes in this family will place them in proper relationship to other comparable procedures.

Federal Register: Vol. 66, No. 212 / Thursday, November 1, 2001

Laparoscopy, Surgical; Colectomy, Partial With Anastomosis (CPT Code 44204) and Laparoscopy, Surgical; Colectomy, Partial, With Removal of Terminal Ileum With Ileocecostomy (CPT Code 44205)

The RUC recommended 22.00 RVUs for CPT code 44204 and 19.50 RVUs for CPT Code 44205 based on the reference code 44140 (*Colectomy, partial; with anastomosis*) which, at the time of the recommendation, had a work RVU of 18.35. We increased the work RVU of CPT Code 44140 to 21 as part of the 5- year review of physician work. In order to prevent rank order anomalies we are assigning work RVUs of 25.08 and 22.23 to CPT Codes 44204 and 44205, respectively. These work RVUs represent a 14 percent increase over the RUC recommendation and are consistent with our valuation of CPT Code 44140.

Althought the survey median RVWs for the new codes has ranked the procedures correctly vis-à-vis their open counterparts, we are recommending an RVW that is equal to 19.43% higher than the comparable open procedures for AW1-AW4 and AW6 (44143, 44145, 44146, 44150, and 44155). For new code AW5, we are recommending an RVW that is equal to 19.43% higher than the average of its comparable open procedures (44152 and 44153). The table below presents the current RVW for the open procedure codes, the median survey RVW for the new laparoscopic codes and the recommended RVW for each code.

Open Proc.	2002 RVW		Lap. Proc	Svy med RVW	RVW RECOMMADATION (19.43% increase over open procedure)
44140	21.00		44204		25.08 (2002 RVW)
44143	22.99		**442X1 AW1**	27.00	**27.46**
44145	26.42		**442X2 AW2**	30.00	**31.55**
44146	27.54		**44208 AW3**	32.00	**32.89**
44150	23.95		**442X3 AW4**	28.00	**28.60**
44152	27.83	29.21 (avg)	**442X4 AW5**	35.00	**34.89**
44153	30.59				
44155	27.86		**442X6 AW6**	32.50	**33.27**

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

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: Colon & Rectal Surgery; 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: Colon & Rectal Surgery; General Surgery Frequency: estimated 6% of total

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: Colon & Rectal Surgery; General Surgery Frequency: estimated 6% of total

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

Physicians trained to use the laparoscope. Not limited to a few medical centers.

New CPT Code: 44210 (AW4) **Global:** 090 **Recommended RVW:** ~~28.60~~
RUC Recommended RVW: 28.00

CPT Descriptor: Laparoscopy, surgical; colectomy, total, abdominal, without proctectomy, with ileostomy or ileoproctostomy

Survey Vignette (Typical Patient)
A 22-year-old female presents with known familial polyposis with minimal number of polyps in the rectum. She undergoes a laparoscopic total abdominal colectomy with ileoproctostomy.

CLINICAL DESCRIPTION OF SERVICE:

Pre-operative work:
The CT scan, lab work including blood bank, pathology and colonoscopic findings are reviewed. Complete history and physical exam are performed with emphasis on any abdominal operations that might make the laparoscopic approach more difficult. The procedure is reviewed with the patient and family as well as the potential complications. All questions answered. Informed consent is obtained. Medication and bowl prep instructions are reviewed. The OR time is confirmed and the patient and family are notified. Review length and type of anesthesia with anesthesiologist. Review planned procedure and positioning and draping of patient. Verify that all necessary surgical instruments and supplies are readily available in the operative suite. Monitor patient positioning (supine with her legs in hydraulic stirrups) and draping, and assist with positioning as needed. All extremities are checked for proper positioning and padding to avoid neuropathy. Scrub and gown.

INTRA-OPERATIVE WORK:
At operation, the initial trocar is placed in the umbilical port using the open technique and then four additional trocars (two on each side) are placed under direct vision. The bowel is completely mobilized by incising the lateral peritoneal attachments and by separating the omentum from the transverse colon. Starting with the left colon and then proceeding proximally the mesentery of the abdominal colon is divided using a combination of clips and the harmonic scalpel. The rectosigmoid junction is divided using an endoscopic linear stapler/cutter. The umbilical port site is then enlarged allowing the colon to be extracted out through this site. The terminal ileum is divided just proximal to the ileocecal valve and a 28 mm. circular stapler anvil is placed in the terminal ileum with a purse-string suture. The terminal ileum is then placed back within the abdominal cavity, the incision closed, and pneumoperitoneum re-established. The circular stapler is passed transanally and the spike brought out through the end of the rectal stump. The anvil in the terminal ileum is fitted to the stapler and the stapler is then fired forming an end-to-end anastomosis. An air test is performed and then all the trocars are removed. The fascia is closed at the 10mm trocar sites and the all skin incisions closed with subcuticular stitches.

Post-operative work, in hospital:
Sterile dressings are applied. Write an op note in the patient's record. Sign OR forms, indicating pre and post-op diagnosis and operation performed, and any pathology forms. Write orders for post-op labs, films, medications, diet, and patient activity. Review recovery room care and medications with staff. Discuss procedure outcome with family. Discuss procedure outcome with patient after emergence from anesthesia. Dictate post-op report. Dictate procedure outcome and expected recovery letter for primary care physician and / or insurance company. The patient is evaluated for sepsis, bowel function, cardiorespiratory function and analgesia initially post operatively then on a daily basis and documented in the medical record. Revisit patient to assess progress, pulmonary, cardiac, renal function and status of abdominal dressings. Write and summarize orders for floor nurse. Write discharge order to floor unless done by anesthesiologist. Examine patient, check wounds and patient progress daily as necessary. Check 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 labs, films, medications, diet, and patient activity. Chart patient progress notes. The patient is discharged when there is return of bowel function and adequate pain control with oral analgesics. Prior

to discharge the pathology is reviewed with the patient. Home restrictions (i.e.; diet, activity, bathing, return visits) are discussed with the patient and family members. All appropriate medical records are completed, including day of discharge progress notes, discharge summary, and discharge instructions, prescriptions, and insurance forms.

Post-operative work, in office:
At the first post op visit, sutures/drains are removed. At each post-op visit, the patient is examined and the wound assessed. Post discharge labs/films are ordered and reviewed. The patient is assessed for adequacy of pain control. All patient and family questions are answered. Discuss any additional or adjuvant treatment that may be required and referrals. Evaluation and management components are recorded and pertinent information forwarded to the primary care physician.

SURVEY DATA

Presenter(s): Anthony Senagore, MD
David Margolin, MD

Specialty(s): American Society of Colon and Rectal Surgeons
American Society of General Surgeons

Sample Size: 50 **Resp n:** 29 **Resp %:** 58%

Sample Type: Random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	26.00	27.00	28.00	31.00	34.95
Pre-Service			75		
Intra-Service	180	213	240	240	280

Post-Service	Total Min	CPT code / # of visits
Day of Surgery:		
Immediate	35	
Other	30	99232
After Day of Surgery:		
Critical Care	0	
Other Hospital	87	99232X1 99231X3
Dischg Day Mgmt	36	99238
Office Visits	99	99214X1 99213X2 99212X1

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'02 RVW	Glob
44204	Laparoscopy, surgical; colectomy, partial, with anastomosis	25.08	90

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

	Svy CPT	Ref CPT
TIME ESTIMATES (MEDIAN)	AW4	44204
Pre-service time	75	45
Intra-service time	240	180
Same Day Immediate Post-service time	35	30
Same Day Other Post-service time	30	87
Post Total critical care time (not same day)	0	
Post Total other hospital visit time (not same day)	87	
Discharge management time	36	36
Total office visit time	99	61
TOTAL TIME	*602*	*439*

INTENSITY/COMPLEXITY MEASURES (mean)

TIME SEGMENTS

Pre-service	3.18	3.27
Intra-service	4.55	4.00
Post-service	3.18	3.27

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.18	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.36	3.73
Urgency of medical decision making	4.18	4.27

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.45	3.64
Physical effort required	4.55	4.00

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.36	4.30
Outcome depends on the skill and judgment of physician	4.27	4.50
Estimated risk of malpractice suit with poor outcome	4.09	4.20

RATIONALE:

In 2001, CMS increased the family of colectomy codes by 14% to bring them into line with five year review changes recommended by the RUC - and approved by CMS - for general surgery, vascular surgery, and cardiothoracic surgery codes. In 2001, CMS also assigned a value for new code 44204 that included the 14% increase in the open colectomy codes and accounted for the 19.43% difference accepted by the RUC between 44204 (Laparoscopic, colectomy, partial, with anastomosis) and 44140 (open, colectomy, partial, with anastomosis).

Federal Register: Volume 66, Number 111, June 8, 2001

The RUC recommended no change in the work RVUs for this family of codes based on lack of compelling evidence for changing the RVUs of the fully surveyed code 44140 (Partial colectomy). Moreover, the intraservice time for code 44140 had not changed since the last 5-year review. Additionally, the RUC compared code 44140 to code 32480 (Removal of lung, other than total pneumonectomy; single lobe (lobectomy)) and code 50230 (Nephrectomy, including partial ureterectomy, any approach including rib resection; radical, with regional lymphadenectomy and/or vena caval thrombectomy) that have similar work RVUs to 44140 and were believed to be longer, more intense procedures with more postoperative

care. We disagree with this recommendation. If the RVUs for procedures in this family are not changed, the procedures will be significantly undervalued compared to other general surgery codes (Family 5 and Family 7) and vascular surgery codes. As an example, we note that the RUC-recommended work RVU for code 44153 Colectomy, total, abdominal, without proctectomy; with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loop, will significantly undervalue this code compared to code 45113, Proctectomy, partial, with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with our without loop ileostomy, thus creating a rank-order anomaly.

We compared code 44140 to code 32480 for which the RUC is recommending a work RVU increase to 23.75. These procedures have similar intraservice times, and the postoperative visits show that although the initial care required for code 32480 is more intense, the length of stay for code 44140 is frequently longer. We also compared code 44140 to codes 37617, Ligation, major artery (eg post-traumatic, rupture); abdomen, and 35221, Repair blood vessel, direct; intra-abdominal. Code 37617, for which the RUC recommended work RVUs of 22.06, is an emergency operation with a slightly shorter intraservice time and shorter hospital stay. Code 35221, which has RUC-recommended work RVUs of 24.39, is also an emergency operation with an intraservice time and length of stay identical to code 44140. Based on these comparisons, we believe that the survey's 25th percentile work RVUs of 21.00 are appropriate and correctly rank code 44140 to the comparison procedures. This increase is 14 percent greater than the current work RVUs and, with the exception of the two codes discussed below, applying this 14 percent increase to the other codes in this family will place them in proper relationship to other comparable procedures.

Federal Register: Vol. 66, No. 212 / Thursday, November 1, 2001

Laparoscopy, Surgical; Colectomy, Partial With Anastomosis (CPT Code 44204) and Laparoscopy, Surgical; Colectomy, Partial, With Removal of Terminal Ileum With Ileocecostomy (CPT Code 44205)

The RUC recommended 22.00 RVUs for CPT code 44204 and 19.50 RVUs for CPT Code 44205 based on the reference code 44140 (*Colectomy, partial; with anastomosis*) which, at the time of the recommendation, had a work RVU of 18.35. We increased the work RVU of CPT Code 44140 to 21 as part of the 5- year review of physician work. In order to prevent rank order anomalies we are assigning work RVUs of 25.08 and 22.23 to CPT Codes 44204 and 44205, respectively. These work RVUs represent a 14 percent increase over the RUC recommendation and are consistent with our valuation of CPT Code 44140.

Althought the survey median RVWs for the new codes has ranked the procedures correctly vis-à-vis their open counterparts, we are recommending an RVW that is equal to 19.43% higher than the comparable open procedures for AW1-AW4 and AW6 (44143, 44145, 44146, 44150, and 44155). For new code AW5, we are recommending an RVW that is equal to 19.43% higher than the average of its comparable open procedures (44152 and 44153). The table below presents the current RVW for the open procedure codes, the median survey RVW for the new laparoscopic codes and the recommended RVW for each code.

Open Proc.	2002 RVW		Lap. Proc	Svy med RVW	RVW RECOMMADATION (19.43% increase over open procedure)
44140	21.00		44204		25.08 (2002 RVW)
44143	22.99		**442X1 AW1**	27.00	**27.46**
44145	26.42		**442X2 AW2**	30.00	**31.55**
44146	27.54		**442XX2 AW3**	32.00	**32.89**
44150	23.95		**44210 AW4**	28.00	**28.60**
44152	27.83	29.21 (avg)	**442X4 AW5**	35.00	**34.89**
44153	30.59				
44155	27.86		**442X6 AW6**	32.50	**33.27**

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

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: Colon & Rectal Surgery; 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: Colon & Rectal Surgery; General Surgery Frequency: estimated 6% of total

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: Colon & Rectal Surgery; General Surgery Frequency: estimated 6% of total

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

Physicians trained to use the laparoscope. Not limited to a few medical centers.

New CPT Code: 44211 (AW5) **Global:** 090 **Recommended RVW:** ~~34.89~~
RUC Recommended RVW: 35.00

CPT Descriptor: Laparoscopy, surgical; colectomy, total , abdominal, with proctectomy, with ileoanal anastomosis, with creation of reservoir (S or J), with loop ileostomy, with or without rectal mucosectomy.

Survey Vignette (Typical Patient)
An 18-year-old female from a known familial polyposis kindred presents with diffuse polyposis. She undergoes a laparoscopic total proctocolectomy, ileoanal anastomosis, creation of ileal reservoir, loop ileostomy, and mucosectomy.

CLINICAL DESCRIPTION OF SERVICE:

Pre-operative work:
The CT scan, lab work including blood bank, pathology and colonoscopic findings are reviewed. Complete history and physical exam are performed with emphasis on any abdominal operations that might make the laparoscopic approach more difficult. The records from the radiotherapist and medical oncologist are reviewed. The procedure is reviewed with the patient and family as well as the potential complications. All questions answered. Informed consent is obtained. Medication and bowl prep instructions are reviewed. The OR time is confirmed and the patient and family are notified. Review length and type of anesthesia with anesthesiologist. Review planned procedure and positioning and draping of patient. Potential stoma sites are identified and marked. Verify that all necessary surgical instruments and supplies are readily available in the operative suite. Monitor patient positioning (supine with her legs in hydraulic stirrups) and draping, and assist with positioning as needed. All extremities are checked for proper positioning and padding to avoid neuropathy. Scrub and gown.

INTRA-OPERATIVE WORK:
At operation, the initial port is placed in the umbilical port using the open technique and then four additional trocars (two on each side) are placed under direct vision. The bowel is completely mobilized by incising the lateral peritoneal attachments and by separating the omentum from the transverse colon. Starting with the left colon and then proceeding proximally the mesentery of the abdominal colon is divided using a combination of clips and the harmonic scalpel. Dissection is then carried out in pelvis. The ureters are both identified and the peritoneum incised circumferentially. The presacral space and the rectovaginal plane are entered and dissection carried out down to the pelvic floor. The rectal dissection is then carried out transanally with a mucosectomy being carried out using a Lone Star retractor. A low transverse incision is made to gain access to the abdominal cavity. The rectum is divided just above the pelvic floor and the colon and rectum delivered out through the low transverse incision. The terminal ileum is divided at the ileocecal junction and then a J pouch is constructed using linear stapler/cutters. The J pouch is then placed back inside the abdomen and delivered to the pelvis. A hand-sewn ileoanal anastomosis is completed and then air-tested. A significant air leak is detected and the anastomosis is found to have a small defect that is then repaired. Because of the repair and some moderate tension on the anastomosis, it is elected to perform a diverting ileostomy. A proximal loop of ileum is chosen for the diverting ileostomy and a penrose drain placed around the bowel at this point. The right lower quadrant trocar is removed and this site used for the ileostomy. The skin is excised in a circular fashion and the muscle and fascia split. The ileum is brought out through the stoma site. The low transverse incision is closed after irrigating out the abdominal cavity. After removing all the remaining trocars, the fascia is closed at the 10mm trocar sites and the all skin incisions closed with subcuticular stitches. The ileostomy is matured by incising on the antimesenteric border and then forming a Brooke type ileostomy. An ileostomy appliance and sterile dressings are applied and the patient is transferred to PACU.

Post-operative work, in hospital:
An ileostomy appliance and sterile dressings are applied. Sign OR forms, indicating pre and post-op diagnosis and operation performed, and any pathology forms. Write orders for post-op labs, films, medications, diet, and patient activity. Review recovery room care and medications with staff. Discuss procedure outcome with family. Discuss procedure outcome with patient after emergence from anesthesia. Dictate post-op report. Dictate procedure outcome and expected recovery letter for primary care physician and / or insurance company. The patient is evaluated for sepsis, bowel function, cardiorespiratory function and analgesia initially post operatively then on a daily basis and documented in the medical record. Revisit patient to assess progress, pulmonary, cardiac, renal function and status of abdominal dressings. Write and summarize orders for floor nurse. Write discharge order to floor unless done by anesthesiologist. Examine patient, check wounds and patient progress daily as necessary. Check 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 labs, films, medications, diet, and patient activity. Chart patient progress notes. The patient is discharged when there is return of bowel function and adequate pain control with oral analgesics. Prior to discharge the pathology is reviewed with the patient. The wound and stoma are examined. Home restrictions I(.e.; diet, activity, bathing, return visits) are discussed with the patient and family members. All appropriate medical records are completed, including day of discharge progress notes, discharge summary, and discharge instructions, prescriptions, and insurance forms.

Post-operative work, in office:
At the first post op visit, sutures/drains are removed. At each post-op visit, the patient is examined and the wound and ileostomy are assessed. Post discharge labs/films are ordered and reviewed. The patient is assessed for adequacy of pain control. (Note multiple visits are necessary because stoma). All patient and family questions are answered, including repetitive questions about the stoma. Discuss any additional or adjuvant treatment that may be required and referrals. Evaluation and management components are recorded and pertinent information forwarded to the primary care physician.

SURVEY DATA

Presenter(s): Anthony Senagore, MD
David Margolin, MD
Specialty(s): American Society of Colon and Rectal Surgeons
American Society of General Surgeons

Sample Size: 50 **Resp n:** 29 **Resp %:** 58%

Sample Type: Random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	26.00	33.58	35.00	36.95	47.00
Pre-Service			80		
Intra-Service	250	300	300	310	430

Post-Service	**Total Min**	**CPT code / # of visits**
Day of Surgery:		
Immediate	35	
Other	30	99232X1
After Day of Surgery:		
Critical Care	0	
Other Hospital	87	99232X1 99231X3
Dischg Day Mgmt	36	99238
Office Visits	99	99214X1 99213X2 99212X1

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'02 RVW	Glob
44204	Laparoscopy, surgical; colectomy, partial, with anastomosis	25.08	90

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

	Svy CPT	Ref CPT
TIME ESTIMATES (MEDIAN)	AW5	44204
Pre-service time	80	45
Intra-service time	300	180
Same Day Immediate Post-service time	35	30
Same Day Other Post-service time	30	87
Post Total critical care time (not same day)	0	
Post Total other hospital visit time (not same day)	87	
Discharge management time	36	36
Total office visit time	99	61
TOTAL TIME	*667*	*439*

INTENSITY/COMPLEXITY MEASURES (mean)

TIME SEGMENTS

Pre-service	3.27	3.36
Intra-service	4.55	4.09
Post-service	3.27	3.36

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	3.27	3.64
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.45	3.82
Urgency of medical decision making	4.64	3.91

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	5.00	3.73
Physical effort required	4.91	4.00

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	5.00	4.30
Outcome depends on the skill and judgment of physician	5.00	4.30
Estimated risk of malpractice suit with poor outcome	4.82	4.00

RATIONALE:

In 2001, CMS increased the family of colectomy codes by 14% to bring them into line with five year review changes recommended by the RUC - and approved by CMS - for general surgery, vascular surgery, and cardiothoracic surgery codes. In 2001, CMS also assigned a value for new code 44204 that included the 14% increase in the open colectomy codes and accounted for the 19.43% difference accepted by the RUC between 44204 (Laparoscopic, colectomy, partial, with anastomosis) and 44140 (open, colectomy, partial, with anastomosis).

Federal Register: Volume 66, Number 111, June 8, 2001

The RUC recommended no change in the work RVUs for this family of codes based on lack of compelling evidence for changing the RVUs of the fully surveyed code 44140 (Partial colectomy). Moreover, the intraservice time for code 44140 had not changed since the last 5-year review. Additionally, the RUC compared code 44140 to code 32480 (Removal of lung, other than total pneumonectomy; single lobe (lobectomy)) and code 50230 (Nephrectomy, including partial ureterectomy, any approach including rib resection; radical, with regional lymphadenectomy and/or vena caval thrombectomy) that have similar work RVUs to 44140 and were believed to be longer, more intense procedures with more postoperative

care. We disagree with this recommendation. If the RVUs for procedures in this family are not changed, the procedures will be significantly undervalued compared to other general surgery codes (Family 5 and Family 7) and vascular surgery codes. As an example, we note that the RUC-recommended work RVU for code 44153 Colectomy, total, abdominal, without proctectomy; with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loop, will significantly undervalue this code compared to code 45113, Proctectomy, partial, with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with our without loop ileostomy, thus creating a rank-order anomaly.

We compared code 44140 to code 32480 for which the RUC is recommending a work RVU increase to 23.75. These procedures have similar intraservice times, and the postoperative visits show that although the initial care required for code 32480 is more intense, the length of stay for code 44140 is frequently longer. We also compared code 44140 to codes 37617, Ligation, major artery (eg post-traumatic, rupture); abdomen, and 35221, Repair blood vessel, direct; intra-abdominal. Code 37617, for which the RUC recommended work RVUs of 22.06, is an emergency operation with a slightly shorter intraservice time and shorter hospital stay. Code 35221, which has RUC-recommended work RVUs of 24.39, is also an emergency operation with an intraservice time and length of stay identical to code 44140. Based on these comparisons, we believe that the survey's 25th percentile work RVUs of 21.00 are appropriate and correctly rank code 44140 to the comparison procedures. This increase is 14 percent greater than the current work RVUs and, with the exception of the two codes discussed below, applying this 14 percent increase to the other codes in this family will place them in proper relationship to other comparable procedures.

Federal Register: Vol. 66, No. 212 / Thursday, November 1, 2001

Laparoscopy, Surgical; Colectomy, Partial With Anastomosis (CPT Code 44204) and Laparoscopy, Surgical; Colectomy, Partial, With Removal of Terminal Ileum With Ileocecostomy (CPT Code 44205)

The RUC recommended 22.00 RVUs for CPT code 44204 and 19.50 RVUs for CPT Code 44205 based on the reference code 44140 (*Colectomy, partial; with anastomosis*) which, at the time of the recommendation, had a work RVU of 18.35. We increased the work RVU of CPT Code 44140 to 21 as part of the 5- year review of physician work. In order to prevent rank order anomalies we are assigning work RVUs of 25.08 and 22.23 to CPT Codes 44204 and 44205, respectively. These work RVUs represent a 14 percent increase over the RUC recommendation and are consistent with our valuation of CPT Code 44140.

Althought the survey median RVWs for the new codes has ranked the procedures correctly vis-à-vis their open counterparts, we are recommending an RVW that is equal to 19.43% higher than the comparable open procedures for AW1-AW4 and AW6 (44143, 44145, 44146, 44150, and 44155). For new code AW5, we are recommending an RVW that is equal to 19.43% higher than the average of its comparable open procedures (44152 and 44153). The table below presents the current RVW for the open procedure codes, the median survey RVW for the new laparoscopic codes and the recommended RVW for each code.

Open Proc.	2002 RVW		Lap. Proc	Svy med RVW	RVW RECOMMADATION (19.43% increase over open procedure)
44140	21.00		44204		25.08 (2002 RVW)
44143	22.99		**442X1 AW1**	27.00	**27.46**
44145	26.42		**442X2 AW2**	30.00	**31.55**
44146	27.54		**442XX2 AW3**	32.00	**32.89**
44150	23.95		**442X3 AW4**	28.00	**28.60**
44152	27.83	29.21 (avg)	**44211 AW5**	35.00	**34.89**
44153	30.59				
44155	27.86		**442X6 AW6**	32.50	**33.27**

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

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: Colon & Rectal Surgery; 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: Colon & Rectal Surgery; General Surgery Frequency: estimated 6% of total

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: Colon & Rectal Surgery; General Surgery Frequency: estimated 6% of total

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

Physicians trained to use the laparoscope. Not limited to a few medical centers.

New CPT Code: 44212 (AW6) **Global:** 090 **Recommended RVW:** ~~33.27~~
RUC Recommended RVW: 32.50

CPT Descriptor: Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileostomy

Survey Vignette (Typical Patient)
A 32-year-old female with familial polyposis presents with a large, fixed rectal cancer. Following adjuvant chemoradiotherapy (reported by another physician), she undergoes a laparoscopic total proctocolectomy with ileostomy.

CLINICAL DESCRIPTION OF SERVICE:

Pre-operative work:
The CT scan, lab work including blood bank, pathology and colonoscopic findings are reviewed. Complete history and physical exam are performed with emphasis on any abdominal operations that might make the laparoscopic approach more difficult. The procedure is reviewed with the patient and family as well as the potential complications. All questions answered. Informed consent is obtained. Medication and bowl prep instructions are reviewed. The OR time is confirmed and the patient and family are notified. Review length and type of anesthesia with anesthesiologist. Review planned procedure and positioning and draping of patient. Potential stoma sites are identified and marked. Verify that all necessary surgical instruments and supplies are readily available in the operative suite. Monitor patient positioning (supine with her legs in hydraulic stirrups) and draping, and assist with positioning as needed. All extremities are checked for proper positioning and padding to avoid neuropathy. Scrub and gown.

INTRA-OPERATIVE WORK:
At operation, the initial port is placed in the umbilical port using the open technique and then four additional trocars (two on each side) are placed under direct vision. The bowel is completely mobilized by incising the lateral peritoneal attachments and by separating the omentum from the transverse colon. Starting with the left colon and then proceeding proximally the mesentery of the abdominal colon is divided using a combination of clips and the harmonic scalpel. The terminal ileum is divided just proximal to the ileocecal valve and the rectum is then dissected out. First, both ureters are identified and the peritoneum incised circumferentially. The presacral space and the rectovaginal plane are entered and dissection carried out down to the pelvic floor. The operating surgeon then goes to the pelvis and makes an elliptical incision around the anus, incises through the ischiorectal fossa and then the levator muscle to completely free the rectum. The colorectum is delivered out through the perineal wound. The perineal wound is closed in layers and pneumoperitoneum re-established. The terminal ileum is grasped, an ileostomy site is fashioned through all layers in the right lower quadrant, and the terminal ileum brought out through this opening. All the trocars are removed. The fascia is closed at the 10mm trocar sites and the all skin incisions closed with subcuticular stitches. The ileostomy is matured in a Brooke type fashion.

Post-operative work, in hospital:
Sterile dressings and an ileostomy appliance are applied. Sign OR forms, indicating pre and post-op diagnosis and operation performed, and any pathology forms. Write orders for post-op labs, films, medications, diet, and patient activity. Review recovery room care and medications with staff. Discuss procedure outcome with family. Discuss procedure outcome with patient after emergence from anesthesia. Dictate post-op report. Dictate procedure outcome and expected recovery letter for primary care physician and / or insurance company. The patient is evaluated for sepsis, bowel function, cardiorespiratory function and analgesia initially post operatively then on a daily basis and documented in the medical record. Revisit patient to assess progress, pulmonary, cardiac, renal function and status of abdominal dressings. Write and summarize orders for floor nurse. Write discharge order to floor unless done by anesthesiologist. Examine patient, check wounds and patient progress

daily as necessary. Check 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 labs, films, medications, diet, and patient activity. Chart patient progress notes. The patient is discharged when there is return of bowel function and adequate pain control with oral analgesics. Prior to discharge the pathology is reviewed with the patient. The wound and stoma are examined. Home restrictions I(.e.; diet, activity, bathing, return visits) are discussed with the patient and family members. All appropriate medical records are completed, including day of discharge progress notes, discharge summary, and discharge instructions, prescriptions, and insurance forms.

Post-operative work, in office:
At the first post op visit, sutures/drains are removed. At each post-op visit, the patient is examined and the wound and ileostomy are assessed. Post discharge labs/films are ordered and reviewed. The patient is assessed for adequacy of pain control. (Note multiple visits are necessary because stoma). All patient and family questions are answered, including repetitive questions about the stoma. Discuss any additional or adjuvant treatment that may be required and referrals. Evaluation and management components are recorded and pertinent information forwarded to the primary care physician.

SURVEY DATA

Presenter(s): Anthony Senagore, MD
David Margolin, MD

Specialty(s): American Society of Colon and Rectal Surgeons
American Society of General Surgeons

Sample Size: 50 **Resp n:** 29 **Resp %:** 58%

Sample Type: Random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	26.00	30.00	32.50	35.00	40.76
Pre-Service			75		
Intra-Service	180	245	270	300	400

Post-Service	Total Min	CPT code / # of visits
Day of Surgery:		
Immediate	35	
Other	30	99232X1
After Day of Surgery:		
Critical Care	0	
Other Hospital	87	99232X1 99231X3
Dischg Day Mgmt	36	99238
Office Visits	99	99214X1 99213X2 99212X1

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'02 RVW	Glob
44204	Laparoscopy, surgical; colectomy, partial, with anastomosis	25.08	90

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

	Svy CPT	Ref CPT
TIME ESTIMATES (MEDIAN)	AW6	44204
Pre-service time	75	45
Intra-service time	270	180
Same Day Immediate Post-service time	35	30
Same Day Other Post-service time	30	87
Post Total critical care time (not same day)		
Post Total other hospital visit time (not same day)	87	
Discharge management time	36	36
Total office visit time	99	61
TOTAL TIME	*632*	*439*

INTENSITY/COMPLEXITY MEASURES (mean)

TIME SEGMENTS

Pre-service	3.18	3.18
Intra-service	4.45	4.09
Post-service	3.18	3.27

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.09	3.64
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.18	3.82
Urgency of medical decision making	4.18	4.27

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.45	3.73
Physical effort required	4.45	4.09

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.27	4.30
Outcome depends on the skill and judgment of physician	4.55	4.20
Estimated risk of malpractice suit with poor outcome	4.18	4.30

RATIONALE:

In 2001, CMS increased the family of colectomy codes by 14% to bring them into line with five year review changes recommended by the RUC - and approved by CMS - for general surgery, vascular surgery, and cardiothoracic surgery codes. In 2001, CMS also assigned a value for new code 44204 that included the 14% increase in the open colectomy codes and accounted for the 19.43% difference accepted by the RUC between 44204 (Laparoscopic, colectomy, partial, with anastomosis) and 44140 (open, colectomy, partial, with anastomosis).

Federal Register: Volume 66, Number 111, June 8, 2001

The RUC recommended no change in the work RVUs for this family of codes based on lack of compelling evidence for changing the RVUs of the fully surveyed code 44140 (Partial colectomy). Moreover, the intraservice time for code 44140 had not changed since the last 5-year review. Additionally, the RUC compared code 44140 to code 32480 (Removal of lung, other than total pneumonectomy; single lobe (lobectomy)) and code 50230 (Nephrectomy, including partial ureterectomy, any approach including rib resection; radical, with regional lymphadenectomy and/or vena caval thrombectomy) that have similar

work RVUs to 44140 and were believed to be longer, more intense procedures with more postoperative care. We disagree with this recommendation. If the RVUs for procedures in this family are not changed, the procedures will be significantly undervalued compared to other general surgery codes (Family 5 and Family 7) and vascular surgery codes. As an example, we note that the RUC-recommended work RVU for code 44153 Colectomy, total, abdominal, without proctectomy; with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loop, will significantly undervalue this code compared to code 45113, Proctectomy, partial, with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with our without loop ileostomy, thus creating a rank-order anomaly.

We compared code 44140 to code 32480 for which the RUC is recommending a work RVU increase to 23.75. These procedures have similar intraservice times, and the postoperative visits show that although the initial care required for code 32480 is more intense, the length of stay for code 44140 is frequently longer. We also compared code 44140 to codes 37617, Ligation, major artery (eg post-traumatic, rupture); abdomen, and 35221, Repair blood vessel, direct; intra-abdominal. Code 37617, for which the RUC recommended work RVUs of 22.06, is an emergency operation with a slightly shorter intraservice time and shorter hospital stay. Code 35221, which has RUC-recommended work RVUs of 24.39, is also an emergency operation with an intraservice time and length of stay identical to code 44140. Based on these comparisons, we believe that the survey's 25th percentile work RVUs of 21.00 are appropriate and correctly rank code 44140 to the comparison procedures. This increase is 14 percent greater than the current work RVUs and, with the exception of the two codes discussed below, applying this 14 percent increase to the other codes in this family will place them in proper relationship to other comparable procedures.

Federal Register: Vol. 66, No. 212 / Thursday, November 1, 2001

Laparoscopy, Surgical; Colectomy, Partial With Anastomosis (CPT Code 44204) and Laparoscopy, Surgical; Colectomy, Partial, With Removal of Terminal Ileum With Ileocecostomy (CPT Code 44205)

The RUC recommended 22.00 RVUs for CPT code 44204 and 19.50 RVUs for CPT Code 44205 based on the reference code 44140 (*Colectomy, partial; with anastomosis*) which, at the time of the recommendation, had a work RVU of 18.35. We increased the work RVU of CPT Code 44140 to 21 as part of the 5- year review of physician work. In order to prevent rank order anomalies we are assigning work RVUs of 25.08 and 22.23 to CPT Codes 44204 and 44205, respectively. These work RVUs represent a 14 percent increase over the RUC recommendation and are consistent with our valuation of CPT Code 44140.

Althought the survey median RVWs for the new codes has ranked the procedures correctly vis-à-vis their open counterparts, we are recommending an RVW that is equal to 19.43% higher than the comparable open procedures for AW1-AW4 and AW6 (44143, 44145, 44146, 44150, and 44155). For new code AW5, we are recommending an RVW that is equal to 19.43% higher than the average of its comparable open procedures (44152 and 44153). The table below presents the current RVW for the open procedure codes, the median survey RVW for the new laparoscopic codes and the recommended RVW for each code.

Open Proc.	2002 RVW		Lap. Proc	Svy med RVW	RVW RECOMMADATION (19.43% increase over open procedure)
44140	21.00		44204		25.08 (2002 RVW)
44143	22.99		**442X1 AW1**	27.00	**27.46**
44145	26.42		**442X2 AW2**	30.00	**31.55**
44146	27.54		**442XX2 AW3**	32.00	**32.89**
44150	23.95		**442X3 AW4**	28.00	**28.60**
44152	27.83	29.21 (avg)	**442X4 AW5**	35.00	**34.89**
44153	30.59				
44155	27.86		**44212 AW6**	32.50	**33.27**

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

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: Colon & Rectal Surgery; 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: Colon & Rectal Surgery; General Surgery Frequency: estimated 6% of total

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: Colon & Rectal Surgery; General Surgery Frequency: estimated 6% of total

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

Physicians trained to use the laparoscope. Not limited to a few medical centers.

	A	B	C	D	E	F	G	H	I
1	**Tab O 442XX PE Details (April 2002)**	**CPT:**		**44206 (AW1)**	**44207 (AW2)**	**44208 (AW3)**	**44210 (AW4)**	**44211 (AW5)**	**44212 (AW6)**
2		**DESCRIPTOR:**		Lap, surg; colectomy, partial, w/end colostomy and closure of distal segment (Hartmann type procedure)	Lap, surg; colectomy, partial, w/anastomosis, w/coloproctostomy (low pelvic anastomosis)	Lap, surg; colectomy, partial, w/anastomosis, w/coloproctostomy (low pelvic anastomosis) w/colostomy	Lap, surg; colectomy, total, abdominal, w/o proctectomy, w/ileostomy or ileoproctostomy	Lap, surg; colectomy, total , abdominal, w/proctectomy, w/ileoanal anastomosis, w/creation of reservoir (S or J)	Lap, surg; colectomy, total, abdominal, w/proctectomy, w/ileostomy
3			**GLOBAL:**	90	90	90	90	90	90
4		**CMS Code**	**CMS Desc**	**Fac Only**	**Fac Only**	**Fac Only**	**Fac Only**	**Fac Only**	**Fac Only**
5	**PRE-service time**	130	RN/LPN/MA	**15**	**60**	**65**	**62.5**	**65**	**65**
6	**SERVICE time**	130	RN/LPN/MA	**12**	**12**	**12**	**12**	**12**	**12**
7	**POST-service time**	130	RN/LPN/MA	**137**	**99**	**120**	**166**	**180**	**180**
8	**PRE-SERVICE CLINICAL STAFF TIME**								
9	**BEGINS after consultation when a decision to perform surgery was made. (90-day off / fac)**								
10	Complete pre-service diagnostic & referral forms (5/5)	130	RN/LPN/MA	**5**	**5**	**5**	**5**	**5**	**5**
11	Coordinate pre-surgery services, review test/exam results (10/20)	130	RN/LPN/MA	**20**	**20**	**20**	**20**	**20**	**20**
12	OV before surgery: Review test and exam results (0/0)	130	RN/LPN/MA	**0**	**0**	**0**	**0**	**0**	**0**
13	Schedule space and equipment in facility (0/8)	130	RN/LPN/MA	**8**	**8**	**8**	**8**	**8**	**8**
14	Provide pre-service education/obtain consent (10/20)	130	RN/LPN/MA	**25**	**20**	**25**	**22.5**	**25**	**25**
15	Follow-up phone calls & prescriptions (10/7)	130	RN/LPN/MA	**7**	**7**	**7**	**7**	**7**	**7**
16	**ENDS with admission to site of service**								
17	**SERVICE PERIOD CLINICAL STAFF TIME**	**CMS Code**	**CMS Desc**						
18	**BEGINS with admission to site of service**								
19	99238 discharge visit			**1**	**1**	**1**	**1**	**1**	**1**
20	***99238 discharge time***	130	RN/LPN/MA	**12**	**12**	**12**	**12**	**12**	**12**
21	**End: Patient leaves site of service**								
22	**POST-SERVICE PERIOD CLINICAL STAFF TIME**	**CMS Code**	**CMS Desc**						
23	**Start: Patient leaves site of service**								
24	99211 16 minutes			**0**	**0**	**0**	**0**	**0**	**0**
25	99212 27 minutes			**1**	**1**	**1**	**1**	**1**	**1**
26	99213 36 minutes			**1**	**2**	**2**	**2**	**2**	**2**
27	99214 53 minutes			**1**	**0**	**0**	**1**	**1**	**1**
28	99215 63 minutes			**0**	**0**	**0**	**0**	**0**	**0**
29	***Total Office Visit Time:***	130	RN/LPN/MA	**116**	**99**	**99**	**152**	**152**	**152**
30	Postop time related to stoma @7min per visit	130	RN/LPN/MA	**21**	**0**	**21**	**14**	**28**	**28**
31	**End: at completion of global period**								
32	**MEDICAL SUPPLIES - POST-OP OFFICE VISITS**	**CMS Code**	**CMS Desc**						
33	**Post-op Multispecialty Visit Package**	peac	pack	**3**	**3**	**3**	**4**	**4**	**4**
34	**Post-op Suture Care Kit:**	peac	pack	**1**	**1**	**1**	**1**	**1**	**1**
35	***Additional OFFICE VISIT Supplies (specify):***								
36	stoma adhesive	31126	ounce	**1.5**	**0**	**1.5**	**1**	**2**	**2**
37	bag and wafer, colostomy	93601	item	**3**	**0**	**3**	**2**	**4**	**4**
38	**EQUIPMENT**	**CMS Code**							
39	exam lamp	E30006		**1**	**1**	**1**	**1**	**1**	**1**
40	exam table	E11001		**1**	**1**	**1**	**1**	**1**	**1**

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Intraoperative Colonic Lavage

A new code was created to reflect a intra-operative colonic lavage that is gaining widespread acceptance. This procedure allows a single stage colon resection for obstructing lesions, and thus avoiding the creation of a colostomy with it's associated complications. Furthermore, this procedure avoids a second major operation (colostomy closure) which is associated with a high level of morbidity.

44701
The RUC reviewed the additional inter-operative work associated with this code, and understood that the lavage involved compacted stool being flushed through a large section of the colon. It was explained that much of the work involves the proper manipulation of the colon for the lavage to be successful. The RUC reviewed the survey results, and believed that the time for the lavage was lower than the survey median time of 45 minutes. The RUC believed that the specialty surveyed 25th percentile for CPT code 44701 represented the proper values for this code. **The RUC recommends the specialty society's 25th percentile survey results of a relative work value of 3.10 and an intra-service time of 35 minutes.** The specialty society concurred with this recommendation.

Practice Expense
The RUC recommends no practice expense inputs for this ZZZ day global code.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
+●44701	AX1	Intraoperative colonic lavage (List separately in addition to code for primary procedure) (Use 44701 in conjunction with code 44140, 44145, 44150, or 44604 as appropriate) (If necessary to perform an appendectomy for this indication, report separately as 44955) (Do not report 44701 in conjunction with 44300, 44950, or 44960)	ZZZ	3.10

New CPT Code: 44701 (AX1) **Global:** ZZZ **Recommended RVW:** ~~3.50~~
RUC Recommended RVW: 3.10

CPT Descriptor: Intraoperative colonic lavage (List separately in addition to code for primary procedure)
(Use 44701 in conjunction with code 44140, 44145, 44150, or 44604 as appropriate)
(If necessary to perform an appendectomy for this indication, report separately as 44955)
(Do not report 44701 in conjunction with 44300, 44950, or 44960)

Survey Vignette (Typical Patient)
On-table colonic lavage is performed on a 65-year-old male who is undergoing emergency surgery for an obstructing sigmoid colon cancer. Please consider only the additional intraoperative physician work to perform the lavage. The primary procedure(s) and any incidental operation(s) (eg, appendectomy) is/are separately reportable and should NOT be considered in responding to this survey.

CLINICAL DESCRIPTION OF SERVICE:

Intra-operative work:
After resection of the cancer (separately reportable), a decision to perform on-table –colonic lavage is made. Mobilization of both the hepatic and splenic flexures is performed. The cecum is cannulated with a Foley catheter through the base of the newly removed appendix. The distal end of the previously resected colon is opened and cannulated with a piece of sterile corrugated anesthesia tubing. The tubing is secured in place with an umbilical tape. The tube is then passed off the operating table and connected to a plastic container. The colon is then irrigated through the catheter in the appendix with approximately five liters of warm normal saline or until the effluent is clear. The Foley catcher is removed, the appendiceal stump closed. The anesthesia tubing is removed, the distal end of the bowel swabbed with provide-iodine solution. A one-stage operation is then completed.

SURVEY DATA

Presenter(s): Anthony Senagore, MD
David Margolin, MD

Specialty(s): American Society of Colon and Rectal Surgeons

CPT: 44701

Sample Size: 40 **Resp n:** 31 **Resp %:** 78%

Sample Type: Random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	2.00	**3.10**	3.50	5.00	8.00
Intra-service	25	**35**	45	45	60

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'02 RVW	Glob
44139	Mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure)	2.23	ZZZ

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

	Svy CPT	Ref CPT
TIME ESTIMATES (MEDIAN)	AX1	44139
Intra-service time	35	30
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Intra-service	3.25	2.57
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	2.79	2.29
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.39	2.25
Urgency of medical decision making	2.96	2.54
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	3.32	2.93
Physical effort required	3.39	2.93
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	3.32	2.96
Outcome depends on the skill and judgment of physician	3.39	3.04
Estimated risk of malpractice suit with poor outcome	3.32	3.00

RATIONALE:

Code 44139 is for mobilization of the splenic flexure. New code 44701 requires mobilization of both the splenic flexure and the hepatic flexure, and if the appendix is in place, it needs to be mobilized, too. Additionally, the new code includes the work of irrigation. The survey median RVW of 3.50 is recommeded for this code which takes into consideration the greater work (both time and intensity) involved in 44701 when compared with 44139.

FREQUENCY INFORMATION

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

44139-22 or unlisted 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: Colon & Rectal Surgery; 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: Colon & Rectal Surgery; General Surgery Frequency: estimated at 2% of 44140 claims

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: Colon & Rectal Surgery; General Surgery Frequency: estimated at 2% of 44140 claims

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

Many physicians.

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Anal Fistula Glue Repair

In order to provide an increased level of specificity and granularity in CPT coding for the repair of anal fistula, this code was created.

46706
The RUC reviewed the survey results provided by the specialty society and believed that the specialties reference code, code 46275 *Surgical treatment of anal fistula (fistulectomy/fistulotomy); submuscular* (Work RVU= 4.56) involved much more work and intensity than code 46706 . The then RUC reviewed and compared codes 46020 *Placement of seton* (Work RVU=2.90) and 46940 *Curettage or cautery of anal fissure, including dilation of anal sphincter (separate procedure); initial* (Work RVU = 2.32). The RUC and the specialty society agreed that the specialty society's 25th percentile survey results were more representative of the work involved than the median survey results. **The RUC recommends the specialty society's 25th percentile survey results with a relative work value of 2.95 for CPT code 46706.**

Practice Expense
The RUC reviewed in detail the practice expense inputs for code 46706 and agreed and recommends that the pre-service time for this facility only 010 day global code be 35 minutes. The RUC also recommends the appropriate PEAC standard office visit time, medical supply packages, and equipment as shown on the attached practice expense spreadsheet. The RUC recommends no practice expense inputs in the non-facility setting, as this service is currently provided in the facility setting only.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●46706	AY1	Repair of anal fistula with fibrin glue	010	2.95

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION **(April 2002)**

New CPT Code: 46706 (AY1) **Global:** 010 **Recommended RVW:** ~~3.20~~
RUC Recommended RVW: 2.95

CPT Descriptor: Repair of anal fistula with fibrin glue

Survey Vignette (Typical Patient)
A 24-year-old female presents with an anterior fistula-in ano from a peri-rectal abscess. Treatment of the fistula using fibrin glue application is performed to minimize the complications of fecal incontinence and rectovaginal fistula associated with anterior division of the anal sphincter muscle.

CLINICAL DESCRIPTION OF SERVICE:

Pre-service work:
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
Review length and type of anesthesia with anesthesiologist. Review planned procedure and positioning and draping of patient. Verify that all necessary surgical instruments and supplies are readily available in the operative suite. Monitor patient positioning in either lithotomy position or prone jack-knife position. Monitor prepping and draping. Scrub and gown.

Intra-operative work:
Under spinal anesthesia, a digital rectal exam is performed. Anoscopic evaluation is performed. A probe is passed from the internal fistula opening to the outer opening. After establishing the course of the tract, all granulation tissue is curetted away. Utilizing a flexible catheter, a bead of fibrin glue is placed at the internal fistula opening. A stream of fibrin glue is utilized to fill the fistula tract.

Post-operative work, in facility:
After a dry dressing is applied, the patient is taken to the recovery room. Orders are written for medication, diet, and patient activity. Answer patient/family questions. After monitoring the effects of anesthesia, vital signs are obtained and the patient is discharged from the facility. All appropriate medical records are completed, including the operative dictation. Dictate procedure outcome and expected recovery letter for referring physician

Post-operative work, in office:
Obtain history and examine patient to assess for the efficacy of treatment. Discuss patient progress with referring physician (verbal/ written). Dictate patient progress notes for medical chart.

SURVEY DATA
Presenter(s): Anthony Senagore, MD ; David Margolin, MD
Specialty(s): American Society of Colon and Rectal Surgeons

Sample Size: 40 **Resp n:** 32 **Resp %:** 80%
Sample Type: Random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	2.50	**2.95**	3.20	4.56	6.00
Pre-Service			35		
Intra-Service	11	**15**	21	30	40

Post-Service	**Total Min**	**CPT code / # of visits**
Day of Surgery:		
Immediate	15	
Other	18	99238 x 0.5
After Day of Surgery:		
Office Visits	15	99212x1

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'02 RVW	Glob
46275	Surgical treatment of anal fistula (fistulectomy/fistulotomy); submuscular	4.56	90

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

	Svy CPT	Ref CPT
TIME ESTIMATES (MEDIAN)	AY1	46275
Pre-service time	35	60
Intra-service time	15	40
Same Day Immediate Post-service time	15	30
Same Day Other Post-service time	18	18
Total office visit time	15	38
TOTAL TIME	98	186
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	2.67	2.58
Intra-service	2.42	2.75
Post-service	1.83	1.75
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	2.42	2.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.25	2.17
Urgency of medical decision making	2.17	2.42
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	2.67	2.42
Physical effort required	2.00	2.00
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	1.92	2.42
Outcome depends on the skill and judgment of physician	2.58	2.75
Estimated risk of malpractice suit with poor outcome	2.58	2.58

RATIONALE:

Intraoperatively, new code 46706 and 46275 both involve anoscopic evaluation, delineation of the fistula tract, and removal of all granulation tissue. Next, for 46706, the tract is filled slowly with fibrin glue, whereas with the fistulotomy, the tract is laid open and packed. With respect to pre-/post-operative work, code 46275 has a 90-day global period and therefore would include more work than 46706. We recommend the survey median RVW of 3.20 which reasonable accounts for the similarities and differences in work, time, and global period for both codes.

FREQUENCY INFORMATION

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

46999 Unlisted procedure, anus

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: Colon & Rectal Surgery; 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: Colon & Rectal Surgery; General Surgery Frequency: estimated at 20% of 46275 claims

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: Colon & Rectal Surgery; General Surgery Frequency: estimated at 20% of 46275 claims

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

Many physicians.

	A	B	C	D	E
1	Tab P 46706 PE Details (April 2002)	CPT:		46706 (AY1)	
2		DESCRIPTOR:		Repair of anal fistula with fibrin glue	
3			GLOBAL:	10	
4		CMS Code	CMS Desc	Non-Facility	Facility
5	**PRE-service time**	130	RN/LPN/MA	**0**	**35**
6	**SERVICE time**	130	RN/LPN/MA	**0**	**6**
7	**POST-service time**	130	RN/LPN/MA	**0**	**27**
8	**PRE-SERVICE CLINICAL STAFF TIME**				
9	**BEGINS after consultation when a decision to perform surgery was made. (90-day off / fac)**				
10	Complete pre-service diagnostic & referral forms (5/5)	130	RN/LPN/MA	**0**	**3**
11	Coordinate pre-surgery services, review test/exam results (10/20)	130	RN/LPN/MA	**0**	**12**
12	OV before surgery: Review test and exam results (0/0)	130	RN/LPN/MA	**0**	**0**
13	Schedule space and equipment in facility (0/8)	130	RN/LPN/MA	**0**	**5**
14	Provide pre-service education/obtain consent (10/20)	130	RN/LPN/MA	**0**	**12**
15	Follow-up phone calls & prescriptions (10/7)	130	RN/LPN/MA	**0**	**3**
16	**ENDS with admission to site of service**				
17	**SERVICE PERIOD CLINICAL STAFF TIME**	**CMS Code**	**CMS Desc**		
18	**BEGINS with admission to site of service**				
19	99238 discharge visit			**0**	**0.5**
20	***99238 discharge time***	130	RN/LPN/MA	**0**	**6**
21	**End: Patient leaves site of service**				
22	**POST-SERVICE PERIOD CLINICAL STAFF TIME**	**CMS Code**	**CMS Desc**		
23	**Start: Patient leaves site of service**				
24	99211 16 minutes			0	0
25	99212 27 minutes			0	1
26	99213 36 minutes			0	0
27	99214 53 minutes			0	0
28	99215 63 minutes			0	0
29	***Total Office Visit Time:***	130	RN/LPN/MA	**0**	**27**
30	**End: at completion of global period**				
31	**MEDICAL SUPPLIES - POST-OP OFFICE VISITS**	**CMS Code**	**CMS Desc**		
32	**Post-op Multispecialty Visit Package**	peac	pack	1	1
33	***Additional OFFICE VISIT Supplies (specify):***				
34	none				
35	**EQUIPMENT**	**CMS Code**			
36	exam lamp	E30006		**1**	**1**
37	exam table	E11001		**1**	**1**

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2002

Insertion of Permanent Intraperitoneal Catheter for Chemotherapy

49419 H1

CPT Code 49419 *Insertion of Permanent Intraperitoneal Catheter for Chemotherapy* was created to allow physicians to accurately reflect the greater complexity of this procedure as compared to the reference code 49421 *Insertion of intraperitoneal cannula or catheter for drainage or dialysis; permanent(work RVU= 5.54)*. In current practice, there are several differences in the two procedures that result in the greater complexity of the new code. The intraservice time for both procedures differs because; 1) 49419 requires 2 incisions while 49421 requires 1 incision, 2) the first incision needs to anchor the port with several sutures and the second incision is a limited laparotomy, and 3) the second incision makes 49419 a limited open procedure while 49421 is a closed procedure.

The postservice time differs because: 1) 49419 requires the care of 2 incisions while 49421 requires the care of 1 incision, 2) 49419 requires the care and management of a catheter with a port while the catheter in 49421 does not have a port, and 3) 49419 requires the flushing of the port while 49421 does not have a port. The work unit values of other laparatomy codes such as code 47015 (work RVU= 10.49) *Laparotomy, with aspiration and/or injection of hepatic parasitic (eg, amoebic or echinococcal) cyst(s) or abscess(es)* and 58960 *Laparotomy, for staging or restaging of ovarian, tubal or primary peritoneal malignancy (second look), with or without omentectomy, peritoneal washing, biopsy of abdominal and pelvic peritoneum, diaphragmatic assessment with pelvic and limited para-aortic lymphadenectomy* (work RVU= 14.65) were reviewed since the proposed code is a limited laparatomy procedure. The RUC believed that in relation to the physican work of the reference code, other laparatomy codes, and the survey results, code 49419 should be valued at 6.65 RVUs. **The RUC recommends a work relative value of 6.65 for CPT code 49419.**

Practice Expense

The RUC agreed to a standard pre-service time of 60 minutes for the 090 global code 49419. The RUC the assigned the standard pre-service time of 60 minutes, 6 minutes for discharge day charge management, and one office visit. In addition, the code was assigned the approved ob/gyn office visit packet and additional supplies as indicated on the attached recommendation form. There are no in-the-office practice expense inputs.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●49419	H1	Insertion of intraperitoneal cannula or catheter, with subcutaneous reservoir, permanent (i.e., totally implantable) (For removal, use 49422)	090	6.65

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 49419 Tracking Number: HI Global Period: 090 **RUC Recommended RVW:** 6.65

CPT Descriptor: Insertion of permanent intraperitoneal cannula or catheter, with subcutaneous reservoir, permanent (ie totally implantable) (For removal use 49422)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 42 year old woman with stage IIIC ovarian cancer underwent initial surgery followed by multi-agent chemotherapy after which a second look laparotomy revealed microscopic foci of residual carcinoma limited to the peritoneal cavity. The patient was counseled about treatment options and was advised to undergo intraperitoneal chemotherapy administration. In order to accomplish this procedure the patient is advised that she will need to have an intraperitoneal catheter inserted with a subcutaneous reservoir.

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: A 6-7 cm incision is made in the upper abdomen. The incision is carried down to the peritoneum, and the peritoneal cavity is entered. Dissection of bowel and adhesions may be required to achieve a completely open peritoneal cavity. A subcutaneous pocket is created on top of the rectus fascia. The portacath is then sutured to the rectus fascia. The portacath is filled with heparinized saline. The catheter of the portacath is then tunneled into the peritoneal cavity approximately 3-4 cm lateral to the fascia and peritoneal incision. The portacath is arranged in a manner that will allow it to have free flow into the peritoneal cavity. The incision in the peritoneum and rectus fascia and skin are then closed in layers.

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 one day in the hospital postoperatively, requiring two 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 two office visits during the 90-day global period.

SURVEY DATA:

Presenter(s): George Hill, MD and Sandra B. Reed, MD

Specialty(s): The American College of Obstetricians and Gynecologists (ACOG)

Sample Size: 120 Response Rate: (%): 28% (33 surveys) Median RVW: 6.65

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: 120 surveys with cover letter were mailed to a targeted national mailing list of gynecological oncologists.

25th Percentile RVW: 5.775 75th Percentile RVW: 8.313 Low: 5.5 High: 17

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

25th Percentile Intra-Svc Time: 45 min 75th Percentile Intra-Svc Time: 60 min Low: 25 min High: 120 min

Median Post-Service Time:	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	30 min	
Critical Care:	0 min	N/A
Other Hospital Visits:	19 min	99231 (1 visit)
Discharge Day Mgmt.:	36 min	99238 (1 visit)
Office Visits:	23 min	99213 (1 visit)

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
49421	Insertion of intraperitoneal cannula or catheter for drainage or dialysis	5.54

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:**
Median Pre-Time	60 min	67 min
Median Intra-Time	60	41
Median Immediate Post-service Time	30	67
Median of Aggregate Critical Care Times	0	0
Median of Aggregate Other Hospital Visit Times	19	47.5
Median Discharge Day Management Time	36	36
Median of Aggregate Office Visit Times	23	30

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.281	2.667
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.313	2.8
Urgency of medical decision making	2.875	3.033

Technical Skill/Physical Effort (Mean)

Technical skill required	3.469	2.867
Physical effort required	3.063	2.7

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.531	3
Outcome depends on the skill and judgement of physician	3.469	2.933
Estimated risk of malpractice suit with poor outcome	3.063	2.9

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.21	2.889
Intra-Service intensity/complexity	3.357	2.852
Post-Service intensity/complexity	3.037	2.692

ADDITIONAL RATIONALE

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

SURVEY METHOD

The American College of Obstetricians and Gynecologists (ACOG) in collaboration with the Society of Gynecological Oncologists (SG0) disseminated the RUC survey to a targeted national mailing list of 120 gynecological oncologists. The survey was mailed 1st class via the USPS. Thirty-three surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG and SGO reviewed the results and drafted the final recommendations.

PANEL DISCUSSION

The panel developed the recommendation in the following manner:

1. Reviewing the survey data
2. Comparing the proposed code (49419) with the reference code (49421)
3. Comparing the proposed code with other laparotomy codes

Survey Data – ACOG received 33 completed surveys. The median RVW from the data was 7. Due to three outliers the panel felt that this number was slightly inflated. Once the outliers were removed the median decreased to 6.65. The panel felt this was a more accurate recommendation for this procedure.

Reference code 49421 – The reference code is valued at 5.54. While these procedures are similar the panel felt it was appropriate for 49419 to have a higher value because of the greater complexity of this procedure. The panel identified several differences in the two procedures that results in the greater complexity of the new code.

Intraservice

1. 49419 requires 2 incisions while 49421 requires 1 incision
2. The first incision needs to anchor the port with several sutures and the second incision is a limited laparotomy
3. This second incision makes makes 49419 a limited open procedure while 49421 is a closed procedure

Postservice

1. 49419 requires the care of 2 incisions while 49421 requires the care of 1 incision
2. 49419 requires the care and management of a catheter with a port while the catheter in 49421 does not have a port
3. 49419 requires the flushing of the port while 49421 does not have a port

Survey Data – The panel also reviewed the intensity/complexity measures from the survey. 49419 ha higher mean value for ten out of the eleven measures. The panel felt that these numbers accurately reflected the greater intensity and complexity of the proposed code to the reference code. This difference in intensity and complexity is the result of the differences in the two procedures that are described above.

Other Laparatomy Codes – The panel also looked at the work unit values of other laparatomy codes since the proposed code is a limited laparatomy procedure. These procedures ranged in value from 10.49 – 14.65.

1. 47015 – 15.11
2. 49000 – 11.68
3. 49002 – 10.49
4. 58960 – 14.65

Since the proposed code is only a limited laparotomy procedure the panel felt relative to the values of these codes that the recommended value was appropriate.

The panel strongly supports the recommendation of 6.65 for 49419.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) CPT code 49421, Insertion of intraperitoneal cannula or catheter for drainage or dialysis

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

Specialty ACOG _____ ____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 _____ACOG_____ Frequency__2,000_____

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 _____ACOG_____ Frequency_____750_____

Specialty _____ Frequency_____

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

CPT Code: 49419
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: 120 Response Rate: (%): 28% (33 surveys) Global Period: 090

Tracking Number: HI Reference Code 1: 49421 Reference Code 2_____

Geographic Practice Setting %: Rural: 0% Suburban: 22% Urban: 78%

Type of Practice %: 13% - Solo Practice
5% - Single Specialty Group
22% - Multispecialty Group
60% - 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 College of Obstetricians and Gynecologists (ACOG) in collaboration with the Society of Gynecological Oncologists (SGO) disseminated the RUC survey to a targeted national mailing list of 120 gynecological oncolo
The survey was mailed 1st class via the USPS. Thirty-three surveys were returned to ACOG via mail and fax. A staff summarized the data. A panel of physicians from ACOG and SGO reviewed the results and drafted the final recommendations.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

During the pre-service the clinical staff completes pre-service diagnostic and referral forms, coordinates pre-surgery services and schedules space and equipment in the facility. In addition, staff provides pre-service education and obtains consent and conducts follow-up phone calls and prescriptions.

Intra-Service Clinical Labor Activities:
N/A

Post-Service Clinical Labor Activities:
Staff assists with the office visit.

CPT Code: 49419
Specialty Society('s): ACOG

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							
1130	RN/LPN/MTA	60 min	6 min			1	36 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)
	Approved ob/gyn office visit packet	1	Packet	$1.36 (CMS)
91117	Huber needle	1	Item	
	Post-op incision care kit	1	Kit	$12.26 (CMS)
53009	Heparin flush	1	Vial	
91407	Syringe, 10cc	2	Item	
	Saline flush	2	10 ml	$4.30 (CMS)

* 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)

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

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 -RN/LPN/MA
Coordinate pre-surgery services	20	RN, LPN, MA, Other -RN/LPN/MA
Schedule space and equipment in facility	8	RN, LPN, MA, Other -RN/LPN/MA
Office visit before surgery/procedure Review test and exam results	0	RN, LPN, MA, Other _____
Provide pre-service education/obtain consent	20	RN, LPN, MA, Other -RN/LPN/MA
Follow-up phone calls & prescriptions	7	RN, LPN, MA, Other -RN/LPN/MA
Other Activity (please specify) _____	0	RN, LPN, MA, Other _____
End: When patient enters hospital for surgery/procedure		
Service Period		
Start: Patient admitted to hospital for surgery/procedure		
Pre-service services		
Review charts	0	RN, LPN, MA, Other _____
Greet patient and provide gowning	0	RN, LPN, MA, Other _____
Obtain vital signs	0	RN, LPN, MA, Other _____
Provide pre-service education/obtain consent	0	RN, LPN, MA, Other _____
Prepare room, equipment, supplies	0	RN, LPN, MA, Other _____
Prepare and position patient/ monitor patient/ set up IV	0	RN, LPN, MA, Other _____
Sedate/apply anesthesia	0	RN, LPN, MA, Other _____
Intra-service		
Assist physician in performing surgery/procedure	0	RN, LPN, MA, Other _____

'ost-service

Monitor pt. following service/check tubes, monitors, drains	0	RN, LPN, MA, Other _____
Clean room/equipment by physician staff	0	RN, LPN, MA, Other _____
Assist with ICU or hospital visits	0	RN, LPN, MA, Other _____
Total Number of ICU visits	_____	
Total Number of hospital visits	1 (99231)	
Complete diagnostic forms, lab & X-ray requisitions	0	RN, LPN, MA, Other _____
Review/read X-ray, lab, and pathology reports	0	RN, LPN, MA, Other _____
Discharge day management services, check dressings & wound/ home care instructions/coordinate office visits/prescriptions	6	RN, LPN, MA, Other -**RN/LPN/MA**
Coordination of care by staff in office	0	RN, LPN, MA, Other _____
Other Activity (please specify)		
_____	0	RN, LPN, MA, Other _____

End: Patient discharge from hospital

'ost-Service Period
tart: Patient discharge from hospital

Conduct phone calls/call in prescriptions	0	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	99213 - 1	-
	A 36 min	RN, LPN, MA, Other -**RN/LPN/MA**
List total number of office visits	**B** 1	
Total office visit time (A * B)	36 min	-
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

Omental Flap

CPT code 49905 was revised and CPT code 49904 *Omental flap, extra-abdominal (eg, for reconstruction of sternal and chest wall defects)* was created to accurately describe the physician work being performed when:

1) a surgeon of one specialty debrides a sternal wound and a second surgeon of another specialty immediately follows the first surgeon and uses a pedicled omental flap for reconstruction;
2) the service described by CPT code 49905 was done at a separate operative session as the primary or only procedure.

In both these circumstances, it was impossible to accurately use CPT code 49905, since it is an add-on code. The CPT Editorial Panel revised the terminology of CPT code 49905 without changing the physician work involved. **The RUC recommends no change in the work RVU of CPT code 49905. The RUC recommends a work RVU of 6.55 for code 49905.**

The RUC recognized that the work associated with the reconstruction of the chest wall using an omental flap (49904), is similar to the work associated with 15734 *Muscle, myocutaneous, or fasciocutaneous flap; trunk* (work RVU 17.79). Both flaps are indicated for open and/or infected wounds. Both involve harvesting of a flap on its vascular pedicle, transfer and insetting of the flap to a different site and closure of the donor site. If the muscle flap is being used for sternal wound reconstruction then both share a risk to major structures such as the heart, great vessels, coronary artery bypass grafts and the lungs.

The omental flap, however, typically involves greater work and intensity during the pre and postoperative service periods. The omental flap because of its greater risk and intensity is performed rarely and is usually reserved for patients who: are not candidates for muscle or myocutaneous flap closure; have previously failed flap closure; have unusually large wounds; or have associated illnesses (diabetes, previous irradiation).

The preoperative work for 49904 has a higher intensity because the patient typically has cardiovascular disease, is elderly and has recently undergone a major cardiovascular procedure. The wound is almost always infected and requires one or more debridements. The patient has typically had a prolonged hospital stay, with progressive malnutrition and decreased physical stamina. Management must be coordinated with multiple physicians, including cardiologist, cardiovascular surgeon, infectious disease physician and the

primary care physician. Discussions with the patient and family are complicated by the fact that the patient has had a serious postoperative complication and the resultant prolonged hospital stay.

The intraoperative work can vary greatly depending on the status of the abdomen. Multiple previous surgeries will result in greater adhesions of the omentum to the surrounding viscera. The omentum may have been previously debrided forcing the need for greater mobilization of the remaining omentum. Mobilization of the omentum places several intrabdominal structures at risk including several major arteries and veins, the colon, spleen, stomach and liver. Insetting may be complicated by the inadequacy of the previous mediastinal debridements and the presence of exposed structures.

The postoperative work is again complicated by the need to coordinate management with multiple physicians. Wound management must be more vigilant to look for possible recurrent infection. The abdominal harvest results in an abdominal ileus, which further depresses the nutritional status. Care must be coordinated regarding prolonged antibiotic therapy, physical therapy and nutritional replenishment. These patients typically require a stay in an extended care facility and then require visiting nurses for a period after that.

The RUC understood that 49904 requires more work and is more intense than 15734. The current survey data for 49904 compared with Harvard study data for 15734, also indicated that 49904 requires more work and has a higher intensity/complexity profile than 15734. Based on this discussion, **the RUC recommends the survey median work RVU of 20.00 for CPT code 49904.**

Practice Expense

The RUC is recommending using the RUC approved practice expense standard packages for CPT code 49904. Only inputs for the facility setting is provided since these procedures are not performed in the office. Additionally, the staff blend of RN/LPN/MTA is recommended. The RUC agreed that CPT code 49904 required 13 minutes of pre-service clinical labor time, 6 minutes of service period clinical labor time representing discharge day management, and 153 minutes of post-service clinical labor time. For medical supplies the RUC is recommending the standard minimum supply packages for each post-operative office visit as well as post operative incision care supplies. The specific practice expense inputs are attached to these recommendations.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
49905	B1	Omental flap, intra-abdominal ~~(eg, for reconstruction of sternal and chest wall defects)~~ (List separately in addition to code for primary procedure) (Do not report 49905 with code 47700)	ZZZ	6.55 (no change)
•49904	B2	Omental flap, extra-abdominal (eg, for reconstruction of sternal and chest wall defects) (Code 49904 includes harvest and transfer. If a second surgeon harvests the omental flap, then the two surgeons should code 49904 as co-surgeons, using modifier '-62')	090	20.00

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION

CPT Code: 49904 **Global:** 090 **RUC Recommended RVW: 20.00**

Descriptor: Omental flap, extra-abdominal (eg, for reconstruction of sternal chest wall defects)

Survey Vignette (Typical Patient)

A 67-year-old man developed a sternal wound infection two weeks after open-heart surgery for coronary artery bypass. He is referred to the plastic surgeon for repair of the sternal wound defect following two extensive debridement procedures by the thoracic surgeon. The plastic surgeon reviews the patient's medical history and laboratory values, examines the sternal wound, chest and abdomen, and confers with the referring thoracic surgeon. After the surgeon discusses the present problem and treatment alternatives with the patient and his family, the patient chooses to proceed with an omental flap reconstruction of the sternal wound defect. (Code 49904 includes harvest and transfer. If a second surgeon harvests the omental flap, then the two surgeons should code 49904 as co-surgeons, using the –62 modifier.)

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, re-examine wound; review chest x-ray; review laboratory results (CBC, electrolytes, renal function); review microbiology reports; review CT scans; cardiology assessment; review pulmonary function tests and arterial blood gas values
- Review previous operative reports
- Discuss patient status and status of previous cardiovascular procedures with CV surgeon
- Review planned 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, 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 antibiotics and prophylaxis for deep venous thrombosis / pulmonary embolus are provided (e.g. subcutaneous heparin administration, or placement of support stockings, or sequential compression devices on lower extremities).
- Place padding and support beneath head/neck
- Place padding/pillows beneath patient, particularly extremities, to prevent neuropraxia
- 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:

- The abdomen is entered through an upper midline incision that extends to just below the umbilicus. The skin, subcutaneous layer and linea alba of the midline fascia are incised. The peritoneum is incised and the abdominal cavity is entered.
- A nasogastric tube is inserted and its position is checked from within the abdomen. A brief exploration of the abdominal organs is performed. As needed a lysis of adhesions is performed to release the omentum from the overlying abdominal wall and the underlying viscera.
- Attention is now turned to assessing the omentum and its vascular pattern. Temporary digital occlusion together with flow assessment, of the left and right gastroepiploic vessels is used to determine which vessels are the dominant blood supply to the omentum. An assessment is also made as to which pedicle will provide the best omental flap length and arc of rotation. These assessments are then combined to determine which pedicle the omental flap will be based on.
- After the greater omentum is freed from the underlying small bowel it must then be freed from the transverse colon along the tenia omentalis. Special care must be taken to release the omentum without

injury to the colon or injury to the epiploic vessels traveling throughout the greater omentum. Care is taken to avoid injury to the middle colic vessels within the transverse mesocolon. Small blood vessels are individually clamped and ligated with fine silk ties.

- The omentum now remains attached to the greater curvature of the stomach by the right and left gastroepiploic vessels. Depending upon the previous assessment either the right or left gastroepiploic vessel will be preserved to provide blood supply to the flap and the other will be ligated, If the right gastroepiploic artery is chosen to be ligated the artery must be dissected enough to verify that the gastroduodenal and superior pancreaticoduodenal arteries will be preserved. If the left gastroepiploic artery is chosen care must be taken not to injure the spleen or splenic artery. To further mobilize the omentum all (15 – 20) of the short vessels between the gastroepiploic arch and the greater curvature of the stomach are individually clamped and ligated close to the gastric serosa. The omentum is now lifted from the abdomen and over the chest to ascertain its reach.
- The area above the stomach and liver is then cleared of adhesions. Often the falciform ligament must be ligated and divided. A defect is created in the anterior diaphragm to allow passage of the omentum out of the abdomen into the chest defect. The lower sternal wound is extended in a subcutaneous plane until it communicates with the diaphragmatic opening. The omental flap is then transposed into the chest defect. Care is taken to ensure that the omental pedicle is lying unobstructed and without compression as it passes from the abdomen to the chest area. Also care must be taken to insure that the gastroepiploic vessels are not tethered, which could cause gastric outlet obstruction or vascular compromise.
- The omental flap is carefully placed so as to fill the sternal defect in all directions. It is secured to the surrounding structures with several interrupted sutures taking care not to injure any of the structures of the mediastinum or disrupt the previous cardiovascular surgery grafts. Several drains are placed under the flap and brought out through separate exit wounds and anchored to the skin with a 2-0 silk suture. The skin on either side of the sternal wound is mobilized so that it can be closed over the omentum. Final closure is usually in three layers; a deep fascial layer, a subdermal layer and a surface skin layer.
- The abdomen is also closed in layers. Heavy interrupted sutures are used to close the linea alba. The subcutaneous fat is closed with interrupted sutures to eliminate any dead space. The skin is then closed with an interrupted subdermal layer and then a final surface skin layer. The wounds are cleansed and sterile dressings are applied. The patient is taken to the recovery area.

Post-op same day work through discharge from recovery:

- Sterile dressings are applied to the incisions
- The suction drains are inspected to ensure that adequate suction and adequate water seal are in place and working
- Dictate operative note for patient's chart
- 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
- Review ICU care and medications with ICU staff
- Discuss procedure outcome with family
- Discuss procedure outcome with patient after emergence from anesthesia
- 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

Post-op same day work after discharge from recovery

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Answer patient / family questions
- Answer nursing/other staff questions
- Monitor and evaluate critical care elements of pulmonary, cardiology, neurology, and hematology (including but not limited to ventilator settings, arterial blood gases, heart rate and rhythm, blood pressure, etc.)
- 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 and talk with patient
- Extubate patient as appropriate or required
- Encourage ambulation and vigorous pulmonary physiotherapy
- Check wounds and patient progress
- Review chest radiograph
- Treat cardiac arrhythmias (in approximately 15% of patients)
- Discuss patient progress with referring physician (verbal and written)
- Coordinate care with other physicians (cardiology, infectious disease, cardiovascular surgery)
- Review nursing/other staff patient chart notes
- Answer patient/family questions
- Answer nursing/other staff questions (verbal and written)
- Answer insurance staff questions
- Write orders for post-op labs, films, medications, diet, and patient activity
- Chart patient progress notes
- As appropriate, write discharge order to telemetry unit or general care ward

Discharge day work:

- Examine and talk with patient
- 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.
- Check wounds and patient progress
- Coordinate care with other physicians (cardiology, infectious disease, cardiovascular surgery)
- Coordinate post operative physical therapy
- Arrange for care at extended care facility (approx 50% of patients)
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient
- 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

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

- Examine and talk with patient
- Check wounds and patient progress
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician (verbal and written)
- Review records from extended care facility (approx 50% of patients)
- 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): Keith Brandt, MD

Specialty(s): American Society of Plastic Surgeons

CPT: 49904

Sample Size: 43 **Resp n:** 23 **Resp %:** 53%

Sample Type: Random (sample size low because this is an infrequently performed procedure)

	Low	25th pctl	Median	75th pctl	High
Survey RVW	15.00	18.80	20.00	25.00	35.58
Pre-Service			83		
Intra-Service	120	173	205	240	360

Post-Service	Total Min	CPT code / # of visits	
Day of Surgery:			
Immediate	30		
Other	30	99232	
After Day of Surgery:			LOS = 9
Critical Care	0		
Other Hospital	155	99232x2 99231x5	
Dischg Day Mgmt	36	99238	
Office Visits	91	99213x2 99212x3	

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2001 RVW	Glob
15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk	17.79	090

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S)	Svy CPT 49904	Ref CPT 15734 (Hvd)
TIME ESTIMATES (MEDIAN)		
Pre-service time	83	87
Intra-service time	205	194
Same Day Immediate Post-service time	30	47
Same Day Other Post-service time	30	
Post Total critical care time (not same day)	0	0
Post Total other hospital visit time (not same day)	155	95
Discharge management time	36	36
Total office visit time	91	60
TOTAL PRE/POST TIME	425	325
TOTAL TIME	630	519
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Pre-service	4.00	3.65
Intra-service	4.47	3.82
Post-service	3.68	3.35
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.09	3.60
Urgency of medical decision making	4.27	3.55
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	4.32	3.80
Physical effort required	3.91	3.70
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	4.64	3.55
Outcome depends on the skill and judgment of physician	4.45	3.90
Estimated risk of malpractice suit with poor outcome	3.73	3.25

RATIONALE:
The work associated with the reconstruction of the chest wall using an omental flap (49904), is similar to the work associated with 15734 (Muscle, myocutaneous, or fasciocutaneous flap; trunk). Both flaps are indicated for open and/or infected wounds. Both involve harvesting of a flap on its vascular pedicle, transfer and insetting of the flap to a different site and closure of the donor site. If the muscle flap is being used for sternal wound reconstruction then both share a risk to major structures such as the heart, great vessels, coronary artery bypass grafts and the lungs.

The omental flap, however, typically involves greater work and intensity during the pre and postoperative service periods. The omental flap because of its greater risk and intensity is performed rarely and is usually reserved for patients who: are not candidates for muscle or myocutaneous flap closure; have previously failed flap closure; have unusually large wounds; or have associated illnesses (diabetes, previous irradiation).

The preoperative work for 49904 has a higher intensity because the patient typically has cardiovascular disease, is elderly and has recently undergone a major cardiovascular procedure. The wound is almost always infected and requires one or more debridements. The patient has typically had a prolonged hospital stay, with progressive malnutrition and decreased physical stamina. Management must be coordinated with multiple physicians, including cardiologist, cardiovascular surgeon, infectious disease physician and the primary care physician. Discussions with the patient and family are complicated by the fact that the patient has had a serious postoperative complication and the resultant prolonged hospital stay.

The intraoperative work can vary greatly depending on the status of the abdomen. Multiple previous surgeries will result in greater adhesions of the omentum to the surrounding viscera. The omentum may have been previously debrided forcing the need for greater mobilization of the remaining omentum. Mobilization of the omentum places several intrabdominal structures at risk including several major arteries and veins, the colon, spleen, stomach and liver. Insetting may be complicated by the inadequacy of the previous mediastinal debridements and the presence of exposed structures.

The postoperative work is again complicated by the need to coordinate management with multiple physicians. Wound management must be more vigilant to look for possible recurrent infection. The abdominal harvest results in an abdominal ileus, which further depresses the nutritional status. Care must be coordinated regarding prolonged antibiotic therapy, physical therapy and nutritional replenishment. These patients typically require a stay in an extended care facility and then require visiting nurses for a period after that.

All of this illustrates that 49904 requires more work and is more intense than 15734. The current survey data for 49904 compared with Harvard study data for 15734, also indicates that 49904 requires more work and has a higher intensity/complexity profile than 15734. Based on this discussion, the survey median RVW of 20.00 is recommended for 49904.

Building Block Analyses	Proposed RVW 49904 *20.00*			RVW 15734 *17.79*		
Pre-op	Time	Intensity	*(=time x intensity)*	Time	Intensity	*(=time x intensity)*
Day prior evaluation	45	0.0224	1.01	45	0.0224	1.01
Same day evaluation	38	0.0224	0.85	42	0.0224	0.94
minus Pre-op RVW sum			***1.86***			***1.95***
Post-op	Time	Intensity	*(=time x intensity)*	Time	Intensity	*(=time x intensity)*
Immediate post	30	0.0224	0.67	30	0.0224	0.67
Subsequent visits:	Visit n	E/M RVW	*(=n x E/M RVW)*	Visit n	E/M RVW	*(=n x E/M RVW)*
99291	0.0	4.00	0.00	0.0	4.00	0.00
99292	0.0	2.00	0.00	0.0	2.00	0.00
99233	0.0	1.51	0.00	0.0	1.51	0.00
99232	**3.0**	**1.06**	**3.18**	0.0	1.06	0.00
99231	**5.0**	**0.64**	**3.20**	**6.0**	**0.64**	**3.84**
99238	**1.0**	**1.28**	**1.28**	**1.0**	**1.28**	**1.28**
99239	0.0	1.75	0.00	0.0	1.75	0.00
99215	0.0	1.73	0.00	0.0	1.73	0.00
99214	0.0	1.08	0.00	0.0	1.08	0.00
99213	**2.0**	**0.65**	**1.30**	**4.0**	**0.65**	**2.60**
99212	**3.0**	**0.43**	**1.29**	0.0	0.43	0.00
99211	0.0	0.17	0.00	0.0	0.17	0.00
minus Post-op RVW sum			***10.92***			***8.39***
	Time	IWPUT		Time	IWPUT	
equals Intra-op RVW	*205*	***0.035***	***7.22***	*194*	***0.038***	***7.45***

FREQUENCY INFORMATION

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

The codes (-modifiers) listed below may have been used to report this service, but none of them would have been accurate:

49999 Unlisted procedure, abdomen, peritoneum and omentum
49906-52 Free omental flap with microvascular anastomosis (reduced services)
15734-22 Muscle, myocutaneous, or fasciocutaneous flap; trunk (unusual procedural services)
49905 Omental flap (List separately in addition to code for primary procedure) (ZZZ-global)

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: Plastic surgery/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: Plastic surgery/general surgeryFrequency: 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: Plastic surgery/general surgeryFrequency: 100

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

Limited to tertiary medical centers.

	A	B	C	D	E	F	G	H	I	J	K	L
1	**Clinical Labor, Medical Supplies, and Procedure Equipment Practice Expense Data**									**CPT**	**49904**	**49904**
2										**Global**	**090**	**090**
3										**Number/Level of Post OV:**	**N/A**	**99213x2 99212x3**
4	**CLINICAL LABOR**						**Code**	**staff desc**		**Price**	**IN Off**	**OUT off**
5	**TOTAL TYPICAL TIME**						1130	RN/LPN/MA		$ 0.317	**0**	**178**
6	**PRE-service time**						1130	RN/LPN/MA		$ 0.317	**0**	**13**
7	**SERVICE time**						1130	RN/LPN/MA		$ 0.317	**0**	**12**
8	**POST-service time**						1130	RN/LPN/MA		$ 0.317	**0**	**153**
9	**PRE-SERVICE**											
10	**BEGINS after procedure consult. (in off / out off)**										**Min**	**Min**
11	Complete pre-service diagnostic & referral forms (5/5)						1130	RN/LPN/MA		$ 0.317	**0**	**5**
12	Coord pre-proc services/review test/exam results (10/20)						1130	RN/LPN/MA		$ 0.317	**0**	**0**
13	Schedule space and equipment in facility (0/8)						1130	RN/LPN/MA		$ 0.317	**0**	**8**
14	OV before surgery/procedure - review test/exam results (0/0)						1130	RN/LPN/MA		$ 0.317	**0**	**0**
15	Provide pre-service education/obtain consent (10/20)						1130	RN/LPN/MA		$ 0.317	**0**	**0**
16	Follow-up phone calls & prescriptions (10/7)						1130	RN/LPN/MA		$ 0.317	**0**	**0**
17	**Other Pre-Service Activities (please specify):**											
18	none						1130	RN/LPN/MA		$ 0.317	**0**	**0**
19	**ENDS with admission to facility/office**											
20	**SERVICE PERIOD**											
21	**Starts with admission to facility/office**										**Min**	**Min**
22	Discharge Management						1130	RN/LPN/MA		$ 0.317	**0**	**12**
23	**Ends with discharge from facility/office**											
24	**POST-SERVICE**											
25	**Begins after discharge from facility/office**										**Min**	**Min**
26	**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**
38	**Other Activities (please specify):**											
39	**ENDS after 90 days from day of procedure.**											
40	**MEDICAL SUPPLIES**						**Code**	**Unit Size**	**Unit Cnt**	**Price**	**Out Off**	**Out Off**
41											**QTY**	**QTY**
42	**PEAC Minimum visit package (multi-specialty):**						**PEAC**	**PKG**	**1**	**$ 1.310**	**0**	**5**
43	exam table paper (7 ft)						11111	foot	1	$ 0.015		
44	gloves, non-sterile (2 pair)						11302	pair	1	$ 0.120		
45	patient gown, disposable						11107	item	1	$ 0.570		
46	pillow case, disposable						11112	item	1	$ 0.320		
47	thermometer probe cover, disposable						11509	item	1	$ 0.069		
48	**Add'l per visit supplies:**											
49	patient education booklet						11115	item	1	$ 0.920	**0**	**1**
50											**Out Off**	**Out Off**
51	**Postop incision care supplies:**						**Code**	**Unit Size**	**Unit Cnt**	**Price**	**QTY**	**QTY**
52	staple remover kit						31702	item	1	$ 6.830	**0**	**1**
53	suture removal kit						31703	item	1	$ 1.950	**0**	**2**
54	Ace wrap 6"						31503	each	1	$ 3.320	**0**	**5**
55	Kerlix roll 4"						32013	each	1	$ 2.210	**0**	**5**
56	Adaptic dressing 5"x9" (NDC: 56091-0020-19)*						see NDC	each	1	$ 1.750	**0**	**5**
57	ABD combine dressing 5"x9" (NDC:00839-0138-43)*						see NDC	each	1	$ 0.232	**0**	**10**
58	**PROCEDURE SPECIFIC EQUIPMENT**											
59	Power Table						E11003	1		$ 6,939	**0**	**1**
60	Exam Lamp						E30006	1			**0**	**1**
61	*Note: NDC=national drug code. Price shown is AWP (average wholesale price per unit)											

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2002

Laproscopic Urological Procedures

The creation of four new laproscopic urological procedure codes allows physicians to accurately capture the surgical technique and work effort involved laproscopically compared to an open procedure. These procedures are increasingly being preformed, accepted, and viewed as less invasive alternatives to the open procedures. The RUC reviewed survey data from 50 urologists.

50542

The RUC compared code 50542 with other ablation codes in general, and with the intra service work intensity of its reference code 50240 *Nephrectomy, partial* (work RVU = 22.00), and it was agreed that the survey results supported the physician work involved. The RUC noted that similar procedures performed using different technologies should have, and do have similar work values. **The RUC recommends a work relative value of 20.00 for CPT code 50542.**

50543

The RUC reviewed and agreed that the survey data collected by the specialty reflected the physician work, time, and intensity of this procedure. The reference code 50545 *Laparoscopy, surgical; radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy)* (work RVU = 24.00), with 180 minutes of intra-service physician work, provided additional support for the recommended work value, and **the RUC recommends a work relative value of 25.50 for CPT code 50543.**

55866

The RUC reviewed this code in relation to its reference codes 55845 *Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes* (work value = 28.55), 51595 *Cystectomy, partial, with reimplantation of ureter(s) into bladder (ureteroneocystostomy)* (work value = 37.14), and 50360 *Renal allotransplantation, implantation of graft; excluding donor and recipient nephrectomy* (work value = 31.53). The RUC reviewed the intra-service time and total time between 5586[redacted] and the reference codes. The RUC agreed the surveyed median RVU reflected the work associated with the code. **The RUC recommends a relative work value of 30.74 for CPT code 55866.**

Separately, the RUC recommended that code 5586X3 be flagged for the next 5 year review for its physician time components.

Practice Expense

The RUC is recommending using the RUC approved practice expense standard packages for CPT codes 50542, 50543, and 5054X. Only inputs for the facility setting is provided since these procedures are not performed in the office. The staff blend of RN/LPN/MTA is recommended. The RUC agreed that CPT codes 50542, 50543, and 5054X required 60 minutes of pre-service clinical labor time, 6 minutes of coordination of care clinical labor time, and 6 minutes of discharge day management clinical labor time. In addition, each post-operative visit contains the standard clinical staff time associated with the level of service. For medical supplies the RUC is recommending the standard minimum supply packages for each post-operative office visit as well as a 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
(For excision of retroperitoneal tumor or cyst, see 49200, 49201)				
(For laparoscopic ablation of renal mass lesion(s), use 50542)				
50200		*Renal biopsy; percutaneous, by trocar or needle*		
		(For radiological supervision and interpretation, see 76003, 76360, 76393, 76942)		
50240		*Nephrectomy, partial*		
		(For laparoscopic partial nephrectomy, use 50543)		
50541		*Laparoscopy, surgical; ablation of renal cysts*		
50544		*pyeloplasty*		
●50542	Y1	ablation of renal mass lesion(s) (For open procedure, see 50220-50240)	090	20.00

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●50543	Y2	partial nephrectomy (For open procedure, use 50240	090	25.50
●50562	Y3	with resection of tumor	000	*Specialty to re-survey for April 2002 RUC meeting*
55840	*Prostatectomy, retropubic radical, with or without nerve sparing;*			
55842	*with lymph node biopsy(s) (limited pelvic lymphadenectomy)*			
55845	*with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes* *(If 55845 is carried out on separate days, use 38770 with modifier '-50' and 55840)* (For laparoscopic retropubic radical prostatectomy, use 50543) Laparoscopy *Surgical laparoscopy always includes diagnostic laparoscopy. To report a diagnostic laparoscopy (peritoneoscopy) (separate procedure), use 49320.*			
●55866	Y4	Laparoscopy, surgical prostatectomy; retropubic radical, including nerve sparing (For open procedure, use 55840)	090	30.74

CPT Code: 50542 Tracking Number: Y1 Global Period: 090 **Recommended RVW: 20.00**

CPT Descriptor: **Laparoscopy, surgical; ablation of renal mass lesion(s)**

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: **A 59-year-old male has a routine abdominal CT performed for evaluation of abdominal pain. The CT demonstrates gallstones, however two incidental 2cm solid masses consistent with renal cell carcinoma are discovered involving the posterior hilum of the left kidney. Because of the size and location of the tumors, it is elected to proceed with laparoscopic ablation.**

Pre-service Work- *Day before surgery*:

- Review pre-op lab results
- Review medical record
- Write pre-op orders (to be faxed to 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

Description of Intra-Service Work:

- The patient is taken to the operating room, positioned, padded and secured to the operating table in a modified left flank position
- His left flank is prepped and draped in the normal sterile fashion
- A pneumoperitoneum is achieved in the standard manner and three trocars are placed, a 10mm trocar above the umbilicus, another 10mm trocar lateral to the rectus muscle half way between the umbilicus and ribcage and a 5mm trocar halfway between the umbilicus and xiphoid
- All trocars are placed under direct vision and secured to the skin with 2-0 Vycryl sutures
- The laparoscope is placed into the abdominal cavity through the port
- Utilizing sharp dissection the colon is reflected medially
- The left kidney is identified and dissected away from the Gerota's fascia
- The renal artery and vein are identified and freed up
- Once the kidney is free, an ultrasound probe is utilized and demonstrates a solitary lesion at the posterior hilum consistent with the CT scan
- The ablation device is deployed into the lesion, under ultrasound guidance, and the tumor is ablated in two cycles of up to 90 watts power
- Once the lesion appears to be completely ablated the device is removed
- A small drain is placed in the retroperitoneum on the left side and sutured to the skin
- All bleeding points are thoroughly coagulated
- The trocar sites are removed and closed with 2-0 Vicryl sutures after all gas has been removed from the abdomen
- The skin is closed with 4-0 Vicryl sutures and Steri-strips.

Description of Post-Service Work:

Post-op Same day work through discharge from recovery

- Apply dressings
- Assist in transfer of patient from operating table to post-op stretcher
- Accompany anesthesiologist with patient to recovery area
- Assist in transfer of patient to recovery area bed
- Write post-op orders
- Review recovery area care and medications with staff
- Meet with family and discuss the procedure, expected outcome, planned post operative care in hospital and out of hospital
- Discuss procedure with patient as necessary in recovery area when awake
- Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)
- Dictate detailed operative narrative

Post-op Same day work after discharge from recovery

- Examine patient, check wound and patient progress
- Review patient hospital medical record notes (nursing, pharmacy, dietary, discharge planner)
- Answer patient and family questions
- Answer nursing and other staff questions
- Write any further necessary orders
- Write note in progress note section of medical record

Post-op Other Hospital Work – *Beginning on post op-day 1, until discharge day*

- 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 wound 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:

Presenter(s) Thomas P. Cooper, MD

Specialty(s): American Urological Association

Sample Size: 100 Response Rate: (%): 51 Median RVW: 20.00

Type of Sample: Panel, random

Explanation of sample size: **American Urological Members who were identified as performing laparoscopic procedures.**

	Low	25th %	Median	75 %	High
Survey RVW	11.94	18.00	20.00	22.55	28
Pre-Service Time	0	38	75	95	180
Intra-Service Time	0	120	180	205	240

Post-Service:	Total Time	CPT code &/# of visits
Immed. Post-Service	30	
Critical Care		
Other Hospital	30	1-99232
Discharge Day Mgmt	36	1-99238
Office Visits	82	2-99213, 1-99214

KEY REFERENCE SERVICE:

CPT	Descriptor	2002 RVW	% RESP	GLOBE
50240	**Nephrectomy, partial**	**22.00**	**14%**	**090**
50545	Laparoscopy, surgical; radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy)	24.00	12%	090
50945	Laparoscopy, surgical; ureterolithotomy	17.00	10%	090

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: 50542**	**Key Reference CPT Code: 50240- 1st 5 Year Review**
Median Pre-Time	75	75
Median Intra-Time	180	180
Median Immediate Post-service Time	30	
Median of Aggregate Critical Care Times	0	0
Median of Aggregate Other Hospital Visit Times	30	152
Median Discharge Day Management Time	36	36
Median of Aggregate Office Visit Times	84	92
INTENSITY/COMPLEXITY MEASURES (Mean)		
Mental Effort and Judgement (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.66
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.09	3.66
Urgency of medical decision making	3.40	3.34
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.29	4.06
Physical effort required	3.89	3.91
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.00	3.88
Outcome depends on the skill and judgement of physician	4.31	4.16
Estimated risk of malpractice suit with poor outcome	3.91	3.63

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.71	3.50
Intra-Service intensity/complexity	4.14	3.94
Post-Service intensity/complexity	3.34	3.38

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation:
Our RUC recommendations are based on survey responses from urologists located across the country, including urologists from single-specialty, multi-specialty and academic practices. Once responses are compiled, a panel of urologists comprised of a representative sample of the above described group convenes to examine the data associated with each code and determine the final RUC recommendations.

FREQUENCY INFORMATION

- How was this service previously reported? **50549- Unlisted laparoscopy procedure, renal, 50240- Nephrectomy, partial**

(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: **American Urological Association** _____Commonly **XX** 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 Urological Association** Frequency: **less than 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: **American Urological Association** Frequency: **less than 1000**

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

CLINICAL LABOR	CMS Code	50542 (Y1) Laparoscopy, surgical; ablation of renal mass lesion(s)	
LOCATION		In Office	Out Office
GLOBAL PERIOD		90	90
TOTAL CLINICAL LABOR TIME		0	197
PRE-SERVICE			
Start: Following visit when decision for surgery or procedure made			
Complete pre-service diagnostic & referral forms			5
Coordinate pre-surgery services			20
Schedule space and equipment in facility (for out of office only)			8
Office visit before surgery/procedure: Review test and exam results			
Provide pre-service education/obtain consent			20
Follow-up phone calls & prescriptions			7
Other Clinical Activity (please specify)			
End:When patient enters office for surgery/procedure			
TOTAL PRE-SERVICE CLINICAL TIME		0	60
SERVICE PERIOD			
Start: When patient enters office for surgery/procedure			
Pre-service services			
Review charts			
Greet patient and provide gowning			
Obtain vital signs			
Provide pre-service education/obtain consent			
Prepare room, equipment,supplies			
Prepare and position patient/ monitor patient/ set up IV			
Sedate/apply anesthesia			
Intra-service			
Assist physician in performing procedure			
Post-Service			
Monitor pt. following service/check tubes, monitors, drains			
Clean room/equipment by physician staff			
Assist with ICU or hospital visits (for out of office only)			
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			
Coordination of care by staff in office (for out of office only)			6
Other Clinical Activity: Discharge day managment			6
End: Patient leaves office			
TOTAL INTRA-SERVICE CLINICAL TIME		0	12
POST-SERVICE Period			
Start: Patient leaves office			
Discharge day management care			
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 or outpatient care			
List Number and Level of Office Visits			
99211 16 minutes			
99212 27 minutes			
99213 36 minutes			2
99214 53 minutes			1
99215 63 minutes			
Other			
Total Office Visit Time		0	125
Conduct phone calls between office visits			
Other Activity (please specify)			
End: with last office visit before end of global period			
TOTAL POST-SERVICE CLINICAL TIME		0	125
Supplies			
minimum visit package (multi-specialty)			3
post-op incision care kit, basic			1
Equipment			
exam table	E11001		1

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 50543 Tracking Number: Y2 Global Period: 090 **RUC Recommended RVW: 25.50**

CPT Descriptor: **Laparoscopy, surgical; partial nephrectomy**

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: **A 49-year-old female was noted to have microscopic hematuria on a routine visit to her internist and was referred to a urologist for further evaluation. An abdominal CT was performed which demonstrated a 3.0cm solid mass consistent with a renal cell carcinoma involving the lower pole of her right kidney. Because of the size and location of the tumor, it was elected to perform a nephron sparing procedure via a laparoscopic approach.**

Pre-service Work- *Day before surgery*:

- Review pre-op lab results
- Review medical record
- Write pre-op orders (to be faxed to 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

Description of Intra-Service Work:

- The patient is taken to the operating room and positioned in the modified right flank position
- Patient is adequately padded and taped to the table and the flank is prepped and draped in a sterile fashion
- A pneumoperitoneum is achieved and then three trocars are placed: a 10mm trocar roughly 6cm above the umbilicus in the midline, a 5mm trocar two finger breaths off the xiphoid in the midline and a 10mm trocar at the level of the first trocar in the midclavicular line
- All trocars are placed under direct vision and secured to the skin with 2-0 Vicryl sutures
- The liver is retracted anteriorly by placing a 3 mm port to the left of the midline, halfway between the midline trocars
- A paddle retractor is used to retract the liver anteriorly
- Then the peritoneum over the kidney is circumscribed and using blunt and sharp dissection the kidney is dissected out within the Gerota's fascia
- Inspection of the kidney confirms a pedunculated 3 cm solid mass originating from the lower pole that is easily visualized
- The renal artery and vein are dissected free by fulgurating lymphatic channels in the hilum
- There are two renal arteries and one renal vein
- The ureter is preserved and the periureteric tissue is preserved
- The surface of the kidney is scored and bulldog clamps are placed on the arteries and veins
- The tumor is excised, placed in the lap sac and removed
- Biopsies are taken of the base of the kidney resection margin and frozen sections are reported as negative
- The tumor is also sent for frozen section and good margins are also confirmed
- All blood vessels are sutured with 3-0 Vicryl sutures
- The collecting system is seen and closed with figure-of-eight 3-0 Vicryl
- Argon beam coagulator is used to fulgurate the parenchyma
- Fibrin glue is applied over where the collecting system is closed and over the hilum of the incision
- Pledgets, made of SurgiSeal, are placed in the base and then the capsule is reapproximated using 3-0 Vicryl sutures
- The bulldogs are removed
- Total ischemic time is 25 minutes

- The kidney pinks up nicely and papaverine was placed on the arteries
- There appeares to be good perfusion at the end of the procedure
- An 1/8" round drain is placed through a lateral stab incision and placed posterior to the kidney and sutured to the skin with 0 silk suture
- Prior to leaving the abdomen, the abdomen is inspected for bleeding, with no bleeding being noted
- The 10mm trocar sites are closed with 2-0 Vicryl suture
- All trocars are removed under direct vision
- All gas is removed prior to removing the last trocar
- The skin is closed with 4-0 Vicryl and Stri-strips

Description of Post-Service Work:

Post-op Same day work through discharge from recovery

- Apply dressings
- Assist in transfer of patient from operating table to post-op stretcher
- Accompany anesthesiologist with patient to recovery area
- Assist in transfer of patient to recovery area bed
- Write post-op orders
- Review recovery area care and medications with staff
- Meet with family and discuss the procedure, expected outcome, planned post operative care in hospital and out of hospital
- Discuss procedure with patient as necessary in recovery area when awake
- Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)
- Dictate detailed operative narrative

Post-op Same day work after discharge from recovery

- Examine patient, check wound and patient progress
- Review patient hospital medical record notes (nursing, pharmacy, dietary, discharge planner)
- Answer patient and family questions
- Answer nursing and other staff questions
- Write any further necessary orders
- Write note in progress note section of medical record

Post-op Other Hospital Work – *Beginning on post op-day 1, until discharge day*

- Examine and talk to patient
- Check wounds and dressings
- Check serum creatinine as patient has a solitary kidney
- Discuss patient progress with patient and family
- Review all patient hospital medical record notes
- Discuss post operative care of wound 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 wound 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:

Presenter(s) Thomas P. Cooper, MD

Specialty(s): American Urological Association

Sample Size: 100 Response Rate: (%): 44% Median RVW: 25.50

Type of Sample: Panel, random

Explanation of sample size: **American Urological Members who were identified as performing laparosocipic procedures.**

	Low	25th %	Median	75 %	High
Survey RVW	22.00	25.00	25.50	28.00	39.00
Pre-Service Time	0	54	60	116	180
Intra-Service Time	0	200	240	240	360

Post-Service:	Total Time	CPT code &/# of visits
Immed. Post-Service	30	
Critical Care		
Other Hospital	68	2-99231, 1-99232
Discharge Day Mgmt	36	1-99238
Office Visits	107	3-99213, 1-99214

KEY REFERENCE SERVICE:

CPT	Descriptor	2002 RVW	% RESP	GLOBE
50545	**Laparoscopy, surgical; radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy)**	**24.00**	**20%**	**090**
50547	Laparoscopy, surgical; donor nephrectomy from living donor (excluding preparation and maintenance of allograft)	25.50	16%	090
50548	Laparoscopy, surgical; nephrectomy with total ureterectomy	24.40	11%	090
55845	Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	28.55	11%	090

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: 50543	Key Reference CPT Code: 50545- Feb 2000 RUC
Median Pre-Time	60	60
Median Intra-Time	240	240
Median Immediate Post-service Time	30	30
Median of Aggregate Critical Care Times	0	0
Median of Aggregate Other Hospital Visit Times	68	57
Median Discharge Day Management Time	36	36
Median of Aggregate Office Visit Times	107	61

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	4.41	3.94
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.16	4.03
Urgency of medical decision making	3.60	3.54

Technical Skill/Physical Effort (Mean)

Technical skill required	4.90	4.50
Physical effort required	4.57	4.17

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.65	4.28
Outcome depends on the skill and judgement of physician	4.76	4.56
Estimated risk of malpractice suit with poor outcome	4.08	3.78

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.68	3.67
Intra-Service intensity/complexity	4.73	4.33
Post-Service intensity/complexity	3.68	3.46

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation:
Our RUC recommendations are based on survey responses from urologists located across the country, including urologists from single-specialty, multi-specialty and academic practices. Once responses are compiled, a panel of urologists comprised of a representative sample of the above described group convenes to examine the data associated with each code and determine the final RUC recommendations.

FREQUENCY INFORMATION

- How was this service previously reported? **50549- Unlisted laparoscopy procedure, renal, 50240- Nephrectomy, partial**

(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: **American Urological Association** _____Commonly **XX** 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 Urological Association** Frequency: **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: **American Urological Association** Frequency: **1,000**

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

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CLINICAL LABOR	CMS Code	50543 (Y2) Laparoscopy, surgical; partial nephrectomy	
LOCATION		In Office	Out Office
GLOBAL PERIOD		90	90
TOTAL CLINICAL LABOR TIME		0	233
PRE-SERVICE			
Start: Following visit when decision for surgery or procedure made			
Complete pre-service diagnostic & referral forms			5
Coordinate pre-surgery services			20
Schedule space and equipment in facility (for out of office only)			8
Office visit before surgery/procedure: Review test and exam results			
Provide pre-service education/obtain consent			20
Follow-up phone calls & prescriptions			7
Other Clinical Activity (please specify)			
End:When patient enters office for surgery/procedure			
TOTAL PRE-SERVICE CLINICAL TIME		0	60
SERVICE PERIOD			
Start: When patient enters office for surgery/procedure			
Pre-service services			
Review charts			
Greet patient and provide gowning			
Obtain vital signs			
Provide pre-service education/obtain consent			
Prepare room, equipment,supplies			
Prepare and position patient/ monitor patient/ set up IV			
Sedate/apply anesthesia			
Intra-service			
Assist physician in performing procedure			
Post-Service			
Monitor pt. following service/check tubes, monitors, drains			
Clean room/equipment by physician staff			
Assist with ICU or hospital visits (for out of office only)			
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			
Coordination of care by staff in office (for out of office only)			6
Other Clinical Activity:Discharge day management care			6
End: Patient leaves office			
TOTAL INTRA-SERVICE CLINICAL TIME		0	12
POST-SERVICE Period			
Start: Patient leaves office			
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 or outpatient care			
List Number and Level of Office Visits			
99211 16 minutes			
99212 27 minutes			
99213 36 minutes			3
99214 53 minutes			1
99215 63 minutes			
Other			
Total Office Visit Time		0	161
Conduct phone calls between office visits			
Other Activity (please specify)			
End: with last office visit before end of global period			
TOTAL POST-SERVICE CLINICAL TIME		0	161
Supplies			
minimum visit package (multi-specialty)			4
post-op incision care kit, basic			1
suture removal kit	31703		1
Equipment			
exam table	E11001		1

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 55866 Tracking Number: Y4 Global Period: 090 **Recommended RVW: 30.74**

CPT Descriptor: **Laparoscopy, surgical, prostatectomy; retropubic radical, including nerve sparing**

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: **A 48-year-old male with a PSA of 3.5 undergoes a prostate biopsy which reveals Gleason 7 adenocarcinoma of both lobes. He is counseled on the risks and benefits of surgery verses radiation and has chosen laparoscopic radical prostatectomy.**

Pre-service Work- ***Day before surgery*****:**

- Review pre-op lab results
- Review medical record
- Write pre-op orders (to be faxed to 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

Description of Intra-Service Work:

- The patient is taken to the operating room and placed in the modified lithotomy position
- The lower abdomen is prepped and draped in the standard fashion
- A pneumoperitoneum is achieved in the standard fashion and four trocars are placed
- The laparoscope is introduced and attention is turned to first dissecting the seminal vesicles and vas deferens
- The peritoneum at the reflection point of the anterior rectum and posterior bladder is incised
- The vas deferens is identified on each side and then divided
- The seminal vesicles are carefully dissected out using the harmonic scalpel to divide all bleeding vessels until the structures are completely freed
- The space just posterior to the seminal vesicles is dissected in order to open Denonvilliers fascia, thereby revealing a pre-rectal fat plane
- Attention is then turned to complete mobilization of the opening of the peritoneum and mobilization of the bladder
- The median umbilical ligaments and urachus are divided close to the umbilicus
- Careful blunt dissection is used to reflect the bladder away from the abdominal wall
- This exposes the endo-pelvic fascia
- The fat overlying the endo-pelvic fascia is then cleared off and the endo-fascia is incised bilaterally to free the prostate away from the lateral pelvic side wall
- The dorsal vein complex is developed and suture ligated with a 2-0 Dexon suture
- The bladder neck is then opened
- The Foley is removed and a curved urethral sound is placed to aide in traction of the prostate
- This allows identification of the posterior bladder neck, which is then carefully dissected away from the base of the prostate
- The area of the pedicles of the prostate are then taken down
- The tissue is opened overlying the seminal vesicles, these structures are then withdrawn into the area of dissection and used as traction
- Both lateral pedicles are then taken down, up to the level near the apex
- The dorsal vein complex is then divided
- Careful sharp dissection is used around the apex of the prostate

- The prostate is rocked back and forth and dissection continues along the lateral pedicle plane to define the apex of the prostate posteriorly
- The urethra is then identified and sharp dissection is used to divide the anterior and posterior urethra and the rectourethralis muscle
- Then the final attachments are undone and the specimen is withdrawn in the endo-cath sac
- Hemostasis is assured
- The vesicourethral anastomosis is performed with interrupted 2-0 Vicryl suture
- A 20- French Foley catheter is placed through the anastomosis
- A 19- French JP drain is placed through one of the abdominal side ports
- All of the four trocar sites are inspected, as well all surgical sites inspected at 5mmHg pressure before removing the trocars under direct vision

Description of Post-Service Work:

Post-op Same day work through discharge from recovery

- Apply dressings
- Assist in transfer of patient from operating table to post-op stretcher
- Accompany anesthesiologist with patient to recovery area
- Assist in transfer of patient to recovery area bed
- Write post-op orders
- Review recovery area care and medications with staff
- Meet with family and discuss the procedure, expected outcome, planned post operative care in hospital and out of hospital
- Discuss procedure with patient as necessary in recovery area when awake
- Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)
- Dictate detailed operative narrative

Post-op Same day work after discharge from recovery

- Examine patient, check wound and patient progress
- Review patient hospital medical record notes (nursing, pharmacy, dietary, discharge planner)
- Answer patient and family questions
- Answer nursing and other staff questions
- Write any further necessary orders
- Write note in progress note section of medical record

Post-op Other Hospital Work – *Beginning on post op-day 1, until discharge day*

- 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 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 wound 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
- Review bladder control exercises after catheter removed
- 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:

Presenter(s) Thomas P. Cooper, MD

Specialty(s): American Urological Association

Sample Size: 100 Response Rate: (%): 37% Median RVW: 30.74

Type of Sample: Panel, random
Explanation of sample size: **American Urological Members who were identified as performing laparoscopic procedures.**

	Low	25th %	Median	75 %	High
Survey RVW	24.50	30.00	30.74	35.25	50.00
Pre-Service Time	15	35	80	116	180
Intra-Service Time	100	300	310	360	550

Post-Service:	Total Time	CPT code &/# of visits
Immed. Post-Service	40	[redacted]
Critical Care	[redacted]	[redacted]
Other Hospital	[redacted]	2-99232
Discharge Day Mgmt	[redacted]	1-99238
Office Visits	[redacted]	1-99212, 2-99213, 1-99214

KEY REFERENCE SERVICE:

CPT	Descriptor	2002 RVW	% RESP	GLOBE
55845	**Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes**	**28.55**	**68%**	**090**
51595	Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including bowel anastomosis; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	37.14	14%	090
50360	Renal allotransplantation, implantation of graft; excluding donor and recipient nephrectomy	31.53	5%	090

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: 55866**	**Key Reference CPT Code: 55845- Harvard Time**
Median Pre-Time	**80**	**Pre + Post: 315**
Median Intra-Time	**310**	**247**
Median Immediate Post-service Time	**40**	
Median of Aggregate Critical Care Times	**0**	**0**
Median of Aggregate Other Hospital Visit Times	**60**	**150**
Median Discharge Day Management Time	**36**	**30**
Median of Aggregate Office Visit Times	**99**	**45**
INTENSITY/COMPLEXITY MEASURES (Mean)		
Mental Effort and Judgement (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	**4.18**	**3.89**
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	**3.79**	**3.92**
Urgency of medical decision making	**3.25**	**3.41**
Technical Skill/Physical Effort (Mean)		
Technical skill required	**4.89**	**4.00**
Physical effort required	**4.82**	**3.96**
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	**4.50**	**4.11**
Outcome depends on the skill and judgement of physician	**4.79**	**4.37**
Estimated risk of malpractice suit with poor outcome	**4.11**	**3.81**

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.54	3.44
Intra-Service intensity/complexity	4.82	3.96
Post-Service intensity/complexity	3.61	3.67

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation:
Our RUC recommendations are based on survey responses from urologists located across the country, including urologists from single-specialty, multi-specialty and academic practices. Once responses are compiled, a panel of urologists comprised of a representative sample of the above described group convenes to examine the data associated with each code and determine the final RUC recommendations.

FREQUENCY INFORMATION

- How was this service previously reported? **55840- Prostatectomy, retropubic radical, with or without nerve sparing, 55842- Prostatectomy, retropubic radical, with or without nerve sparing; with lymph node biopsy(s) (limited pelvic lymphadenectomy), 55845- Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes, 55899- Unlisted procedure, male genital system**

(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: **American Urological Association** _____Commonly **XX** 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 Urological Association** Frequency: **less than 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: **American Urological Association** Frequency: **less than 1,000**

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

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CLINICAL LABOR	CMS Code	55866 (Y4) Laparoscopy, surgical prostatectomy; retropubic radical, with or without nerve sparing	
LOCATION		In Office	Out Office
GLOBAL PERIOD		90	90
TOTAL CLINICAL LABOR TIME		0	224
PRE-SERVICE			
Start: Following visit when decision for surgery or procedure made			
Complete pre-service diagnostic & referral forms			5
Coordinate pre-surgery services			20
Schedule space and equipment in facility (for out of office only)			8
Office visit before surgery/procedure: Review test and exam results			
Provide pre-service education/obtain consent			20
Follow-up phone calls & prescriptions			7
Other Clinical Activity (please specify)			
End:When patient enters office for surgery/procedure			
TOTAL PRE-SERVICE CLINICAL TIME		0	60
SERVICE PERIOD			
Start: When patient enters office for surgery/procedure			
Pre-service services			
Review charts			
Greet patient and provide gowning			
Obtain vital signs			
Provide pre-service education/obtain consent			
Prepare room, equipment,supplies			
Prepare and position patient/ monitor patient/ set up IV			
Sedate/apply anesthesia			
Intra-service			
Assist physician in performing procedure			
Post-Service			
Monitor pt. following service/check tubes, monitors, drains			
Clean room/equipment by physician staff			
Assist with ICU or hospital visits (for out of office only)			
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			
Coordination of care by staff in office (for out of office only)			6
Other Clinical Activity: Discharge day management care			6
End: Patient leaves office			
TOTAL INTRA-SERVICE CLINICAL TIME		0	12
POST-SERVICE Period			
Start: Patient leaves office			
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 or outpatient care			
List Number and Level of Office Visits			
99211 16 minutes			
99212 27 minutes			1
99213 36 minutes			2
99214 53 minutes			1
99215 63 minutes			
Other			
Total Office Visit Time		0	152
Conduct phone calls between office visits			
Other Activity (please specify)			
End: with last office visit before end of global period			
TOTAL POST-SERVICE CLINICAL TIME		0	152
Supplies			
minimum visit package (multi-specialty)			4
post-op incision care kit, basic			1
Equipment			
exam table	E11001		1

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Renal Endoscopy

Renal endoscopy through an established nephrostomy or pyelostomy with transpelvic resection of tumor is a rarely performed procedure for the treatment of renal pelvic tumors. New generation endoscopes have permitted better visualization and endoscopic manipulation of the renal pelvis. Performing a renal endoscopy involves a completely different operative approach and work effort compared to performing a cystoscopic resection of a bladder tumor or a ureteroscopic resection of a ureteral tumor, and thus the need for this new code.

50562
The RUC reviewed the physician time, work, and global period status of several codes among and across specialties to properly value 50562. The RUC then concentrated on three relative codes:

- 43265 *Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde destruction, lithotripsy of calculus/calculi, any method* (Work RVU = 10.02), 000 day global with intra service work time of 83.5 minutes (RUC).
- 50574 *Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy* (Work RVU = 10.02), 000 day global with intra-service work time of 114 minutes (Harvard)
- 52346 *Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (e.g., balloon dilation, laser, electrocautery, and incision)* (Work RVU = 9.22), 000 day global with intra-service work time of 120 minutes (RUC).

The RUC concluded that the intensity of the work of code 50562 was greater than code 52346 and similar to code 43265. Using the intra-service work intensity of code 43265 for an additional 9 minutes of intra-service time, the RUC agreed that a relative value of 10.90 was appropriate. The RUC in addition discussed and agreed that code 50574 involved less work than 50562 and therefore agreed the code was properly rank ordered.
The RUC recommends a relative work value of 10.90 for CPT code 50562.

Practice Expense:
The standard 90-day global practice expense inputs were used for code 50562 with a pre-service time of 60 minutes and a service period time of 6 minutes for a half day of discharge day management. The committee recommends no practice expense inputs in the office setting, as these procedures are typically performed in the facility setting.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
50551 Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;				
50561		with removal of foreign body or calculus		
●50562	Y3	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with resection of tumor	000	10.90

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 50562 Tracking Number: Y3 Global Period: ~~XXX~~ 000 ~~Recommended RVW: 13.98~~
RUC Recommended RVW: 10.90

CPT Descriptor: **Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; *with resection of tumor***

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: **A 69-year-old female with a solitary left kidney is referred to a urologist for gross painless hematuria. An IVP demonstrates a papillary filling defect involving the medial aspect of the renal pelvis just above the UPJ. A nephrostomy has been previously established two days earlier. A voided cytology is positive for transitional cell carcinoma and confirms the neoplastic nature of the visualized lesion. Because the patient has only one kidney and the tumor involves the renal pelvis, it is elected to endoscopically resect the tumor.**

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
- The patient is taken to the operating room and placed in the left flank position
- The field is sterilized, prepped and draped

Description of Intra-Service Work:
- Under fluoroscopic guidance the left kidney is identified and a percutaneous guide wire placed into the left renal pelvis
- A Percutaneous tract is then established and segmentally dilated up to 28 French in order to accept an appropriate resectoscope
- Renal endoscopy is performed with a flexible nephroscope and confirms a low-grade papillary transitional cell cancer on the medial wall of the renal pelvis
- The nephroscope is removed and a resectoscope is then passed into the renal pelvis
- The tumor is carefully resected, being careful not to perforate the thin wall of the renal pelvis or injure the renal pedicle
- The tumor is then irrigated out of the pelvis with an Ellik evacuator and all bleeding points fulgerated
- The resectoscope is removed and a temporary nephrostomy tube placed to allow for drainage
- The tube is secured to the patient's skin with a 2-0 Vicryl suture

Description of Post-Service Work:
Post-op Same day work through discharge from recovery
- Apply dressings
- Assist in transfer of patient from operating table to post-op stretcher
- Accompany anesthesiologist with patient to recovery area
- Assist in transfer of patient to recovery area bed
- Write post-op orders
- Review recovery area care and medications with staff
- Meet with family and discuss the procedure, expected outcome, planned post operative care in hospital and out of hospital
- Discuss procedure with patient as necessary in recovery area when awake
- Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)
- Dictate detailed operative narrative

CPT CODE 50562

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

SURVEY DATA:

Presenter(s) James B. Regan, M.D, Jeffery A. Dann, M.D.

Specialty(s): American Urological Association

Sample Size: 100 Response Rate: (%): 33% Median RVW: 13.98
Type of Sample: Panel, random

Explanation of sample size: **The Endourological Society was contacted and mailing list obtained.**

	Low	25th %	Median	75 %	High
Survey RVW	6.62	8.2	13.98	14.5	20
Pre-Service Time	15	35	46	60	115
Intra-Service Time	50	90	92.5	120	180

Post-Service:	Total Time	CPT code &/# of visits
Immed. Post-Service	30	
Critical Care		
Other Hospital		
Discharge Day Mgmt	18	99238 x 0.5
Office Visits		

KEY REFERENCE SERVICE:

CPT	Descriptor	2002 RVW	% RESP	GLOBE
50575	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with endopyelotomy (includes cystoscopy, ureteroscopy, dilation of ureter and ureteral pelvic junction, incision of ureteral pelvic junction and insertion of endopyelotomy stent)	13.98	30%	000
50561	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus	7.59	20%	000
50557	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus	6.62	20%	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.**

TIME ESTIMATES (Median)	**New/Revis. CPT Code: 50562**	**Key Reference CPT Code: 50575- April 1993 RUC**
Median Pre-Time	46	
Median Intra-Time	92.5	
Median Immediate Post-service Time	10	
Median of Aggregate Critical Care Times	N/A	
Median of Aggregate Other Hospital Visit Times	N/A	
Median Discharge Day Management Time	N/A	
Median of Aggregate Office Visit Times	N/A	
INTENSITY/COMPLEXITY MEASURES (Mean)		
Mental Effort and Judgement (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.25	4.27
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.34	4.00
Urgency of medical decision making	4.29	3.93
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.75	4.53
Physical effort required	4.06	3.93
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.50	4.13
Outcome depends on the skill and judgement of physician	4.72	4.53
Estimated risk of malpractice suit with poor outcome	4.13	4.00

CPT CODE 50562

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.06	4.00
Intra-Service intensity/complexity	4.59	4.33
Post-Service intensity/complexity	3.97	3.80

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation:
Our RUC recommendations are based on survey responses from urologists located across the country, including urologists from single-specialty, multi-specialty and academic practices. Once responses are compiled, a panel of urologists comprised of a representative sample of the above described group convenes to examine the data associated with each code and determine the final RUC recommendations.

FREQUENCY INFORMATION

How was this service previously reported? **55899- Unlisted procedure, male genital system, 50557- Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy**

(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: **American Urological Association** _____Commonly **XX** 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 Urological Association** Frequency: **500**

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 Urological Association** Frequency: **500**

Do many physicians perform this service across the United States? _____Yes **XX** No

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CLINICAL LABOR	CMS Code	50562 (Y3) Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with resection of tumor	
LOCATION		**In Office**	**Out Office**
GLOBAL PERIOD		**0**	**0**
TOTAL CLINICAL LABOR TIME		**0**	**66**
PRE-SERVICE			
Start: Following visit when decision for surgery or procedure made			
Complete pre-service diagnostic & referral forms			**5**
Coordinate pre-surgery services			**20**
Schedule space and equipment in facility (for out of office only)			**8**
Office visit before surgery/procedure: Review test and exam results			
Provide pre-service education/obtain consent			**20**
Follow-up phone calls & prescriptions			**7**
Other Clinical Activity (please specify)			
End:When patient enters office for surgery/procedure			
TOTAL PRE-SERVICE CLINICAL TIME		**0**	**60**
SERVICE PERIOD			
Start: When patient enters office for surgery/procedure			
Pre-service services			
Review charts			
Greet patient and provide gowning			
Obtain vital signs			
Provide pre-service education/obtain consent			
Prepare room, equipment,supplies			
Prepare and position patient/ monitor patient/ set up IV			
Sedate/apply anesthesia			
Intra-service			
Assist physician in performing procedure			
Post-Service			
Monitor pt. following service/check tubes, monitors, drains			
Clean room/equipment by physician staff			
Assist with ICU or hospital visits (for out of office only)			
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			
Coordination of care by staff in office (for out of office only)			**6**
Other Clinical Activity (please specify)			
End: Patient leaves office			
TOTAL INTRA-SERVICE CLINICAL TIME		**0**	**6**
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 or outpatient care			
List Number and Level of Office Visits			
99211 16 minutes			
99212 27 minutes			
99213 36 minutes			
99214 53 minutes			
99215 63 minutes			
99238 6 minutes			
Total Office Visit Time		**0**	**0**
Conduct phone calls between office visits			
Other Activity (please specify)			
End: with last office visit before end of global period			
TOTAL POST-SERVICE CLINICAL TIME		**0**	**0**

Supplies	
no supplies	10000
Equipment	
no equipment	E99997

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

April 2002

Insertion of Bladder Catheters

During 2001 the CPT Editorial Panel requested the review of current catheter codes with regard to the descriptor nomenclature and need to transition G0002 into a CPT code. The American Urological Association examined the current three codes; G0002, *office procedure, insertion of temporary indwelling catheter, foley type (separate procedure)* (Work RVU=0.50), 53670, *Catheterization, urethra; simple* (Work RVU=0.50), and 53675, *Catheterization, urethra; complicated (may include difficult removal of balloon catheter)* (Work RVU=1.47). From the review it became apparent that there was a potential for overlap in the nomenclature of the codes. The CPT Editorial Panel created three distinct catheterization procedures; non-indwelling catheterization, simple and indwelling catheterization, complex. The panel then deleted the existing codes and therefore eliminated overlapping nomenclature and potential confusion of the codes.

The RUC reviewed the specialty's request to crosswalk the physician work values of the existing codes to the new codes, and agreed that it would be appropriate to recommend the same values. Therefore, **the RUC recommends relative work values of 0.50, 0.50, and 1.47 for codes 51701, 51702, and 51703 respectively. The RUC also recommends the physician time be cross-walked as well and is as follows:**

CPT Code	Intra Serv Time	Total Time
51701		25
51702	8	20
51703	29	56

Practice Expense
The RUC reviewed in great detail the practice expense inputs in both the facility and non-facility settings for codes;
51701 *Insertion of non-indwelling bladder catheter (eg, straight catheterization for residual urine)*
51702 *Insertion of temporary indwelling bladder catheter; simple (eg, Foley)*
51703 *Insertion of temporary indwelling bladder catheter; complicated (eg, altered anatomy, fractured catheter/balloon)*

The RUC decided to lower the clinical labor time for each of the codes from the specialty society's recommendation since the physician performs much of the work. In addition, an E/M visit is often performed on the same date. The RUC recommends the following facility and non-facility total clinical labor time:

Code	RUC Rec In office- CL Time	RUC Rec Out of office – CL Time
51701	18	5
51702	42	12
51703	60	18

In addition the RUC agreed to eliminate the irrigation fluid and tubing, the leg bag for 51701, the sterile drape, and the thermometer from the medical supplies. The revised practice expense inputs are attached to the recommendations for these codes.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
~~G0002~~		~~Office procedure, insertion of temporary indwelling catheter, foley type (separate procedure)~~		N/A
•51701	Z1	Insertion of non-indwelling bladder catheter (eg, straight catheterization for residual urine)	000	0.50
•51702	Z2	Insertion of temporary indwelling bladder catheter; simple (eg, Foley)	000	0.50
•51703	Z3	complicated (eg, altered anatomy, fractured catheter/balloon)	000	1.47

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
~~53670~~		~~Catheterization, urethra; simple~~ (53670 has been deleted. To report, see 51701, 51702	000	N/A
~~53675~~		~~complicated (may include difficult removal of balloon catheter)~~ (53675 has been deleted. To report, use 51703)	000	N/A

	A	B	C	D	E	F	G	H	I	J	K
1		CMS Code	Unit of Measure	Invoice Qnty.	Price	51701 - Insertion of non-indwelling bladder catheter (eg, straight catheterization for residual urine)		51702 - Insertion of temporary indwelling bladder catheter; simple (eg, Foley)		51703 - Insertion of temporary indwelling bladder catheter; complicated (eg, altered anatomy, fractured	
2	LOCATION					In Office	Out Office	In Office	Out Office	In Office	Out Office
3	GLOBAL PERIOD					0	0	0	0	0	0
4	TOTAL CLINICAL LABOR TIME					18	5	42	12	60	18
5	PRE-SERVICE	1130									
6	Start: Following visit when decision for surgery or procedure made										
7	Complete pre-service diagnostic & referral forms							5	2	5	2
8	Coordinate pre-surgery services							3	4	3	4
9	Schedule space and equipment in facility (for out of office only)						2				3
10	Office visit before surgery/procedure: Review test and exam results										
11	Provide pre-service education/obtain consent					3		5		9	3
12	Follow-up phone calls & prescriptions							3	3	3	3
13	Other Clinical Activity (please specify)										
14	End:When patient enters office for surgery/procedure										
15	TOTAL PRE-SERVICE CLINICAL TIME					3	2	16	9	20	15
16	SERVICE PERIOD										
17	Start: When patient enters office for surgery or procedure										
18	Pre-service services										
19	Review charts										
20	Greet patient and provide gowning										
21	Obtain vital signs										
22	Provide pre-service education/obtain consent										
23	Prepare room, equipment, supplies					3		3		5	
24	Prepare and position patient/ monitor patient/ set up IV					2		2		4	
25	Sedate/apply anesthesia										
26	Intra-service										
27	Assist physician in performing procedure					3		5		12	
28	Post-Service										
29	Monitor pt. following service/check tubes, monitors, drains							3		2	
30	Clean room/equipment by physician staff					4		5		7	
31	Assist with ICU or hospital visits (for out of office only)										
32	Complete diagnostic forms, lab & X-ray requisitions					3		3		3	
33	Review/read X-ray, lab, and pathology reports										
34	Check dressings & wound/ home care instructions/coordinate office visits/prescriptions							5		7	
35	Coordination of care by staff in office (for out of office only)						3		3		3
36	Other Clinical Activity (please specify)										
37	End: Patient leaves office										
38	TOTAL INTRA-SERVICE CLINICAL TIME					15	3	26	3	40	3
39	POST-SERVICE Period										
40	Start: Patient leaves office										
41	Conduct phone calls/call in prescriptions										
42	*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 or outpatient care										
43	*List Number and Level of Office Visits*										
44	99211 16 minutes										
45	99212 27 minutes										
46	99213 36 minutes										
47	99214 53 minutes										
48	99215 63 minutes										
49	Other										
50	*Total Office Visit Time*					0	0	0	0	0	0
51	Conduct phone calls between office visits										
52	Other Activity (please specify)										
53	End: with last office visit before end of global period										
54	TOTAL POST-SERVICE CLINICAL TIME					0	0	0	0	0	0
55											
56											
57											
58	*Supplies*										

	A	B	C	D	E	F	G	H	I	J	K
1		CMS Code	Unit of Measure	Invoice Qnty.	Price	51701 - Insertion of non-indwelling bladder catheter (eg, straight catheterization for residual urine)		51702 - Insertion of temporary indwelling bladder catheter; simple (eg, Foley)		51703 - Insertion of temporary indwelling bladder catheter; complicated (eg, altered anatomy, fractured	
2	LOCATION					In Office	Out Office	In Office	Out Office	In Office	Out Office
3	GLOBAL PERIOD					0	0	0	0	0	0
59	Betadine	52301	ml	10	0.07	10		10		10	
60	Catheter Insertion Kit	93102	item	1	15.89			1			
61	catheter, stylet	93124	item	1	5.45					1	
62	Chux	11102	item	1	$0.05	2		2		2	
63	drainage bag	93114	item	1	$3.05	1		1		1	
64	foley catheter	93101	item	1	8.87	1		1		1	
65	gloves, sterile	14005	pair	1	0.89	1		1		1	
66	gown, staff, impervious, disposable	11304	item	1	1.38	1		1		1	
67	irrigation fluid 1000cc	93401	liter	1	1.7						
68	irrigation tubing	93402	item	1	3.85						
69	leg bag	93107	item	1	3.21			1		1	
70	lidocaine jelly 30ml package	51301	ml	30	11.85	5		5		5	
71	minimum visit package (multi-specialty)		package	1	$1.31	1		1		1	
72	needle, 25 & 26 guage	91403	item	1	0.1	1		1		1	
73	Sani-wipe	11113	item	1	0.13	5		5		5	
74	shoe covers	11307	pair	1	0.9	1		1		1	
75	sterile drape 22 in. x 25 in.	14001	item	1	0.5	0		0		0	
76	surgical cap	11305	item	1	0.21	1		1		1	
77	surgical mask, with face shield	11301	item	1	1.44	1		1		1	
78	swab, alcohol	31101	item	1	0.017	2		2		2	
79	syringe, 10 cc or 12 cc	91407	item	1	0.23	1		1		1	
80	thermometer, disposable	11510	item	1	0.095						
81											
82	*Equipment*										
83	Power Table	E11003			$6,939.00	1		1		1	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2002

Male Urinary Incontinence Procedures

53440

The original code 53440 stated *Operation for correction of male urinary incontinence* with no mention of the sling or different materials. This old code described placement of a Kaufman prosthesis, placed underneath the urethra to improve incontinence. The Kaufman technology has become obsolete, and the code has recently been used as a male sling operation to differentiate it from the placement of the artificial sphincter.

The RUC reviewed the specialty's reference codes, CPT code 57288 *Sling operation for stress incontinence (eg, fascia or synthetic)* (work RVU = 13.02), and CPT code 53445 *Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff* (work RVU=14.06), in relation to the physician work and time of 53442 and believed they were similar in physician work. It was understood by the RUC that the physician time and intensity for 53442 was similar to a sling operation and to inserting a sphincter. It was also explained that this type of operation is typically more difficult for a male patient than a female patient as in a male patient the surgeon would typically be going through scared tissue from previous operations. However, CMS requested a further description of the differences between male and female sling operations and removals, which the AUA and the ACOG agreed to provide. During the RUC's discussion one of the post-operative visit office codes was changed from a 99214 to a 99213, reflecting the typical post-operative physician work involved. **The RUC recommends a relative work value of 13.62 for CPT code 53440.**

53442

As in code 53440, original code did not adequately reflect the surgical advances and work that had taken place with this procedure, for which it is currently being billed. The code had recently been used to differentiate it from the removal or revision of an artificial sphincter, and needed revision to reflect the surgical technique and physician work involved.

The RUC reviewed the specialty's reference codes, CPT code 57288 *Sling operation for stress incontinence (eg, fascia or synthetic)* (work RVU = 13.02), and CPT code 53445 *Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff* (work RVU=14.06), in relation to the physician time and intensity of 53442 and believed they were similar in physician work. In addition, the RUC understood that the removal or revision of a sling required much more work than the old code, as it was typical to have an infected area, and existing scar tissue under the new procedure rather than the old. The RUC reviewed

codes 57288 and 57287 *Removal or revision of sling for stress incontinence (eg, fascia or synthetic)* (work RVU = 10.71), which are comparable codes for sling operations and sling removals in women. The sling removal work RVU in women is 85% of the sling insertion in women. The RUC recommends a similar ratio for the male codes. **The RUC recommends a relative work value of 11.57 for CPT code 53442.**

Practice Expense

The RUC is recommending using the RUC approved practice expense standard packages for CPT codes 53440 and 53442. 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. The RUC agreed that CPT codes 53440 and 53442 required 60 minutes of pre-service clinical labor time, 6 minutes of service period clinical labor time, and 144 minutes of post-service clinical labor time. 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 as supplies. The specific practice expense inputs are attached to these recommendations.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲53440	AB1	Sling o~~O~~peration for correction of male urinary incontinence (eg, fascia or synthetic)~~, with or without introduction of prosthesis~~	090	13.62
▲53442	AB2	Removal or revision of sling for male urinary ~~of perineal prosthesis introduced for~~ incontinence (eg, fascia or synthetic)	090	11.57

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 53440 Tracking Code: AB1 Global Period: 090 ~~Recommended RVW: 14.06~~
RUC Recommended RVW: 13.62

CPT Descriptor: **Sling operation for correction of male urinary incontinence (e.g. fascia or synthetic)**

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: **A 62-year-old male status post radical retropubic prostatectomy has a 1-year history of severe urinary incontinence uncontrolled by medication. He currently soaks 5 pads per day and is embarrassed by his incontinence. Urodynamic studies reveal external sphincteric dysfunction. The patient is advised that there are two methods of treatment for his incontinence; a sling procedure or an artificial sphincter. He elects a sling procedure.**

Pre-service Work- ***Day before surgery*****:**
- Review pre-op lab results
- Review medical record
- Write pre-op orders (to be faxed to 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

Description of Intra-Service Work:
- The patient is placed in the lithotomy position and a 16F foley catheter passed into the bladder
- First a transverse incision is made in the suprapubic area and carried down to the rectus fascia; the rectus fascia is opened and the retropubic space entered
- Then a second U-shaped perineal incision is made in the perineum under the scrotum and carried down to the bulbospongiosus muscle
- The urethra is carefully disected and the retropubic is entered on both sides lateral to the urethra
- A ligature passer is used to traverse the retropubic space through the incision from above, perforating the endopelvic fascia and exiting in the perineum on the left of the urethra
- A sling graft **(fascia or synthetic)** is soaked and placed under the urethra
- One end of the sling is attached to the ligature passer and then pulled up through the endopelvic fascia into the retropubic space on the left side
- The ligature passer is then passed again from above, this time exiting on the right of the urethra
- The other side of the sling is then pulled up through the retropubic space on the right
- The sling is seated underneath the urethra and the tension adjusted to provide support but not obstruction
- The perineal wound is closed in a layered fashion
- The abdominal fascia is closed with a O Vicryl suture
- The sling sutures are tunneled through the inferior leaf of the rectus fascia and tied down firmly over the closed rectus fascia
- The subcutaneous and skin layers are then closed.

Description of Post-Service Work:
Post-op Same day work through discharge from recovery
- Apply dressings
- Assist in transfer of patient from operating table to post-op stretcher
- Accompany anesthesiologist with patient to recovery area
- Assist in transfer of patient to recovery area bed

- Write post-op orders
- Review recovery area care and medications with staff
- Meet with family and discuss the procedure, expected outcome, planned post operative care in hospital and out of hospital
- Discuss procedure with patient as necessary in recovery area when awake
- Call referring physician regarding outcome of procedure and any unusual aspects of post operative car (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 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 wound 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
- Check patient for urinary retention
- 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:

Presenter(s) Thomas P. Cooper, MD
Specialty(s): American Urological Association

Sample Size: 100 Response Rate: (%): 30%Median RVW: 14.06

Type of Sample: Panel, random
Explanation of sample size: **American Urological Association members who identified themselves as specializing in incontinence.**

	Low	25th %	Median	75 %	High
Survey RVW	12.00	14.00	14.06	14.50	21.00
Pre-Service Time	0	40	58	100	195
Intra-Service Time	0	75	100	120	210

Post-Service:	Total Time	CPT code &/# of visits
Immed. Post-Service	30	
Critical Care		
Other Hospital	60	2-99232
Discharge Day Mgmt	36	1-99238
Office Visits	92	4-99213

KEY REFERENCE SERVICE:

CPT	Descriptor	2002 RVW	% RESP	GLOBE
57288	**Sling operation for stress incontinence (eg, fascia or synthetic)**	**13.02**	**43%**	**090**
53445	Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff	14.06	40%	090

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: 53440**	**Key Reference CPT Code: 57288- Harvard Time**
Median Pre-Time	**58**	**Pre + Post: 156**
Median Intra-Time	**100**	**64**
Median Immediate Post-service Time	**30**	
Median of Aggregate Critical Care Times	**0**	**0**
Median of Aggregate Other Hospital Visit Times	**60**	**30**
Median Discharge Day Management Time	**38**	**30**
Median of Aggregate Office Visit Times	**92**	**30**

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	**3.81**	**3.84**
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	**3.89**	**3.76**

Urgency of medical decision making	2.44	2.44

Technical Skill/Physical Effort (Mean)

Technical skill required	4.26	4.12
Physical effort required	3.67	3.52

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.81	3.72
Outcome depends on the skill and judgement of physician	4.48	4.36
Estimated risk of malpractice suit with poor outcome	3.85	3.62

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.59	3.48
Intra-Service intensity/complexity	4.04	3.80
Post-Service intensity/complexity	3.35	3.21

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation:
Our RUC recommendations are based on survey responses from urologists located across the country, including urologists from single-specialty, multi-specialty and academic practices. Once responses are compiled, a panel of urologists comprised of a representative sample of the above described group convenes to examine the data associated with each code and determine the final RUC recommendations.

FREQUENCY INFORMATION

How was this service previously reported? **53440- Operation for correction of male urinary incontinence, with or without introduction of prosthesis, 53899- Unlisted procedure, urinary system**

(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: **American Urological Association** _____Commonly **XX** 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 Urological Association** Frequency: **less than 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: **American Urological Association** Frequency: **less than 1,000**

Do many physicians perform this service across the United States? _____Yes **XX** No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 53442 Tracking Code: AB2 Global Period: 090 ~~Recommended RVW: 14~~
RUC Recommended RVU :11.57

CPT Descriptor: **Removal or revision of sling for male urinary incontinence (e.g. fascia or synthetic)**

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: **A 70-year-old male had a periurethral sling placed 8 months ago for post radical prostatectomy urinary incontinence. He now presents with swelling and pain in the perineal region and pyuria. An office cystoscopy reveals erosion of the sling into the urethra. Removal of the sling is planned.**

Pre-service Work- *Day before surgery*:
- Review pre-op lab results
- Review medical record
- Write pre-op orders (to be faxed to 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

Description of Intra-Service Work:
- The patient is placed in the lithotomy position and a 16 F foley catheter placed into the bladder.
- A perineal incision is made under the scrotum and carried down to the bulbospongiosus muscle
- The urethra and surrounding sling are identified
- The sling is freed up from the surrounding urethra being careful not to further injure the urethra or its vasculature
- The sling is then mobilized laterally at its exit through the endopelvic fascia and into the retropubic space
- A second incision is then made suprapubically and the abdominal ends of the sling identified
- The sling is mobilized through the abdominal fascia into the retropubic space from above
- The sling is then removed by pulling it downward from the perineal wound
- The urethral erosion is debrided and closed with interrupted 4-0 monocryl sutures
- The abdominal and perineal wounds are irrigated with antibiotic solution and individually closed with 0 vicryl sutures
- A ¼" penrose is placed in the perineum and the abdominal wound before closure is complete

Description of Post-Service Work:
Post-op Same day work through discharge from recovery
- Apply dressings
- Assist in transfer of patient from operating table to post-op stretcher
- Accompany anesthesiologist with patient to recovery area
- Assist in transfer of patient to recovery area bed
- Write post-op orders
- Review recovery area care and medications with staff
- Meet with family and discuss the procedure, expected outcome, planned post operative care in hospital and out of hospital
- Discuss procedure with patient as necessary in recovery area when awake
- Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)

- Dictate detailed operative narrative

Post-op Same day work after discharge from recovery

- Examine patient, check wound and patient progress
- Review patient hospital medical record notes (nursing, pharmacy, dietary, discharge planner)
- Answer patient and family questions
- Answer nursing and other staff questions
- Write any further necessary orders
- Write note in progress note section of medical record

Post-op Other Hospital Work – *Beginning on post op-day 1, until discharge day*

- Examine and talk to patient
- Check wounds and dressings
- Check drain, decide when to remove
- Discuss patient progress with patient and family
- Review all patient hospital medical record notes
- Discuss post operative care of wound 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 wound 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 about urinary incontinence as patient is now again totally incontinent
- 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:

Presenter(s) Thomas P. Cooper, MD

Specialty(s): American Urological Association

Sample Size: 100 Response Rate: (%): 27% Median RVW: 14.00

Type of Sample: Panel, random

Explanation of sample size: **American Urological Association members who identified themselves as specializing in incontinence.**

	Low	25th %	Median	75 %	High
Survey RVW	10.00	12.90	14.00	15.00	20.00
Pre-Service Time	0	43	65	94	210
Intra-Service Time	0	60	90	120	180

Post-Service:	Total Time	CPT code &/# of visits
Immed. Post-Service	30	
Critical Care		
Other Hospital	60	2-99232
Discharge Day Mgmt	36	1-99238
Office Visits	90	4-99213

KEY REFERENCE SERVICE:

CPT	Descriptor	2002 RVW	% RESP	GLOBE
57288	**Sling operation for stress incontinence (eg, fascia or synthetic)**	**13.02**	**30%**	**090**
53445	**Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff**	**14.06**	**30%**	**090**

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: 53442	Key Reference CPT Code: 57288- Harvard Time
Median Pre-Time	65	Pre + Post: 156
Median Intra-Time	90	64
Median Immediate Post-service Time	30	
Median of Aggregate Critical Care Times	0	0

Median of Aggregate Other Hospital Visit Times	60	30
Median Discharge Day Management Time	30	30
Median of Aggregate Office Visit Times	92	30

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.58	3.79
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.42	3.71
Urgency of medical decision making	3.77	2.63

Technical Skill/Physical Effort (Mean)

Technical skill required	3.96	4.08
Physical effort required	3.62	3.58

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.96	3.71
Outcome depends on the skill and judgement of physician	4.08	4.25
Estimated risk of malpractice suit with poor outcome	4.19	3.75

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.76	3.39
Intra-Service intensity/complexity	3.92	3.96
Post-Service intensity/complexity	3.71	3.32

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation:
Our RUC recommendations are based on survey responses from urologists located across the country, including urologists from single-specialty, multi-specialty and academic practices. Once responses are compiled, a panel of urologists comprised of a representative sample of the above described group convenes to examine the data associated with each code and determine the final RUC recommendations.

FREQUENCY INFORMATION

How was this service previously reported?

(if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty: **American Urological Association** _____Commonly _____Sometimes **XX** 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 Urological Association** Frequency: **less than 500**

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 Urological Association** Frequency: **less than 500**

Do many physicians perform this service across the United States? _____Yes **XX** No

CLINICAL LABOR	CMS Code	53440 (AB1) Sling operation for correction of male urinary incontinence (eg, fascia or synthetic)	
LOCATION		In Office	Out Office
GLOBAL PERIOD		90	90
TOTAL CLINICAL LABOR TIME		0	216
PRE-SERVICE			
Start: Following visit when decision for surgery or procedure made			
Complete pre-service diagnostic & referral forms			5
Coordinate pre-surgery services			20
Schedule space and equipment in facility (for out of office only)			8
Office visit before surgery/procedure: Review test and exam results			
Provide pre-service education/obtain consent			20
Follow-up phone calls & prescriptions			7
Other Clinical Activity (please specify)			
End:When patient enters office for surgery/procedure			
TOTAL PRE-SERVICE CLINICAL TIME		0	60
SERVICE PERIOD			
Start: When patient enters office for surgery/procedure			
Pre-service services			
Review charts			
Greet patient and provide gowning			
Obtain vital signs			
Provide pre-service education/obtain consent			
Prepare room, equipment,supplies			
Prepare and position patient/ monitor patient/ set up IV			
Sedate/apply anesthesia			
Intra-service			
Assist physician in performing procedure			
Post-Service			
Monitor pt. following service/check tubes, monitors, drains			
Clean room/equipment by physician staff			
Assist with ICU or hospital visits (for out of office only)			
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			
Coordination of care by staff in office (for out of office only)			6
Other Clinical Activity (please specify)			
End: Patient leaves office			
TOTAL INTRA-SERVICE CLINICAL TIME		0	6
POST-SERVICE Period			
Start: Patient leaves office			
Conduct phone calls/call in prescriptions			6
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 or outpatient care			
List Number and Level of Office Visits			
99211 16 minutes			
99212 27 minutes			
99213 36 minutes			4
99214 53 minutes			
99215 63 minutes			
Other			
Total Office Visit Time		0	144
Conduct phone calls between office visits			
Other Activity (please specify)			
End: with last office visit before end of global period			
TOTAL POST-SERVICE CLINICAL TIME		0	150
Supplies			
minimum visit package (multi-specialty)			4
post-op incision care kit, basic			1
Equipment			
exam table	E11001		1

CLINICAL LABOR	CMS Code	53442 (AB2) Removal or revision of sling for male urinary incontinence (eg, fascia or synthetic)	
LOCATION		In Office	Out Office
GLOBAL PERIOD		90	90
TOTAL CLINICAL LABOR TIME		0	216
PRE-SERVICE			
Start: Following visit when decision for surgery or procedure made			
Complete pre-service diagnostic & referral forms			5
Coordinate pre-surgery services			20
Schedule space and equipment in facility (for out of office only)			8
Office visit before surgery/procedure: Review test and exam results			
Provide pre-service education/obtain consent			20
Follow-up phone calls & prescriptions			7
Other Clinical Activity (please specify)			
End:When patient enters office for surgery/procedure			
TOTAL PRE-SERVICE CLINICAL TIME		0	60
SERVICE PERIOD			
Start: When patient enters office for surgery/procedure			
Pre-service services			
Review charts			
Greet patient and provide gowning			
Obtain vital signs			
Provide pre-service education/obtain consent			
Prepare room, equipment,supplies			
Prepare and position patient/ monitor patient/ set up IV			
Sedate/apply anesthesia			
Intra-service			
Assist physician in performing procedure			
Post-Service			
Monitor pt. following service/check tubes, monitors, drains			
Clean room/equipment by physician staff			
Assist with ICU or hospital visits (for out of office only)			
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			
Coordination of care by staff in office (for out of office only)			6
Other Clinical Activity (please specify)			
End: Patient leaves office			
TOTAL INTRA-SERVICE CLINICAL TIME		0	6
POST-SERVICE Period			
Start: Patient leaves office			
Conduct phone calls/call in prescriptions			6
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 or outpatient care			
List Number and Level of Office Visits			
99211 16 minutes			
99212 27 minutes			
99213 36 minutes			4
99214 53 minutes			
99215 63 minutes			
Other			
Total Office Visit Time		0	144
Conduct phone calls between office visits			
Other Activity (please specify)			
End: with last office visit before end of global period			
TOTAL POST-SERVICE CLINICAL TIME		0	150
Supplies			
minimum visit package (multi-specialty)			4
post-op incision care kit, basic			1
Equipment			
exam table	E11001		1

American Urological Association, Inc.®

Paul Rudolf, M.D.
Chief Medical Officer
Center for Medicare and Medicaid Services
Provider Payment Group, RM C4-03-25
7500 Security Boulevard
Mailstop C4-01-26
Baltimore, MD 21244

Dear Dr. Rudolf:

This letter is written to review and clarify the February 2, 2002 AUA presentation and final recommendations of the AMA Relative Value Update Committee for male sling procedures (CPT codes 53440, 53442) for urinary incontinence. The focus of this letter is to illustrate the clinical differences between sling procedures for men versus those done for women in order to explain the slightly higher recommended work values for the procedures when performed in men. The American College of Obstetrics and Gynecology (ACOG) participated in the facilitation committee that decided on the recommended work values for these codes and agrees with the clinical rationale for the differences. The RUC Advisors for AUA and ACOG are both signatories to this letter.

Clinical Differences Between Sling Procedures for Male Versus Female Patients:

The placement of a sling procedure to correct incontinence typically produces the same clinical results for men versus women patients; however, technically the placement of the artificial fascia for this procedure is different and more difficult in men for several reasons. First, the use of a sling to correct or maintain urinary continence in male patients almost always occurs in men being treated for prostate cancer who have already undergone a previous operation to remove all or portions of a cancerous prostate gland. The corresponding procedure on females is rarely performed on women who have experienced previous surgery for an existing cancer.

The previous surgery performed on these male patients leaves significant scarring of the urethra and surrounding tissues whereas women receiving slings have not usually been operated on and are unscarred. This scarring is always in the abdominal portion of the male patient and results in much more extensive perineal dissection. The pelvic structures (endopelvic fascia) of men are also considerably denser then those found in female patients and again require more extensive navigation and dissection in order to facilitate sling placement.

For the reasons explained above, the .6 work value difference approved by the AMA Relative Value Update Committee for insertion and/or removal of slings for urinary

incontinence in men is warranted. Please do not hesitate to contact the RUC advisors from either the AUA or ACOG who would be happy to answer any additional questions or concerns. A separate letter explaining the reasoning for the use of previously existing coding for these new procedures will be forwardly from AUA in addition to this rationale.

Thank you for your consideration of this matter.

Sincerely,

William F. Gee, M.D., Chair
AUA Health Policy Council
AUA RUC Advisor

Barbara Levy, M.D.
ACOG RUC Advisor

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Colposcopy Procedures

To better define the various types of colposcopy services, the CPT Editorial Panel revised three existing codes and added seven codes to differentiate between colposcopy of the vulva, entire vagina and cervix including upper/adjacent vagina.

56820, 57420 and 57452

The RUC examined the survey results for codes 56820 *Colposcopy of the vulva;*, 57420 *Colposcopy of the entire vagina; with cervix if present* and 57452 *Colposcopy ~~(vaginoscopy)~~ of the cervix including upper/adjacent vagina; ~~(separate procedure)~~*. The RUC felt that these codes were the three base codes for the 10 proposed colposcopy codes. After much consideration of the survey data provided by the specialty society, the RUC compared these codes with their reference codes, 53600 *Dilation of urethral stricture by passage of sound or urethral dilator, male; initia* (work RVU 1.21), and code 53605 *Dilation of urethral stricture or vesical neck by passage of sound or urethral dilator, male, general or conduction (spinal) anesthesia* (work RVU 1.28), code 54050 *Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical* (work RVU 1.24). The RUC felt that the work of the colposcopy was greater than these reference codes however, was less work that code 54100 *Biopsy of penis; (separate procedure)* (work RVU 1.90). Based on a comparison to these reference codes, the RUC assigned values to these codes, to place them in rank order. **The RUC recommends a work relative value for 56820 of 1.50, for 57420 of 1.60 and 57452 of 1.50.**

56821, 57421 and 57454

Once the values of the base codes were determined, the incremental work involved with biopsy for codes 56821 *Colposcopy of the vulva; with biopsy(s)*, 57421 *Colposcopy of the entire vagina; with cervix if present; with biopsy(s)* and 57454 *Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage* were calculated. To value 56821 and 57421 codes, first, the RUC established that the incremental work determined by the specialty society survey was appropriate for a biopsy for all of these codes and therefore used this increment to value these codes. Consequently, to value 56821, the RUC began with its recommendation of 56820 (recommended work RVU 1.50) and then added the surveyed biopsy increment between 56820 and 56821 (0.55) to get a value of 2.05. For 57421, the RUC began with its recommendation for 57420 (recommended work RVU 1.6) and then added the surveyed biopsy increment between 57420 and 57421 (0.60) to get a value of 2.2. To value 57454, the RUC began with its recommendation for 57452 (recommended RVU of 1.50) and then added half of *57500 Biopsy, single or multiple, or local*

excision of lesion, with or without fulguration, separate procedure (RVU= 0.97) and half of 57505 *Endocervical curettage* (RVU = 1.14) minus the RVU for a 99212 office visit (RVU = 0.45). Resulting in a total value of 2.33 RVUs.

1.5 RVU	CPT code 57452, *Colposcopy of the cervix including upper/adjacent vagina* (RVU = 1.5)
+0.485 RVU	Half CPT code 57500, *Biopsy, single or multiple, or local excision of lesion, with or without fulguration, separate procedure* (RVU = 0.97)
+0.345 RVU	Half (57505 *Endocervical curettage* (RVU = 1.14) – 99212 office visit (RVU = 0.45))
=2.33 RVU	**Recommendation for 57454**

Therefore, the RUC recommends a work relative value of 2.05 for 56821, 2.20 for 57421 and 2.33 for 57454.

57455, 57456 and 57461

A building block approach was used to calculate the recommendations for these codes. For 57455, *Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix,* the RUC began with the recommended work RVU of 57452 (1.50) then added half of the current relative work value for CPT code 57500, *Biopsy, single or multiple, or local excision of lesion, with or without fulguration, separate procedure)* (0.49). This calculation results in an overall recommendation for 57455 of 1.99. For 57456, the RUC began with the recommended work RVU of 57452 (1.50) then added half or CPT code 57505, *Endocervical curettage* (1.14) minus the work for a 99212 office visit (0.35). This calculation results in an overall value of 1.85. For 57461, *Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix*, the RUC began with recommended work RVU of 57452 (1.50) then added half of the current relative work value for CPT code 57522 *Conization of the cervix, with or without dilation and curettage, with or without repair; loop electrode excision* (3.36) minus the work for a 99213 office visit (0.67). This calculation results in an overall recommendation for 57461 of 3.44. See tables below for clarification.

1.5 RVU	CPT code 57452 *Colposcopy of the cervix including upper/adjacent vagina* (RVU = 1.5)
+ 0.485 RVU	Half CPT code 57500, *Biopsy, single or multiple, or local excision of lesion, with or without fulguration, separate procedure* (RVU = 0.97)
=1.99 RVU	**Recommendation for 57455**

1.5 RVU	CPT code 57452 *Colposcopy of the cervix including upper/adjacent vagina* (RVU = 1.5)
+0.345 RVU	Half (57505 *Endocervical curettage* (RVU = 1.14) – 99212 office visit (RVU = 0.45))
=1.85 RVU	**Recommendation for 57456**

2.69 RVU	CPT code 57522 *Conization of the cervix, with or without dilation and curettage, with or without repair; loop electrode excision* (RVU = 3.36) – 99213 office visit (RVU = 0.65)
+0.75 RVU	Half CPT code 57452 *Colposcopy of the cervix including upper/adjacent vagina* (RVU = 1.5)
=3.44 RVU	**Recommendation for 57461**

Therefore, the RUC recommends a work relative value of 1.99 for 57455 and 1.85 for 57456.and 3.44 for 57461.

~~57461~~ 57460

For code 57461, *Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy of the cervix* (RVU = 2.83), the RUC agreed that this code should not have a change in value and recommend its existing value of 2.83 RVUs. **Therefore, the RUC recommends no change in the work relative value for 57461.** 1.0

Practice Expense

The specialty society utilized established PEAC methodology to when developing the practice expense for the colposcopy procedure codes. However, there were a few minor revisions to the staff times and equipment. **Therefore, the RUC approved the practice expense inputs with necessary revisions as presented by the specialty society.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●56820	AZ1	Colposcopy of the vulva;	000	1.50
●56821	AZ2	with biopsy (s) (For colposcopic examinations/procedures involving the vagina and cervix, see 57420, 57421 and 57452-57461)	000	2.05
●57420	AZ3	Colposcopy of the entire vagina; with cervix if present	000	1.60

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●57421	AZ4	with biopsy(s) (For colposcopic visualization of cervix and adjacent upper vagina, use 57452) (When reporting colposcopies of multiple sites, use modifier –51 as appropriate. For colposcopic examinations/procedures involving the vulva and cervix, see 56820, 56821, 57452-57461)	000	2.20
▲57452	AZ5	Colposcopy ~~(vaginoscopy)~~ of the cervix including upper/adjacent vagina; ~~(separate procedure)~~ (Do not report 57452 in addition to 57454 – 57461)	000	1.50
▲57454	AZ6	with biopsy(s) of the cervix and~~/or~~ endocervical curettage	000	2.33
●57455	AZ7	with biopsy(s) of the cervix	000	1.99
●57456	AZ8	with endocervical curettage	000	1.85
▲57460	AZ9	with loop electrode ~~excision procedure~~ biopsy(s) of the cervix	000	2.83

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 56820 Tracking Number: AZ1 Global Period: 0 **Recommended RVW: ~~2.00~~**
RUC Recommendation: 1.5

CPT Descriptor: Colposcopy of the vulva

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
A 44-year old female presents with a one-year history of vulvar irritation and itching. She has a past history of HPV changes to Pap smear and has previously undergone cryotherapy of the cervix. Her family physician has tried antifungal as well as antibiotic cream preparations and yet her symptoms persist. She presents now for further evaluation of the vulva to exclude vulvar intraepithelial neoplasia. Acetic acid is applied to the vulva. A colposcopic examination of the entire vulva is performed.

Description of Pre-Service Work:
Pre-service work includes the following:

- review of patient's chart
- review of pap smear and other related reports
- obtain consent
- confirm that colposcopic instruments are present and functioning properly

Description of Intra-Service Work:
The vulva is cleansed several times with 5% acetic acid. After adequate time for the acetic acid effect, the colposcope is then directed at the vulva under appropriate magnification. The entire vulva is visualized with the colposcope at several magnifications. As no suspicious lesions are found the patient is reassessed and biopsies are not performed.

Description of Post-Service Work:
Post-service work includes the following:

- documentation of procedure
- instructions to patient for follow-up
- formulation of plan for follow-up treatment

SURVEY DATA:

Presenter(s): Michael Berman, MD, FACOG and Sandra Reed, MD, FACOG

Specialty(s): American College of Obstetricians and Gynecologists (ACOG) and Society of Gynecological Oncologists (SGO)

Sample Size: 750 Response Rate: (%): 6% (48 out of 750) Median RVW: 2.20

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: 750 surveys with cover letter were mailed to a targeted mailing list of gynecological oncologists and OB/GYN generalists.

25th Percentile RVW: 2 75th Percentile RVW: 2.75 Low: .70 High: 4.10

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

25th Percentile Intra-Svc Time: 10 75th Percentile Intra-Svc Time: 15 Low: 5 High: 30

Median Post-Service Time: 10

Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)

Immediate Post Service Time:	10
Critical Care:	N/A
Other Hospital Visits:	N/A
Discharge Day Mgmt.:	N/A
Office Visits:	N/A

CPT Code: 56820

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
58555	Hysteroscopy, diagnostic (separate procedure)	0	3.33

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including 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:
Median Pre-Time	15	30
Median Intra-Time	15	25
Median Immediate Post-service Time	10	20
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 Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.86	2.80
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.65	2.73
Urgency of medical decision making	2.37	2.51

Technical Skill/Physical Effort (Mean)

Technical skill required	3.18	2.92
Physical effort required	2.43	2.37

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.96	2.22
Outcome depends on the skill and judgment of physician	3.2	2.8
Estimated risk of malpractice suit with poor outcome	2.57	2.57

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.3	2.8
Intra-Service intensity/complexity	2.7	3.0
Post-Service intensity/complexity	2.2	2.6

ADDITIONAL RATIONALE

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

SURVEY METHOD

The American College of Obstetricians and Gynecologists (ACOG) in collaboration with the Society of Gynecological Oncologists (SGO) disseminated the RUC survey to a targeted national mailing list of 750 gynecological oncologists and OB/GYN generalists. The survey was mailed 1st class via the USPS. Forty-eight surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG and SGO reviewed the results and drafted the final recommendations.

PANEL DISCUSSION

The panel developed the recommendation in the following manner:

1. Reviewing the survey data
2. Comparing the surveyed code with other related codes

Survey Data – The 25th percentile RVW from the survey was 2.00. The panel realized that this was an increase from the current values of colposcopy codes. After a discussion of the data the general agreement among panel members was that the current codes were never surveyed and that the baseline value as assigned by Hsiao was too low.

Comparing the surveyed code with other related codes – The panel also compared the code to related 0 day global codes.

		RELATED 0-DAY GLOBAL CODES	
CPT Code	**RVW**	**INTRA-SERVICE TIME**	**TOTAL TIME**
56820	2.0	15 min	40 min
Colposcopy of the vulva			
31510	1.92	20 min	45 min (Harvard Time)
Laryngoscopy, indirect; with biopsy			
31512	2.07	20 min	57 min (Harvard Time)
Laryngoscopy, indirect; with removal of lesion			
52000	2.01	14 min	38 min (Harvard Time)
Cystourethroscopy (separate procedure)			

After reviewing data on related codes the panel felt the recommendation for the surveyed code fell into line with related codes. The panel felt comfortable recommending the 25th percentile of 2.0 RVW for this code.

FREQUENCY INFORMATION

How was this service previously reported? 57452 (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: ACOG ____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: ACOG Frequency: 18,000

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: ACOG Frequency: 3000

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 56821 Tracking Number: AZ2 Global Period: 0 **Recommended RVW: ~~2.55~~**
RUC Recommendation: 2.05

CPT Descriptor: Colposcopy of the vulva; with biopsy(s)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
A 55 year-old woman with a history of vulvar intraepithelial neoplasia complains of vulvar itching. Physical examination does not reveal an obvious lesion. Acetic acid is applied to the vulva and a colposcopic examination of the entire vulva is performed. An area of aceto white epithelium is identified. The area is infiltrated with 1% lidocaine and 4mm punch biopsy is obtained. Hemostasis is obtained with silver nitrate.

Description of Pre-Service Work:
Pre-service work includes the following:

- review of patient's chart
- review of pap smear and other related reports
- obtain consent
- confirm that colposcopic instruments are present and functioning properly

Description of Intra-Service Work:
The vulva is cleansed several times with 5% acetic acid. After adequate time for acetic acid effect, colposcopic examination is done at appropriate magnification. The entire vulva is visualized with the colposcope at several magnifications. Abnormal area suspicious for cancer is identified. The area is cleansed with Betadine and locally infiltrated with lidocaine. A 3mm Keys punch biopsy instrument is used to obtain a biopsy. The biopsy site is treated with Silver Nitrate or Monsel's solution to control bleeding.

Description of Post-Service Work:
Post-service work includes the following:

- documentation of procedure
- instructions to patient for follow-up
- review of pathology report
- precautions to control bleeding
- formulation of plan for follow-up treatment

SURVEY DATA:

Presenter(s): Michael Berman, MD, FACOG and Sandra Reed, MD, FACOG

Specialty(s): American College of Obstetricians and Gynecologists (ACOG) and Society of Gynecological Oncologists (SGO)

Sample Size: 750 Response Rate: (%): 6% (47 out of 750) Median RVW: 2.67

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: 750 surveys with cover letter were mailed to a targeted mailing list of gynecological oncologists and OB/GYN generalists.

25th Percentile RVW: 2.40 75th Percentile RVW: 3.05 Low: .75 High: 4.25

Median Pre-Service Time: 15 Median Intra-Service Time: 20

25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 20 Low: 8 High: 45

Median Post-Service Time: 10

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

CPT Code: 56821

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
58555	Hysteroscopy, diagnostic (separate procedure)	0	3.33

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including 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:**
Median Pre-Time	15	30
Median Intra-Time	20	25
Median Immediate Post-service Time	10	20
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 Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.87	2.73
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.79	2.8
Urgency of medical decision making	2.51	2.52

Technical Skill/Physical Effort (Mean)

Technical skill required	3.32	2.8
Physical effort required	2.72	2.44

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.80	2.44
Outcome depends on the skill and judgment of physician	3.26	2.8
Estimated risk of malpractice suit with poor outcome	2.74	2.73

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.7	2.9
Intra-Service intensity/complexity	2.6	2.9
Post-Service intensity/complexity	2.8	2.9

ADDITIONAL RATIONALE

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

SURVEY METHOD

The American College of Obstetricians and Gynecologists (ACOG) in collaboration with the Society of Gynecological Oncologists (SGO) disseminated the RUC survey to a targeted national mailing list of 750 gynecological oncologists and OB/GYN generalists. The survey was mailed 1st class via the USPS. Forty-seven surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG and SGO reviewed the results and drafted the final recommendations.

PANEL DISCUSSION

The panel felt that this code naturally lent itself to using the building block approach as a method developing an RVW recommendation.

The results of the building block approach are described below. The value of 2 RVW was used for the base code. The value of the base code was discussed in the recommendation for 56820.

2 RVW (CPT code 56820, Colposcopy of the vulva)
+
(.5) 1.10 RVW (CPT code 56605, Biopsy of the vulva)
= 2.55 RVW

The panel compared the 25th percentile RVW survey value of 2.4RVW to the value obtained from using the building block approach.

Building Block = 2.55 RVW
Survey = 2.40 RVW

The panel felt the comparison validated the building block method and they supported the recommendation of 2.55 RVW for 56821.

FREQUENCY INFORMATION

How was this service previously reported? 57454 (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: ACOG ____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: ACOG Frequency: 6000

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

Specialty: ACOG Frequency: 1000

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

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 57420 Tracking Number: AZ3 Global Period: 0 **Recommended RVW: ~~2.15~~**
RUC Recommendation: 1.6(

CPT Descriptor: Colposcopy of the entire vagina; with cervix if present

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
A 42-year old female has a Pap smear test result showing atypical cells of undetermined significance; the physician cannot rule out dysplasia. Three years ago she was treated with a radical hysterectomy and adjuvant radiation therapy for Stage IB squamouscarcinoma of the cervix. Acetic acid is applied to the vagina and all vaginal surface areas are examined with the colposcope.

Description of Pre-Service Work:
Pre-service work includes the following:

- review of patient's chart
- review of pap smear and other relevant reports
- obtain consent
- confirm that colposcopic instruments are present and functioning properly

Description of Intra-Service Work:
Acetic acid is applied to the entire vagina. After adequate time for acetic acid effect, all vaginal surfaces are evaluated with a colposcope at several magnifications. Colposcopic evaluation shows no evidence of neoplastic or pre-neoplastic changes and the abnormal cytologic changes are interpreted as being due to radiation effect. Accordingly biopsies are not performed.

Description of Post-Service Work:
Post-service work includes the following:

- documentation of procedure
- instructions to patient for follow-up
- formulation of plan for follow-up treatment

SURVEY DATA:

Presenter(s): Michael Berman, MD, FACOG and Sandra Reed, MD, FACOG

Specialty(s): American College of Obstetricians and Gynecologists (ACOG) and Society of Gynecological Oncologists (SGO)

Sample Size: 750 Response Rate: (%): 7% (49 out of 750) Median RVW: 2.50

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: 750 surveys with cover letter were mailed to a targeted mailing list of gynecological oncologists and OB/GYN generalists.

25th Percentile RVW: 2.15 75th Percentile RVW: 3.00 Low: .75 High: 4.50

Median Pre-Service Time: 14.14 Median Intra-Service Time: 18.52

25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 20 Low: 5 High: 40

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

CPT Code: 57420

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
58555	Hysteroscopy, diagnostic (separate procedure)	0	3.33

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including 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:**
Median Pre-Time	14.14	30
Median Intra-Time	18.52	25
Median Immediate Post-service Time	10	20
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 Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.02	2.74
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.88	2.78
Urgency of medical decision making	2.58	2.5

Technical Skill/Physical Effort (Mean)

Technical skill required	3.4	2.86
Physical effort required	2.29	2.37

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.28	2.29
Outcome depends on the skill and judgment of physician	2.96	2.63
Estimated risk of malpractice suit with poor outcome	2.52	2.33

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.5	2.9
Intra-Service intensity/complexity	2.9	3.1
Post-Service intensity/complexity	2.5	3

ADDITIONAL RATIONALE

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

SURVEY METHOD

The American College of Obstetricians and Gynecologists (ACOG) in collaboration with the Society of Gynecological Oncologists (SGO) disseminated the RUC survey to a targeted national mailing list of 750 gynecological oncologists and OB/GYN generalists. The survey was mailed 1st class via the USPS. Forty-nine surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG and SGO reviewed the results and drafted the final recommendations.

PANEL DISCUSSION

The panel developed the recommendation in the following manner:

1. Reviewing the survey data
2. Comparing the surveyed code with other related codes

Survey Data – The 25th percentile RVW from the survey was 2.15. The panel realized that this was an increase from the current values of colposcopy codes. After a discussion of the data the general agreement among panel members was that the current codes were never surveyed and that the baseline value as assigned by Hsiao was too low.

Comparing the surveyed code with other related codes – The panel also compared the code to related 0 day global codes.

		RELATED 0-DAY GLOBAL CODES	
CPT Code	**RVW**	**INTRA-SERVICE TIME**	**TOTAL TIME**
57420 Colposcopy of the vulva	2.15	18.52 min	42.66 min
31510 Laryngoscopy, indirect; with biopsy	1.92	20 min	45 min (Harvard Time)
31512 Laryngoscopy, indirect; with removal of lesion	2.07	20 min	57 min (Harvard Time)
52000 Cystourethroscopy (separate procedure)	2.01	14 min	38 min (Harvard Time)

After reviewing data on related codes the panel felt the recommendation for the surveyed code fell into line with related codes. The panel felt comfortable recommending the 25th percentile of 2.15 RVW for this code.

FREQUENCY INFORMATION

How was this service previously reported? 57452 (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: ACOG ____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: ACOG Frequency: 18,000

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: ACOG Frequency: 3000

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 57421 Tracking Number: AZ4 Global Period: 0 **Recommended RVW: ~~2.75~~**
RUC recommendation: 2.20

CPT Descriptor: Colposcopy of the entire vagina, with cervix if present; with biopsy(s)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
A 42 year-old female has a Pap smear showing high-grade squamous intraepithelial lesion. Three years ago she has had a radical hysterectomy for Stage IB squamous cell carcinoma of the cervix. Acetic acid is applied to the vagina. Colposcopic examination of the entire vagina is performed. An area of aceto white changes is identified. The area is infiltrated with 1% lidocaine and a biopsy is obtained under colposcopic guidance. Hemostasis is obtained with silver nitrate or monsol solution.

Description of Pre-Service Work:
Pre-service work includes the following:

- review of patient's chart
- review of pap smear and other relevant reports
- obtain consent
- confirm that colposcopic instruments are present and functioning properly

Description of Intra-Service Work:
Acetic acid is applied to the entire vagina. After adequate time for acetic acid effect surfaces of the vagina are evaluated with the colposcope at several magnifications. Colposcopic evaluation reveals a suspicious lesion at the vaginal cuff and a second area in the mid- vagina. Both areas are injected with local anesthetic, biopsies are taken, and bleeding is controlled with Monsel's solution or Silver Nitrate.

Description of Post-Service Work:
Post-service work includes the following:

- documentation of procedure
- instructions to patient for follow-up
- review of pathology report
- precautions to control bleeding
- formulation of plan for follow-up treatment

SURVEY DATA:

Presenter(s): Michael Berman, MD, FACOG and Sandra Reed, MD, FACOG

Specialty(s): American College of Obstetricians and Gynecologists (ACOG) and Society of Gynecological Oncologists (SGO)

Sample Size: 750 Response Rate: (%): 7% (49 out of 750) Median RVW: 3.00

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: 750 surveys with cover letter were mailed to a targeted mailing list of gynecological oncologists and OB/GYN generalists.

25th Percentile RVW: 2.50 75th Percentile RVW: 3.50 Low: .78 High: 4.50

Median Pre-Service Time: 15 Median Intra-Service Time: 20

25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 25 Low: 8 High: 45

Median Post-Service Time: 10

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

CPT Code: 57421

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
58555	Hysteroscopy, diagnostic (separate procedure)	0	3.33

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including 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:**
Median Pre-Time	15	30
Median Intra-Time	20	25
Median Immediate Post-service Time	10	20
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 Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.02	2.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.77	2.71
Urgency of medical decision making	2.66	2.47

Technical Skill/Physical Effort (Mean)

Technical skill required	3.47	2.76
Physical effort required	2.46	2.86

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.37	2.39
Outcome depends on the skill and judgment of physician	3.29	2.67
Estimated risk of malpractice suit with poor outcome	2.94	2.55

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.6	2.9
Intra-Service intensity/complexity	2.8	3.0
Post-Service intensity/complexity	3.1	3.1

ADDITIONAL RATIONALE

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

SURVEY METHOD

The American College of Obstetricians and Gynecologists (ACOG) in collaboration with the Society of Gynecological Oncologists (SGO) disseminated the RUC survey to a targeted national mailing list of 750 gynecological oncologists and OB/GYN generalists. The survey was mailed 1st class via the USPS. Forty-nine surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG and SGO reviewed the results and drafted the final recommendations.

PANEL DISCUSSION

The panel felt that this code naturally lent itself to using the building block approach as a method for developing an RVW recommendation.

The results of the building block approach are described below. The value of 2.15 RVW was used for the base code. The value of the base code was discussed in the recommendation for 5746X2.

2.15- RVW (CPT code 57420, Colposcopy of the entire vagina, with cervix if present; with biopsy(s))
+
(.5) 1.20 RVW (CPT code 57100, Biopsy of the vaginal mucosa; simple (separate procedure))
=
2.75RVW

The panel compared the 25th percentile RVW survey value of 2.50RVW to the value obtained from using the building block approach.

Building Block = 2.75 RVW
Survey = 2.50 RVW

The panel felt the comparison validated the building block method and they supported the recommendation of 2.75 RVW for 57421.

FREQUENCY INFORMATION

How was this service previously reported? 57454 (if unlisted code, please ensure that the Medicare frequenc 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: ACOG ____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: ACOG Frequency: 6000

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

Specialty: ACOG Frequency: 1000

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

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 57452 Tracking Number: AZ5 Global Period: 0 **Recommended RVW: ~~2.00~~**
RUC Recommendations: 1.~~5~~

CPT Descriptor: Colposcopy of the cervix including upper/adjacent vagina

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
A 30-year old woman with a mildly abnormal Pap smear result is advised to undergo colposcopic visualization of the cervix. She is advised that a biopsy will be obtained if a lesion is identified.

Description of Pre-Service Work:
Pre-service work includes the following:

- review of patient's chart
- review of pap smear and other related reports
- obtain consent
- confirm that colposcopic instruments are present and functioning properly

Description of Intra-Service Work:
The cervix including upper/adjacent vagina is cleaned several times with 3% acetic acid. After adequate time for acetic acid affect the cervix and vaginal fornices are examined with colposcope at several magnifications. The transformation zone (area at risk for cervical cancer) is seen completely and no colposcopically abnormal areas are identified, accordingly no biopsy procedure is performed.

Description of Post-Service Work:
Post-service work includes the following:

- documentation of procedure
- instructions to patient for follow-up
- formulation of plan for follow-up treatment

SURVEY DATA:

Presenter(s): Michael Berman, MD, FACOG and Sandra Reed, MD, FACOG

Specialty(s): American College of Obstetricians and Gynecologists (ACOG) and Society of Gynecological Oncologists (SGO)

Sample Size: 750 Response Rate: (%): 6% (46 out of 750) Median RVW: 2.20

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: 750 surveys with cover letter were mailed to a targeted mailing list of gynecological oncologists and OB/GYN generalists.

25th Percentile RVW: 2 75th Percentile RVW: 2.79 Low: .7 3 High: 3.75

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

25th Percentile Intra-Svc Time: 10.50 75th Percentile Intra-Svc Time: 15.75 Low: 5 High: 30

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

CPT Code: 57452

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
58555	Hysteroscopy, diagnostic (separate procedure)	0	3.33

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including 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:**
Median Pre-Time	15	30
Median Intra-Time	15	25
Median Immediate Post-service Time	10	20
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 Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.91	2.57
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.59	2.61
Urgency of medical decision making	2.39	2.41

Technical Skill/Physical Effort (Mean)

Technical skill required	3.22	2.74
Physical effort required	2.54	2.43

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.13	2.39
Outcome depends on the skill and judgment of physician	3.15	2.65
Estimated risk of malpractice suit with poor outcome	2.87	2.5

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.4	3.0
Intra-Service intensity/complexity	2.6	3.2
Post-Service intensity/complexity	2.8	2.9

ADDITIONAL RATIONALE

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

SURVEY METHOD

The American College of Obstetricians and Gynecologists (ACOG) in collaboration with the Society of Gynecological Oncologists (SGO) disseminated the RUC survey to a targeted national mailing list of 750 gynecological oncologists and OB/GYN generalists. The survey was mailed 1st class via the USPS. Forty-six surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG and SGO reviewed the results and drafted the final recommendations.

PANEL DISCUSSION

The panel developed the recommendation in the following manner:

1. Reviewing the survey data
2. Comparing the surveyed code with other related codes

Survey Data – The 25th percentile WRVU from the survey was 2.0. The panel realized that this was an increase from the current values of colposcopy codes. After a discussion of the data the general agreement among panel members was that the current codes were never surveyed and that the baseline value as assigned by Hsiao was too low.

Comparing the surveyed code with other related codes – The panel also compared the code to related 0 day global codes.

		RELATED 0-DAY GLOBAL CODES	
CPT Code	**RVW**	**INTRA-SERVICE TIME**	**TOTAL TIME**
56820	2.00	15 min	40 min
Colposcopy of the vulva			
31510	1.92	20 min	45 min (Harvard Time)
Laryngoscopy, indirect; with biopsy			
31512	2.07	20 min	57 min (Harvard Time)
Laryngoscopy, indirect; with removal of lesion			
52000	2.01	14 min	38 min (Harvard Time)
Cystourethroscopy (separate procedure)			

After reviewing data on related codes the panel felt the recommendation for the surveyed code fell into line with related codes. The panel felt comfortable recommending the 25th percentile of 2.0 RVW for this code.

FREQUENCY INFORMATION

How was this service previously reported? 57452 (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: ACOG _____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: ACOG Frequency: 180,000

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: ACOG Frequency: 30,000

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 57454 Tracking Number: AZ6 Global Period: 0 **Recommended RVW: ~~2.61~~**
RUC Recommendation: 2.33

CPT Descriptor: Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
A 30-year old woman with an abnormal Pap smear is advised to undergo colposcopic visualization of the cervix. She is advised that a biopsy will be obtained if a lesion is identified.

Description of Pre-Service Work:
Pre-service work includes the following:

- review of patient's chart
- review of pap smear and other relevant reports
- obtain consent
- confirm that colposcopic instruments are present and functioning properly

Description of Intra-Service Work:
The cervix including upper/adjacent vagina is cleaned several times with 3% acetic acid. After adequate time for acetic acid effect the cervix and vagina fornices are examined with a colposcope at several magnifications. The transformation zone (area at risk for cervical cancer) is seen completely and abnormal aceto white areas are noted at 12 o'clock extending into the endocervical canal. An endocervical curettage and a cervical biopsy at 12 o'clock is performed. The biopsy site is treated with Monsel's solution or Silver Nitrate for hemostasis.

Description of Post-Service Work:
Post-service work includes the following:

- documentation of procedure
- instructions to patient for follow-up
- precautions to control bleeding
- review of pathology report
- formulation of plan for follow-up treatment

SURVEY DATA:

Presenter(s): Michael Berman, MD, FACOG and Sandra Reed, MD, FACOG

Specialty(s): American College of Obstetricians and Gynecologists (ACOG) and Society of Gynecological Oncologists (SGO)

Sample Size: 750 Response Rate: (%): 6% (48 out of 750) Median RVW: 2.78

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: 750 surveys with cover letter were mailed to a targeted mailing list of gynecological oncologists and OB/GYN generalists.

25th Percentile RVW: 2.48 75th Percentile RVW: 3.40 Low: .78 High: 4.02

Median Pre-Service Time: 15 Median Intra-Service Time: 20

25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 25 Low: 8 High: 30

Median Post-Service Time: 10
Level of Service by CPT Code

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

CPT Code: 57454

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
58555	Hysteroscopy, diagnostic (separate procedure)	0	3.33

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including 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:**
Median Pre-Time	15	30
Median Intra-Time	20	25
Median Immediate Post-service Time	10	20
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 Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.97	2.63
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.70	2.69
Urgency of medical decision making	2.48	2.46

Technical Skill/Physical Effort (Mean)

Technical skill required	3.35	2.73
Physical effort required	2.82	2.79

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.45	2.49
Outcome depends on the skill and judgment of physician	3.28	2.81
Estimated risk of malpractice suit with poor outcome	2.94	2.62

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.9	3.0
Intra-Service intensity/complexity	3.1	3.2
Post-Service intensity/complexity	2.8	3.0

ADDITIONAL RATIONALE

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

SURVEY METHOD

The American College of Obstetricians and Gynecologists (ACOG) in collaboration with the Society of Gynecological Oncologists (SGO) disseminated the RUC survey to a targeted national mailing list of 750 gynecological oncologists and OB/GYN generalists. The survey was mailed 1st class via the USPS. Forty-eight surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG and SGO reviewed the results and drafted the final recommendations.

PANEL DISCUSSION

The panel felt that this code naturally lent itself to using the building block approach as a method for developing an RVW recommendation.

The results of the building block approach are described below. The value of 2.00 RVW was used for the base code. The value of the base code was discussed in the recommendation for 57452.

2.0- RVW (CPT code 57452, Colposcopy of the cervix including upper/adjacent vagina)
+
(.5) .97 RVW (CPT code 57500, Biopsy, single or multiple, or local excision of lesion, with or without fulguration (separate procedure))
+
(.5) 1.14 RVW (CPT Code 57505, Endocervical curettage)
- .45 RVW (CPT code 99212)
=
2.61 RVW

The panel compared the 25th percentile RVW survey value of 2.48RVW to the value obtained from using the building block approach.

Building Block = 2.61 RVW
Survey = 2.48 RVW

The panel felt the comparison validated the building block method and they supported the recommendation of 2.61 RVW for 57454.

FREQUENCY INFORMATION

How was this service previously reported? 57454 (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: ACOG _____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: ACOG Frequency: 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: ACOG Frequency: 5000

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

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 57455 Tracking Number: AZ7 Global Period: 0 **Recommended RVW: ~~2.49~~**
RUC Recommendation: 1.9

CPT Descriptor: Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
A 27-year old female has a Pap smear test result of epithelial cell abnormality. The descriptive report includes any of the following: ASCUS, possible HPV, dysplasia; low-grade squamous intraepithelial lesion encompassing HPV, mild dysplasia, CIN I; any reference to moderate or high-grade dysplasia, CIN III, or invasive carcinoma. Acetic acid is applied to the cervix and upper vagina. The cervix and vaginal fornices are carefully inspected with the colposcope at various magnifications. An area of mosaicism is identified and a biopsy is obtained under colposcopic guidance. Bleeding is controlled with monsel's solution

Description of Pre-Service Work:
Pre-service work includes the following:

- review of patient's chart
- review of pap smear and other related reports
- obtain consent
- confirm that colposcopic instruments are present and functioning properly

Description of Intra-Service Work:
The cervix including upper/adjacent vagina is cleaned several times with 3% acetic acid. After adequate time for acetic acid effect the cervix and vagina fornices are examined with a colposcope several magnifications. An adequate exam views entire transformation zone (area at risk for cervical cancer). An abnormality consisting of leukoplakia, mosaicism, punctation, or atypical vessels is noted during exam. Abnormal aceto white areas are noted at 12 o'clock not extending into the endocervical canal. A cervical biopsy at 12 o'clock is done. The biopsy site is treated with Monsel's solution or Silver Nitrate for hemostasis.

Description of Post-Service Work:
Post-service work includes the following:

- documentation of procedure
- instructions to patient for follow-up
- precautions to control bleeding
- review of pathology report
- formulation of plan for follow-up treatment

SURVEY DATA:

Presenter(s): Michael Berman, MD, FACOG and Sandra Reed, MD, FACOG

Specialty(s): American College of Obstetricians and Gynecologists (ACOG) and Society of Gynecological Oncologists (SGO)

Sample Size: 750 Response Rate: (%): 6% (46 out of 750) Median RVW: 2.75

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: 750 surveys with cover letter were mailed to a targeted mailing list of gynecological oncologists and OB/GYN generalists.

25th Percentile RVW: 2.40 75th Percentile RVW: 3.23 Low: 1.00 High: 4.01

Median Pre-Service Time: 15 Median Intra-Service Time: 20

25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 20 Low: 8 High: 35

Median Post-Service Time: 10

Level of Service by CPT Code

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

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
58555	Hysteroscopy, diagnostic (separate procedure)	0	3.33

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including 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:**
Median Pre-Time	15	30
Median Intra-Time	20	25
Median Immediate Post-service Time	10	20
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 Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.00	2.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.72	2.63
Urgency of medical decision making	2.48	2.41

Technical Skill/Physical Effort (Mean)

Technical skill required	3.39	2.80
Physical effort required	2.67	2.46

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.33	2.39
Outcome depends on the skill and judgment of physician	2.71	2.53
Estimated risk of malpractice suit with poor outcome	2.59	2.41

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.8	3.1
Intra-Service intensity/complexity	2.8	3.0
Post-Service intensity/complexity	2.6	2.8

ADDITIONAL RATIONALE

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

SURVEY METHOD

The American College of Obstetricians and Gynecologists (ACOG) in collaboration with the Society of Gynecological Oncologists (SGO) disseminated the RUC survey to a targeted national mailing list of 750 gynecological oncologists and OB/GYN generalists. The survey was mailed 1st class via the USPS. Forty-six surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG and SGO reviewed the results and drafted the final recommendations.

PANEL DISCUSSION

The panel felt that this code naturally lent itself to using the building block approach as a method for developing an RVW recommendation.

The results of the building block approach are described below. The value of 2.00 RVW was used for the base code. The value of the base code was discussed in the recommendation for 57452.

2.0- RVW (CPT code 57452, Colposcopy of the cervix including upper/adjacent vagina)
+
(.5) .97 RVW (CPT code 57500, Biopsy, single or multiple, or local excision of lesion, with or without fulguration (separate procedure))

=
2.49 RVW

The panel compared the 25th percentile RVW survey value of 2.40 RVW to the value obtained from using the building block approach.

Building Block = 2.49 RVW
Survey = 2.40 RVW

The panel felt the comparison validated the building block method and they supported the recommendation of 2.49 RVW for 57455.

FREQUENCY INFORMATION

How was this service previously reported? 57454 (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: ACOG _____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: ACOG Frequency: 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: ACOG Frequency: 5000

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

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 57456 Tracking Number: AZ8 Global Period: 0 **Recommended RVW: 2.12**
RUC Recommendation:1.85

CPT Descriptor: Colposcopy of the cervix including upper/adjacent vagina; with endocervical curettage

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
A 27 year-old female has a Pap smear test result of epithelial cell abnormality. The descriptive report includes any of the following: ASCUS, possible HPV, dysplasia; low-grade squamous intraepithelial lesion encompassing HPV, mild dysplasia, CIN I; any reference to moderate or high-grade dysplasia, CIN III, or invasive carcinoma. A colposcopic exam of the cervix is performed. The cervix is well visualized both before and after liberal application of 3-5% acetic acid. A suspicious lesion is noted in the endocervical canal. The exocervix is completely normal. An endocervical curettage is done under direct colposcopic visualization.

Description of Pre-Service Work:
Pre-service work includes the following:

- review of patient's chart
- review of pap smear and other relevant reports
- obtain consent
- confirm that colposcopic instruments are present and functioning properly

Description of Intra-Service Work:
The cervix including upper/adjacent vagina is cleaned several times with 3% acetic acid. After adequate time for acetic acid effect the cervix and vagina fornices are examined with a colposcope at several magnifications. A suspicious lesion is noted in the endocervical canal. The exocervix is completely normal. An endocervical curettage is done under direct colposcopic visualization.

Description of Post-Service Work:
Post-service work includes the following:

- documentation of procedure
- instructions to patient for follow-up
- formulation of plan for follow-up treatment

SURVEY DATA:

Presenter(s): Michael Berman, MD, FACOG and Sandra Reed, MD, FACOG

Specialty(s): American College of Obstetricians and Gynecologists (ACOG) and Society of Gynecological Oncologists (SGO)

Sample Size: 750 Response Rate: (%): 6% (43 out of 750) Median RVW: 2.75

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: 750 surveys with cover letter were mailed to a targeted mailing list of gynecological oncologists and OB/GYN generalists.

25th Percentile RVW: 2.4 75th Percentile RVW: 3.4 Low: .75 High: 4.5

Median Pre-Service Time: 15 Median Intra-Service Time: 20

25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 20 Low: 8 High: 35

Median Post-Service Time: 10
Level of Service by CPT Code

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

CPT Code: 57456

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
58555	Hysteroscopy, diagnostic (separate procedure)	0	3.33

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including 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:**
Median Pre-Time	15	30
Median Intra-Time	20	25
Median Immediate Post-service Time	10	20
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 Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3	2.65
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.76	2.70
Urgency of medical decision making	2.64	2.49

Technical Skill/Physical Effort (Mean)

Technical skill required	3.36	2.70
Physical effort required	2.76	2.47

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.60	2.40
Outcome depends on the skill and judgment of physician	3.24	2.63
Estimated risk of malpractice suit with poor outcome	2.93	2.57

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.2	2.9
Intra-Service intensity/complexity	2.9	2.8
Post-Service intensity/complexity	2.9	3.0

ADDITIONAL RATIONALE

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

SURVEY METHOD

The American College of Obstetricians and Gynecologists (ACOG) in collaboration with the Society of Gynecological Oncologists (SGO) disseminated the RUC survey to a targeted national mailing list of 750 gynecological oncologists and OB/GYN generalists. The survey was mailed 1st class via the USPS. Forty-three surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG and SGO reviewed the results and drafted the final recommendations.

PANEL DISCUSSION

The panel felt that this code naturally lent itself to using the building block approach as a method for developing an RVW recommendation.

The results of the building block approach are described below. The value of 2.00 RVW was used for the base code. The value of the base code was discussed in the recommendation for 57452.

2.0- RVW (CPT code 57452, Colposcopy of the cervix including upper/adjacent vagina)
+
(.5) 1.14 RVW (CPT Code 57505, Endocervical curettage)
- .45 RVW (CPT code 99212)
=
2.12 RVW

- The panel compared the 25th percentile RVW survey value of 2.40 RVW to the value obtained from using the building block approach.

  Building Block = 2.12 RVW
  Survey = 2.40 RVW

The panel felt the comparison validated the building block method and they supported the recommendation of 2.12 RVW for 57456.

FREQUENCY INFORMATION

How was this service previously reported? 57454 (if unlisted code, please ensure that the Medicare frequenc 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: ACOG _____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: ACOG 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: ACOG Frequency: 2000

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

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 57460 Tracking Number: AZ9 Global Period: 0 **Recommended RVW: ~~2.80~~**
RUC Recommendation: 2.8

CPT Descriptor: Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) the cervix

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
A 25-year old woman with an abnormal Pap smear is advised to undergo colposcopic visualization of the cervix. She is advised that a biopsy will be obtained if a lesion is visualized.

Description of Pre-Service Work:
Pre-service work includes the following:

- review of patient's chart
- review of pap smear and other relevant reports
- obtain consent
- confirm that colposcopic instruments are present and functioning properly

Description of Intra-Service Work:
The cervix including upper/adjacent vagina is cleaned several times with 3% acetic acid. After adequate time for acetic acid effect the cervix and vagina fornices are examined with a colposcope at several magnifications. A suspicious lesion is noted in the endocervical canal. The exocervix is completely normal. An endocervical curettage is done under direct colposcopic visualization.

Description of Post-Service Work:
Post-service work includes the following:

- documentation of procedure
- instructions to patient for follow-up
- precautions against bleeding
- review of pathology report
- formulation of plan for follow-up treatment

SURVEY DATA:

Presenter(s): Michael Berman, MD, FACOG and Sandra Reed, MD, FACOG

Specialty(s): American College of Obstetricians and Gynecologists (ACOG) and Society of Gynecological Oncologists (SGO)

Sample Size: 750 Response Rate: (%): 6% (42 out of 750) Median RVW: 3.5

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: 750 surveys with cover letter were mailed to a targeted mailing list of gynecological oncologists and OB/GYN generalists.

25th Percentile RVW: 2.8 75th Percentile RVW: 4.0 Low: 1.75 High: 6.00

Median Pre-Service Time: 15 Median Intra-Service Time: 25

25th Percentile Intra-Svc Time: 20 75th Percentile Intra-Svc Time: 30 Low: 10 High: 45

Median Post-Service Time: 10

Level of Service by CPT Code

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

CPT Code: 57460

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
58555	Hysteroscopy, diagnostic (separate procedure)	0	3.33

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including 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:**
Median Pre-Time	15	30
Median Intra-Time	25	25
Median Immediate Post-service Time	10	20
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 Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.95	2.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.78	2.73
Urgency of medical decision making	2.65	2.51

Technical Skill/Physical Effort (Mean)

Technical skill required	3.41	2.88
Physical effort required	2.98	2.59

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.83	2.68
Outcome depends on the skill and judgment of physician	3.29	2.93
Estimated risk of malpractice suit with poor outcome	3.10	2.80

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.1	2.9
Intra-Service intensity/complexity	3.4	2.9
Post-Service intensity/complexity	3.1	2.9

ADDITIONAL RATIONALE

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

SURVEY METHOD

The American College of Obstetricians and Gynecologists (ACOG) in collaboration with the Society of Gynecological Oncologists (SGO) disseminated the RUC survey to a targeted national mailing list of 750 gynecological oncologists and OB/GYN generalists. The survey was mailed 1st class via the USPS. Forty-two surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG and SGO reviewed the results and drafted the final recommendations.

PANEL DISCUSSION

The panel agreed to recommend the 25th percentile RVW survey value for 57460. They came to this conclusion using a modified building block method. The panel compared 57461 to 57460.

57461 includes:
CPT code 57452
+
CPT code 57522

- excising portions of the exocervix
- excising portions of the endocervix

57460 includes:
CPT code 57452
+
\-

- excising portions of the exocervix

The panel compared the 25th percentile RVW survey value of the two codes:
57461 = 3.50 RVW
57460 = 2.80 RVW

The panel agreed that the difference in work between the two codes was fairly valued at .70 RVW. The panel recommended the value of 2.80 RVW for 57460.

FREQUENCY INFORMATION

How was this service previously reported? 57460 (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: ACOG ____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: ACOG Frequency: 12,000

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

Specialty: ACOG Frequency: 2000

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 57461 Tracking Number: AZ10 Global Period: 0 **Recommended RVW: ~~3.01~~**
RUC Recommendation: 3.44

CPT Descriptor: Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
A 31-year old female patient previously underwent a colposcopic evaluation following a Class IV Pap smear. She was found to have CIN III, extending into the endocervix, confirmed by biopsy and endocervical curettage. Acetic acid is applied to the cervix. After 3-4 minutes the cervix is visualized with the colposcope. A teflon coated speculum is hooked up to suction. A grounding pad is placed. The cervix is infiltrated from 1-12 o'clock with lidocaine. Using a loop electrode a conization is performed. A second smaller loop is then used to excise the entire endocervical canal. At the conclusion of the excision, a curette is used to sample the upper boundary of the excision to assure complete removal of the dysplasia.

Description of Pre-Service Work:
Pre-service work includes the following:

- review of patient's chart
- review of pap smear and related reports
- obtain consent
- confirm that colposcopic instruments are present and functioning properly

Description of Intra-Service Work:

The cervix is cleansed several times with 3% acetic acid. After adequate time for acetic acid effect, the cervix and vaginal fornices are examined with the colposcope at several magnifications. The size of the lesion is determined. A grounding pad is placed. A teflon coated speculum is hooked up to suction. The cervix is infiltrated from 1-12 o'clock with lidocain. An appropriate-sized loop electrode is then used to ensure excision of the lesion on the ectocervix with adequate margins. A second loop is then utilized to remove the involved portion of the endocervix. Homeostasis is achieved with electrocautery and topical Monsel's solution.

Description of Post-Service Work:
Post-service work includes the following:

- documentation of procedure
- instructions to patient for follow-up
- precautions against bleeding
- review of pathology report
- formulation of plan for follow-up treatment

SURVEY DATA:

Presenter(s): Michael Berman, MD, FACOG and Sandra Reed, MD, FACOG

Specialty(s): American College of Obstetricians and Gynecologists (ACOG) and Society of Gynecological Oncologists (SGO)

Sample Size: 750 Response Rate: (%): 6% (45 out of 750) Median RVW: 4.00

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: 750 surveys with cover letter were mailed to a targeted mailing list of gynecological oncologists and OB/GYN generalists.

25th Percentile RVW: 3.50 75th Percentile RVW: 4.15 Low: 2.40 High: 6.00

Median Pre-Service Time: 15 Median Intra-Service Time: 28

25th Percentile Intra-Svc Time: 25 75th Percentile Intra-Svc Time: 35 Low: 12 High: 45

Median Post-Service Time: 15

Level of Service by CPT Code

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

CPT Code: 57461

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
58555	Hysteroscopy, diagnostic (separate procedure)	0	3.33

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including 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:**
Median Pre-Time	15	30
Median Intra-Time	28	25
Median Immediate Post-service Time	15	20
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 Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.02	2.84
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.89	2.82
Urgency of medical decision making	2.81	2.69

Technical Skill/Physical Effort (Mean)

Technical skill required	3.54	3.09
Physical effort required	3.01	2.71

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.20	2.87
Outcome depends on the skill and judgment of physician	3.42	3.09
Estimated risk of malpractice suit with poor outcome	3.24	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.8	2.9
Intra-Service intensity/complexity	3.9	3.1
Post-Service intensity/complexity	3.3	3.0

ADDITIONAL RATIONALE

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

SURVEY METHOD

The American College of Obstetricians and Gynecologists (ACOG) in collaboration with the Society of Gynecological Oncologists (SGO) disseminated the RUC survey to a targeted national mailing list of 750 gynecological oncologists and OB/GYN generalists. The survey was mailed 1st class via the USPS. Forty-five surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG and SGO reviewed the results and drafted the final recommendations.

PANEL DISCUSSION

The panel felt that this code naturally lent itself to using the building block approach as a method for developing an RVW recommendation.

The results of the building block approach are described below. The value of 2.00 RVW was used for the base code. The value of the base code was discussed in the recommendation for 57452.

2.0- RVW (CPT code 57452, Colposcopy of the cervix including upper/adjacent vagina)
+
(.5) 3.36 RVW (CPT Code 57522, Conization of the cervix, with or without dilation and curettage, with or without repair; loop electrode excision)
- .67 RVW (CPT code 99213)
=
3.01 RVW

The panel compared the 25th percentile RVW survey value of 2.80 RVW to the value obtained from using the building block approach.

Building Block = 3.01 RVW
Survey = 2.8 RVW

The panel felt the comparison validated the building block method and they supported the recommendation of 3.01 for 57461.

FREQUENCY INFORMATION

How was this service previously reported? 57460 (if unlisted code, please ensure that the Medicare frequen 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: ACOG ____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: ACOG 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: ACOG Frequency: 2000

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

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		FAMILY 1							
		CPT Code - 56820		CPT Code - 56821		CPT Code -57420		CPT Code - 57421	
	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Code Descriptor - Colposcopy of the vulva		Code Descriptor - Colposcopy of the vulva; with biopsy(s)		Code Descriptor - Colposcopy of the entire vagina, with cervix if present		Code Descriptor - Colposcopy of the entire vagina, with cervix if present; with biopsy(s)	
LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office
GLOBAL PERIOD		0	0	0	0	0	0	0	0
TOTAL CLINICAL LABOR TIME		57	11	64	11	57	11	64	11
PRE-SERVICE									
Start: Following visit when decision for surgery or procedure made									
Complete pre-service diagnostic & referral forms		0	0	0	0	0	0	0	0
Coordinate pre-surgery services		0	0	0	0	0	0	0	0
Office visit before surgery/procedure: Review test and exam results		4	4	4	4	4	4	4	4
Provide pre-service education/obtain consent		7	7	7	7	7	7	7	7
Follow-up phone calls & prescriptions		0	0	0	0	0	0	0	0
Other Clinical Activity (please specify)		0	0	0	0	0	0	0	0
End:When patient enters office for surgery/procedure									
SERVICE PERIOD									
Start: When patient enters office for surgery/procedure									
Pre-service services									
Review charts		2	0	2	0	2	0	2	0
Greet patient and provide gowning		3	0	3	0	3	0	3	0
Obtain vital signs		5	0	5	0	5	0	5	0
Provide pre-service education/obtain consent		5	0	5	0	5	0	5	0
Prepare room, equipment,supplies		5	0	5	0	5	0	5	0
Prepare and position patient/ monitor patient/ set up IV		2	0	2	0	2	0	2	0
Sedate/apply anesthesia		0	0	0	0	0	0	0	0
Intra-service									
Assist physician in performing procedure		15	0	17	0	15	0	17	0
Post-Service									
Monitor pt. following service/check tubes, monitors, drains		0	0	2	0	0	0	2	0
Clean room/equipment by physician staff		4	0	4	0	4	0	4	0
Complete diagnostic forms, lab & X-ray requisitions		0	0	3	0	0	0	3	0
Review/read X-ray, lab, and pathology reports		0	0	0	0	0	0	0	0
Check dressings & wound/ home care instructions /coordinate office visits /prescriptions		5	0	5	0	5	0	5	0
Other Clinical Activity (please specify)		0	0	0	0	0	0	0	0
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 or outpatient care									
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									

		CPT Code - 56820		CPT Code - 56821		CPT Code -57420		CPT Code - 57421	
	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Code Descriptor - Colposcopy of the vulva		Code Descriptor - Colposcopy of the vulva; with biopsy(s)		Code Descriptor - Colposcopy of the entire vagina, with cervix if present		Code Descriptor - Colposcopy of the entire vagina, with cervix if present with biopsy(s)	
LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office
MEDICAL SUPPLIES									
Ob-Gyn in office procedure package (A+B)		1 item		1 item		1 item		1 item	
sterile gloves	14005	1 pair		1 pair		1 pair		1 pair	
drape sheet	11106	1 item		1 item		1 item		1 item	
acetic acid	53001	.0676 oz		.0676 oz		.0676 oz		.0676 oz	
betadine	52301			5 ml		5 ml		5 ml	
cotton tipped applicators	31103	2 items		2 items		2 items		2 items	
Monsel's solution	92029							2 ml	
needle, 18 to 24 gauge	91402			1 item				1 item	
needle, spinal	92016								
smoke evacuation cartridge									
silver nitrate stick	52304			2 items				2 items	
suction tubing	93606								
swab, alcohol	31101								
syringe, 10cc	91405			1 item				1 item	
Xylocaine 1%(20ml)	51503			10 units				10 units	
film, Polaroid	73406	1 exposure		1 exposure		1 exposure		1 exposure	
lugols staining solution	92017	2ml		2ml		2ml		2ml	
autoclave tape (1" x 1")	14009			.6667 yard				.6667 yard	
autoclave bags	14006			2 items				2 items	
loop electrode									
bovie spatula									
grounding pad	31713								
bovie pencil and cord									
extender									
oxford specimen jar	75076			1 item				1 item	1 item
needle, 30 gauge	91416			1 item				1 item	
punch biopsy				1 item					
Equipment									
Colposcope	E13401	29 min		29 min		29 min		29 min	
LEEP System	E13403								
smoke evacuation system									
Power table	E11003	29 min		29 min		29 min		29 min	
Fiberoptic exam light	E11006	29 min		29 min		29 min		29 min	
Digital camera	E51020	29 min		29 min		29 min		29 min	
Autoclave	E11003			29 min				29 min	

		CPT Code - 57452		CPT Code - 57454		CPT Code -574555		CPT Code - 57456	
	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Code Descriptor - Colposcopy of the cervix including upper/adjacent vagina		Code Descriptor - Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage		Code Descriptor - Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix		Code Descriptor - Colposcopy of the cervix including upper/adjacent vagina; with endocervical curettage	
LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office
GLOBAL PERIOD		0	0	0	0	0	0	0	0
TOTAL CLINICAL LABOR TIME		64	11	64	11	64	11	64	11
PRE-SERVICE									
Start: Following visit when decision for surgery or procedure made									
Complete pre-service diagnostic & referral forms		0	0	0	0	0	0	0	0
Coordinate pre-surgery services		0	0	0	0	0	0	0	0
Office visit before surgery/procedure· Review test and exam results		4	4	4	4	4	4	4	4
Provide pre-service education/obtain consent		7	7	7	7	7	7	7	7
Follow-up phone calls & prescriptions		0	0	0	0	0	0	0	0
Other Clinical Activity (please specify)		0	0	0	0	0	0	0	0
End:When patient enters office for surgery/procedure									
SERVICE PERIOD									
Start: When patient enters office for surgery/procedure									
Pre-service services									
Review charts		2	0	2	0	2	0	2	0
Greet patient and provide gowning		3	0	3	0	3	0	3	0
Obtain vital signs		5	0	5	0	5	0	5	0
Provide pre-service education/obtain consent		5	0	5	0	5	0	5	0
Prepare room, equipment,supplies		5	0	5	0	5	0	5	0
Prepare and position patient/ monitor patient/ set up IV		2	0	2	0	2	0	2	0
Sedate/apply anesthesia		0	0	0	0	0	0	0	0
Intra-service									
Assist physician in performing procedure		17	0	17	0	17	0	17	0
Post-Service									
Monitor pt. following service/check tubes, monitors, drains		2	0	2	0	2	0	2	0
Clean room/equipment by physician staff		4	0	4	0	4	0	4	0
Complete diagnostic forms, lab & X-ray requisitions		3	0	3	0	3	0	3	0
Review/read X-ray, lab, and pathology reports		0	0	0	0	0	0	0	0
Check dressings & wound/ home care instructions /coordinate office visits /prescriptions		5	0	5	0	5	0	5	0
Other Clinical Activity (please specify)		0	0	0	0	0	0	0	0
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 or outpatient care									
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									

		CPT Code - 57452		CPT Code - 57454		CPT Code -574555		CPT Code - 57456	
	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Code Descriptor - Colposcopy of the cervix including upper/adjacent vagina		Code Descriptor - Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage		Code Descriptor - Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix		Code Descriptor - Colposcopy of the cervix including upper/adjacent vagina; with endocervical curettage	
LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office
MEDICAL SUPPLIES									
Ob-Gyn in office procedure package (A+B)		1 item		1 item		1 item		1 item	
sterile gloves	14005	1 pair		1 pair		1 pair		1 pair	
drape sheet	11106	1 item		1 item		1 item		1 item	
acetic acid	53001	.0676 oz		.0676 oz		.0676 oz		.0676 oz	
betadine	52301								
cotton tipped applicators	31103	2 items		2 items		2 items		2 items	
Monsel's solution	92029					2 ml		2 ml	
needle, 18 to 24 gauge	91402								
needle, spinal	92016								
smoke evacuation cartridge									
silver nitrate stick	52304								
suction tubing	93606								
swab, alcohol	31101								
syringe, 10cc	91405								
Xylocaine 1%(20ml)	51503								
film, Polaroid	73406	1 exposure		1 exposure		1 exposure		1 exposure	
lugols staining solution	92017	2ml		2ml		2ml		2ml	
autoclave tape (1" x 1")	14009			.6667 yard		.6667 yard		.6667 yard	
autoclave bags	14006			2 items		2 items		2 items	
loop electrode									
bovie spatula									
grounding pad	31713								
bovie pencil and cord									
extender									
oxford specimen jar	75076			1 item	1 item	3 items	3 items	1 item	1 item
needle, 30 gauge	91416								
punch biopsy									
Equipment									
Colposcope	E13401	29 min		29 min		29 min		29 min	
LEEP System	E13403								
smoke evacuation system									
Power table	E11003	29 min		29 min		29 min		29 min	
Fiberoptic exam light	E11006	29 min		29 min		29 min		29 min	
Digital camera	E51020	29 min		29 min		29 min		29 min	
Autoclave	E11003			29 min		29 min		29 min	

		CPT Code - 57460		CPT Code - 57461		CPT Code		CPT Code	
	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Code Descriptor - Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix		Code Descriptor - Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix		Description		Description	
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		85	11	85	11				
PRE-SERVICE									
Start: Following visit when decision for surgery or procedure made									
Complete pre-service diagnostic & referral forms		0	0	0	0				
Coordinate pre-surgery services		0	0	0	0				
Office visit before surgery/procedure: Review test and exam results		4	4	4	4				
Provide pre-service education/obtain consent		7	7	7	7				
Follow-up phone calls & prescriptions		0	0	0	0				
Other Clinical Activity (please specify)		0	0	0	0				
End:When patient enters office for surgery/procedure									
SERVICE PERIOD									
Start: When patient enters office for surgery/procedure									
Pre-service services									
Review charts		2	0	2	0				
Greet patient and provide gowning		3	0	3	0				
Obtain vital signs		5	0	5	0				
Provide pre-service education/obtain consent		5	0	5	0				
Prepare room, equipment,supplies		10	0	10	0				
Prepare and position patient/ monitor patient/ set up IV		2	0	2	0				
Sedate/apply anesthesia		0	0	0	0				
Intra-service									
Assist physician in performing procedure		27	0	27	0				
Post-Service									
Monitor pt. following service/check tubes, monitors, drains		2	0	2	0				
Clean room/equipment by physician staff		10	0	10	0				
Complete diagnostic forms, lab & X-ray requisitions		3	0	3	0				
Review/read X-ray, lab, and pathology reports		0	0	0	0				
Check dressings & wound/ home care instructions /coordinate office visits /prescriptions		5	0	5	0				
Other Clinical Activity (please specify)		0	0	0	0				
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 or outpatient care									
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									

		CPT Code - 57460		CPT Code - 57461		CPT Code		CPT Code	
	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Code Descriptor - Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix		Code Descriptor - Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix		Description		Description	
LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office
MEDICAL SUPPLIES									
Ob-Gyn in office procedure package (A+B)		1 item		1 item					
sterile gloves	14005	2 pairs		2 pairs					
drape sheet	11106	1 item		1 item					
acetic acid	53001	20 ml	20 ml	20 ml	20 ml				
betadine	52301	5 ml		5 ml					
cotton tipped applicators	31103	6 items		6 items					
Monsel's solution	92029	2 ml		2 ml					
needle, 18 to 24 gauge	91402	1 item		1 item					
needle, spinal	92016	1 item		1 item					
smoke evacuation cartridge		1 item		1 item					
silver nitrate stick	52304	2 items		2 items					
suction tubing	93606	4 feet		4 feet					
swab, alcohol	31101	4 items		4 items					
syringe, 10cc	91405	1 item		1 item					
Xylocaine 1%(20ml)	51503	10 units		10 units					
film, Polaroid	73406	1 exposure		1 exposure					
lugols staining solution	92017	2 ml		2 ml					
autoclave tape (1" x 1")	14009	.667 yards		.667 yards					
autoclave bags	14006	2 items		2 items					
loop electrode		1 item		1 item					
bovie spatula		1 item		1 item					
grounding pad	31713	1 item		1 item					
bovie pencil and cord		1 item		1 item					
extender		1 item		1 item					
oxford specimen jar	75076	1 item	1 item	3 items	3 items				
needle, 30 gauge	91416								
punch biopsy									
Equipment									
Colposcope	E13401	27 min		27 min					
LEEP System	E13403	27 min		27 min					
smoke evacuation system		27 min		27 min					
Power table	E11003	27 min		27 min					
Fiberoptic exam light	E11006	27 min		27 min					
Digital camera	E51020	27 min		27 min					
Autoclave	E11003	27 min		27 min					

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Vaginal Hysterectomy/Myomectomy Procedures

Evidence indicates that the vaginal route of surgery for hysterectomies is associated with reduced complication rates, reduced pain, absence of external scars and a shorter hospital stay. Historically, an enlarged uterus (defined as a uterus over 250 grams) has commonly been considered a contraindication to vaginal hysterectomy and was often cited as justification for the abdominal, and more recently, the laproscopic approach. In recent years practitioners have developed improved techniques in dealing with the excision of the larger uterus vaginally. Techniques employed by physicians to remove the larger uterus vaginally include bisection, morcellation, myomectomy and coring when uterine mobility and access are adequate. These techniques are generally not necessary with a uterus less than 250 grams. Employing these techniques results in a modest increase in operative time. Therefore, these codes 58146 and 58290-94 were created to specifically describe vaginal hysterectomy/myomectomy procedures for enlarged uteri.

58146

The RUC evaluated code 58146 *Myomectomy, excision of fibroid tumor(s) of uterus, 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams, abdominal approach.* The specialty society's survey median RVU for this code was 19.00 and the survey 25th percentile was 16.00. The RUC noted that the building block approach with an IWPUT of 0.080 – 0.088 (depending on the IWPUT used for pre and post work) supported an RVU of 19.00. The specialty society provided several cross-walk reference codes. The RUC agreed that CPT code 58200 *Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube(s), with or without removal of ovary(s)* with the same intra-service time of 150 minutes and greater total RUC time (435 minutes versus 411 for 58146) further supported the value of 19.00. The RUC noted several other cross-walk codes (43631 *Gastrectomy, partial, distal; with gastroduodenostomy* (RVU = 22.59) which has a pre-service time of 75 minutes, and intra service time of 150 minutes and a post-service time of 30 minutes and 44140 *Colectomy, partial; with anastomosis* (RVU = 21.00) with a pre-service time of 90 minutes and intra-service time of 150 minutes and a post-service time of 40 minutes) with the same intra-service times, similar intensity of procedure and work RVUs in the range on 21.00 to 23.00. **The RUC recommends a work relative value of 19.00 for 58146.**

58290

The RUC examined the survey results for CPT code 58290 *Vaginal hysterectomy, for uteri greater than 250 grams;*. The RUC evaluated code 58290. The survey median was 19.5 and the 25th percentile was 17.5. The specialty society's proposal used the building block approach with an IWPUT of 0.11 to support the survey median recommendation. The specialty society representatives expounded on the difficulty and intensity of the procedure to support the IWPUT of 0.11. Members of the RUC were not convinced that an IWPUT of 0.11 was justified and evaluated three alternative methods of evaluating the value of 58290. Method #1: The reference code was 58260, *Vaginal hysterectomy* (RVU = 12.98) with 60 minutes intra service time. Taking the value of 58260 (12.98) and adding to it the value of 60 intra-service minutes at an IWPUT of 0.10 yielded a value of 18.98. Method #2: The RUC also looked at several add-on codes with intra-service times of 60 minutes and noted that 22216 *Osteotomy of spine, posterior or posterolateral approach, one vertebral segment; each additional vertebral segment (List separately in addition to primary procedure)* (RVU = 6.04) was a surrogate for the 60 minutes difference in intra-service time between 58290 and its reference code. Adding 6.04 to the value of the reference code yields 19.02. Method #3 Using the building block approach as outlined in the specialty society's proposal but substituting an IWPUT of 0.1 yields and RVU f 18.91. Thus, three methods yielded an RVU very close to the survey median of 19. **The RUC recommends a work relative value of 19.00 for 58290.**

58291-58294

The RUC then examined 58291 *Vaginal hysterectomy, for uteri greater than 250 grams; with removal of tube(s) and/ or ovary(s),* 58292 *Vaginal hysterectomy, for uteri greater than 250 grams; with removal of tube(s) and/or ovary(s) with repair of enterocele,* 58293 *Vaginal hysterectomy, for uteri greater than 250 grams; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type, with or without endoscopic control)* and 58294 *Vaginal hysterectomy, for uteri greater than 250 grams; vaginal hysterectomy, with repair of entercele.* The RUC decided that these codes should be valued in relation to 58290 using the same incremental values as already approved for the established hysterectomy codes (58260-58270). Below is a summary of the RUC's recommendation.

CPT Code	Descriptor	RVW	Difference with 58260	Survey Code	Recommendation
58260	Vaginal hysterectomy	12.98	-	58290	19.0
58262	Vaginal hysterectomy, with removal of tubes	14.77	1.79	58291	20.79
58263	Vaginal hysterectomy, with removal of tubes and/or ovary(s), with repair of enterocele	16.06	3.08	58292	22.08
58267	Vaginal hysterectomy with colpourethrocystopexy	17.04	4.06	58293	23.06
58270	Vaginal hysterectomy with repair of enterocele	14.26	1.28	58294	20.28

The RUC recommends a relative work value of 20.79 for 58291, 22.08 for 58292, 23.06 for 58293 and 20.28 for 58294.

Practice Expense

The RUC approved the practice expense inputs for 58146 and 58290-58294. The RUC recommends that the 90- day global period standard should apply for all of these codes. Since these codes are typically performed only in the facility setting the RUC recommends no PE in the office setting. **The RUC recommends all the practice expense inputs presented by the specialty society.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲58140	AC1	Myomectomy, excision, ~~of leiomyomata~~ fibroid tumor(s) of uterus, 1-4 intramural myomas weight of 250 grams or less, and/or removal of surface myomas ~~single or multiple (separate procedure)~~; abdominal approach	090	14.60 (no change)
▲58145	AC2	vaginal approach	090	8.04 (no change)
●58146	AC3	Myomectomy, excision of fibroid tumor(s) of uterus, 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams, abdominal approach (Do not report 58146 in addition to 58140 – 58145, 58150 – 58240)	090	19.00
▲58260	AC4	Vaginal hysterectomy; for a uterus, 250 grams or less;	090	12.98 (no change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲58262	AC5	with removal of tube(s) and/or ovary(s)	090	14.77 (no change)
▲58263	AC6	with removal of tube(s) and/or ovary(s), with repair of enterocele	090	16.06 (no change)
▲58267	AC7	with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type, with or without endoscopic control)	090	17.04 (no change)
▲58270	AC8	with repair of enterocele	090	14.26 (no change)
●58290	AC9	Vaginal hysterectomy, for uteri greater than 250 grams;	090	19.00
●58291	AC10	with removal of tube(s) and/or ovary(s)	090	20.79
●58292	AC11	with removal of tube(s) and/or ovary(s), with repair of enterocele	090	22.08
●58293	AC12	with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type, with or without endoscopic control)	090	23.06
●58294	AC13	vaginal hysterectomy; with repair of enterocele	090	20.28

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 58146 **Tracking Number:** AC3 **Global Period:** 090 **Recommended RVW:** 19

CPT Descriptor:
Myomectomy, excision of fibroid tumor(s) for uterus, 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams, abdominal approach

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
A 35 year-old nulligravid patient is evaluated for menorrhagia with anemia. She is recently married and is anxious to have children. On examination she is found to have a 16-week size fibroid uterus. Ultrasound confirms a 15cm uterus with multiple fibroids distorting the endometrium. Management options are discussed with her. The patient expresses a desire to keep fertility options open to her and keep her uterus. The patient elects a myomectomy. An abdominal myomectomy is performed.

Description of Pre-Service Work:
The pre-service work includes performing the pre-operative history and physical, dictating an admission history and physical and writing 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 taken to the OR and positioned on the operating table.

Description of Intra-Service Work:
Exam under anesthesia is performed. The patient is prepped and draped in a sterile fashion. A foley catheter is inserted into the bladder. A low transverse abdominal incision is made. This incision provides good exposure and allows good assistance and careful isolation of the tumors. A multi-arm self-retaining retractor is inserted. A rubber tourniquet is applied to the entire uterine mass. As the uterus is approached, the location and direction of the blood supply is assessed. The uterus is also assessed as to how to make as few incisions as possible. Pifressin is injected into the myometrium overlaying the fibroids. An incision is made on the uterus parallel with the course of the vascular bed.

Once the first myoma is exposed, it is grasped with a tenaculum. The myoma is dissected free from the surrounding myometrium using a combination of sharp and principally blunt dissections. The dissection is carried down to the pedicle that contains the main blood supply to the myoma. The pedicle is isolated and clamped before the myoma is removed. The patient is found to have eight myomas ranging from 4cm to 6cm in size. Multiple uterine incisions are utilized to remove all of the intramural fibroids. The physician then repairs the multiple uterine incisions that were made during the procedure. Each uterine incision is closed in layers to obtain hemostasis and preserve the anatomic relationship. The tourniquet is removed. The uterus is observed during reperfusion and additional sutures are placed in each incision to assure complete hemostasis.

The physician then closes the layers of the abdominal incision.

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 is evaluated and stabilized. The patient and her family are counseled about the results of the procedure. She is monitored for three days in the hospital. The patient is followed on an ambulatory basis with approximately two office visits during the 90-day global period.

SURVEY DATA:

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

Specialty(s): American College of Obstetricians and Gynecologists (ACOG)

Sample Size: 371 Response Rate: (%): 13% (50 out of 371) Median RVW: 19.00

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

Explanation of sample size: 371 surveys with cover letter were mailed to a targeted mailing list of reproductive surgeons.

25th Percentile RVW: 16.00 75th Percentile RVW: 21.95 Low: 14.60 High: 28.50

Median Pre-Service Time: 70 min Median Intra-Service Time: 150 min

25th Percentile Intra-Svc Time: 120 min 75th Percentile Intra-Svc Time: 180min
Low: 45 min High: 210 min

Median Post-Service Time: 30min

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	30 min	
Critical Care:	0 min	
Other Hospital Visits:	79 min	(1-99233, 2-99231)
Discharge Day Mgmt:	36 min	(1-99238)
Office Visits:	46 min	(2-99213)

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
58140	Myomectomy, excision of leiomyomata of uterus, single or multiple (separate procedure); abdominal approach	090	14.60

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 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:
Median Pre-Time	70 min	60 min
Median Intra-Time	150 min	120 min
Median Immediate Post-service Time	30 min	30 min
Median of Aggregate Critical Care Times	0 min	0 min
Median of Aggregate Other Hospital Visit Times	79 min	68 min
Median Discharge Day Management Time	36 min	36 min
Median of Aggregate Office Visit Times	46 min	46 min

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	4.06	3.42
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.86	3.45
Urgency of medical decision making	3.88	3.18

Technical Skill/Physical Effort (Mean)

Technical skill required	4.68	3.68
Physical effort required	4.24	3.52

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.08	3.58
Outcome depends on the skill and judgement of physician	4.64	3.96

Estimated risk of malpractice suit with poor outcome	3.78	3.55

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.79	3.55
Intra-Service intensity/complexity	4.51	3.64
Post-Service intensity/complexity	3.4	3.00

ADDITIONAL RATIONALE

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

SURVEY METHOD

The American College of Obstetricians and Gynecologists (ACOG) in collaboration with the American Society for Reproductive Medicine (ASRM) disseminated the RUC survey to a targeted national mailing list of 371 reproductive surgeons. The survey was mailed 1st class via the USPS. Fifty surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG and ASRM reviewed the results and drafted the final recommendations.

PANEL DISCUSSION

The panel developed the recommendation in the following manner:

1. Reviewing the survey data
2. Comparing the surveyed code (58146) with the reference code (58140)
3. Comparing the surveyed code with other related codes

Survey Data – ACOG received fifty completed surveys. The median RVW from the data was 19.00. The panel tested the validity of the median surveyed RVW using the building block approach. Applying the formula to the surveyed code resulted in an IWPUT of .08. The panel concluded that .08 was an appropriate value for this level of service.

19 - {.027(70min) + .027(30 min + 79 min +36 min + 46 min)} /150 min = .08 IWPUT

Reference code 58140 – Next the panel compared the surveyed code (58146) with the reference code (58140). The most significant difference in survey data between the two codes was intra-service time. 58146 surveyed at 150-min intra-service time while current RUC data is 120 min intra-service time for 58140. The panel was in an agreement that although these were both abdominal myomectomy procedures these were very different operations and comparing these two procedures by time alone did not provide a complete picture of the differences between these two procedures.

For 58146, the increased risk to the patient, the greater number of incisions made, the skill level and experience demanded from the physician for this procedure, the type of fibroids being rem (intramural versus sub serosal), the complex uterine reconstruction and the much larger volur fibroids removed make this a more intense procedure than 58140. Taking these factors into account the 150 minutes for 58146 is significantly different and much more intense than the 120 minutes for 58140.

Applying the building block approach to determine the IWPUT for 58140 results in an intra-service intensity of .06. The panel felt that the higher intensity for the surveyed code was reasonable due to the factors listed above.

Other related codes: – The panel also looked at the work unit values of related codes to see if the recommendation for the surveyed code fell into line with related codes.

RELATED 90-DAY GLOBAL CODES

CPT Code	RVW	INTRA-SERVICE TIME	TOTAL TIME
58146	19	150	411
58200	21.59	150	435
35661	19	120	424
35650	19	110	355

When comparing the surveyed code to these related codes the recommendation of 19 RVW seemed to be an appropriate and fair recommendation.

The panel supports the recommendation of 19 RVW for 58146.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) CPT code 58140

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 College of Obstetricians and Gynecologists (ACOG) ____Commonly
____Sometimes X Rarely

Specialty: American Society of Reproductive Medicine Specialists (ASRM) ____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: ACOG Frequency: 0

Specialty: ASRM Frequency: Less than 1% of all myomectomies performed

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: ACOG Frequency: 0

Specialty: ASRM Frequency: 0

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

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 58290 Tracking Number: AC9 Global Period: 090 **Recommended RVW:~~19.5~~**
RUC recommendation: 19.0

CPT Descriptor:
Vaginal hysterectomy, for uterus greater than 250 grams;

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
A 45 year-old G1P1 is evaluated for profound menorrhagia with anemia. Her hematocrit is 25% despite daily iron therapy and treatment of oral contraceptives. On physical examination she has an irregular, mobile 14-week size fibroid uterus. Ultrasound confirms multiple uterine fibroids, several of which impinge on the endometrium. After management options are discussed with her, the patient elects hysterectomy. A vaginal hysterectomy is performed.

Description of Pre-Service Work:
The pre-service work includes dictating an admission history and physical and writing the admission orders. The patient is scheduled for a longer than usual operative time. The physician confirms that experienced assistants are scheduled for the procedure and that the necessary additional instruments are available.

The patient is greeted in the pre-operative holding area with appropriate consents verified or taken. All pre-operative laboratory and x-ray studies are reviewed. The patient is positioned, with her legs in lithotomy poles and her hips well abducted.

Description of Intra-Service Work:
As soon as the patient is under anesthesia, a careful bimanual pelvic examination is conducted. Through this examination it is determined that:

- the uterus is clearly mobile,
- there is surgical accessibility to the lower uterine segment and
- the size and configuration of the uterine fibroids are determined

All of these factors indicate that although it is an enlarged uterus, the conditions are favorable for it to be removed transvaginally.

Since the uterine size greatly limits the surgeon, s/he focuses on reducing the uterine size intra-operatively to facilitate the vaginal hysterectomy. Once the pelvic examination is complete, the cervix is grasped by tenaculums bilaterally. A circumferential incision is made at the junction of the vagina and cervix so that the vagina could be reflected upwards, thereby freeing the attachments of the bladder to the uterus. The anterior and posterior culde sacs are entered. The uterosacral, cardinal and broad ligaments are bilaterally clamped, cut and ligated. The uterus is bisected in antero-posterior direction with a knife with progressive reposition of tenaculums till the fundus is reached and pedicles clamped. Bisection assists in reducing the tension on the infundibulopelvic ligament. This allows the descent of the uterus and it also helps in removal of myomas during the course thus reducing the bulk of the uterus. Once the uterine fundus can be delivered into the vagina, it is removed in multiple separate pieces.

All procedures are now complete. All pedicles are carefully inspected to assure hemostasis. The peritoneum and vaginal cuff are closed.

Description of Post-Service Work:
The patient is accompanied to the recovery room where post-operative orders are written and the operative report is dictated. The patient is evaluated and stabilized. The patient and her family are counseled about the results of the procedure. Typically, these patients are monitored for three days in the hospital. The patient is followed on an ambulatory basis with approximately two office visits during the 90-day global period.

SURVEY DATA:

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

Specialty(s): American College of Obstetricians and Gynecologists (ACOG)

Sample Size: 262 Response Rate: (%):11% (30 out of 262) Median RVW: 19.5

Type of Sample (Circle One): random, panel, **convenience.** Explanation of sample size: 262 surveys with a cover letter were mailed to a targeted mailing list of gynecological surgical specialists.

25th Percentile RVW: 17.5 75th Percentile RVW: 20.5 Low: 14.5 High: 30.48

Median Pre-Service Time: 75 min Median Intra-Service Time: 120 min

25th Percentile Intra-Svc Time: 100 min 75th Percentile Intra-Svc Time: 135 min
Low: 60 min High: 210 min

Median Post-Service Time: 30 min

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	30 min	
Critical Care:	0 min	
Other Hospital Visits:	60 min	2-99232
Discharge Day Mgmt.:	36 min	1-99238
Office Visits:	46 min	2-99213

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
58260	Vaginal hysterectomy	090	12.98

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:**
Median Pre-Time	75	60
Median Intra-Time	120	60
Median Immediate Post-service Time	30	30
Median of Aggregate Critical Care Times	0	0
Median of Aggregate Other Hospital Visit Times	60	49
Median Discharge Day Management Time	36	36
Median of Aggregate Office Visit Times	46	61

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	3.92	3.24
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.62	3.12
Urgency of medical decision making	3.54	3.08

Technical Skill/Physical Effort (Mean)

Technical skill required	4.85	3.68
Physical effort required	4.73	3.56

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.35	3.4
Outcome depends on the skill and judgment of physician	4.65	3.84

Estimated risk of malpractice suit with poor outcome	4.54	3.88

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.52	3.24
Intra-Service intensity/complexity	4.84	3.95
Post-Service intensity/complexity	3.17	3.00

ADDITIONAL RATIONALE

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

SURVEY METHOD

The American College of Obstetricians and Gynecologists (ACOG) disseminated the RUC survey to a targeted national mailing list of 262 gynecological surgeons. The survey was mailed 1st class via the USPS. Thirty surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG, which included gynecological surgeons, reviewed the results and drafted the final recommendations.

PANEL DISCUSSION

The panel developed the recommendation in the following manner:

1. Reviewing the survey data
2. Comparing the surveyed code (58290) with the reference code (58260)
3. Comparing the surveyed code with other related codes

Survey Data – ACOG received thirty completed surveys. The median RVW from the data was 19.5. The panel tested the validity of the median surveyed RVW using the building block approach. Applying the formula to the surveyed code resulted in an IWPUT of .11. The panel concluded that certain types of procedures tend to be higher intensity in comparison to abdominal procedures, which have a generally accepted IWPUT of .08. Vaginal and vascular procedures are two examples of such types of procedures. They do not have the reduced intensity times during opening and closing, as do abdominal surgeries. With these factors in mind, the panel was comfortable with an IWPUT of .11.

58146 - IWPUT Calculation
19.5 – {.027(75) + .027 (30 + 60 +36 + 45)} / 120 = .11

Example of vascular procedure – Laser destruction of vascular skin lesion (90-day global, 20 min intra-service time)
17106 – IWPUT Calculation
4.54 – {.027(20) + .027(30)} / 20 = .16

Reference code 58260 – Next the panel compared the surveyed code (58290) with the reference code (58260). In general, the surveyed code had higher values throughout the survey. This made sense to the panel.

The higher numbers in mental effort and judgment

- only a small number of ob/gyns do this procedure that requires a much higher level of skill and expertise than does 58260

The higher numbers in pre-service time

- physician need to counsel patient that they may need to convert to an abdominal approach
- physician needs to ensure that all equipment for both a vaginal and abdominal approach are available

The higher numbers in intra-service time

- the patient may start bleeding which can increase work techniques employed by physicians to remove the larger uterus vaginally include
    - bisection
    - morcellation
    - myomectomy
    - coring when uterine mobility and access are adequate
- these techniques are not needed for the removal of a smaller uterus
- visibility is limited due to the uterine size, creating increased difficulty in achieving hemostasis

Related Codes – The panel also looked at the work unit values of related codes to see if the recommendation for the surveyed code fell into line with related codes.

RELATED 90-DAY GLOBAL CODES

CPT Code	RVW	INTRA-SERVICE TIME	TOTAL TIME
58290	19.5	120 min	366 min
58152	20.6	113 min	309 min (Harvard data)
31584	19.64	118	339 (Harvard data)

When comparing the surveyed code to these related codes the recommendation of 19.5 RVW seeme be an appropriate and fair recommendation.

The panel supports the recommendation of 19.5 WRVU for 58290.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) CPT code 58260

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

Specialty: ACOG ____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: ACOG Frequency: less than 1% of the frequency for CPT code 58260

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

Specialty ACOG Frequency: 0*

*** Fibroids this large occur pre-menopausal. In instances when they do occur post-menopausal it is an indication of cancer and the procedure is done abdominally.**

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
Out-Of-Office Direct Inputs

Sample Size:_50_____ Response Rate: (%):__13%____ Global Period:__90___

Tracking Number:____AC3_____ Reference Code 1__58140_____ Reference Code 2_____

Geographic Practice Setting %: Rural__2%__ Suburban__40%___ Urban_58%____

Type of Practice %: __38%___Solo Practice
___40%__Single Specialty Group
___5%__Multispecialty Group
___13%__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 College of Obstetricians and Gynecologists (ACOG) in collaboration with the American Society of Reproductive Medicine (ASRM) disseminated the RUC survey to a targeted national mailing list of 371 reproductive specialists. The survey was mailed 1st class via the USPS. Fifty surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG and ASRM reviewed the results and draf e final recommendations.

These recommendations are consistent with PEAC approved clinical staff time standards for 90-day global procedures and post-op E&M visits.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

During the pre-service the clinical staff completes pre-service diagnostic and referral forms, coordinates pre-surgery services and schedules space and equipment in the facility. In addition, staff provides pre-service education and obtains consent and conducts follow-up phone calls and prescriptions.

Intra-Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities:
Staff assists with the office 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 min	12 min			2	72 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. 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)
	ACOG PEAC-approved supply package A	2		
	ACOG PEAC-approvedsupply package B	2		
	ACOG PEAC-approved supply package C	1		
11106	Drape sheet	1		

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

HCFA's Equipment Code*	Medical Equipment	Minutes of use per procedure	Cost Estimate and Source (if applicable)
E1101	Exam table	72	

From HCFA's Labor, Medical Supply, and Equipment List. 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 **RN/LPN/MA**
Coordinate pre-surgery services	20	RN, LPN, MA, Other **RN/LPN/MA**
Schedule space and equipment in facility	8	RN, LPN, MA, Other **RN/LPN/MA**
Office visit before surgery/procedure Review test and exam results	0	RN, LPN, MA, Other **RN/LPN/MA**
Provide pre-service education/obtain consent	20	RN, LPN, MA, Other **RN/LPN/MA**
Follow-up phone calls & prescriptions	7	RN, LPN, MA, Other **RN/LPN/MA**
Other Activity (please specify) _____	_____	RN, LPN, MA, Other **RN/LPN/MA**
End: When patient enters hospital for surgery/procedure		
Service Period *Start: Patient admitted to hospital for surgery/procedure* *Pre-service services*		
Review charts	_____	RN, LPN, MA, Other _____
Greet patient and provide gowning	_____	RN, LPN, MA, Other _____
Obtain vital signs	_____	RN, LPN, MA, Other _____
Provide pre-service education/obtain consent	_____	RN, LPN, MA, Other _____
Prepare room, equipment, supplies	_____	RN, LPN, MA, Other _____
Prepare and position patient/ monitor patient/ set up IV	_____	RN, LPN, MA, Other _____
Sedate/apply anesthesia	_____	RN, LPN, MA, Other _____
Intra-service		
Assist physician in performing surgery/procedure	_____	RN, LPN, MA, Other _____

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	0	
Total Number of hospital visits	3 (1-99233, 2-99231)	RN/LPN/MA
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	12 min (1-99238)	RN, LPN, MA, Other RN/LPN/MA
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	A 36 min	RN, LPN, MA, Other _____
List total number of office visits	B 2	
Total office visit time (A * B)	72 min	
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 Update Process
RUC Summary of Recommendation
010 or 090 Day Global Periods
Out-Of-Office Direct Inputs

Sample Size:_30_____ Response Rate: (%):__11%____ Global Period:__90___

Tracking Number:____AC5_____ Reference Code 1__58260_____ Reference Code 2_____

Geographic Practice Setting %: Rural__0%__ Suburban__30%___ Urban_70%____

Type of Practice %: __19%___Solo Practice
___24%__Single Specialty Group
___10%__Multispecialty Group
___47%__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 College of Obstetricians and Gynecologists (ACOG) disseminated the RUC survey to a targeted national mailing list of 262 gynelogical surgical specialists. The survey was mailed 1st class via the USPS. Fifty surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG reviewed the results and drafted the final recommendations.

These recommendations are consistent with PEAC approved clinical staff time standards for 90-day global procedures and post-op E&M visits.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

During the pre-service the clinical staff completes pre-service diagnostic and referral forms, coordinates pre-surgery services and schedules space and equipment in the facility. In addition, staff provides pre-service education and obtains consent and conducts follow-up phone calls and prescriptions.

Intra-Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities:
Staff assists with the office 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 min	12 min			2	72 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. 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)
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	ACOG PEAC-approvedsupply package B	2		
	ACOG PEAC-approved supply package C	1		
11106	Drape sheet	1		

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

HCFA's Equipment Code*	Medical Equipment	Minutes of use per procedure	Cost Estimate and Source (if applicable)
E1101	Exam table	72	

* From HCFA's Labor, Medical Supply, and Equipment List. 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 **RN/LPN/MA**
Coordinate pre-surgery services	20	RN, LPN, MA, Other **RN/LPN/MA**
Schedule space and equipment in facility	8	RN, LPN, MA, Other **RN/LPN/MA**
Office visit before surgery/procedure Review test and exam results	0	RN, LPN, MA, Other **RN/LPN/MA**
Provide pre-service education/obtain consent	20	RN, LPN, MA, Other **RN/LPN/MA**
Follow-up phone calls & prescriptions	7	RN, LPN, MA, Other **RN/LPN/MA**
Other Activity (please specify) _____	_____	RN, LPN, MA, Other **RN/LPN/MA**
End: When patient enters hospital for surgery/procedure		
Service Period *Start: Patient admitted to hospital for surgery/procedure* *Pre-service services*		
Review charts	_____	RN, LPN, MA, Other _____
Greet patient and provide gowning	_____	RN, LPN, MA, Other _____
Obtain vital signs	_____	RN, LPN, MA, Other _____
Provide pre-service education/obtain consent	_____	RN, LPN, MA, Other _____
Prepare room, equipment, supplies	_____	RN, LPN, MA, Other _____
Prepare and position patient/ monitor patient/ set up IV	_____	RN, LPN, MA, Other _____
Sedate/apply anesthesia	_____	RN, LPN, MA, Other _____
Intra-service		
Assist physician in performing surgery/procedure	_____	RN, LPN, MA, Other _____

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	0	
Total Number of hospital visits	2 (2-99232)	RN/LPN/MA
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	12 min (1-99238)	RN, LPN, MA, Other RN/LPN/MA
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	A 36 min	RN, LPN, MA, Other _____
List total number of office visits	B 2	
Total office visit time (A * B)	72 min	
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

April 2002 and February 2003

Laproscopic Hysterectomy/Myomectomy Procedures

Interim Recommendation from April 2002 Meeting:

New codes 58545, 58546, 58550, and 58552-58554 were created to specifically describe vaginal hysterectomy/myomectomy procedures performed on enlarged uteri.

At the April 2002 meeting, the specialty society stated that they would need to re-survey these codes, as the correct global period for these services should be 90 days not 10 days as stated on their survey instrument. The specialty society presented survey data at the February 2003 RUC meeting. In the interim, the RUC recommended that these laproscopic codes be valued equivalent to the recommended relative work values of the open approach hysterectomy codes as follows:

New Code	Tracking Number	Crosswalk to Code	Work RVU (Interim 2003)
58545	BA1	58140	14.60
58546	BA2	58146	19.00
58550	BA3	58550 (old code number 56308)	14.19 (no change)
58552	BA4	58550 (old code number 56308)	14.19
58553	BA5	58290	19.00
58554	BA6	58290	19.00

58550 and 58552 both compared to 58550 *Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)* (RVU = 14.19) because there is no difference in the work of removing the tube or ovaries in the laproscopic approach. The same applies to 58553 and 58554 where both are crosswalked to

58290 *Vaginal hysterectomy, for uteri greater than 250 grams* (recommended RVU 19.00). Therefore, the RUC recommended interim 2003 work relative values of 14.60 for 58545, 19.00 for 58546, 14.19 for 58550 and 58552, 19.00 for 58553 and 58554.

RUC Recommendations from the February 2003 Meeting:

At the February 2003 meeting, the specialty society presented survey data for all 6 codes. For all codes, the specialty society determined that a 090-day global period should be used for the survey. The RUC expressed concern that the pre-service time of 90 minutes for all six of these procedures is too high and suggested that it be reduced to 60 minutes to be consistent with other major surgical procedures. The specialty society agreed to modify its recommendation of pre-service time to 60 minutes for all six codes. The RUC also discussed the issue of work neutrality for these codes, as the new codes are derived from existing services. The RUC agreed with the specialty that the new codes described new techniques that were not previously performed under the existing codes. In addition, these services would not likely be provided to Medicare patients.

New CPT Codes 58545 *Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; excision of 1-4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas* and 58546, *Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams* replace deleted CPT code 58551 *Laparoscopy, surgical; with removal of leiomyomata (single or multiple)* (work value = 14.21). Old CPT code 58551 was previously assigned a global of 010, while the new CPT codes are assigned a 090 day global. The specialty society had presented a median survey result of 14.86 and an IWPUT comparison to reference code 58140 *Myomectomy, excision of leiomyomata of uterus, single or multiple (separate procedure); abdominal approach* (14.60 RVU). However, the RUC did not agree that the work described in 58545 differed than the work described in the existing code, 58551 (14.21). The RUC recommends the 25th percentile of the survey median of 14.21. **The RUC recommends work relative values of 14.21 for code 58545.**

The RUC had previously recommended an interim value of 19.00 for new CPT code 58546, utilizing 58146 *Myomectomy, excision of fibroid tumor(s) of uterus, 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams, abdominal approach* (work value = 19.00) as a crosswalk. The specialty society then conducted a survey, which also resulted in a survey median of 19.00. The specialty society's survey indicated more intra-service time for the laparoscopic approach (180 vs. 150 minutes), but a lower amount of hospital visit time (30 vs. 79 minutes). The RUC agreed that the open approach remained an appropriate crosswalk and recommends 19.00 for 58546. The specialty clarified that the post-surgical office visits should be revised from one 99214 visit and one 99212 visit to two 99213 visits. The RUC's comments on the work neutrality above apply to this service. It was also noted that the

services now described by 58546 had previously been performed as open procedures, under code 58146. **The RUC recommends a work relative value of 19.00 for code 58546.**

Existing CPT code 58550 was modified and three new codes (58552, 58553, and 58554) were created to specifically differentiate between laparoscopic hysterectomies performed with or without removal of tube(s) and/or ovary(s) and to differentiate based on size of the uteri. CPT code 58550 will now specifically states that it is reported for laparoscopic vaginal hysterectomies only, for uteri less than 250 grams. The RUC understands that this is how this code was originally evaluated when it was added to CPT in 2003. At that time, the work value for this code was determined by comparing the code to CPT 58260 *Vaginal hysterectomy* which did not include the removal of tube(s), and/or ovary(s). The specialty surveyed thirty-six physicians and a consensus panel of physicians to determine the final recommendations for code 58550 For code 58550, a work relative value of 14.19 reflected the 25th percentile of survey responses. The validity of the 25th percentile value was tested using IWPUT analysis. The specialty society determined that the resulting IWPUT of .08 was an appropriate value for this procedure since the laparoscopic route for hysterectomies is chosen over the vaginal route due to some factor impeding the vaginal route. The RUC agreed that the work relative value for this service should not change for its current value of 14.19. **The RUC recommends a work relative value of 14.19 for CPT code 58550.**

CPT code 58552 *Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)* now describes the services in which the tube(s) and/or ovary(s) are also removed. The work relative value survey median for this service was 16.00. The validity of the median value was checked using IWPUT analysis that resulted in an IWPUT of .07, which the specialty society concluded was appropriate. In addition, the society used a building block approach to validate the recommendation and to identify the appropriate value for removal of tubes and ovary(s). The increment between the laparoscopic hysterectomy only procedure described by 58550 and the hysterectomy with removal of the tube(s) and/or ovaries, described by 58552, was 1.81 RVUs. In comparison to the traditional procedure codes CPT code 58260, *Vaginal hysterectomy* (RVU = 12.98), and CPT code 58262, *Vaginal hysterectomy; with removal of tube(s), and/or ovary(s)* (RVU =14.77) the increment of 1.79 RVUs, is a very similar increment. In addition, when comparing the surveyed code (58550) with similar codes 58150, *Total abdominal hysterectomy,* and CPT code 58260, *Vaginal hysterectomy*, the specialty felt that the relative value recommendation was consistent with other hysterectomy codes. The RUC agreed that the increment and the overall relativity was correct and recommends the survey median of 16.00. **The RUC recommends a work relative value of 16.00 for CPT code 58552.**

New CPT code 58553, *Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams; without removal of tube(s) and/or ovary(s)*, and code 58554, *Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)*, were created to reflect new techniques allowing surgeons to remove larger uteri laparoscopically. The specialty society stated that there is additional work with the more complex procedures thereby necessitating the new codes. For code 58553, the

specialty society analyzed data received from thirty-one surveys and tested the validity of the median surveyed RVW using IWPUT analysis. The specialty society determined that an IWPUT of 0.08 was an appropriate value for the level of service for these codes. The specialty society also compared the surveyed code 58553 with similar codes 58150, *Total abdominal hysterectomy* and 58290, *Vaginal hysterectomy, for uterus greater than 250 grams*. CPT code 58150 is valued at 15.24 RVW and the RUC approved 19.00 RVW for 58290 at the April 2002 meeting. The RUC agreed with the survey median, which indicated that the median value for code 58553 was 20.00, a value slightly larger than 58290 due to the increased work for removing larger uteri laparoscopically. The specialty modified the post-service visits from one 99214 and one 99212 to two 99213 visits. **The RUC recommends work relative values of 20.00 for CPT code 58553.**

Analysis of the survey results for new CPT code 58554 indicated median of 22.00 RVUs. The specialty society tested the validity of the survey results using IWPUT analysis and found an IWPUT of 0.09. The 0.09 intensity was slightly higher than for 58553. The specialty agreed that complexity and physician skill required of this procedure should result in a greater intensity, and therefore determined it to be appropriate. The specialty compared the difference in similar vaginal procedures CPT code 58260 *Vaginal hysterectomy* (12.98 RVUs) and CPT code 58262, *Vaginal hysterectomy with removal of tubes and ovary(s)* (14.77 RVU). The difference in the work increment between these two codes is 1.79 RVUs. In comparison, the difference in the recommended values for the laparoscopic codes 58553 and 58554 is 2.00 RVUs. The RUC agreed that this increment and the overall relativity for this code was appropriate and recommends the survey median of 22.00. **The RUC recommends work relative values of 22.00 for CPT code 58554.**

Practice Expense

The RUC approved the practice expense inputs for 58545,58546, 58550, and 58552-58554. The RUC understood that the 090- day global period standard should apply for all of these codes. The revised practice expense sheets are attached to this recommendation. **The RUC recommends all the practice expense inputs presented by the specialty society**.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●58545	BA1	Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; 1 to 4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas	090	14.21

●58546	BA2	5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams	090	19.00
▲58550 56308 (old code #)	BA3	Laparoscopy surgical~~;~~ ,with vaginal hysterectomy, for uterus 250 grams or less; ~~with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy~~	090	14.19 (no change)
~~58551(D)~~ 56309 (old code #)		~~with removal of leiomyomata (single or multiple)~~ (58551 has been deleted. To report see 58545, 58546)	090	N/A
●58552	BA4	with removal of tube(s) and/or ovary(s)	090	16.00
●58553	BA5	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams;	090	20.00
●58554	BA6	with removal of tube(s) and/or ovary(s)	090	22.00

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 58545 **Tracking Number:** BA1 **Global Period:** 090 **Recommended RVW:** ~~14.88~~
RUC Recommendation: 14.21

CPT Descriptor: Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; excision of 1-4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
A 42-year old multigravida woman has been evaluated for an enlarging symptomatic pelvic mass. The uterus has increased from 6-12 weeks' size over 8 months and is causing urinary frequency, nocturia, and dyspareunia. Ultrasound documented a leiomyomatous uterus with two separate myomas 4X5 and 3X4 cm. Management options are discussed with her. The patient expresses a desire to keep her fertility options open and keep her uterus. The patient elects a myomectomy. A laparoscopic myomectomy is performed. All fibroids are removed and the uterine incisions are closed in multiple layers using laparoscopic suturing technique.

Description of Pre-Service Work:
The preservice work includes performing a comprehensive preoperative medical history, physical exam including a detailed pelvic exam. A physician must then dictate a history and physical, including writing of all admission orders. The patient is identified in the preoperative holding area with the appropriate consents. Patient identification is verified. The patient's family is also spoken to. All preoperative documentation is also reviewed at this time. This includes imaging studies, including ultrasounds and associated laboratory data. The physician reviews with the OR personnel the operative instrumentation necessary for the advanced laparoscopy. This includes ensuring that the video monitors are in proper working order. The patient is taken to the OR and correctly positioned on the operating table. This includes positioning of the lower extremities to avoid any potential injury.

Description of Intra-Service Work:
The patient is prepped and draped in a sterile fashion. A pelvic exam is performed under anesthesia. A Foley catheter is inserted into the bladder. The uterus is sounded. The size and flexion of the uterus is noted and the uterine manipulator is placed. The cervix must be dilated and the uterine manipulator applied. The manipulator allows "hand assistance" of exposing and manipulating the uterus to facilitate surgical removal of myomas. A vertical umbilical incision is then made. A veries needle is carefully inserted into the abdominal cavity. The insufflator is attached and correct pressure readings reflect proper intraabdominal placement. The abdominal cavity is then insufflated. The veries needle is removed and a trochar is carefully inserted into the abdominal cavity. The trochar is then removed from the obturator and a 10 mm laparoscope is inserted. The pelvis and lower abdomen are then grossly inspected. A decision is reached on the placement of the lower quadrant trochars. Using the anatomy of the anterior abdominal wall, the sites are chosen for entry of the right and left lower quadrant trochars, which are placed under direct visualization. The patient is then placed in Trendelenberg position. The small and large bowel are carefully grasped and placed in the upper abdomen. The myomas are inspected and a surgical plan is developed as to which myoma to approach first and how surgery shall proceed. A vasopressant agent such as Pitressin may be injected along the myometrium to minimize blood loss. A harmonic scalpel or similar cutting coagulating instrument is utilized to incise the myometrium overlying the fibroids. The incision is made on the uterus parallel to the course of the vascular supply.

Once the myoma has been exposed, it is grasped with a specially designed myoma forceps. Careful dissection is carried to free the myoma from surrounding myometrium. This would be a combination of sharp as well as blunt dissection. If pedicle is identified, it is isolated and independently coagulated and then transected. Once the myoma has been completely removed, hemostasis from the bed of the myoma is achieved. This most often involves a series of laparoscopic sutures. Once hemostasis is achieved within the bed of the myometrium, the uterus itself must be reconstructed. Care is taken to place several sutures through the myometrium. They are then tied in sequence using extracorporeal knot tying techniques. Depending on size of the myoma itself it is either suture tagged or placed in the cul-de-sac for later retrieval. The second, third and fourth myomas are removed in a similar fashion. Again, care

is taken to suture tag the myomas upon their removal. With each myoma there is suture placement for hemostasis within the bed of the myometrium followed by uterine reconstruction. Upon achieving hemostasis and uterine reconstruction, the myomas are then individually retrieved and morcellated. Then the myomas must individually be fed to the morcellator, which removes 1 cm strips of tissue at a time. This process can take a long period of time, depending on the size and nature of the myomas. Once the myomas have been completely removed, the trochars are then removed within the abdominal wall. The trochar sites are closed using again laparoscopic suturing techniques. The skin incision is closed with a subcuticular closure.

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 is evaluated and stabilized. The family is then counseled regarding the results of the procedure and the anticipated convalescence. Once the patient is alert, she too is counseled regarding the outcome of surgery and the anticipated hospital stay and subsequent convalescence. She is monitored the day of surgery as well as the following day in the hospital. She is discharged in the evening or afternoon of post day #1. She will be followed as an outpatient with approximately two to three office visits during the 90-day global period.

SURVEY DATA

Presenter(s):	George Hill, MD, FACOG and Sandra Reed, MD, FACOG					
Specialty(s):	American College of Obstetricians and Gynecologists (ACOG)					
CPT Code:	58545, Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; excision of 1-4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas					
Sample Size:	70	**Resp n:**	29	**Resp %:**	41%	
Sample Type:	Survey was distributed at the American Association of Gynecological Laparoscopists (AAGL) annual meeting.					
		Low	**25th pctl**	**Median**	**75th pctl**	**High**
Survey RVW:		13.1	14.21	16.00	18.00	28
Pre-Service Time: (day preceding procedure)		5	30	45 **30**	60	180
Pre-Service Time: (day of procedure)		15	30	40 **30**	55	60
Intra-Service Time:		50	90	**120**	150	210

Post-Service	**Total Min***	**CPT code / # of visits**
Immed. Post-time:	**30**	
Critical Care time/visit(s):	**0**	
Other Hospital time/visit(s):	**30**	**99232/1**
Discharge Day Mgmt:	**36**	**99238/1**
Office time/visit(s):	**46**	**99213/2**

*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
58140	Myomectomy, excision of fleiomyomata of uterus, single or multiple (separate procedure); abdominal approach	90	14.60

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 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: 5854X**	**Key Reference CPT Code: 58140**
Median Pre-Service Time	~~90~~ 60	60
Median Intra-Service Time	120	120
Median Immediate Post-service Time	30	30
Median Critical Care Time	0	0
Median Other Hospital Visit Time	30	68
Median Discharge Day Management Time	36	36
Median Office Visit Time	46	46
Median Total Time	~~352~~ 322	**360**

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	3.46	3.31
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.35	3.73
Urgency of medical decision making	3.23	3.38

Technical Skill/Physical Effort (Mean)

Technical skill required	4.48	3.80
Physical effort required	4.33	3.64

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.19	3.71
Outcome depends on the skill and judgement of physician	4.44	3.84
Estimated risk of malpractice suit with poor outcome	4.33	3.92

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.46	3.31
Intra-Service intensity/complexity	4.35	3.73
Post-Service intensity/complexity	3.23	3.38

ADDITIONAL RATIONALE

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

SURVEY METHOD

At the September 2002 RUC meeting, the RUC research subcommittee approved the revised multiple code survey instrument proposed by the American College of Obstetricians and Gynecologists (ACOG).

ACOG in collaboration with the American Association of Gynecological Laparoscopists (AAGL) disseminated the RUC survey at the November 2002 AAGL annual meeting. Twenty-nine surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG and AAGL reviewed the results and drafted the final recommendations.

PANEL DISCUSSION

The panel developed the recommendation in the following manner:

1. Comparing the surveyed code to CPT code 58551
2. Evaluating the recommendation using IWPUT analysis
3. Comparing the surveyed code (58545) with the reference code (58140)
4. Comparing the surveyed code value with other codes

CPT code 58551 –

CPT code 58551, the previous laparoscopic myomectomy code was valued at 14.21. While it could be argued that the more difficult myomectomies will now be coded by 5854X2, the panel agreed that only a handful of physicians across the country would be performing the more complex myomectomy procedure.

A more significant issue is that the laparoscopic myomectomy went from a 10-day to a 90-day global. The committee agreed that 14.21 was a fair value for a 10-day global but adding the value of the 1 additional hospital visit now that it was a 90 day global was appropriate. This results in an addition of 1-99213:

14.21 + 0.65(99231) = 14.86

The panel felt this justified the recommendation of 14.86.

IWPUT Analysis

The panel tested the validity of 14.86using the IWPUT analysis. **Applying the formula to the surveyed code resulted in an IWPUT of .07. The panel concluded that .07 was an appropriate value for this level of service.**

CPT code values: 99232= 1.06; 99238=1.28; 99213= .67

14.86 - {.0224(90min) + .0224(30 min) + 1.06 + .1.28 + .67 + .67} /120 min = .07 IWPUT

The panel agreed that a .07 IWPUT was an appropriate intensity level for a laparoscopic myomectomy. The panel discussed .08 being a generally accepted level of intensity for most abdominal surgical procedures. They felt that certain factors of laparoscopic surgery in general and this procedure in particular could justify an even higher level of intensity.

- Laparoscopic surgery does not have the reduced intensity times during opening and closing, as do abdominal surgeries.
- Laparoscopic surgery requires the development of specialized skills
- Laparoscopic surgery requires the physician to view their surgical environment using cameras and other technology
- Laparoscopic myomectomy specifically is not just clipping and taking out an organ but it requires suturing and organ repair. This can increase hemostasis.

All of these factors result in high levels of intensity during the surgery.

After reviewing the IWPUT analysis the committee agreed that a recommendation of 14.88 was not only fair but also a conservative recommendation.

Reference code 58140 – Next the panel compared the surveyed code (58545) with the reference code (58140). CPT code 58140 is valued at 14.60 RVW. For your reference, a summary of the times is listed below.

CPT CODE	58545	58140
RVW	14.88	14.60
PRE-SERVICE TIME	~~90 min~~ 60 min	60 min
INTRA SERVICE TIME	120 min	120 min
IMMEDIATE POST-SERVICE TIME	30 min	30 min
HOSPITAL VISITS TIME	30 min	68 min
DISCHARGE TIME	36 min	36 min
OFFICE VISIT TIME	46 min	46 min
TOTAL TIME	~~352 min~~ 322 min	360 min

After comparing the data, the recommendation of 14.88 seemed to be an appropriate and fair recommendation.

Other related codes: – The panel compared the surveyed code to other laparoscopic procedures

CPT CODE	Short Descriptor	INTRA SERVICE TIME	RVW	GLOBAL
47564	Laparoscopic cholecystectomy		14.23	90
58545	**Laparoscopic myomectomy**	**~~120 min~~ 90 min**	**14.88**	**90**
44204	Laparoscopic partial colectomy	180 min	25.08	90
50546	Laparoscopic nephrectomy	205 min	20.48	90

After reviewing the survey data to other laparoscopic codes in the RUC database the committee felt that the recommendation of 14.86 was consistent with other laparoscopic codes.

The panel concluded their discussion stating they were very comfortable with the recommendation of 14.86 RVW for 58545. They reviewed the data using a number of factors and all of the factors indicated that 14.88 was a reasonable and fair if not somewhat conservative recommendation.

The panel unanimously supported the recommendation of 14.86 RVW for CPT code 58545.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported?
CPT code 58551, Laparoscopy, surgical; with removal of leiomyomata (single or multiple)

(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 American Association of Gynecological Laparoscopists (AAGL)
_____Commonly
X Sometimes
_____Rarely

Specialty American College of Obstetricians and Gynecologists (ACOG)
_____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.

It is estimated that 10-15% of abdominal myomectomies are now done laparoscopically

Specialty _____ Frequency_____

CPT Code: 58545

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.
It is unlikely that this procedure will be performed on Medicare patients.

Specialty _____ Frequency_____

Specialty _____ Frequency_____

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 58546 **Tracking Number:** BA2 **Global Period:** 090 **Recommended RVW:** 19.00

CPT Descriptor: Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 35-year old nulligravid patient is evaluated for menorrhagia with anemia. She is recently married and anxious to have children. On examination she is found to have a 16-week size fibroid uterus. Ultrasound confirms a 15cm uterus with six distinct intramural myomas distorting the endometrium. Management options are discussed with her. The patient expresses a desire to keep her fertility options open and keep her uterus. The patient elects a myomectomy. A laparoscopic myomectomy is performed. All fibroids are removed and the uterine incisions are closed in multiple layers using a laparoscopic suturing technique.

Description of Pre-Service Work:

The preservice work includes performing a comprehensive preoperative medical history, physical exam including a detailed pelvic exam. A physician must then dictate a history and physical, including writing of all admission orders. The patient is identified in the preoperative holding area with the appropriate consents. Patient identification is verified. The patient's family is also spoken to. All preoperative documentation is also reviewed at this time. This includes imaging studies, including ultrasounds and associated laboratory data. The physician reviews with the OR personnel the operative instrumentation necessary for the advanced laparoscopy. This includes ensuring that the video monitors are in proper working order. The patient is taken to the OR and correctly positioned on the operating table. This includes positioning of the lower extremities to avoid any potential injury.

Description of Intra-Service Work:

The patient is prepped and draped in a sterile fashion. A pelvic exam is performed under anesthesia. A Foley catheter is inserted into the bladder. The uterus is sounded. The size and flexion of the uterus is noted and the uterine manipulator is placed. The cervix must be dilated and the uterine manipulator applied. The manipulator allows "hand assistance" of exposing and manipulating the uterus to facilitate surgical removal of myomas. A vertical umbilical incision is then made. A veries needle is carefully inserted into the abdominal cavity. The insufflator is attached and correct pressure readings reflect proper intraabdominal placement. The abdominal cavity is then insufflated. The veries needle is removed and a trochar is carefully inserted into the abdominal cavity. The trochar is then removed from the obturator and a 10 mm laparoscope is inserted. The pelvis and lower abdomen are then grossly inspected. A decision is reached on the placement of the lower quadrant trochars. Using the anatomy of the anterior abdominal wall, the sites are chosen for entry of the right and left lower quadrant trochars, which are placed under direct visualization. The patient is then placed in Trendelenberg position. The small and large bowel are carefully grasped and placed in the upper abdomen. The myomas are inspected and a surgical plan is developed as to which myoma to approach first and how surgery shall proceed. A vasopressant agent such as Pitressin may be injected along the myometrium to minimize blood loss. A harmonic scalpel or similar cutting coagulating instrument is utilized to incise the myometrium overlying the fibroids. The incision is made on the uterus parallel to the course of the vascular supply.

Once the myoma has been exposed, it is grasped with a specially designed myoma forceps. Careful dissection is carried to free the myoma from surrounding myometrium. This would be a combination of sharp as well as blunt dissection. If pedicle is identified, it is isolated and independently coagulated and then transected. Once the myoma has been completely removed, hemostasis from the bed of the myoma is achieved. This most often involves a series of laparoscopic sutures. Once hemostasis is achieved within the bed of the myometrium, the uterus itself must be reconstructed. Care is taken to place several sutures through the myometrium. They are then tied in sequence using extracorporeal knot tying techniques. Depending on size of the myoma itself it is either suture tagged or placed in the cul-de-sac for later retrieval. Four additional myomas are removed in a similar fashion. Again, care is taken to

suture tag the myomas upon their removal. With each myoma there is suture placement for hemostasis within the bed of the myometrium followed by uterine reconstruction. Upon achieving hemostasis and uterine reconstruction, the myomas are then individually retrieved and morcellated. Then the myomas must individually be fed to the morcellator, which removes 1 cm strips of tissue at a time. This process can take a long period of time, depending on the size and nature of the myomas. Once the myomas have been completely removed, the trochars are then removed within the abdominal wall. The trochar sites are closed using again laparoscopic suturing techniques. The skin incision is closed with a subcuticular closure.

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 is evaluated and stabilized. The family is then counseled regarding the results of the procedure and the anticipated convalescence. Once the patient is alert, she too is counseled regarding the outcome of surgery and the anticipated hospital stay and subsequent convalescence. She is monitored the day of surgery as well as the following day in the hospital. She is discharged in the evening or afternoon of post day #1. She will be followed as an outpatient with approximately two to three office visits during the next 90day global period.

SURVEY DATA

Presenter(s):	George Hill, MD, FACOG and Sandra Reed, MD, FACOG					
Specialty(s):	American College of Obstetricians and Gynecologists (ACOG)					
CPT Code:	58546, Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams					
Sample Size:	70	**Resp n:**	21	**Resp %:**	30%	
Sample Type:	Survey was distributed at the American Association of Gynecological Laparoscopists (AAGL) annual meeting.					
		Low	**25th pctl**	**Median**	**75th pctl**	**High**
Survey RVW:		14.21	17.85	19.00	23.50	28.85
Pre-Service Time: (day preceding procedure)		15	30	~~60~~ **30**	60	90
Pre-Service Time: (day of procedure)		45	30	~~45~~ **30**	60	60
Intra-Service Time:		75	150	**180**	210	290

Post-Service	**Total Min***	**CPT code / # of visits**
Immed. Post-time:	**30**	
Critical Care time/visit(s):	**0**	
Other Hospital time/visit(s):	**30**	**99232/1**
Discharge Day Mgmt:	**36**	**99238/1**
Office time/visit(s):	~~53~~ **46**	~~99214/1 and 99212/1~~ **2 - 99213**

*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
58140	Myomectomy, excision of leiomyomata of uterus, single or multiple (separate procedure); abdominal approach	90	14.60

CPT Code: 58546

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: 58546	Key Reference CPT Code: 58140
Median Pre-Service Time	~~90~~ 60	60
Median Intra-Service Time	180	120
Median Immediate Post-service Time	30	30
Median Critical Care Time	0	0
Median Other Hospital Visit Time	30	68
Median Discharge Day Management Time	36	36
Median Office Visit Time	~~53~~ **46**	46
Median Total Time	~~419~~ **382**	**360**

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	3.94	3.47
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.0	3.73
Urgency of medical decision making	3.72	3.60

Technical Skill/Physical Effort (Mean)

Technical skill required	4.67	3.87
Physical effort required	4.61	3.80

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.56	4.00
Outcome depends on the skill and judgement of physician	4.78	3.87
Estimated risk of malpractice suit with poor outcome	4.39	4.07

CPT Code: 58546

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.72	3.59
Intra-Service intensity/complexity	4.72	4.00
Post-Service intensity/complexity	3.67	3.59

ADDITIONAL RATIONALE

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

SURVEY METHOD

At the September 2002 RUC meeting, the RUC research subcommittee approved the revised multiple code survey instrument proposed by the American College of Obstetricians and Gynecologists (ACOG).

ACOG in collaboration with the American Association of Gynecological Laparoscopists (AAGL) disseminated the RUC survey at the November 2002 AAGL annual meeting. Twenty-one surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG and AAGL reviewed the results and drafted the final recommendations.

PANEL DISCUSSION

The panel developed the recommendation in the following manner:

1. Reviewing the survey data
2. Comparing the surveyed code (58546) with the reference code (58140)
3. Compared the surveyed code with other laparoscopic codes
4. Comparing the surveyed value of the code with the interim value

Survey Data – ACOG received nineteen completed surveys. The median RVW from the data was 19.00. The panel tested the validity of the median surveyed RVW using IWPUT analysis. **Applying the formula to the surveyed code resulted in an IWPUT of .07. The panel concluded that .07 was an appropriate value for this level of service.**
CPT code values: 99232= 1.06; 99238=1.28; 99214= 1.10; 99212= .45

19.00 - {.0224(90min) + .0224(30 min) + 1.06 + .1.28 + .1.10 + .45} /180 min = .07 IWPUT

Many of the same issues regarding laparoscopic procedures as described in the recommendation form for 5854X1 were again discussed. In addition, the panel discussed the difference between this code and the simple laparoscopic myomectomy. The entire panel agreed that very few physicians perform the more complex myomectomy procedure. CPT code 58546 is much more surgically challenging and requires a much higher surgical skill level. While only a few physicians currently will use this code, the panel emphasized the importance in encouraging physicians to expand their surgical skills. As discussed in the CPT proposal, doing this procedure laparoscopically versus abdominally has a variety of benefits for the patient.

Reference code 58140 – Next the panel compared the surveyed code (58546) with the reference code (58140). CPT code 58140 is values at 14.60 RVW. For your reference, a summary of the times is listed below.

CPT CODE	5854X1	58140
RVW	19.00	14.60
PRE-SERVICE TIME	~~90 min~~ **60 min**	60 min
INTRA SERVICE TIME	180 min	120 min
IMMEDIATE POST-SERVICE TIME	30 min	30 min
HOSPITAL VISITS TIME	30 min	36 min
DISCHARGE TIME	36 min	68 min
OFFICE VISIT TIME	~~53 min~~ **46 min**	46 min
TOTAL TIME	~~419 min~~ **389 min**	360 min

The panel concluded that the greater physician time reflected in the data for 58546 justified the higher RVW.

Other laparoscopic procedures
The panel also compared the surveyed code to other laparoscopic codes.

CPT CODE	Short Descriptor	INTRA SERVICE TIME	RVW	GLOBAL
47564	Laparoscopic cholecystectomy		14.23	90
5854X	**Laparoscopic myomectomy**	~~180~~ **120 min**	**19.00**	**90**
44204	Laparoscopic partial colectomy	180 min	25.08	90
50546	Laparoscopic nephrectomy	205 min	20.48	90

After reviewing the survey data to other laparoscopic codes in the RUC database the committee felt that the recommendation of 19.00 was consistent with other laparoscopic codes.

Interim value: – When comparing the surveyed code to the interim value the recommended RVW seemed to be appropriate and fair. 19.00 RVW was also recommended in April 2002 for the interim value.

The panel supports the recommendation of 19.00 RVW for 58546.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each,

summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported?
CPT code 58551, Laparoscopy, surgical; with removal of leiomyomata (single or multiple)

(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 American Association of Gynecological Laparoscopists (AAGL)
_____Commonly
X Sometimes
_____Rarely

Specialty American College of Obstetricians and Gynecologists (ACOG)
_____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.

It is estimated that 10-15% of abdominal myomectomies are now done laparoscopically

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.
It is unlikely that this procedure will be performed on Medicare patients.

Specialty _____ Frequency_____

Specialty _____ Frequency_____

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

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 58550 **Tracking Number:** BA3 **Global Period:** 090 **Recommended RVW:** 14.19

CPT Descriptor: Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 45 year-old G1P1 is evaluated for profound menorrhagia with anemia. Her hematocrit is 25% despite daily iron therapy and treatment with oral contraceptives. On physical examination she has an irregular, mobile 4-6 week size fibroid uterus. Ultrasound confirms multiple uterine fibroids, several of which impinge on the endometrium. After management options are discussed with her, the patient elects a hysterectomy. A laparoscopic assisted vaginal hysterectomy (LAVH) is performed.

Description of Pre-Service Work:

The preservice work includes performing a comprehensive preoperative medical history, physical exam including a detailed pelvic exam. A physician must then dictate a history and physical, including in writing of all admission orders. The patient is identified in the preoperative holding area with the appropriate consents. Patient identification is verified. The patient's family is also spoken to. All preoperative documentation is also reviewed at this time. This includes imaging studies, including ultrasounds and associated laboratory data. The physician reviews with the OR personnel the operative instrumentation necessary for the advanced operative laparoscopy. This includes ensuring that video monitors are in proper working order. The patient is taken to the OR and correctly positioned on the operating table. This includes positioning of the lower extremities to avoid any potential injury. The physician also will position the monitors prior to the beginning of the case.

Description of Intra-Service Work:

After general anesthesia is obtained, an exam under anesthesia is performed and compared to operative finding. The patient is then prepped and draped in the usual sterile fashion. In the dorsal lithotomy position a Foley catheter is then inserted to provide a means of intermittent bladder drainage. A weighted speculum is placed into the patient's vagina and the anterior lip of the cervix is grasped using a single tooth tenaculum. The uterus is then sounded and the cervix is then dilated in order to facilitate the Valchev uterine manipulator. The weighted speculum is then removed.

The laparoscopic portion of the procedure is begun by first placing the veries needle umbilically and achieving and adequate pneumoperit. A 10 mm trochar is then placed at this site and a laparoscope is used to confirm appropriate entrance and no injury to any pelvic or abdominal structures. Next, using laparoscopic guidance, two additional 10 mm trochar ports are then placed in the right and left lower quadrant. A careful inspection of the abdomen and pelvis are made and findings documented. The ureters are then carefully identified bilaterally. The procedure is then begun by using either the seitzinger (tripolar) forceps or using the harmonic scalpel. The round ligaments are identified bilaterally, clamped, cauterized and transected. The uteroovarian vasculature is clamped, cauterized and suture ligated until freed from the fundal region of the uterus bilaterally.

Next, attention is turned to the vaginal portion of the procedure. The Valchev uterine manipulator is removed and the single tooth tenaculum is repositioned to provide a means of traction on the uterus. Using the Bovie, a circumferential incision is made at the cervicovaginal junction. Using careful sharp dissection, the anterior and posterior cul-de-sacs are entered sharply. The posterior peritoneum is identified and a figure-of-eight stay sutures then placed for hemostasis and securement of the posterior peritoneum.

A narrow weighted speculum is then placed in the posterior cul-de-sac and using Haney clamps the uterosacral ligaments, cardinal and broad ligament are bilaterally clamped, cut and suture ligated. Hemostasis is assured. Once completely freed, the uterus is then delivered. Both ovaries are identified and all pedicles are assured for hemostasis. The hysterectomy portion of the procedure is complete. The peritoneum and vaginal cuff are closed in the usual fashion. Attention is then turned to the abdominal incisions where the trochars are removed and the abdominal incisions are closed in the usual fashion.

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 is evaluated and stabilized. The family is then counseled regarding the results of the procedure and the anticipated convalescence. Once the patient is alert, she too is counseled regarding the outcome of the surgery and the subsequent convalescence. She is monitored the day of surgery as well as the following hospital day in the hospital. She is discharged in the evening or afternoon of post op day #1. She will be followed as an outpatient with approximately two to three office visits during the 90-day global period.

SURVEY DATA

Presenter(s):	George Hill, MD, FACOG and Sandra Reed, MD, FACOG					
Specialty(s):	American College of Obstetricians and Gynecologists (ACOG)					
CPT Code:	58550, Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less					
Sample Size: 70	**Resp n:** 36	**Resp %:** 51%				
Sample Type:	Survey was distributed at the American Association of Gynecological Laparoscopists (AAGL) annual meeting.					
		Low	**25th pctl**	**Median**	**75th pctl**	**High**
Survey RVW:		13.25	14.19	15.00	18.00	28.14
Pre-Service Time: (day preceding procedure)		0	30	~~40~~ **30**	60	90
Pre-Service Time: (day of procedure)		15	30	~~45~~ **30**	50	60
Intra-Service Time:		15	80	**100**	120	180
Post-Service	**Total Min***	**CPT code / # of visits**				
Immed. Post-time:	**30**					
Critical Care time/visit(s):	**0**					
Other Hospital time/visit(s):	**38**	**99231/2**				
Discharge Day Mgmt:	**36**	**99238/1**				
Office time/visit(s):	**61**	**99213/2 and 99212/1**				

*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
58550	Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)	10	14.19

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: 58550**	**Key Reference CPT Code: 58550**
Median Pre-Service Time	~~90~~ 60	
Median Intra-Service Time	100	
Median Immediate Post-service Time	30	
Median Critical Care Time	0	
Median Other Hospital Visit Time	38	
Median Discharge Day Management Time	36	
Median Office Visit Time	61	
Median Total Time	~~355~~ 325	

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	3.68	3.55
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.56	3.48
Urgency of medical decision making	3.28	3.23

Technical Skill/Physical Effort (Mean)

Technical skill required	4.24	3.76
Physical effort required	3.94	3.58

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.03	3.79

Outcome depends on the skill and judgement of physician	4.26	3.94
Estimated risk of malpractice suit with poor outcome	4.21	4.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.06	3.67
Intra-Service intensity/complexity	3.82	3.18
Post-Service intensity/complexity	3.68	3.55

ADDITIONAL RATIONALE

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

SURVEY METHOD

At the September 2002 RUC meeting, the RUC research subcommittee approved the revised multiple code survey instrument proposed by the American College of Obstetricians and Gynecologists (ACOG).

ACOG in collaboration with the American Association of Gynecological Laparoscopists (AAGL) disseminated the RUC survey at the November 2002 AAGL annual meeting. Thirty-six surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG and AAGL reviewed the results and drafted the final recommendations.

PANEL DISCUSSION

The panel developed the recommendation in the following manner:

1. Reviewing the survey data
2. Comparing the surveyed code (58550) with similar codes
3. Comparing the surveyed value with the interim value

Survey Data – ACOG received thirty-four completed surveys. The 25th percentile RVW from the data was 14.19. The panel tested the validity of the 25th percentile value using IWPUT analysis. **Applying the formula to the surveyed code resulted in an IWPUT of .08. The panel concluded that .08 was an appropriate value for this procedure.** In their experience the panel agreed that generally laparoscopic hysterectomies are a little more difficult than vaginal hysterectomies because the laparoscopic route is chosen over the vaginal route due to some factor impeding the vaginal route.

CPT code values: 99231= .64; 99238=1.28; 99213= 0.65; 99212= 0.43

14.19 - {.0224(60min) + .0224(30 min) + .64 + .1.28 + .67 + .67 + .45} /100 min = .08 IWPUT

Similar code s – Next the panel compared the surveyed code (5854X2) with similar codes 58150, Total abdominal hysterectomy and CPT code 58260, Vaginal hysterectomy. For your reference, a summary of the times for both codes is listed below.

CPT CODE	58550	58260	58150
RVW	14.19	12.98	15.24
PRE-SERVICE TIME	~~90 min~~ **60 min**	60 min	60 min
INTRA SERVICE TIME	100 min	60 min	120 min
IMMEDIATE POST-SERVICE TIME	30 min	30 min	40 min
HOSPITAL VISITS TIME	38 min	49 min	87 min
DISCHARGE TIME	36 min	36 min	36 min
OFFICE VISIT TIME	61 min	61 min	46 min
TOTAL TIME	~~355 min~~ **325 min**	296 min	389 min

After reviewing this data the panel felt that the recommendation was consistent with other hysterectomy codes.

Interim value – The panel also compared the survey value of the code with the interim value. It was the same. The panel agreed that the survey results validated the interim values.

The panel supports the recommendation of 14.19 RVW for 58550.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported?

CPT Code: 58550

CPT code 58550, Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)

(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 American Association of Gynecological Laparoscopists (AAGL)
_____Commonly
X Sometimes
_____Rarely

Specialty American College of Obstetricians and Gynecologists (ACOG)
_____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.

It is estimated that 10-15% of abdominal hysterectomies are now done laparoscopically

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.
It is unlikely that this procedure will be performed on Medicare patients.

Specialty _____ Frequency_____

Specialty _____ Frequency_____

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 58552 **Tracking Number:** BA4 **Global Period:** 090 **Recommended RVW:** 16.00

CPT Descriptor: Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 45 year-old G1P1 is evaluated for profound menorrhagia with anemia. Her hematocrit is 25% despite daily iron therapy and treatment with oral contraceptives. On physical examination she has an irregular, mobile 4-6 week size fibroid uterus. Ultrasound confirms multiple uterine fibroids, several of which impinge on the endometrium. After management options are discussed with her, the patient elects a hysterectomy. A laparoscopic assisted vaginal hysterectomy (LAVH) is performed. The patient has a strong history of ovarian cancer in her family and does not desire any more children therefore her tube(s) and ovary(s) removed.

Description of Pre-Service Work:

The preservice work includes performing a comprehensive preoperative medical history, physical exam including a detailed pelvic exam. A physician must then dictate a history and physical, including in writing of all admission orders. The patient is identified in the preoperative holding area with the appropriate consents. Patient identification is verified. The patient's family is also spoken to. All preoperative documentation is also reviewed at this time. This includes imaging studies, including ultrasounds and associated laboratory data. The physician reviews with the OR personnel the operative instrumentation necessary for the advanced operative laparoscopy. This includes ensuring that the video monitors are in proper working order. The patient is taken to the OR and correctly positioned on the operating table. This includes positioning of the lower extremities to avoid any potential injury. The physician also will position the monitors prior to the beginning of the case.

Description of Intra-Service Work:

After general anesthesia is obtained and the patient is prepped and draped in the usual sterile fashion, an exam under anesthesia is to be performed and compared to preoperative findings.

The procedure begins with placing a weighted speculum into the patient's vagina. The anterior lip of the cervix is grasped using a single tooth tenaculum and the uterus is then sounded. Next, the cervix is then dilated beginning with a #9 French and progressing to an #18 French dilator. This facilitates the placement of a Valchev uterine manipulator, which is then placed into the cervix and connected with a single tooth tenaculum to provide means of manipulating the uterus. At that time the weighted speculum is removed and a Foley catheter is placed to provide intermittent bladder drainage. The laparoscopic portion of the procedure then ensues by first elevating the abdomen and placing the veries needle into the abdominal cavity and insufflating the abdomen until an adequate pneumoperitoneum is achieved. Once an adequate pneumoperitoneum is achieved, a 10 mm trochar is placed umbilically. A laparoscope is then used to confirm adequate placement and to also verify no injury to any adjacent structures intrabdominally. Next, two additional 10 mm trochar ports are placed in the right lower quadrant and left lower quadrant using laparoscopic guidance so to avoid any vascular guidance. Next, using either the seitzinger (tripolar) forceps or the harmonic scalpel, the infundibular pelvic ligaments bilaterally are clamped, cauterized and transected. Next, the round ligaments bilaterally are identified, clamped, cauterized and transected. Both ureters are identified bilaterally. At that time the abdominal portion of the procedure is completed. The laparoscope is removed from the patient's abdomen and all gas is allowed to exsufflate from the patient's abdomen. At that time a weighted speculum is placed in the patient's vagina and the Valchev uterine manipulator is removed. The single tooth tenaculum is then used to grasp the cervix for traction purposes. A circumferential incision is then made around the cervix. Next, using sharp dissection, the cervicovesical space is entered anteriorly. Next, in a similar fashion the posterior cul-de-sac is entered using careful sharp dissection. The peritneum is identified. A figure-of-eight stay suture is placed for hemostasis and securement of the posterior peritoneum. A long narrow weighted speculum is placed in the posterior cul-de-sac. Haney clamps are placed at the uterosacral ligaments which are then incised and suture ligated. This is carried bilaterally in an ascending fashion. Haney clamps are intermittently

placed on the immediate paracervical tissue, which is then incised and suture ligated individually. This is carried out along the length of the uterus. Uterine artery vasculature is carefully identified, clamped, incised and suture ligated. The anterior peritoneal fold is identified and incised. The anterior cul-de-sac is entered and the bladder is then retracted anteriorly. Continued intermittent clamping, incising and suture ligation of the paramaterial tissue is carried out along the length of the uterus. Uterine artery vasculature is carefully identified, clamped, incised and suture ligated. The anterior peritoneal field is identified and incised. The anterior cul-de-sac is entered and the bladder is then retracted anteriorly. Continued intermittent clamping, incising and suture ligation of the paramaterial tissue is carried out along the broad ligament until finally the cornual region of the uterus is reached. The uterus, tubes and ovaries are then removed and handed off the field. All pedicles are carefully inspected and hemostasis is assured. The peritoneum and vaginal cuff is closed in the usual fashion.

Next, attention is then redirected to the abdominal incisions which are closed in subcuticular fashion after careful inspection using a laparoscope. The pedicles are yet again identified and inspected and hemostasis is assured. The laparoscope and all trochars are removed and the abdominal incisions are closed in the usual fashion.

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 is evaluated and stabilized. The family is counseled regarding the results of the procedure and the anticipated convalescence. Once the patient is alert, she too is counseled regarding the outcome of the surgery and the anticipated hospital stay and subsequent convalescence. She is monitored the day of the surgery as well as the following day in the hospital. She is discharged in the evening or afternoon of post day #1. She will be followed as an outpatient with approximately two to three office visits during the 90-day global period.

SURVEY DATA

Presenter(s):	George Hill, MD, FACOG and Sandra Reed, MD, FACOG		
Specialty(s):	American College of Obstetricians and Gynecologists (ACOG)		
CPT Code:	58552, Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)		
Sample Size: 70	**Resp n:** 35	**Resp %:** 50%	
Sample Type:	Survey was distributed at the American Association of Gynecological Laparoscopists (AAGL) annual meeting.		

	Low	25th pctl	Median	75th pctl	High
Survey RVW:	13.5	14.64	16	19.5	30.19
Pre-Service Time: (day preceding procedure)	0	30	45 30	60	90
Pre-Service Time: (day of procedure)	15	30	45 30	50	60
Intra-Service Time:	15	90	**120**	140	200

Post-Service	**Total Min***	**CPT code / # of visits**
Immed. Post-time:	**30**	
Critical Care time/visit(s):	**0**	
Other Hospital time/visit(s):	**38**	**99231/2**
Discharge Day Mgmt:	**36**	**99238/1**
Office time/visit(s):	**61**	**99213/2 and 99212/1**

*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU

58550	Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)	10	14.19

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: 58552**	**Key Reference CPT Code: 58550**
Median Pre-Service Time	~~90~~ 60	
Median Intra-Service Time	120	
Median Immediate Post-service Time	30	
Median Critical Care Time	0	
Median Other Hospital Visit Time	38	
Median Discharge Day Management Time	36	
Median Office Visit Time	61	
Median Total Time	~~375~~ 345	

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.75	3.52
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.57	3.42
Urgency of medical decision making	3.82	3.20

Technical Skill/Physical Effort (Mean)

Technical skill required	4.41	3.82
Physical effort required	4.24	3.64

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.18	3.82
Outcome depends on the skill and judgement of physician	4.38	4.00

Estimated risk of malpractice suit with poor outcome	4.32	4.03

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.54	3.32
Intra-Service intensity/complexity	4.19	3.76
Post-Service intensity/complexity	3.54	3.32

ADDITIONAL RATIONALE

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

SURVEY METHOD

At the September 2002 RUC meeting, the RUC research subcommittee approved the revised multiple code survey instrument proposed by the American College of Obstetricians and Gynecologists (ACOG).

ACOG in collaboration with the American Association of Gynecological Laparoscopists (AAGL) disseminated the RUC survey at the November 2002 AAGL annual meeting. Thirty-five surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG and AAGL reviewed the results and drafted the final recommendations.

PANEL DISCUSSION

The panel developed the recommendation in the following manner:

1. Reviewing the survey data using IWPUT analysis
2. Reviewing the survey data using the building block approach

IWPUT analysis – ACOG received thirty-three completed surveys. The median RVW from the data was 16.00. The panel tested the validity of the median surveyed RVW using IWPUT analysis. **Applying the formula to the surveyed code resulted in an IWPUT of .07. The panel concluded that .07 was an appropriate value for this level of service.**
CPT code values: 99231= .64; 99238=1.28; 99213= .67; 99212= .45

16.00 - {.0224(60min) + .0224(30 min) + .64 + .64 + .1.28 + .67 + .67 + .45} /120 min = .07 IWPUT

Building block approach – The panel used the building block approach to validate the recommendation and to identify the appropriate value for removal of tubes and ovary(s).
CPT code 58550, Laparoscopic hysterectomy less than 250 grams = 14.19 RVUs
CPT code 58661, Laparoscopic removal of tubes and ovary(s) = 11.05

14.19 + .50(11.05) = 19.72

Another method is to compare the difference in similar vaginal.
CPT code 58260 Vaginal hysterectomy = 12.98
CPT code 58262, Vaginal hysterectomy with removal of tubes and ovary(s) = 14.77
14.77 – 12.98 = 1.79

The difference between these two codes is 1.79 RVUs. Similarly the difference in the recommended laparoscopic codes is 1.81.
CPT code 58550, Laparoscopic hysterectomy = 14.19
CPT code 5854X1, Laparoscopic hysterectomy with removal of tubes and ovary(s) = 16.00
16.00 – 14.19 = 1.81

The panel agreed that both methods validate the survey median of 16.00 RVW for this code.

The panel concluded discussion of this code by unanimously supporting the recommendation of 16.00 RVW for 58552.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported?
CPT code 58550, Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)

(if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

CPT Code: 58552

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 Association of Gynecological Laparoscopists (AAGL)
_____Commonly
X Sometimes
_____Rarely

Specialty American College of Obstetricians and Gynecologists (ACOG)
_____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.

It is estimated that 10-15% of abdominal hysterectomies are now done laparoscopically

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.
It is unlikely that this procedure will be performed on Medicare patients.

Specialty _____ Frequency_____

Specialty _____ Frequency_____

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 58553 **Tracking Number:** B5 **Global Period:** 090 **Recommended RVW:** 20.00

CPT Descriptor: Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 45 year-old G1P1 is evaluated for profound menorrhagia with anemia. Her hematocrit is 25% despite daily iron therapy and treatment with oral contraceptives. On physical examination she has an irregular, mobile 12-14 week size fibroid uterus. Ultrasound confirms multiple uterine fibroids, several of which impinge on the endometrium. After management options are discussed with her, the patient elects a hysterectomy. A laparoscopic assisted vaginal hysterectomy (LAVH) is performed.

Description of Pre-Service Work:

The preservice work includes performing a comprehensive preoperative medical history, physical exam including a detailed pelvic exam. A physician must then dictate a history and physical, including in writing of all admission orders. The patient is identified in the preoperative holding area with the appropriate consents. Patient identification is verified. The patient's family is also spoken to. All preoperative documentation is also reviewed at this time. This includes imaging studies, including ultrasounds and associated laboratory data. The physician reviews with the OR personnel the operative instrumentation necessary for the advanced operative laparoscopy. This includes ensuring that the video monitors are in proper working order. The patient is taken to the OR and correctly positioned on the operating table. This includes positioning of the lower extremities to avoid any potential injury. The physician also will position the monitors prior to the beginning of the case.

Description of Intra-Service Work:

After being placed on the operating room table, general anesthesia is obtained and an exam under anesthesia is performed and compared to preoperative findings. The patient is prepped and draped in the usual sterile fashion. A Foley catheter is then placed to provide a means for intermittent bladder drainage. Next, attention is then turned to the placement of a weighted speculum. The anterior lip of the cervix is grasped using a single tooth tenaculum and the Valchev uterine manipulator is placed and attached to the single tooth tenaculum. Attention is then directed to the abdominal portion of the procedure where the abdomen is tented and the veries needle is placed through the umbilicus. An adequate pneumoperitoneum is achieved. The veries needle is then removed and a 10 mm trochar is placed. Using the laparoscope, confirmation of no abdominal or pelvic injuries. Next, using the laparoscopic assisted guidance, a right and left lower quadrant 10 mm trochar port is placed ensuring that there is no injury to the abdominal wall vasculature. At this time, decompression of the uterus is performed by performing multiple myomectomies. Multiple large myomas are noted and injected with a solution of dilute Pitressin. Using the harmonic scalpel, the surface of the myomas are incised along their length, and using a combination of blunt and sharp dissection, the myomas are grasped and removed by a means of sharp and blunt dissection. These myomas are then sutured, tagged and placed into the posterior cul-de-sac to be removed at the time of the vaginal portion of the procedure. After adequate decompression is performed, the fibroid beds are then cauterized to achieve adequate hemostasis. Next, attention is then turned to the round ligaments which are then clamped, cauterized and transected bilaterally. Next, the uteroovarian vasculature is again clamped, cauterized and transected bilaterally. Hemostasis is assured.

Next, attention is then turned to the vaginal portion of the procedure. All air is allowed to be exsufflated from the patient's abdomen and the laparoscope is removed. The Valchev uterine manipulator is then removed and the single tooth tenaculum is repositioned for means of traction of the uterus. Using the Bovie, the cervix is then incised circumferentially at the cervicovaginal junction. The anterior and posterior cul-de-sacs are entered carefully using sharp dissection. The peritoneum is identified posteriorly and a figure-of-eight stay suture is placed for hemostasis and securement of the posterior peritoneum. Next, a narrow weighted speculum is placed in the posterior cul-de-sac. Using Haney clamps, the uterosacral, cardinal and broad ligaments are bilaterally clamped, cut and ligated. This is continued until the fundal region is reached. At that time the uterine specimen is delivered and handed off field.

General traction and palpation of the ovaries is done at this time and the pedicles are inspected for excellent hemostasis. After all pedicles are carefully inspected to ensure hemostasis, the peritoneum and vaginal cuff are closed in the usual fashion. Attention is then directed toward the abdomen where, after trochar removal, these abdominal incisions are also closed in the usual fashion.

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 is evaluated and stabilized. The family is then counseled regarding the results of the procedure and the anticipated convalescence. Once the patient is alert, she too is counseled regarding the outcome of the surgery and the anticipated hospital stay and subsequent convalescence. She is monitored the day of surgery as well as the following day in the hospital. She is discharged in the evening or afternoon of post day #1. She will be followed as an outpatient with approximately two or three office visits during the next 90-day global period.

SURVEY DATA

Presenter(s):	George Hill, MD, FACOG and Sandra Reed, MD, FACOG					
Specialty(s):	American College of Obstetricians and Gynecologists (ACOG)					
CPT Code:	58553, Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams					
Sample Size:	70	**Resp n:**	33	**Resp %:**	47%	
Sample Type:	Survey was distributed at the American Association of Gynecological Laparoscopists (AAGL) annual meeting.					
		Low	**25th pctl**	**Median**	**75th pctl**	**High**
Survey RVW:		14.19	17.75	20	23.13	32.14
Pre-Service Time: (day preceding procedure)		5	27.5	~~42.5~~ **30**	60	120
Pre-Service Time: (day of procedure)		0	30	~~45~~ **30**	50	60
Intra-Service Time:		30	120	**150**	180	240
Post-Service	**Total Min***	**CPT code / # of visits**				
Immed. Post-time:	**37.5**					
Critical Care time/visit(s):	**0**					
Other Hospital time/visit(s):	**49**	**99232/1 and 99231/1**				
Discharge Day Mgmt:	**36**	**99238/1**				
Office time/visit(s):	~~53~~ **46**	~~99214/1 and 99212/1~~ **2x 99213**				

*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
58550	Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)	10	14.19

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: 58553	Key Reference CPT Code: 58550
Median Pre-Service Time	~~90~~ 60	
Median Intra-Service Time	150	
Median Immediate Post-service Time	37.5	
Median Critical Care Time	0	
Median Other Hospital Visit Time	49	
Median Discharge Day Management Time	36	
Median Office Visit Time	~~53~~ **46**	
Median Total Time	~~415.5~~ **378.5**	

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	4.08	3.77
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.08	3.77
Urgency of medical decision making	3.67	3.6

Technical Skill/Physical Effort (Mean)

Technical skill required	4.88	4.17
Physical effort required	4.72	3.93

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.59	4.00
Outcome depends on the skill and judgement of physician	4.88	4.17
Estimated risk of malpractice suit with poor outcome	4.63	4.13

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.73	3.48

Intra-Service intensity/complexity	4.70	4.06
Post-Service intensity/complexity	3.80	3.58

ADDITIONAL RATIONALE

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

SURVEY METHOD

At the September 2002 RUC meeting, the RUC research subcommittee approved the revised multiple code survey instrument proposed by the American College of Obstetricians and Gynecologists (ACOG).

ACOG in collaboration with the American Association of Gynecological Laparoscopists (AAGL) disseminated the RUC survey at the November 2002 AAGL annual meeting. Thirty-three surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG and AAGL reviewed the results and drafted the final recommendations.

PANEL DISCUSSION

The panel developed the recommendation in the following manner:

1. Reviewing the survey data
2. Comparing the surveyed code (58553) with similar codes
3. Comparing the surveyed value with the interim value

Survey Data – ACOG received thirty-one completed surveys. The panel recommended 20.00 RVW, the survey median. The panel tested the validity of the median surveyed RVW using IWPUT analysis. **Applying the formula to the surveyed code resulted in an IWPUT of .08. The panel concluded that .08 was an appropriate value for this level of service.**
CPT code values: 99232= 1.06; 99231= .64; 99238=1.28; 99213x2= 1.30

20.00 - {.0224(60min) + .0224(37.5 min) + 1.06 + .64 + .1.28 + .1.30} /150 min = .08 IWPUT

Similar codes – Next the panel compared the surveyed code (5854X2) with similar codes 58150, Total Abdominal Hysterectomy and 58290, Vaginal hysterectomy, for uterus greater than 250 grams. CPT code 58150 is valued at 15.24 RVW and the RUC approved 19.00 RVW for 58290 at the April 2002 meeting. For your reference, a summary of the times for all three codes is listed below.

CPT CODE	58553	58290	58150
RVW	20.00	19.00	15.24
PRE-SERVICE TIME	~~90~~ **60**	75	60
INTRA SERVICE TIME	150	120	120
IMMEDIATE POST-SERVICE TIME	37.5	30	40
HOSPITAL VISITS TIME	49	60	87
DISCHARGE TIME	36	36	36
OFFICE VISIT TIME	~~53~~ **46**	46	46
TOTAL TIME	~~415.5~~ **378.5**	367	389

The panel agreed that the consistently higher times for 58553 supported the recommendation of 20.00 RVW. These higher times were a reflection of the intensity and complexity of this procedure.

Interim value –The interim value recommended by the RUC in April 2002 was 19.00. The interim data, a fair estimation of physician work was in the end an estimation. The panel agreed that survey data provided strong evidence that 20.00, the survey median, is a fair and reasonable recommendation for physician work for this code.

The panel unanimously supports the recommendation of 20.00 RVW for 58553.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported?
CPT code 58550, Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)

(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 American Association of Gynecological Laparoscopists (AAGL)
_____Commonly
X Sometimes
_____Rarely

Specialty American College of Obstetricians and Gynecologists (ACOG)
_____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.

It is estimated that 10-15% of abdominal hysterectomies are now done laparoscopically

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.

It is unlikely that this procedure will be performed on Medicare patients.

Specialty _____ Frequency_____

Specialty _____ Frequency_____

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 58554 **Tracking Number:** B6 **Global Period:** 090 **Recommended RVW:** 22

CPT Descriptor: 58554, Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 45 year-old G1P1 is evaluated for profound menorrhagia with anemia. Her hematocrit is 25% despite daily iron therapy and treatment with oral contraceptives. On physical examination she has an irregular, mobile 12-14 week size fibroid uterus. Ultrasound confirms multiple uterine fibroids, several of which impinge on the endometrium. After management options are discussed with her, the patient elects a hysterectomy. A laparoscopic assisted vaginal hysterectomy (LAVH) is performed. The patient has a strong history of ovarian cancer in her family and does not desire any more children therefore her tube(s) and ovary(s) are removed.

Description of Pre-Service Work:

The preservice work includes performing a comprehensive preoperative medical history, physical exam including a detailed pelvic exam. A physician must dictate a history and physical, including all admission orders. The patient is identified in the preoperative holding area with the appropriate consents. Patient identification is verified. The patient's family is also spoken to. All preoperative documentation is also reviewed at this time. This includes imaging studies, including ultrasounds and associated laboratory data. The physician reviews with the OR personnel the operative instrumentation necessary for the advanced operative laparoscopy. This includes ensuring that the video monitors are in proper working order. The patient is taken to the OR and correctly positioned on the operating table. This includes positioning of the lower extremities to avoid any potential injury. The physician will also position the monitors prior to the beginning of the case.

Description of Intra-Service Work:

An exam under anesthesia is performed and compared to preoperative findings. The patient is then prepped and draped in the usual sterile fashion in the dorsal lithotomy position. A Foley catheter is placed to provide intermittent bladder drainage. Next a weighted speculum is placed into the patient's vagina and the anterior lip of the cervix is grasped using a single tooth tenaculum. A Valchev uterine manipulator is placed after the cervix is adequately dilated to accommodate the Valchev manipulator. The weighted speculum is then removed from the patient's vagina.

Next, attention is turned to the abdominal portion of the procedure. The abdomen is tented and veries needle is inserted. An adequate pneumoperitoneum is achieved and a 10 mm trochar is placed umbillicaly. The laparoscope is then advanced through this port and a survey of the abdomen is performed to ensure no injury to any vasculature, abdominal or pelvic structures. Next, under laparoscopic guidance, two additional 10 mm trochar ports are placed in the right and left lower quadrant with care to avoid any abdominal wall vasculature. Next, a survey of the abdomen and pelvis are performed noting multiple large fibroids. Based on their large size and position a myomectomy must first be performed to allow safe removal of the uterus transvaginally. The large fibroids are injected with a solution of dilute Pittressin until adequate blanching is noted. Using the harmonic scalpel, the surface of each injected fibroid is incised and excellent hemostasis is achieved. Next, using sharp dissection, each large fibroid is removed from the myometrium using careful sharp dissection. Once removed the fibroids are suture tagged and placed into the posterior cul-de-sac to be removed at the time of the vaginal portion of the hysterectomy. This is repeated until adequate decompression is achieved. The fibroid beds within the myometrium are then cauterized until adequate hemostasis is achieved. Next, once the myomectomy portion of this procedure is complete, attention is turned to the BSO portion of the procedure where the round ligaments bilaterally are clamped, cut and transected. The ureters are inspected bilaterally. Next, infundibular pelvic ligaments are clamped, cauterized and transected. Hemostasis is assured.

Next attention is turned to the vaginal portion of the procedure and the laparoscope is removed and all gas is allowed to exsufflate from the patient's abdomen. The Valchev uterine manipulator is removed and the single tooth tenaculum is repositioned to provide traction. Next, the cervix is circumferentially incised at the cervicovaginal junction in a clockwise fashion. The anterior and posterior cul-de-sacs are entered using careful sharp dissection. Posterior the peritoneum is identified and a figure-of-eight stay suture is placed for hemostasis and securement using Haney clamps, the uterosacral, cardinal and broad ligaments are bilaterally clamped, cut and ligated. Once freed, the uterus is then delivered. All pedicles are inspected to ensure hemostasis. The specimen is then handed off the field. The vaginal portion of the procedure is then considered complete. The peritoneum and vaginal cuff are closed in the usual fashion. Attention is then turned to the abdominal incisions, which, after trochar removal, are closed, in the usual fashion.

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 is evaluated and stabilized. The family is then counseled regarding the results of the procedure and the anticipated convalescence. Once the patient is alert, she too is counseled regarding the outcome of the surgery and the anticipated hospital stay and subsequent convalescence. She is monitored the day of surgery as well as the following day in the hospital. She is discharged in the evening or afternoon of post day #1. She will be followed as an outpatient with approximately two to three office visits during the 90-day global period.

SURVEY DATA

Presenter(s):	George Hill, MD, FACOG and Sandra Reed, MD, FACOG					
Specialty(s):	American College of Obstetricians and Gynecologists (ACOG)					
CPT Code:	58554, Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)					
Sample Size:	70	**Resp n:**	34	**Resp %:**	46%	
Sample Type:	Survey was distributed at the American Association of Gynecological Laparoscopists (AAGL) annual meeting.					
		Low	**25th pctl**	**Median**	**75th pctl**	**High**
Survey RVW:		14.19	19.25	22.00	24.00	30.00
Pre-Service Time: (day preceding procedure)		5	30	~~45~~ **30**	60	120
Pre-Service Time: (day of procedure)		25	30	~~45~~ **30**	51.25	60
Intra-Service Time:		15	148.75	**167.5**	210	240

Post-Service	**Total Min***	**CPT code / # of visits**
Immed. Post-time:	**37.5**	
Critical Care time/visit(s):	**0**	
Other Hospital time/visit(s):	**49**	**99232/1 and 99231-1**
Discharge Day Mgmt:	**36**	**99238/1**
Office time/visit(s):	**61**	**99213/2 and 99212/1**

*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
58550	Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)	10	14.19

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: 58554**	**Key Reference CPT Code: 58550**
Median Pre-Service Time	~~90~~ 60	
Median Intra-Service Time	167.5	
Median Immediate Post-service Time	37.5	
Median Critical Care Time	0	
Median Other Hospital Visit Time	49	
Median Discharge Day Management Time	36	
Median Office Visit Time	61	
Median Total Time	~~441~~ **411**	

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.11	3.74
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.11	3.74
Urgency of medical decision making	3.77	3.61

Technical Skill/Physical Effort (Mean)

Technical skill required	4.88	4.13
Physical effort required	4.76	4.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.70	4.03
Outcome depends on the skill and judgement of physician	4.88	4.16
Estimated risk of malpractice suit with poor outcome	4.61	4.13

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.89	3.48
Intra-Service intensity/complexity	4.80	4.06
Post-Service intensity/complexity	4.05	3.61

ADDITIONAL RATIONALE

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

SURVEY METHOD

At the September 2002 RUC meeting, the RUC research subcommittee approved the revised multiple code survey instrument proposed by the American College of Obstetricians and Gynecologists (ACOG).

ACOG in collaboration with the American Association of Gynecological Laparoscopists (AAGL) disseminated the RUC survey at the November 2002 AAGL annual meeting. Thirty-four surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG and AAGL reviewed the results and drafted the final recommendations.

PANEL DISCUSSION

The panel developed the recommendation in the following manner:

1. Reviewing the survey data using IWPUT analysis
2. Reviewing survey data using the building block approach

IWPUT analysis– ACOG received thirty-four completed surveys. The median RVW from the data was 22.00. The panel tested the validity of the median surveyed RVW using IWPUT analysis.
CPT code values: 99232= 1.06; 99231= .64; 99238=1.28; 99213= .67; 99212= .45

22.00 - {.0224(90min) + .0224(37.5 min) + 1.06 + .64 + .1.28 + .67 + .67 + .45} /167.5min = .09 IWPUT

Applying the formula to the surveyed code resulted in an IWPUT of .09. The panel discussed the .09 intensity was slightly higher than 5855X2. While the panel agreed that complexity and physician skill required of this procedure should result in an intensity around that level but the difference in intensity level from CPT code 5855X2 was a result of minor flaws in a small data sample. Therefore the panel concluded that .09 was an appropriate value for this level of service.

Building block approach – The panel then used the building block approach to validate the recommendation and to identify the appropriate value for removal of tube(s) and ovary(s).
CPT code 5855X2, Laparoscopic hysterectomy greater than 250 grams = 20.00 RVUs
CPT code 58661, Laparoscopic removal of tubes and ovary(s) = 11.05

20.00 + .50(11.05) = 25.50 RVUs

Another method is to compare the difference in similar vaginal procedures.
CPT code 58260 Vaginal hysterectomy = 12.98
CPT code 58262, Vaginal hysterectomy with removal of tubes and ovary(s) = 14.77
14.77 – 12.98 = 1.79

The difference between these two codes is 1.79 RVUs. Similarly the difference in the recommended values for the laparoscopic codes is 2.00 RVUs.
CPT code 58554, Laparoscopic hysterectomy greater than 250 grams with removal of tube(s) and ovary(s) = 22.00
CPT code 5855X2, Laparoscopic hysterectomy greater than 250 grams = 20.00
22.00 – 20.00 = 2.00

The panel agreed that both methods validate the survey median of 22.00 RVW for this code.

The panel concluded discussion of this code by unanimously supporting the recommendation of 22.00 RVW for 58554.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported?
CPT code 58550, Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)

(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.

CPT Code: 58554

Specialty American Association of Gynecological Laparoscopists (AAGL)
_____Commonly
X Sometimes
_____Rarely

Specialty American College of Obstetricians and Gynecologists (ACOG)
_____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.

It is estimated that 10-15% of abdominal hysterectomies are now done laparoscopically

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.
It is unlikely that this procedure will be performed on Medicare patients.

Specialty _____ Frequency_____

Specialty _____ Frequency_____

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

	A	B	C	D	E	F	G	H	I
1			FAMILY 1						
2			CPT Code -58545		CPT Code - 58546				
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Code Descriptor - Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; excision of 1-4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas		Code Descriptor - Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams				
4	LOCATION		In Office	Out Office	In Office	Out Office			
5	GLOBAL PERIOD			90		90			
6	TOTAL CLINICAL LABOR TIME		0.0	144.0	0.0	144.0			
7	TOTAL PRE-SERV CLINICAL LABOR TIME		0.0	60.0	0.0	60.0			
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		0.0	12.0	0.0	12.0			
9	TOTAL POST-SERV CLINICAL LABOR TIME		0.0	72.0	0.0	72.0			
10	PRE-SERVICE								
11	**Start: Following visit when decision for surgery or procedure made**								
12	Complete pre-service diagnostic & referral forms			5		5			
13	Coordinate pre-surgery services			20		20			
14	Schedule space and equipment in facility			8		8			
15	Office visit before surgery/procedure· Review test and exam results			0		0			
16	Provide pre-service education/obtain consent			20		20			
17	Follow-up phone calls & prescriptions			7		7			
18	Other Clinical Activity (please specify)			0		0			
19	**End:When patient enters office/facility for surgery/procedure**								
20	SERVICE PERIOD								
21	**Start: When patient enters office/facility for surgery/procedure**								
22	**Pre-service services**								
23	Review charts			0		0			
24	Greet patient and provide gowning			0		0			
25	Obtain vital signs			0		0			
26	Provide pre-service education/obtain consent			0		0			
27	Prepare room, equipment,supplies			0		0			
28	Prepare and position patient/ monitor patient/ set up IV			0		0			
29	Sedate/apply anesthesia			0		0			
30	**Intra-service**								
31	Assist physician in performing procedure			0		0			
32	**Post-Service**								
33	Monitor pt following service/check tubes, monitors, drains			0		0			
34	Clean room/equipment by physician staff			0		0			
35	Complete diagnostic forms, lab & X-ray requisitions			0		0			
36	Review/read X-ray, lab, and pathology reports			0		0			
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions			0		0			
38	Coordination of Care					0			
39	Discharge day management 99238 --12 minutes 99239 --15 minutes			12		12			
40	Other Clinical Activity (please specify)			0		0			
41	**End: Patient leaves office**								
42	POST-SERVICE Period								
43	**Start: Patient leaves office/facility**								
44	Conduct phone calls/call in prescriptions			0		0			
45	*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 or outpatient care								
46	*List Number and Level of Office Visits*								
47	99211 16 minutes	16		0		0			
48	99212 27 minutes	27		0		0			
49	99213 36 minutes	36		72		72			
50	99214 53 minutes	53		0		0			
51	99215 63 minutes	63		0		0			
52	Other								
53									
54	*Total Office Visit Time*		0	72	0	72			
55	Other Activity (please specify)								
56	**End: with last office visit before end of global period**								

	A	B	C	D	E	F	G	H	I
2			CPT Code -58545		CPT Code - 58546				
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Code Descriptor - Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; excision of 1-4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas:		Code Descriptor - Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams				
4	LOCATION		In Office	Out Office	In Office	Out Office			
57	MEDICAL SUPPLIES								
58	OB/GYN Supply Package A			2		2			
59	OB/GYN Supply Package B			2		2			
60	Drape sheet	1106		2		2			
61									
62									
63									
64									
65	Equipment								
66	power table	E11003		80		106			
67	fiberoptic exam light	E11006		80		106			
68									
69									
70									
71									

	A	B	C	D	E	F	G	H	I	J
1			FAMILY 1							
2			CPT Code -58550		CPT Code - 58552		CPT Code - 58553		CPT Code - 58554	
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Code Descriptor - Laparoscopy, surgical, with vaginal hysterectomy; for uterus 250 grams or less		Code Descriptor - Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)		Code Descriptor - Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams		Code Descriptor - Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)	
4	LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office
5	GLOBAL PERIOD			90		90		90		
6	TOTAL CLINICAL LABOR TIME		0.0	171.0	0.0	171.0	0.0	144.0	0.0	171.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME		0.0	60.0	0.0	60.0	0.0	60.0	0.0	60.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		0.0	12.0	0.0	12.0	0.0	12.0	0.0	12.0
9	TOTAL POST-SERV CLINICAL LABOR TIME		0.0	99.0	0.0	99.0	0.0	72.0	0.0	99.0
10	PRE-SERVICE									
11	Start: Following visit when decision for surgery or procedure made									
12	Complete pre-service diagnostic & referral forms			5		5		5		5
13	Coordinate pre-surgery services			20		20		20		20
14	Schedule space and equipment in facility			8		8		8		8
15	Office visit before surgery/procedure Review test and exam results			0		0		0		0
16	Provide pre-service education/obtain consent			20		20		20		20
17	Follow-up phone calls & prescriptions			7		7		7		7
18	Other Clinical Activity (please specify)			0		0		0		0
19	End:When patient enters office/facility for surgery/procedure									
20	SERVICE PERIOD									
21	Start: When patient enters office/facility for surgery/procedure									
22	Pre-service services									
23	Review charts			0		0		0		
24	Greet patient and provide gowning			0		0		0		
25	Obtain vital signs			0		0		0		
26	Provide pre-service education/obtain consent			0		0		0		
27	Prepare room, equipment,supplies			0		0		0		
28	Prepare and position patient/ monitor patient/ set up IV			0		0		0		
29	Sedate/apply anesthesia			0		0		0		
30	Intra-service									
31	Assist physician in performing procedure			0		0		0		
32	Post-Service									
33	Monitor pt. following service/check tubes, monitors, drains			0		0		0		
34	Clean room/equipment by physician staff			0		0		0		
35	Complete diagnostic forms, lab & X-ray requisitions			0		0		0		
36	Review/read X-ray, lab, and pathology reports			0		0		0		
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions			0		0		0		
38	Coordination of Care			0		0		0		
39	Discharge day management 99238 --12 minutes 99239 --15 minutes			12		12		12		12
40	Other Clinical Activity (please specify)			0		0		0		
41	End: Patient leaves office									
42	POST-SERVICE Period									
43	Start: Patient leaves office/facility									
44	Specialty Society: ACOG Recommendation -59812			0		0		0		

	A	B	C	D	E	F	G	H	I	J
2			CPT Code -58550		CPT Code - 58552		CPT Code - 58553		CPT Code - 58554	
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Code Descriptor - Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less		Code Descriptor - Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and /or ovary(s)		Code Descriptor - Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams		Code Descriptor - Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams, with removal of tube(s) and/or ovary(s)	
4	LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office
45	*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 f									
46	*List Number and Level of Office Visits*									
47	99211 16 minutes	16		0		0		0		
48	99212 27 minutes	27		27		27		0		27
49	99213 36 minutes	36		72		72		72		72
50	99214 53 minutes	53		0		0		0		
51	99215 63 minutes	63		0		0		0		
52	Other									
53										
54	*Total Office Visit Time*		0	99	0	99	0	72	0	99
55	Other Activity (please specify)									
56	**End: with last office visit before end of global period**									

	A	B	C	D	E	F	G	H	I	J
2			CPT Code 58550		CPT Code - 58552		CPT Code - 58553		CPT Code - 58554	
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Code Descriptor - Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less		Code Descriptor - Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)		Code Descriptor - Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams;		Code Descriptor - Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)	
4	LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office
57	MEDICAL SUPPLIES									
58	OB/GYN Supply Package A			3		3		2		3
59	OB/GYN Supply Package B			3		3		2		3
60	Drape sheet	1106		3		3		2		3
61										
62										
63										
64										
65	Equipment									
66	power table	E11003		99		99		80		99
67	fiberoptic exam light	E11006		99		99		80		99
68										
69										
70										
71										

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Laproscopic Hysterectomy/Myomectomy Procedures

New codes 58545, 58546, 58550, and 58552-58554 were created to specifically describe vaginal hysterectomy/myomectomy procedures performed on enlarged uteri.

The specialty society stated that they would need to re-survey these codes, as the correct global period for these services should be 90 days not 10 days as stated on their survey instrument. The specialty will present survey data to the RUC at the September 2002 RUC meeting. However, in the interim, the RUC recommends that these laproscopic codes be valued equivalent to the recommended relative work values of the open approach hysterectomy codes as follows:

New Code	Tracking Number	Crosswalk to Code	Work RVU
58545	BA1	58140	14.60
58546	BA2	58146	19.00
58550	BA3	58550 (old code number 56308)	14.19 (no change)
58552	BA4	58550 (old code number 56308)	14.19
58553	BA5	58290	19.00
58554	BA6	58290	19.00

58550 and 58552 both compared to 58550 *Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)* (RVU = 14.19) because there is no difference in the work of removing the tube or ovaries in the laproscopic approach. The same applies to 58553 and 58554 where both are crosswalked to 58290 *Vaginal hysterectomy, for uteri greater than 250 grams* (recommended RVU 19.00). **Therefore, the RUC recommends interim work relative values of 14.60 for 58545, 19.00 for 58546, 14.19 for 58550 and 58552, 19.00 for 58553 and 58554.**

Practice Expense

The RUC approved the practice expense inputs for 58545,58546, 58550, and 58552-58554. The RUC understood that the 90- day global period standard should apply for all of these codes. **The RUC recommends all the practice expense inputs presented by the specialty society.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●58545	BA1	Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; 1 to 4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas	090	14.6 (Interim)
●58546	BA2	5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams	090	19.00 (Interim)
▲58550 56308 (old code #)	BA3	Laparoscopy surgical~~;~~ ,with vaginal hysterectomy, for uterus 250 grams or less; ~~with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy~~	090	14.19 (no change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
~~58551(D)~~ 56309 (old code #)		~~with removal of leiomyomata (single or multiple)~~ (58551 has been deleted. To report see 58545, 58546)	090	N/A
●58552	BA4	with removal of tube(s) and/or ovary(s)	090	14.19 (Interim)
●58553	BA5	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams;	090	19.00 (Interim)
●58554	BA6	with removal of tube(s) and/or ovary(s)	090	19.00 (Interim)

Summary of Crosswalk Physician Time

New Code	Crosswalk Code	Total Time	Pre-Service Time	Intra-Service Time	Post-Service Time	Other Hospital visits	Discharge Day Mgmt	Office Visits
58545	58140	360	60	120	30	68 – 2-99231 and 1-99232	36 – 1-99238	46 – 2-99213
58546	58146	411	70	150	30	79 – 1-99233 and 2-99231	36 – 1-99238	46 – 2-99213
58552	58550	351	N/A	N/A	N/A	-	36 – 1-99238	23 – 1-99213
58553	58290	367	75	120	30	60 – 2-99232	36 – 1-99238	46 – 2-99213
58554	58290	367	75	120	30	60 – 2-99232	36 – 1-99238	46 – 2-99213

	A	B	C	D	E	F	G	H
1								
2			58545		58546		58550	
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; 1 to 4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas		Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; 1 to 4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams		Laparoscopy surgical; with vaginal hysterectomy, for uterus 250 grams or less; with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy	
4	LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office
5	GLOBAL PERIOD			90				
6	TOTAL CLINICAL LABOR TIME		0.0	144.0	0.0	144.0	0.0	108.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME		0.0	60.0	0.0	60.0	0.0	60.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		0.0	12.0	0.0	12.0	0.0	12.0
9	TOTAL POST-SERV CLINICAL LABOR TIME		0.0	72.0	0.0	72.0	0.0	36.0
10	PRE-SERVICE							
11	**Start: Following visit when decision for surgery or procedure made**							
12	Complete pre-service diagnostic & referral forms			5		5		5
13	Coordinate pre-surgery services			20		20		20
14	Schedule space and equipment in facility			8		8		8
15	Office visit before surgery/procedure: Review test and exam results							
16	Provide pre-service education/obtain consent			20		20		20
17	Follow-up phone calls & prescriptions			7		7		7
18	Other Clinical Activity (please specify)							
19	**End:When patient enters office/facility for surgery/procedure**							
20	SERVICE PERIOD							
21	**Start: When patient enters office/facility for surgery/procedure**							
22	**Pre-service services**							
23	Review charts							
24	Greet patient and provide gowning							
25	Obtain vital signs							
26	Provide pre-service education/obtain consent							
27	Prepare room, equipment,supplies							
28	Prepare and position patient/ monitor patient/ set up IV							
29	Sedate/apply anesthesia							
30	**Intra-service**							
31	Assist physician in performing procedure							
32	**Post-Service**							
33	Monitor pt. following service/check tubes, monitors, drains							
34	Clean room/equipment by physician staff							
35	Complete diagnostic forms, lab & X-ray requisitions							
36	Review/read X-ray, lab, and pathology reports							
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions							
38	Coordination of Care							
39	Discharge day management 99238 –12 minutes 99239 –15 minutes			12		12		12
40	Other Clinical Activity (please specify)							
41	**End: Patient leaves office**							
42	POST-SERVICE Period							
43	**Start: Patient leaves office/facility**							
44	Conduct phone calls/call in prescriptions							
45	*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 or outpatient care							
46	*List Number and Level of Office Visits*							
47	99211 16 minutes	16						
48	99212 27 minutes	27						
49	99213 36 minutes	36		72		72		36
50	99214 53 minutes	53						
51	99215 63 minutes	63						
52	Other							
53								
54	*Total Office Visit Time*		0	72	0	72	0	36

	A	B	C	D	E	F	G	H
2			58545		58546		58550	
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; 1 to 4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas		Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; 1 to 4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams		Laparoscopy surgical; with vaginal hysterectomy, for uterus 250 grams or less; with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy	
4	LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office
55	Other Activity (please specify)							
56	End: with last office visit before end of global period							

	A	B	C	D	E	F	G	H
2			58545		58546		58550	
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; 1 to 4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas		Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; 1 to 4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams		Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 grams or less; with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy	
4	LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office
57	MEDICAL SUPPLIES							
58	ACOG PEAC - approved supply package A			2		2		1
59	ACOG PEAC - approved supply package B			2		2		1
60	ACOG PEAC - approved supply package C			1		1		1
61	Drape Sheet	11106		1		1		1
62								
63								
64								
65	Equipment							
66	Exam Table	E1101		72		72		38
67								
68								
69								
70								

	A	B	I	J	K	L	M	N
1								
2			58552		58553		58554	
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Laparoscopy, surgical; with vaginal hysterectomy, for uterus 250 grams or less; with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy; with removal of tube(s) and/or ovary(s)		Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams;		Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)	
4	LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office
5	GLOBAL PERIOD							
6	TOTAL CLINICAL LABOR TIME		0.0	108.0	0.0	144.0	0.0	144.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME		0.0	60.0	0.0	60.0	0.0	60.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		0.0	12.0	0.0	12.0	0.0	12.0
9	TOTAL POST-SERV CLINICAL LABOR TIME		0.0	36.0	0.0	72.0	0.0	72.0
10	**PRE-SERVICE**							
11	**Start: Following visit when decision for surgery or procedure made**							
12	Complete pre-service diagnostic & referral forms			5		5		5
13	Coordinate pre-surgery services			20		20		20
14	Schedule space and equipment in facility			8		8		8
15	Office visit before surgery/procedure· Review test and exam results							
16	Provide pre-service education/obtain consent			20		20		20
17	Follow-up phone calls & prescriptions			7		7		7
18	Other Clinical Activity (please specify)							
19	**End:When patient enters office/facility for surgery/procedure**							
20	**SERVICE PERIOD**							
21	**Start: When patient enters office/facility for surgery/procedure**							
22	**Pre-service services**							
23	Review charts							
24	Greet patient and provide gowning							
25	Obtain vital signs							
26	Provide pre-service education/obtain consent							
27	Prepare room, equipment,supplies							
28	Prepare and position patient/ monitor patient/ set up IV							
29	Sedate/apply anesthesia							
30	**Intra-service**							
31	Assist physician in performing procedure							
32	**Post-Service**							
33	Monitor pt. following service/check tubes, monitors, drains							
34	Clean room/equipment by physician staff							
35	Complete diagnostic forms, lab & X-ray requisitions							
36	Review/read X-ray, lab, and pathology reports							
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions							
38	Coordination of Care							
39	Discharge day management 99238 –12 minutes 99239 –15 minutes			12		12		12
40	Other Clinical Activity (please specify)							
41	**End: Patient leaves office**							
42	**POST-SERVICE Period**							
43	**Start: Patient leaves office/facility**							
44	Conduct phone calls/call in prescriptions							
45	*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 or outpatient care							
46	*List Number and Level of Office Visits*							
47	99211 16 minutes	16						
48	99212 27 minutes	27						
49	99213 36 minutes	36		36		72		72
50	99214 53 minutes	53						
51	99215 63 minutes	63						
52	Other							
53								
54	*Total Office Visit Time*		0	36	0	72	0	72

	A	B	I	J	K	L	M	N
2			58552		58553		58554	
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Laparoscopy, surgical, with vaginal hysterectomy; for uterus 250 grams or less; with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy; with removal of tube(s) and/or ovary(s)		Laparoscopy, surgical, with vaginal hysterectomy; for uterus greater than 250 grams;		Laparoscopy, surgical, with vaginal hysterectomy; for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)	
4	LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office
55	Other Activity (please specify)							
56	End: with last office visit before end of global period							

	A	B	I	J	K	L	M	N
2			58552		58553		58554	
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Laparoscopy surgical; with vaginal hysterectomy, for uterus 250 grams or less; with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy, with removal of tube(s) and/or ovary(s)		Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams;		Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)	
4	LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office
57	MEDICAL SUPPLIES							
58	ACOG PEAC - approved supply package A			1		2		2
59	ACOG PEAC - approved supply package B			1		2		2
60	ACOG PEAC - approved supply package C			1		1		1
61	Drape Sheet	11106		1		1		1
62								
63								
64								
65	Equipment							
66	Exam Table	E1101		36		72		72
67								
68								
69								
70								

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Craniotomy/Cranial Bone Flap Procedures for Trauma

Four new codes and one revised code were created to appropriately describe craniotomy/cranial bone flap procedures for trauma. The RUC reviewed the survey data from 35 neurological surgeons.

61322 and 61323

After review of the survey data, the RUC concluded that the survey was flawed. The reference service list did not reflect the range of services appropriate to the survey of the new services. The highest reference service on the list was CPT 61538 *Craniotomy with elevation of bone flap; for lobectomy with electrocorticography during surgery, temporal lobe* (work RVU = 26.81). The RUC thought the results of the survey suggested that the respondents did not accurately value the work involved in the codes being surveyed. Finally, adopting the survey median values would create disparities in the relative values within the family of neurosurgical codes.

The RUC determined that the survey median did not reflect the work of this procedure as compared to the key reference service 61312, *Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural*, (work RVU = 24.57). In particular the patient population of the surveyed code is sicker than the patients represented by the reference code 61312. While the patients for 61312 recover relatively quickly from local brain trauma, the patients undergoing the surveyed procedure require more time and care for recovery from diffuse brain injury. Compared to the reference service, the intra- time was 30 minutes longer and the length of stay was 3 days longer for the code being surveyed. These factors justified recommending values higher than the survey's fiftieth percentile median values.

The RUC reviewed the new RUC MPC (approved earlier in the day) and agreed that the specialty society recommended work RVUs for both codes were consistent with similarly valued codes on the MPC list. Examples include 33533, *Coronary artery bypass, using arterial graft(s); single arterial graft*, (RVU= 30.00) and 61510, *Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma*, (RVU = 28.45). Considering all of these factors, the RUC recommends the values proposed by the specialty society.

The RUC recommends a work relative value of 29.50 for CPT code 61322.
The RUC recommends a work relative value of 31.00 for CPT code 61323.

61316

The specialty society revised the recommendation from 2.00 to 1.39. Upon further analysis of the survey data and the reference code of 20937, the society felt that the median survey response of 2.00 RVW did not accurately represent the work involved in the performance of this procedure. The intra-service time is 50 percent of the reference service code (20 minutes verses 40 minutes) and the measures of intensity were very similar.

Therefore, the RUC believes a value of 1.39, which is one half the value of the reference code and lies between the 25th and the 50th percentiles of the survey data, accurately represents the total work of this add-on code.

The RUC recommends a work relative value of 1.39 for CPT code 61316.

62148

The removal of the bone flap (62148) is performed electively - sometimes several months - after the original primary cranial procedure. Code 20937, *Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision*) (work RVU = 2.79), typically includes harvesting and placing a bone graft within the same operative site (i.e., exposure and closure are basically part of the primary procedure, with time necessary to fashion the graft). With 62148, re-exploration and dissection of scarred tissue is necessary to elevate the graft. As with the harvesting code 631X3, there is a separate wound that needs to be followed postoperatively. The survey median RVW of 2.00 for 62148 reflects the similarities and differences in "total" work (time/intensity), when compared with the reference code.

The RUC recommends a work relative value of 2.00 for CPT code 62148.

Practice Expense

The RUC recommends the practice expense inputs as submitted. The practice expense inputs are attached to the recommendation.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●61322	BB1	Craniectomy or craniotomy, decompressive, with or without duraplasty, for treatment of intracranial hypertension, without evacuation of associated intraparenchymal hematoma; without lobectomy (Do not report 61313 in addition to 61322) (For subtemporal decompression, use 61340)	090	29.50
●61323	BB2	with lobectomy (Do not report 61313 in addition to 61323) (For subtemporal decompression, use 61340)	090	31.00
▲61340	BB3	~~Other cranial decompression (eg, subtemporal), supratentorial~~ Subtemporal cranial decompression (pseudotumor cerebri, slit ventricle syndrome) (For decompressive craniotomy/craniectomy for intracranial hypertension, without hematoma evacuation, see 61322, 61323)	090	18.66 (no change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●✚61316	BB4	Incision and subcutaneous placement of cranial bone graft (List separately in addition to code for primary procedure) (Use 61316 in conjunction with codes 61304, 61312, 61313, 61340, 61322, 61323, 61570, 61571, 61680-61705)	ZZZ	1.39
●✚62148	BB5	Incision and retrieval of subcutaneous cranial bone graft for cranioplasty (List separately in addition to code for primary procedure) (Use 62148 in conjunction with codes 62140-61247)	ZZZ	2.00

CPT Code: 61322 (BB1) **Global:** 090 **Recommended RVW:** 29.50

CPT Descriptor: Craniotomy/craniectomy, decompressive, with duraplasty, without lobectomy, for treatment of intracranial hypertension, without evacuation of associated intraparenchymal hematoma
(Do not report 61313 in addition to 61322)
(For subtemporal decompression, use 61340)

SURVEY Vignette (Typical Patient)

Typical Patient: A 36-year-old male, involved in a motor vehicle accident, has suffered a severe traumatic brain injury and has been in the Surgical Intensive Care Unit for approximately 24 hours. An intracranial pressure monitor was placed for recording of continuous intracranial pressure (ICP). The patient develops intracranial hypertension uncontrolled by medical therapy. A CT scan revealed multiple non-hemorrhagic supratentorial contusions producing obliteration of the basal cisterns. At operation, a supratentorial decompressive craniotomy/ craniectomy with duraplasty is performed.

SUMMARY FORM Clinical Description Of Service:

Pre- service work:
Review recent work-up to confirm clinical findings: history and physical examination, chest x-ray, laboratory results, CT scans and other staging studies; write pre-operative orders for peri-operative medications; review planned incisions and procedure; confirm OR start time – notify patient/family; change into scrub clothes; review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient /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 have been administered; verify that all necessary surgical instruments, supplies, and devices are available in the operative suite; monitor patient positioning and draping; scrub and gown

Intra- service work -- skin to skin:
Under general anesthesia, the head is positioned and fixed in a pin headholder, using care to protect the intracranial pressure device. A bicoronal incision is made with elevation of a large bifrontal cranial bone flap. Meticulous hemostasis is observed. The frontal sinus opened during the craniotomy is stripped of its mucosa and obliterated with gelfoam. The dura is noted to be extremely tense. The dura is then opened, beginning over the polar areas of the frontal lobes. The dural opening is made very low near the frontal skull base, the sagittal sinus is ligated at its rostral extremity, the falx cerebri is divided, and the dural opening is carried across midline for approximately 10 cm length opening from one temporal to the opposite temporal fossa allowing the frontal lobes to expand through the dural opening. Hemostasis is ensured and the dura is closed with a cadaveric dural graft in a watertight manner to allow for anterior expansion of the swollen brain. The bifrontal bone flap is not replaced. An epidural drain is left in place to prevent epidural hematoma formation. A two-layer closure of the scalp is then completed. (Placement of the bone flap in the abdominal area through a separate incision for subsequent cranioplasty, if elected, is reported separately.)

Post-operative work, in hospital:
A dressing is applied. Orders are written to re-institute medical therapy for intracranial hypertension. An operative note is written in the patient's record. OR forms are signed, including pre- and postoperative diagnosis, operations performed. Orders are written for postop labs, films, medications (including CT scan(s) of the head, to monitor for cerebral edema or hematoma and anticonvulsant drug levels). Procedure outcome is discussed with the family. Postop report is dictated. Procedure outcome is discussed with referring physician. Procedure outcome and expected recovery letter is dictated for referring physician and/or insurance company. Perform on a daily basis, a neurologic exam, wound check, and patient progress. Frequent phone calls

throughout the day are made to keep up with the patient's ICP, fluid balance, and vital signs. Anticonvulsant drug levels are checked for therapeutic ranges. After intracranial pressure normalizes, orders are written for the intracranial pressure monitor to be removed and the patient is weaned from the ventilator and moved to an intermediate care unit. Continue daily neurologic exams and wound checks are performed. Chart patient progress notes daily. Discuss patient progress with referring physician (verbal and written). Coordinate care with other physicians (consultations are ordered from physical medicine, physical and occupational therapy, and speech therapy). Answer patient/family, nursing/other staff, insurance staff questions. When appropriate, the patient is moved to the med/surg floor, where daily neurologic exams and wound checks are continued. Orders are written for NG tube removal and reinstitution of oral diet. At discharge to an inpatient brain injury rehabilitation center, examine and talk with patient/family. Check wounds and patient progress. Check final pathology/lab/film reports and discuss with patient/family. Answer nursing/other staff and insurance staff questions. Write orders for post-discharge labs, films, and medications. Chart patient discharge notes.

Post-operative work, after discharge from hospital:
Coordination of care hospital discharge through discharge from the brain injury rehabilitation center is maintained via phone calls, adjusting treatment orders (labs, films, medications) and reviewing therapy orders/progress, as necessary. At followup office visits through the 90-day global period, a CT scan of the head is ordered and reviewed to evaluate for hydrocephalus; medications are reviewed, adjusted, and refilled as needed; neurologic exams and wound checks are performed and patient progress notes dictated for PCP. Orders are written/reviewed for continued medical/occupational/speech therapy.

SURVEY DATA

Presenter(s):

Specialty(s): The American Association of Neurological Surgeons, Congress of Neurological Surgeons

CPT: 61322

Sample Size: 85 **Resp n:** 41 **Resp %:** 48%

Sample Type: Random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	21.96	24.93	25.50	26.20	40.00
Pre-Service Time			90		
Intra-Service Time	90	120	150	180	210

Post-Service	**Total Min**	**CPT code / # of visits**	
Day of Surgery:			
Immediate	50		
Other	41	99233* x 1	
After Day of Surgery:			
Critical Care	123	99233* x 3	
Other Hospital	223	99232x3 99231x7	LOS=14
Dischg Day Mgmt	36	99238	
Office Visits	84	99213x3 99212x1	

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'02 RVW	Glob
61312	Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural	24.57	90

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

	Svy CPT	Ref CPT
TIME ESTIMATES (MEDIAN)	61322	61312
Pre-service	90	80
Intra-service	150	120
Same Day Immediate Post-service	50	35
Same Day Other Post-service	41	256
Post Total critical care (not same day)	123	
Post Total other hospital visit (not same day)	223	
Discharge management	36	36
Total office visit	84	92
TOTAL TIME	*798*	*619*

INTENSITY/COMPLEXITY MEASURES (mean)

TIME SEGMENTS

Pre-service	4.25	3.84
Intra-service	3.85	3.79
Post-service	4.20	4.00

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.10	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.90	3.45
Urgency of medical decision making	4.85	4.45

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	3.50	3.60
Physical effort required	3.60	3.65

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.55	4.10
Outcome depends on the skill and judgment of physician	3.95	3.65
Estimated risk of malpractice suit with poor outcome	3.85	3.80

RATIONALE: - Please refer to table at the end of summary form for "cell" references.

Based on a discussion of the survey data and a discussion of the nature of the patient requiring 61322 and 61323, the AANS-CNS is recommending 29.50 work-RVUs for 61322 and 31.00 work-RVUs for 61323. Our rationale for these recommendations is presented below.

Pre-/Intra-/Post-operative Day of Surgery Time

The pre-operative times/work for 61322 and 61323 and their reference codes 61312 and 61313 are very similar (see cells D6, D25, J6, J25). Also, relative to each other and to the reference codes, the intra-operative times are aligned correctly between the four procedures (see cells B19, B38, H19, H38). Post-operatively, patients requiring any of these procedures will be transferred to ICU care and require similar same-day attention by the neurosurgeon.

Length of Stay

For new codes 61322 and 61323, the length of stay data is not "tight" around a median as seen by the following LOS statistics:

	Survey LOS Statistic						
CPT	Range	25th pctl.	75th pctl.	Median	Mean	+/- SEM	Std. Dev
61322	7-25	10	17	14.0	14.2	0.7	4.6
61323	6-30	10	15	13.5	14.3	1.0	6.1

A majority of the work for these procedures occurs post-operatively in the management of the patient. Recovery from a decompressive cranial operation for a traumatic brain injury can - by it's nature - be quite variable. This is not dissimilar to procedures for management of pancreatitis (4800X), repair of large omphalocele/gastroschisis (49605), or debridement associated with open fractures (1101X). With each of these codes, 90-day global periods were initially assigned. Subsequent RUC survey of the codes showed that the postoperative work was extremely variable and/or the respondents discounted the postoperative work in their "magnitude estimation" of an RVW. For each code, the primary specialty and the RUC agreed that the survey median RVW data misrepresented the variable and/or lengthy nature of the postoperative care. In each instance, the RUC recommended that the global period be changed from 90 days to 10 or 0 days or the work-RVU be changed to deliver values that were more reflective of both the operation and the documented postoperative care and length of stay. For the pancreatitis and gastroschisis codes, the RVW was increased and the 90-day global period maintained. For the open fracture debridement codes, the global period was set at 010 for one code and 000 for the other two codes.

With respect to 61322 and 61323, the patient can be in the hospital anywhere from six to 30+ days, followed by a stay in a skilled nursing rehabilitation center, followed by elective reconstructive surgery. The length of stay is dependent on the extent of the brain injury and any other co-morbid trauma. Estimating a "typical" LOS for these infrequently performed procedures is difficult, as our survey data shows. The "median" stay is calculated at 14 days, however, the work estimation appears to discount the postoperative care.

Work-RVU Estimation

Relative to reference codes 61312 and 61313, the new codes represent significantly more total work. Side-by-side the new codes have additional intra-operative time (cells B19 vs H19 and cells B38 vs H38) and more postoperative care (cells D17 vs J17 and D36 vs J36), however this is not reflected in the median survey work-RVU. This fact is illustrated in Tables 1 and 2, where iwput calculations for each pair of codes is shown (cells C19 and C38). To arrive at work-RVU recommendations for these codes, we used the iwput for ICU care (=0.0667) to calculate a more reasonable RVU for the intraoperative time. This iwput is below both reference codes. We then added the difference accounted for by the additional/different level postoperative EMs. This methodology reasonably captures "relative" values for the new codes when compared with their similar reference procedures.

Summary

We recommend 29.50 work-RVUs for 61322 (cell G2) and 31.00 work-RVUs for 61323 (cell G21).

FREQUENCY INFORMATION

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

64999 Unlisted procedure, nervous system

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: Neurosurgery ~~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: Neurosurgery Frequency: Unknown, rare

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: Neurosurgery Frequency: Unknown, rare

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

Limited to neurosurgeons, specializing in cranial trauma.

	A	B	C	D	E	F	G	H	I	J
1	**TABLE 1**		**Svy Median RVW 61322**			**Specialty Recommended RVW 61322**			**Reference Code RVW 61312**	
2				**26.00**			**29.50**			**24.57**
3										
4	**Pre-service**	**Time**	**Intensity**	(=time x intensity)	**Time**	**Intensity**	(=time x intensity)	**Time**	**Intensity**	(=time x intensity)
5	Pre Service Time	90	0.0224	2.02	90	0.0224	2.02	80	0.0224	1.79
6	**Pre-service total**			**2.02**			**2.02**			**1.79**
7										
8	**Post-service**	**Time**	**Intensity**		**Time**	**Intensity**		**Time**	**Intensity**	
9	Immediate post time	50	0.0224	1.12	50	0.0224	1.12	35	0.0224	0.78
10	Subsequent visits:	**Visit n**	**E/M RVU**	(=n x E/M RVU)	**Visit n**	**E/M RVU**	(=n x E/M RVU)	**Visit n**	**E/M RVU**	(=n x E/M RVU)
11	99233	4.0	1.51	6.04	4.0	1.51	6.04	2.0	1.51	3.02
12	99232	2.0	1.06	2.12	2.0	1.06	2.12	2.0	1.06	2.12
13	99231	7.0	0.64	4.48	7.0	0.64	4.48	6.0	0.64	3.84
14	Discharge 99238	1.0	1.28	1.28	1.0	1.28	1.28	1.0	1.28	1.28
15	99213	3.0	0.65	1.95	3.0	0.65	1.95	4.0	0.65	2.60
16	99212	1.0	0.43	0.43	1.0	0.43	0.43	0.0	0.43	0.00
17	**Post-service total**			**17.42**			**17.42**			**13.64**
18		**Time**	**IWPUT**		**Time**	**IWPUT**		**Time**	**IWPUT**	
19	**Intra-service**	150	**0.044**	**6.56**	150	**0.067**	**10.06**	120	**0.076**	**9.13**

	A	B	C	D	E	F	G	H	I	J
20	**TABLE 2**		**Svy Median RVW 61323**			**Specialty Recommended RVW 61323**			**Reference Code RVW 61313**	
21				**26.48**			**31.00**			**24.93**
22										
23	**Pre-service**	**Time**	**Intensity**	(=time x intensity)	**Time**	**Intensity**	(=time x intensity)	**Time**	**Intensity**	(=time x intensity)
24	Pre Service Time	90	0.0224	2.02	90	0.0224	2.02	100	0.0224	2.24
25	**Pre-service total**			**2.02**			**2.02**			**2.24**
26										
27	**Post-service**	**Time**	**Intensity**		**Time**	**Intensity**		**Time**	**Intensity**	
28	Immediate post time	50	0.0224	1.12	50	0.0224	1.12	40	0.0224	0.90
29	Subsequent visits:	**Visit n**	**E/M RVU**	(=n x E/M RVU)	**Visit n**	**E/M RVU**	(=n x E/M RVU)	**Visit n**	**E/M RVU**	(=n x E/M RVU)
30	99233	3.0	1.51	4.53	3.0	1.51	4.53	2.0	1.51	3.02
31	99232	3.0	1.06	3.18	3.0	1.06	3.18	2.0	1.06	2.12
32	99231	8.0	0.64	5.12	8.0	0.64	5.12	5.0	0.64	3.20
33	Discharge 99238	1.0	1.28	1.28	1.0	1.28	1.28	1.0	1.28	1.28
34	99213	2.0	0.65	1.30	2.0	0.65	1.30	3.0	0.65	1.95
35	99212	1.0	0.43	0.43	1.0	0.43	0.43	0.0	0.43	0.00
36	**Post-service total**			**16.96**			**16.96**			**12.47**
37		**Time**	**IWPUT**		**Time**	**IWPUT**		**Time**	**IWPUT**	
38	**Intra-service**	180	**0.042**	**7.50**	180	**0.067**	**12.02**	150	**0.068**	**10.22**

CPT Code: 61323 (BB2) **Global:** 090 **Recommended RVW:** 31.00

CPT Descriptor: Craniotomy or craniectomy, decompressive, with lobectomy, with or without duraplasty, for treatment of intracranial hypertension, without evacuation of associated intraparenchymal hematoma
(Do not report 61313 in addition to 61323)
(For subtemporal decompression, use 61340)

SURVEY Vignette (Typical Patient)

Typical Patient: A 25-year-old male has suffered a severe traumatic brain injury and has been in the Surgical Intensive Care Unit for several days. An intracranial pressure monitor was placed for recording of continuous intracranial pressure (ICP). The patient develops intracranial hypertension uncontrolled by medical therapy. CT scan reveals a non-hemorrhagic supratentorial, temporal lobe contusion with significant edema and uncal herniation. At operation, a decompressive supratentorial craniectomy and lobectomy and duraplasty are performed.

SUMMARY FORM Clinical Description Of Service:

Pre- service work:
Review recent work-up to confirm clinical findings: history and physical examination, chest x-ray, laboratory results, CT scans and other staging studies; write pre-operative orders for peri-operative medications; review planned incisions and procedure; confirm OR start time – notify patient/family; change into scrub clothes; review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient /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 have been administered; verify that all necessary surgical instruments, supplies, and devices are available in the operative suite; monitor patient positioning and draping; scrub and gown

Intra- service work – skin to skin:
Under general anesthesia, the head is positioned and fixed in a pin headholder, using care to protect the intracranial pressure device. The neurosurgeon performs a cranial incision and turns a large unilateral bone flap overlying the frontal and temporal lobes. Care is taken to preserve the pericranium, which may be used for a dural expansion graft. Prior to the opening of the dura, close coordination with anesthesia is carried out to maximize medical control of the swollen brain. The dura over the temporal lobe is then opened. The brain is swollen and surgical landmarks are extremely difficult to identify. The anterior 5 centimeters of the temporal lobe are removed including the mesial structures in order to clearly identify the incisura. The vessels in the sylvian fissure are distorted by the underlying edema and are avoided to prevent disruption of major vascular channels. Adequate mesial temporal lobe resection allows the visualization of the third nerve, posterior cerebral artery and lateral portion of the brain stem. Following adequate decompression and thorough hemostasis the dura is closed with a pericranial graft to allow for expansion. The bone flap is replaced, if ICP and brain swelling permit (if brain swelling precludes safe replacement of the cranial flap, it can be placed in a subcutaneous pocket in the abdominal area; separately reportable). A layered closure is completed.

Post-operative work, in hospital:
A dressing is applied. Orders are written to re-institute medical therapy for intracranial hypertension. An operative note is written in the patient's record. OR forms are signed, including pre- and postoperative diagnosis, operations performed. Orders are written for postop labs, films, medications (including CT scan(s) of the head, to monitor for cerebral edema or hematoma and anticonvulsant drug levels). Procedure outcome is discussed with the family. Postop report is dictated. Procedure outcome is discussed with referring physician. Procedure outcome and expected recovery letter is dictated for referring physician and/or insurance company. Perform on a daily basis, a neurologic exam, wound check, and patient progress. Frequent phone calls

throughout the day are made to keep up with the patient's ICP, fluid balance, and vital signs. Anticonvulsant drug levels are checked for therapeutic ranges. After intracranial pressure normalizes, orders are written for the intracranial pressure monitor to be removed and the patient is weaned from the ventilator and moved to an intermediate care unit. Continue daily neurologic exams and wound checks are performed. Chart patient progress notes daily. Discuss patient progress with referring physician (verbal and written). Coordinate care with other physicians (consultations are ordered from physical medicine, physical and occupational therapy, and speech therapy). Answer patient/family, nursing/other staff, insurance staff questions. When appropriate, the patient is moved to the med/surg floor, where daily neurologic exams and wound checks are continued. Orders are written for NG tube removal and reinstitution of oral diet. At discharge to an inpatient brain injury rehabilitation center, examine and talk with patient/family. Check wounds and patient progress. Check final pathology/lab/film reports and discuss with patient/family. Answer nursing/other staff and insurance staff questions. Write orders for post-discharge labs, films, and medications. Chart patient discharge notes.

Post-operative work, after discharge from hospital:
Coordination of care hospital discharge through discharge from the brain injury rehabilitation center is maintained via phone calls, adjusting treatment orders (labs, films, medications) and reviewing therapy orders/progress, as necessary. At followup office visits through the 90-day global period, a CT scan of the head is ordered and reviewed to evaluate for hydrocephalus; medications are reviewed, adjusted, and refilled as needed; neurologic exams and wound checks are performed and patient progress notes dictated for PCP. Orders are written/reviewed for continued medical/occupational/speech therapy.

SURVEY DATA

Presenter(s):

Specialty(s): The American Association of Neurological Surgeons, Congress of Neurological Surgeons

CPT: 61323

Sample Size: 85 **Resp n:** 38 **Resp %:** 45%

Sample Type: Random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	23.00	26.00	26.48	28.00	35.00
Pre-Service Time			90		
Intra-Service Time	90	150	180	200	250

Post-Service	Total Min	CPT code / # of visits	
Day of Surgery:			
Immediate	50		
Other	41	99233* x1	
After Day of Surgery:			
Critical Care	82	99233* x2	
Other Hospital	242	99232x3 99231x8	LOS=14
Dischg Day Mgmt	36	99238	
Office Visits	61 ~~91~~	99213x2 99212x1	

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'02 RVW	Glob
61313	Craniectomy or craniotomy for evacuation of hematoma, supratentorial; intracerebral	24.93	90

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

	Svy CPT	Ref CPT
TIME ESTIMATES (MEDIAN)	61323	61313
Pre-service	90	100
Intra-service	180	150
Same Day Immediate Post-service	50	40
Same Day Other Post-service	41	237
Post Total critical care (not same day)	82	
Post Total other hospital visit (not same day)	242	
Discharge management	36	36
Total office visit	61	69
TOTAL TIME	*782*	*632*

INTENSITY/COMPLEXITY MEASURES (mean)

TIME SEGMENTS

Pre-service	4.28	3.78
Intra-service	4.39	4.00
Post-service	4.39	3.83

MENTAL EFFORT AND JUDGMENT

The number of possible diagnosis and/or the number of management options that must be considered	4.28	3.61
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.06	3.67
Urgency of medical decision making	4.83	4.33

TECHNICAL SKILL/PHYSICAL EFFORT

Technical skill required	4.00	3.56
Physical effort required	3.89	3.56

PSYCHOLOGICAL STRESS

The risk of significant complications, morbidity and/or mortality	4.67	4.17
Outcome depends on the skill and judgment of physician	4.17	3.67
Estimated risk of malpractice suit with poor outcome	4.33	3.78

RATIONALE:

Based on a discussion of the survey data and a discussion of the nature of the patient requiring 61322 and 61323, the AANS-CNS is recommending 29.50 work-RVUs for 61322 and 31.00 work-RVUs for 61323. Our rationale for these recommendations is presented on the Summary Form for 61322.

FREQUENCY INFORMATION

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

64999 Unlisted procedure, nervous system

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: Neurosurgery ~~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: Neurosurgery Frequency: Unknown, rare

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: Neurosurgery Frequency: Unknown, rare

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

Limited to neurosurgeons, specializing in cranial trauma.

CPT Code: 61316 (BB4) **Global:** ZZZ **RUC Recommended RVW:** ~~2.00~~ 1.39

CPT Descriptor: Incision and subcutaneous placement of cranial bone graft
(Use 61316 in conjunction with codes 61304, 61312, 61313, 61340, 61316, 62148, 61570, 61571, 61680-61705)

SURVEY Vignette (Typical Patient)

Typical Patient: A 25-year-old male was taken to the operating room for emergency supratentorial craniotomy and decompressive lobectomy. While in the operating room, at the time of the primary surgical procedure for the treatment of intracranial hypertension (e.g. decompressive craniotomy, lobectomy or evacuation of intracranial hematoma), the surgeon determines that immediate replacement of the cranial bone flap may aggravate intracranial hypertension from brain swelling. The surgeon decides to transplant the bone graft for future reconstructive surgery. A suitable area of the abdominal wall is prepped and draped in a sterile manner. An incision is made and a subcutaneous pocket is created. The cranial bone flap is placed into the subcutaneous space, and a closure of the subcutaneous tissues and skin is completed with application of a sterile dressing.
[Important note: For this survey of physician work, please only consider the additional work for incision and subcutaneous placement of the cranial bone graft in a subcutaneous abdominal pocket. All pre-operative, intraoperative, and post-operative work related to the craniotomy and decompressive lobectomy is separately reportable and should not be considered as part of the work for 61316.]

SUMMARY FORM Clinical Description Of Service:

Add-on work

While in the operating room, at the time of a primary surgical procedure for the treatment of intracranial hypertension (e.g. decompressive craniotomy, lobectomy or evacuation of intracranial hematoma) where immediate replacement of the cranial bone flap may aggravate intracranial hypertension from brain swelling, a suitable area of the abdominal wall is prepped and draped in a sterile manner. An incision is made, and a subcutaneous pocket is created. Hemostasis is achieved. The cranial bone flap is placed into the subcutaneous space. Closure of the subcutaneous tissues and skin is completed. A sterile dressing is applied. Orders appropriate for the primary procedure are written and specific description of the bone graft transplantation is incorporated into the operative report. Postoperative exams of this wound site are made, as necessary, until such time that the graft is used for reconstruction.

SURVEY DATA

Presenter(s):

Specialty(s): The American Association of Neurological Surgeons, Congress of Neurological Surgeons

CPT: 61316

Sample Size: 85 **Resp n:** 35 **Resp %:** 41%

Sample Type: Random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	1.00	1.25	2.00	2.50	5.00
Add-on Time	15	20	20	30	60

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'02 RVW	Glob
20937	Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision)	2.79	ZZZ

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

	Svy CPT	Ref CPT
TIME ESTIMATES (MEDIAN)	61316	20937
Add-On TIME	20	40
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Add-on service	2.00	2.50
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	2.00	1.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.67	1.92
Urgency of medical decision making	2.08	1.58
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	2.00	2.55
Physical effort required	2.08	2.45
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	1.92	2.36
Outcome depends on the skill and judgment of physician	2.00	2.27
Estimated risk of malpractice suit with poor outcome	2.33	2.45

RATIONALE:

For 61316, the bone harvest and placement locations are always through separate distant incisions, whereas with 20937, the donor site may be approached through a fascial incision from the primary operative site. Postoperatively, the placed bone graft for 61316 is followed separately from the primary procedure (eg, additional postop followup is required), whereas with 20937, the bone graft is part of the primary procedure and followup. Although the "surveyed" time for exposure, placement, and closure for 61316 is less than for 20937, 61316 requires follow-up, that is (currently) not part of the RUC survey. Care of this autograft is necessary for a satisfactory reconstruction of the skull deficit at a much later date. Independent questions may arise about this site that are independent of the primary procedure and patient progress. We are recommending the median RVW of 2.00 for 61316 as representative of the "total" work for this "add-on" code.

Additional Rationale:

Upon further analysis of the survey data and the reference code of 20937, we felt the median survey response of 2.0 RVW did not accurately represent the work involved in the performance of this procedure. The intra-service time is 50% of the reference code (20 minutes versus 40 minutes) and the measures of intensity were very similar.

Therefore we are recommending a value. of 1.39 This is one half the value of the reference code and lies between the 25th and 50th percentiles of our survey data. We feel this value more accurately represents the total work of this add-on 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)?

64999 Unlisted procedure, nervous system

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: Neurosurgery ~~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: Neurosurgery Frequency: Unknown, rare

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: Neurosurgery Frequency: Unknown, rare

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

Limited to neurosurgeons, specializing in cranial trauma.

CPT Code: 62148 (BB5) **Global:** ZZZ **Recommended RVW:** 2.00

CPT Descriptor: Incision and retrieval of subcutaneous cranial bone graft for cranioplasty (Use 62148 in conjunction with codes 62140-61247)

SURVEY Vignette (Typical Patient)

Typical Patient: A 25-year-old male, who is status-post emergency craniotomy for decompression with intraoperative placement of the bone graft into an abdominal subcutaneous pocket presents for elective cranioplasty repair of the skull defect. While in the operating room for elective cranioplasty, the abdominal graft site incision is sterilely prepped and draped. The previous incision is opened sharply, and the bone graft is identified. Using blunt dissection and electrocautery, the graft is freed from the surrounding tissue and temporarily placed in antibiotic solution on the back table, pending cranial implantation. The wound is irrigated, hemostasis is ensured and the skin is closed and dressed after completion of the cranial procedure.

[Important note: For this survey of physician work, please only consider the additional work for incision and retrieval of the cranial bone graft from a subcutaneous abdominal pocket. All pre-operative, intraoperative, and post-operative work related to the cranioplasty is separately reportable and should not be considered as part of the work for 62148.]

SUMMARY FORM Clinical Description Of Service:

Add-on work

While in the operating room for elective cranioplasty, the abdominal graft site incision is sterilely prepped and draped. The previous incision is opened sharply, and the bone graft is identified. Using blunt dissection and electrocautery, the graft is freed from the surrounding tissue and temporarily placed in antibiotic solution on the back table, pending cranial implantation. The wound is irrigated, hemostasis is ensured and the skin is closed and dressed after completion of the cranial procedure.

SURVEY DATA

Presenter(s):

Specialty(s): The American Association of Neurological Surgeons, Congress of Neurological Surgeons

CPT: 62148

Sample Size: 85 **Resp n:** 34 **Resp %:** 39%

Sample Type: Random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	1.00	1.21	2.00	2.50	4.00
Add-on Time	15	20	30	30	45

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'02 RVW	Glob
20937	Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision)	2.79	ZZZ

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

	Svy CPT	Ref CPT
TIME ESTIMATES (MEDIAN)	62148	20937
Add-On Time	30	40
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Add-on service	2.29	2.43
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	2.00	2.14
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.93	2.07
Urgency of medical decision making	2.21	1.93
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	2.29	2.57
Physical effort required	2.43	2.50
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	2.36	2.36
Outcome depends on the skill and judgment of physician	2.43	2.36
Estimated risk of malpractice suit with poor outcome	2.57	2.43

RATIONALE:

The removal of the bone flap (62148) is performed electively - sometimes several months - after the original primary cranial procedure. Code 20937 typically includes harvesting and placing a bone graft within the same operative site (ie, exposure and closure are basically part of the primary procedure, with time necessary to fashion the graft). With 62148, reexploration and dissection of scarred tissue is necessary to elevate the graft. As with the harvesting code 631X3, there is a separate wound that needs to be followed postoperatively. We recommend the survey median RVW of 2.00 for 62148 as reflective of the similarities and differences in "total" work (time/intensity), when compared 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)?

64999 Unlisted procedure, nervous system

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: Neurosurgery ~~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: Neurosurgery Frequency: Unknown, rare

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: Neurosurgery Frequency: Unknown, rare

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

Limited to neurosurgeons, specializing in cranioplasty.

	A	B	C	D	E	F	G
1		CPT:		61322	61323	61316	62148
2	**Tab H 613XX and 62148 PE Details (April 2002)**	DESCRIPTOR:		Craniotomy/craniectomy, decompressive, w/ duraplasty, w/o lobectomy, for treatment of intracranial hypertension, w/o evacuation of associated intraparenchymal	Craniotomy / craniectomy, decompressive, w/ lobectomy, w/ or w/o duraplasty, for treatment of intracranial hypertension, w/o evacuation of associated intraparenchymal	Incision and subcutaneous placement of cranial bone graft	Incision and retrieval of subcutaneous cranial bone graft for cranioplasty
3			GLOBAL:	90	90	ZZZ	ZZZ
4		Code	Desc	Facility Only	Facility Only	Facility Only	Facility Only
5	**PRE-service time**	130	RN/LPN/MA	0	0	0	0
6	**SERVICE time**	130	RN/LPN/MA	12	12	0	0
7	**POST-service time**	130	RN/LPN/MA	144	108	0	0
8	**PRE-SERVICE CLINICAL STAFF TIME**						
9	**BEGINS after decision to perform surgery (90-day off / fac)**						
10	Complete pre-service diagnostic & referral forms (5/5)	130	RN/LPN/MA	0	0	0	0
11	Coordinate pre-surgery services, review test/exam results (10/20)	130	RN/LPN/MA	0	0	0	0
12	OV before surgery: Review test and exam results (0/0)	130	RN/LPN/MA	0	0	0	0
13	Schedule space and equipment in facility (0/8)	130	RN/LPN/MA	0	0	0	0
14	Provide pre-service education/obtain consent (10/20)	130	RN/LPN/MA	0	0	0	0
15	Follow-up phone calls & prescriptions (10/7)	130	RN/LPN/MA	0	0	0	0
16	**ENDS with admission to site of service**						
17	**SERVICE PERIOD CLINICAL STAFF TIME**	Code	Desc				
18	**BEGINS with admission to site of service**						
19	99238 discharge visit			1	1	0	0
20	***99238 discharge time***	130	RN/LPN/MA	12	12	0	0
21	**End: Patient leaves site of service**						
22	**POST-SERVICE PERIOD CLINICAL STAFF TIME**	Code	Desc				
23	**Start: Patient leaves site of service**						
24	99211 16 minutes			0	0	0	0
25	99212 27 minutes			1	1	0	0
26	99213 36 minutes			3	2	0	0
27	99214 53 minutes			0	0	0	0
28	99215 63 minutes			0	0	0	0
29	***Total Office Visit Time:***	130	RN/LPN/MA	135	99	0	0
30	Other: Coordination phone calls while in rehab	130	RN/LPN/MA	9	9	0	0
31	**End: at completion of global period**						
32	**MEDICAL SUPPLIES - POST-OP OFFICE VISITS**	Code	Desc				
33	**Post-op Multispecialty Visit Package**	peac	pack	4	3	0	0
34	**Post-op Suture Care Kit:**	peac	pack	0	0	0	0
35	**EQUIPMENT**	Code					
36	exam lamp	E30006		1	1	0	0
37	exam table	E11001		1	1	0	0

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Implantation Brain Interstitial/Intracavitary Chemotherapy

One new add-on code was approved by the CPT Editorial Panel to describe the delivery or a chemotherapeutic agent through interstitial/intercavitary implantation. The RUC reviewed survey data from 31 neurological surgeons.

The RUC compared the following reference service codes that have a ZZZ global period:

20931, *Allograft for spine surgery only; structural* (RVU = 1.81); and
64484, *Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)* (RVU = 1.33).

In comparison to 20931, which includes measuring and fashioning the bone graft, new code 61517 requires less intra-operative time because pre-sized wafers are used. New code 61517 is very similar to 64484 in terms of total work (time/intensity). The total work of 61517 reflects placement of a chemotherapeutic agent into the brain as compared with extradural injection of a non-destructive substance for 64484. The RUC believed that the survey 25th percentile – instead of the survey median – more accurately reflects the time and intensity relationships among 61517, 20931, and 64484. Based on comparison to two reference codes with the same global period (20931 and 64484), this code is also in appropriate rank order. A RUC member requested that the RUC minutes reflect that this code is an example of when addition pre- or post-service time may be appropriate for a ZZZ code.

The RUC recommends a work relative value of 1.38 for CPT Code 61517.

Practice Expense
There are no direct practice expense inputs for this code, as it has a ZZZ global period.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
✚ ● 61517	BC1	Implantation of brain intracavitary chemotherapy agent (List separately in addition to code for primary procedure) (Use 61517 only in conjunction with codes 61510 or 61518) (Do not report 61517 for brachytherapy insertion. For intracavitary insertion of radioelement sources or ribbons, see 77761-77763, 77781-77784)	ZZZ	1.38

CPT Code: 61517 (BC1) **Global:** ZZZ **Recommended RVW:** 1.38

CPT Descriptor: Implantation of brain intracavitary chemotherapy agent (List separately in addition to code for primary procedure)
(Use 61517 only in conjunction with codes 61510 or 61518)
(Do not report 61517 for brachytherapy insertion. For intracavitary insertion of radioelement sources or ribbons, see 77761-77763, 77781-77784)

SURVEY Vignette (Typical Patient)

Typical Patient: A 50-year-old male, who is diagnosed with a recurrent frontal-parietal brain tumor, presents with a glioblastoma multiforme tumor. He undergoes surgery to resect the tumor, followed by implantation of chemotherapy wafers in the resected tumor.

[Important note: For this survey of physician work, please only consider the additional work for implanting and securing the wafers. All pre-operative, intraoperative, and post-operative work related to the tumor resection is separately reportable and should not be considered as part of the work for 61517.]

SUMMARY FORM Clinical Description Of Service:

Add-on work

Prior to operation, the surgeon verifies that all necessary equipment and chemotherapy wafers for implantation are available in the operative suite. At operation, after resection of the malignant brain tumor and prior to closure, chemotherapy wafters are implanted at the resection site. This involves placing each individual wafer in each appropriate area of the tumor bed and then securing each wafer with sheets of oxidized cellulose, avoiding placement adjacent to the ventricular wall or major vessels.

SURVEY DATA

Presenter(s):

Specialty(s): The American Association of Neurological Surgeons, Congress of Neurological Surgeons

CPT: 61517

Sample Size: 85 **Resp n:** 31 **Resp %:** 36%

Sample Type: Random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	0.20	1.38	1.90	3.00	6.00
Add-on Time	2	11	15	28	60

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'02 RVW	Glob
20931	Allograft for spine surgery only; structural	1.81	ZZZ
64484	Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)	1.33	ZZZ

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

	Svy CPT	Ref CPT
TIME ESTIMATES (MEDIAN)	61517	20931
Add-On time	15	20
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Add-on service	2.00	2.25
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	2.75	2.58
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.83	2.08
Urgency of medical decision making	2.50	1.92
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	2.33	2.17
Physical effort required	2.17	2.17
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	3.08	2.33
Outcome depends on the skill and judgment of physician	2.42	2.58
Estimated risk of malpractice suit with poor outcome	2.58	2.42

RATIONALE:

We are recommending the survey 25th percentile RVW of 1.38 for 61517 based on comparison to two reference codes with the same global period (20931 and 64484). In comparison to 20931, which includes measuring and fashioning the bone graft, new code 61517 requires less intraoperative time because pre-sized wafers are used. New code 61517 is very similar to 64484 in terms of total work (time/intensity). The total work of 61517 reflects placement of a chemotherapeutic agent into the brain as compared with extradural injection of a non-destructive substance for 64484. We believe the survey 25th percentile – instead of the survey median – more accurately reflects the time and intensity relationships among 61517, 20931, and 64484.

FREQUENCY INFORMATION

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

96549 - Unlisted chemotherapy procedure
64999 - Unlisted procedure, nervous system

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: Neurosurgery ~~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: Neurosurgery
Frequency: Over 8,000 individuals are diagnosed with glioblastoma multiforme a year in the U.S. Approximately, 80 percent of these patients undergo resection of their tumor and 40 percent will eventually develop recurrent disease requiring a second surgical procedure. This represents approximately 3,200 patients annually with recurrent disease that would be candidates for brain interstitial/intracavitary chemotherapy. Between 1997 and 2001 (five-year period), approximately 6,000 wafer implants (61517) were performed in the U.S.

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: Neurosurgery
Frequency: Unknown percentage of total population, as described in question 3 above.

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

Limited to neurosurgeons trained and familiar with this new technology.

	A	B	C	D
1	**Tab I 61517 PE Details (April 2002)**	**CPT:**		**61517**
2		**DESCRIPTOR:**		**Implantation of brain intracavitary chemotherapy agent**
3		**GLOBAL:**		**ZZZ**
4		**CMS Code**	**CMS Desc**	**Facility Only**
5	**PRE-service time**			**6**
6	**SERVICE time**			**0**
7	**POST-service time**			**0**
8	**PRE-SERVICE CLINICAL STAFF TIME**			
9	**BEGINS after consultation when a decision to perform surgery was made. (90-day off / fac)**			
10	calls to arrange for wafers (equipment)			**6**
11	**ENDS with admission to site of service**			
12	**SERVICE PERIOD CLINICAL STAFF TIME**			
13	**BEGINS with admission to site of service**			
14	none			**0**
15	**End: Patient leaves site of service**			
16	**POST-SERVICE PERIOD CLINICAL STAFF TIME**			
17	**Start: Patient leaves site of service**			
18	additional staff time over primary code for calls/counselling			**16**
19	**End: at completion of global period**			
20	**MEDICAL SUPPLIES - POST-OP OFFICE VISITS**			
21	none			**0**
22	**EQUIPMENT**			
23	none			**0**

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Endovascular Temporary Balloon Occlusion

One new code was created and one code was revised to describe both temporary and permanent balloon occlusions for the assessment of a patient in order to detect cerebral ischemia. The RUC reviewed survey data from 33 neurosurgeons/neuroradiologists.

The specialty groups reviewed the survey data (12.00 RVU) and determined that the median RVU of 16.00 seemed high and that the 25th percentile of the survey data better reflected the physician work involved in performing this procedure. However, upon further review, the RUC recommends an alternate approach based on valuing the incremental components was used to determine the RVU. For CPT code 61623 the incremental components include:

CPT Code/Description	RVU
99233	1.51
Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit	
36216/36217 (average)	5.79
Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family	
Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family	
36218	1.01
Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)	

75898	1.65
Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion	
Total RVU	*9.96*

IWPUT Calculations

Pre-service time	**Intensity**	**(= time x intensity)**
50	0.0224	1.2
Post-service time		
45	0.0224	1.01
Intra-service time		
90	IWPUT –0.087	7.83

Based on incremental components and IWPUT calculations the RUC recommends a relative work value of 9.96.

The RUC recommends a work relative value of 9.96 for CPT code 61623.

Practice Expense

These services are only performed in a facility. The RUC recommends a pre-service time of 15 minutes for this service, cross-walked to CPT 61626. The practice expense inputs are attached to the recommendation.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●61623	BD1	Endovascular temporary balloon arterial occlusion, head or neck, (extracranial/intracranial) including selective catheterization of vessel to be occluded, positioning, and inflation of occlusion balloon, concomitant neurological monitoring and radiologic supervision and interpretation of all angiography required for balloon occlusion and to exclude vascular injury post occlusion. (If selective catheterization and angiography of arteries other than artery to be occluded is performed, use appropriate catheterization and radiologic supervision and interpretation codes) (If complete diagnostic angiography of the artery to be occluded is performed immediately prior to temporary occlusion, use appropriate radiologic supervision and interpretation codes only)	000	9.96
▲61624	BD2	Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)	000	20.15 (no change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 61623 Tracking Number: BD1 Global Period: 000 **RUC Recommended RVW:** 9.96 ~~12.00~~

CPT Descriptor: Endovascular temporary balloon arterial occlusion, head or neck, (extracranial/intracran including concomitant neurological monitoring and all confirmatory and post occlusion angiography.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Typical Patient:

A 70-year-old male presents with right retro-orbital pain, headache, and diplopia, progressively worsening over three months. The patient is evaluated by his physician who finds a right sixth nerve paresis and the physician recommends a brain CT. This excludes a hemorrhage, but suggests a parasellar mass lesion. He is referred to a neurosurgeon who orders an MRI and a cerebral angiogram. These imaging tests demonstrate a wide-necked right cavernous sinus segment internal carotid artery aneurysm measuring 2.5 cm in diameter. The right anterior cerebral artery A1 segment is noted to be hypoplastic and a small right posterior communicating artery is identified. Endovascular trapping with resultant sacrifice of the cavernous right internal carotid artery aneurysm is recommended. Prior to treatment of this aneurysm by endovascular therapy, it is mandatory to ascertain whether occlusion of the internal carotid artery will result in a stroke.

Description of Pre-Service Work:

- The indications for the procedure including the risks and rationale for the procedure are discussed with the patient, family, and referring physician, and informed written consent is obtained.
- Prior imaging studies are reviewed, if available.
- Room preparation is supervised, including sterile preps and drapes and proper patient positioning.
- Equipment preparation used for the procedure, including the imaging equipment, all specialty catheters, tubing, pumps, pressure monitors, sheaths, guidewires, and temporary occlusion balloons is supervised.
- The neuroendovascular operating room staff, nurses and radiological technologists are instructed on the specifics of the procedure, patient reactions, neurological failure, and how to treat failure if necessary.

Description of Intra-Service Work:

- Selective vascular catheterization of the target vessel is performed. (61623 includes selective catheterization of the target vessel and 36216 or 36217 is not reported in addition to 61623)
- Fluoroscopic monitoring is used to guide a diagnostic cerebral angiography catheter into the target vessel (e.g., internal carotid artery, vertebral artery, etc.).
- Diagnostic images are obtained to evaluate possible vessel damage or cerebral embolization
- After systemic anticoagulation is performed, the diagnostic catheter is exchanged for the balloon occlusion catheter
- Fluoroscopic monitoring is performed to assure appropriate placement of the balloon into the high cervical internal carotid artery
- A baseline neurological examination is performed by the physician, consisting of motor function, cognition, sensory function including visual fields, speech, and short and long term memory
- The temporary balloon occlusion catheter inflated and the carotid artery is occluded under radiographical confirmed roadmap technique utilizing contrast injections and filming to confirm absence of vessel injury o over inflation
- Immediately, neurologic examination is performed by the physician (as described above) for confirmation of neurological stability. This is repetitively performed at three-minute intervals.

- After 15 minutes of evaluation with no change in neurological status, systemic hypotension is induced with confirmation of neurological stability by repeated exams including tests of motor strength, speech and cognition over an additional 30 minutes
- After completion of the process of neurological testing, the occlusion balloon is slowly deflated and withdrawn
- Post-procedure arteriogram is performed and evaluated to confirm the absence of trauma to the internal carotid artery at the location of the balloon and to verify that there is no change in the filling of the distal territory of the internal carotid artery as well as the vessels within the brain
- Anticoagulaion is reversed if required, the catheters are removed and hemostasis obtained

Intraservice work NOT included in 61623:

If a diagnostic cerebral arteriogram has not been previously obtained and is performed at the same setting as 61623, it is reported separately using 36215, 36216, and/or 36217 and 75685, 75676 or 75680, 75665 or 75671, as applicable. Selective catheterization of the target vessel is not reported, as it is included in 61623. The additional procedure codes are subject to multiple procedure reductions.

Description of Post-Service Work:

- The patient is re-examined in the recovery room for any neurological change
- The referring physician is contacted and informed of the results of the test
- The patient and family are informed of the results of the test and the implications for further therapy
- After the patient is transferred to his/her room, rounds are performed to confirm neurological stability and absence of stroke
- The endovascular surgical procedure report is dictated, reviewed and signed following review of the films of the intra-procedural images
- The results are discussed with the patient, the patient's referring physician, and consulting physicians

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SURVEY DATA:

Presenter(s) Andrew Ku, MD, J. Arliss Pollock, MD, John Wilson, MD

Specialty(s): American Society of Interventional and Therapeutic Neuroradiology (ASITN), American Association of Neurological Surgeons (AANS), and American College of Radiology (ACR)

Sample Size: 130 Response Rate: (%): 33/130 (25%) Median RVW: 16.00

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: This sample included 80 Interventional Neuroradiologists and 50 Endovascular Neurosurgeons.

25th Percentile RVW: 12.00 75th Percentile RVW: 18.00 Low: 6.04 High: 21.00

Median Pre-Service Time: 50 Median Intra-Service Time: 90

25th Percentile Intra-Svc Time: 70 75th Percentile Intra-Svc Time: 90 Low: 45 High: 180

Median Post-Service Time: 45

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	45	N/A
Critical Care:	N/A	

Other Hospital Visits: N/A
Discharge Day Mgmt.: N/A

Office Visits: N/A

CPT Code: 61623

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVW
61626	Transcatheter occlusion or embolization (eg, for tumor to achieve hemostatis, to occlude a vascular malformation), percutaneous, any method; non-central nervous system, head or neck (extracranial; brachiocephalic branch)	000	16.26

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: 61623**	**Key Reference CPT Code: 61626**
Median Pre-Time	50	303/pr – total time from RUC database
Median Intra-Time	90	N/A
Median Immediate Post-service Time	45	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	3.42	3.44
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.76	3.91
Urgency of medical decision making	2.67	2.81

Technical Skill/Physical Effort (Mean)

Technical skill required	3.39	3.75

Physical effort required	3.42	3.53
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.03	3.31
Outcome depends on the skill and judgement of physician	3.76	4.13
Estimated risk of malpractice suit with poor outcome	3.06	3.16

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.70	3.84
Intra-Service intensity/complexity	4.27	4.47
Post-Service intensity/complexity	4.27	4.16

ADDITIONAL RATIONALE

~~After carefully reviewing the survey data, it was determined that the median RVU of 16.00 seemed high and that recommending the 25th percentile of the survey data is a value that better reflects the physician work involved in performing this procedure. Therefore we recommended an RVU of 12.00 for this procedure which is supported by our survey data.~~

After carefully reviewing the survey data, it was determined that the median RVU of 16.00 seemed high and that recommending the 25th percentile of the survey data which is 12.00 RVUs better reflected the physician work involved in performing this procedure. However, upon further review it seemed that an alternate approach of deriving an appropriate RVU for this code was in order. Our approach for calculating the RVU is based on valuing the incremental components of the procedure. In the case of CPT code 61623 those incremental components include:

~~CPT Code~~	RVU
99233	1.51
36216/36217 (avg.)	5.79
36218	1.01
75898	1.65
Total RVU	**9.96**

IWPUT Calculations:

Pre-service time	Intensity	(=time x intensity)
50	0.0224	1.12
Post-service time		
45	0.0224	1.01
Intra-service time		
90	**IWPUT- 0.087**	**7.83**

Based on this approach, we are amending our current recommendation of 12.00 to 9.96 RVUs.

FREQUENCY INFORMATION

How was this service previously reported? _____64999_____ (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 specialt please provide information for each specialty.

Specialty___ASITN/ASNR_____ _____Commonly ___x__Sometimes _____Rarely

Specialty_____AANS_____ _____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 _____ASTIN/ASNR_____ Frequency_____500_____

Specialty _____AANS_____ Frequency_____200_____

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 _____ASTIN/ASNR_____ Frequency___500_____

Specialty _____AANS_____ Frequency_____200_____

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

CPT Code:_____

Specialty Society('s)_____

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

Sample Size: 80 Response Rate: (%): 30/80 (37%) Global Period: 000

Tracking Number: BD1 Reference Code 1: 61626 Reference Code 2: 61624

Geographic Practice Setting %: Rural - 2/30 (6.6%) Suburban – 2/30 (6.6%) Urban – 26/30 (86%)

Type of Practice %: 1/30 (3.3%) Solo Practice
5/30 (16%) Single Specialty Group
3/30 (10%) Multispecialty Group
21/30 (70%) Medical School Faculty Practice Plan

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

A detailed survey of clinical labor was conducted in March, 2002. Surveys were sent to 80 physicians who perform this procedure, and 30 usable surveys were collected (37% response rate). Each survey contained a vignette designed by members of the ASITN/ASNR, ACR, and AANS, and deemed to represent a typical scenario requiring the identified procedure

Please see attached

CPT Code:_____

Specialty Society('s)_____

61623 PE details	CPT:		61623
	DESCRIPTOR:		Endovascular temporary balloon arterial occlusion, head or neck, (extracranial/intracranial) including concomitant neurological monitoring and all confirmatory and post occlusion angiography.
	GLOBAL:		000
	CMS Code	CMS Desc	NonFac / Facility
PRE-service time	130	RN/LPN/MA	0 / 15
SERVICE time	130	RN/LPN/MA	0 / 0
POST-service time	130	RN/LPN/MA	0 / 0
PRE-SERVICE CLINICAL STAFF TIME			
BEGINS after consultation when a decision to perform surgery was made. (office / facility)			
Complete pre-service diagnostic & referral forms (5/5)	130	RN/LPN/MA	0 / 5
Coord. pre-surgery services, review test/exam results (10/20)	130	RN/LPN/MA	0 / 3
OV before surgery: Review test and exam results (0/0)	130	RN/LPN/MA	0 / 0
Schedule space and equipment in facility (0/8)	130	RN/LPN/MA	0 / 2
Provide pre-service education/obtain consent (10/20)	130	RN/LPN/MA	0 / 2
Follow-up phone calls & prescriptions (10/7)	130	RN/LPN/MA	0 / 3
ENDS with admission to site of service			
SERVICE PERIOD CLINICAL STAFF TIME	CMS Code	CMS Desc	
BEGINS with admission to site of service			
none			0 / 0
End: Patient leaves site of service			
POST-SERVICE PERIOD CLINICAL STAFF TIME	CMS Code	CMS Desc	
none			0 / 0
MEDICAL SUPPLIES - DAY OF PROCEDURE	CMS Code	CMS Desc	
none			0 / 0
Equipment	CMS Code		
none			0 / 0

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Summary of Recommendations

February 2002

Neuroendoscopic Surgical Procedures

New codes 62160-62165 were developed in order fully to capture the endoscopic work involved with intracrainal endoscopy.

62165 and 62164

The RUC examined the survey results for codes 62165 *Neuroendoscopy, intracranial; with excision of pituitary tumor, trans-nasal or trans-sphenoidal approach* and 62164 *Neuroendoscopy, intracranial; with excision of brain tumor, including placement of external ventricular catheter for drainage*. The RUC recommended that the pre-service time for 62165 should be lowered from 115 minutes, the original specialty society's recommendation, to 85 minutes. Additionally, the RUC recommended that the day of surgery hospital visit for 62165 be changed from 99231, the specialty society's recommendation, to 99232. The RUC believed that the physician work of the reference code 61548 *Hypophysectomy or excision of pituitary tumor, transnasal or transseptal approach, nonstereotactic* (21.53 RVW) and 61510 *Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma* (28.45 RVW) could be used effectively to determine the RVW for these two codes. Therefore, by using the building block method, beginning with the intra-service intensity of these reference codes, the RUC believed the 25th percentile of the presenter's survey results represented the true relative values for codes 62165 and 62164. In addition, the RUC understood that 62164 was a more intense procedure than 62165, as demonstrated in their reference codes and required additional post operative hospital and office care. **The RUC recommends a relative work value for 62165 of 22.00 and for 62164 of 27.50.**

62163

Relative to the other codes within the family, code 62163 *Neuroendoscopy, intracranial; with retrieval of foreign body* was compared by the RUC across its presented family of codes and specialty procedures. The RUC compared the physician work of 62163 to other 090 day global codes such as; code 61150 *Burr hole(s) or trephine; with drainage of brain abscess or cyst* (17.57 RVW), code 54406 *Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis* (12.10 RVW), and 49060 *Drainage of retroperitoneal abscess; open* (15.86 RVW). From these comparisons of physician time and work, and through the building block methodology, the committee had the following recommendation for 62163. **The RUC recommends a relative work value for 62163 of 15.50**

62162

The RUC after discussing the survey results for 62162 (I3) *Neuroendoscopy, intracranial; with fenestration or excision of colloid cyst, including placement of external ventricular catheter for drainage* believed that 62162 and 62164 were similar procedures. The committee wanted to maintain the proper rank order within the family, and understood that 62162 takes less time than 62164, 61 and 76 minutes respectively, with the same work intensity. By again using the building block approach of using a reference code, 61510 *Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma* (RVW 28.45), as another methodology to justify the relative values, the committee believed that the 25th percentile of the specialty's survey results reflected the physician work involved for 62162 (I3). **The RUC made the following relative work value recommendation for 62162 of 25.25**

62161

The RUC then compared code 62161 *Neuroendoscopy, intercranial; with dissection of adhesions, fenestration of septum pellucidum or intraventricular cysts, including placement, replacement, or removal of ventricular catheter* to its reference code 62200 *Ventriculocisternostomy, third ventricle* (RVW 18.32). Additionally the RUC believed that the physician work involved in this procedure was more than in 62163 (recommended RVW 15.50) and less than 62162 (recommended RVW 25.25). The RUC discussed the specialty's survey and agreed that the 25th percentile was the correct valuation for 62161. **The RUC recommends a relative work value for 62161 of 20.00**

62160

The RUC then examined code 62160 *Neuroendoscopy, intracranial, for placement or replacement of ventricular catheter and attachment to shunt system or external drainage (List separately in addition to code for primary procedure)(Use 62160 only in conjunction with codes 61107, 61210, 62220, 62223, 62225, or 62230)* and believed that the specialty survey results were consistent with the procedure, however the pre-service time should be zero as the global period for this code is ZZZ. The RUC believed, as they did while valuing the other codes in the family, that the relative value for this code reflected the 25th percentile of the specialty society's survey results. **The RUC recommends a relative work value for 62160 of 3.00**

Practice Expense Inputs for 62165-62160

The RUC reviewed the practice expense inputs for 62160-62165 and understood that the standard developed for the 090-day major surgical procedures could not be applied for 62161-62165 because the pre-service time would be above the PEAC standard of 60 minutes and would require an additional 15 minutes. The codes that include this additional time include: 1.) 62161, pre-service time of 85 minutes, 2.) 62162, pre-service time of 108 minutes, 3.) 62163, pre-service time of 78 minutes, 4.) 62164, pre-service time of 90 minutes and 5.) 62165, pre-service time of 115 minutes. The RUC recommends no inputs in the office setting. Additionally, **the RUC recommends all of the practice expense inputs presented by the specialty society, as attached to this recommendation.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period		Work RVU Recommendation
61105 Twist drill hole for subdural or ventricular puncture;* *(61106 has been deleted)* *61107 for implanting ventricular catheter or pressure recording device* (For intracranial neuroendoscopic ventricular catheter placement, use 62160) 61108 for evacuation and/or drainage of subdural hematoma 61156 Burr hole(s); with aspiration of hematoma or cyst, intracerebral 61210* *for implanting ventricular catheter, reservoir, EEG electrode(s) or pressure recording device (separate procedure)* (For intracranial neuroendoscopic ventricular catheter placement, use 62160)					
CPT Code (•New)	**Tracking Number**	**CPT Descriptor**	**Global Period**		**Work RVU Recommendation**
✚● 62160	I1	Neuroendoscopy, intracranial, for placement or replacement of ventricular catheter and attachment to shunt system or external drainage (List separately in addition to code for primary procedure) (Use 62160 only in conjunction with codes 61107, 61210, 62220, 62223, 62225, or 62230)	ZZZ		3.00

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period		Work RVU Recommendation
●62161	I2	Neuroendoscopy, intracranial; with dissection of adhesions, fenestration of septum pellucidum or intraventricular cysts including placement, replacement, or removal of ventricular catheter	090		20.00
●62162	I3	with fenestration or excision of colloid cyst, including placement of external ventricular catheter for drainage	090		25.25
●62163	I4	with retrieval of foreign body	090		15.50
●62164	I5	with excision of brain tumor, including placement of external ventricular catheter for drainage	090		27.50
●62165	I6	with excision of pituitary tumor, transnasal or trans-sphenoidal approach	090		22.00
62200		*Verntriculocisternostomy, third ventricle;*			
▲62201		stereotactic, neuroendoscopic method (For intracranial neuroendoscopic procedures see 62160-62165)	090		14.86 (no change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period		Work RVU Recommendation
62220		*Creation of shunt; ventriculo-atrial, -jugular, -auricular*			
		(For intracranial neuroendoscopic ventricular catheter placement, use 62160)			
62223		*ventriculo-peritoneal, -pleural, other terminus*			
		(For intracranial neuroendoscopic ventricular catheter placement, use 62160)			
62225		*Replacement or irrigation, ventricular catheter*			
		(For intracranial neuroendoscopic ventricular catheter placement, use 62160)			
62230		*Replacement or revision of cerebrospinal shunt, obstructed valve, or distal catheter in shunt system*			
		(For intracranial neuroendoscopic ventricular catheter placement, use 62160)			

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION **(Feb 2002)**

CPT Code: 62160 **Global: ZZZ** **Recommended RVW: ~~3.15~~**
RUC Recommended: 3.00

CPT Descriptor: Neuroendoscopy, intracranial, for placement or replacement of ventricular catheter and attachment to shunt system or external drainage (List separately in addition to code for primary procedure) (Use 62160 only in conjunction with codes 61107, 61210, 62220, 62223, 62225, or 62230)

Survey Vignette (Typical Patient)
A 5-year-old boy with hydrocephalus secondary to intraventricular hemorrhage and prematurity develops shunt malfunction. Examination of the shunt system shows very slow refilling and CT scan reveals enlarged ventricles with the ventricular catheter positioned along the choroid plexus in the lateral ventricle. He is admitted for replacement of his ventricular catheter using neuroendoscopy to facilitate removal of the obstructed catheter and accurate placement of a new ventricular catheter. **NOTE: For this survey, you are being asked to consider ONLY the ADDITIONAL work of the neuroendoscopic guidance beyond the work of the primary procedure (i.e., shunt revision), which is coded separately.**

CLINICAL DESCRIPTION OF SERVICE:
Pre- service work:
(Note – only the work related to neuroendoscopy is directly related to this add-on procedure.) After being seen in the emergency department, where it is determined that neuroendoscopy is required during a shunt revision, the surgeon plans a surgical approach which will allow him to enter the ventricular system and place a ventricular catheter under direct visualization in the optimal location. The surgeon then discusses the proposed surgery with the patient and family, discussing the nature of the problem, the surgical plan and the need for neuroendoscopy. In the operating room, the surgeon supervises the connection of the neuroendoscope to the light source and the video camera. The surgeon confirms that the video camera is working properly, is in focus, and is oriented properly.

Intra- service work – skin to skin
At operation, the ventricular catheter is replaced (coded separately) using neuroendoscopy. The neuroendoscope is placed through the burr hole into the lateral ventricle and advanced to allow identification of the ventricular catheter, the foramen of Monroe, and the choroid plexus. Under direct visualization, the malfunctioning catheter is removed and a new ventricular catheter is placed in a location away from the choroid plexus. (Only the additional work of the neuroendoscopic guidance beyond the work of the shunt revision which is applicable to this code).

Post- service work: N/A

SURVEY DATA

Presenter(s): John A. Wilson, MD

Specialty(s): American Association of Neurological Surgeons/Congress of Neurological Surgeons

Sample Size: 110 **Resp n:** 28 **Resp %:** 25%

Sample Type: Panel (faxed to CNS endoscopy course participants and pediatric neurosurgeons)

	Low	25th pctl	Median	75th pctl	High
Survey RVW	3.00	3.00	**3.15**	4.75	6.00
Pre-Service					
Intra-Service	10	20	**40**	45	90

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2002 RVW	2002 Glob
61795	Stereotactic computer assisted volumetric (navigational) procedure, intracranial, extracranial, or spinal (List separately in addition to code for primary procedure)	4.04	ZZZ
20938	Autograft for spine surgery only (includes harvesting the graft); structural, bicortical or tricortical (through separate skin or fascial incision)	3.02	ZZZ

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

TIME ESTIMATES (MEDIAN)	Svy CPT 62160	Ref CPT 61795
Pre-service time	0	RUC database = 97 "total" minutes, but this is based on old 000-day global
Intra-service time	40	
Same Day Immediate Post-service time	0	
Same Day Other Post-service time	0	
Post Total other hospital visit time (not same day)	0	
Discharge management time	0	
Total office visit time	0	
INTENSITY/COMPLEXITY MEASURES (mean)		
TIME SEGMENTS		
Intra-service	3.50	3.10
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3.20	2.78
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.40	2.78
Urgency of medical decision making	3.90	2.88
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	4.00	3.22
Physical effort required	2.60	2.44
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	4.10	3.11
Outcome depends on the skill and judgment of physician	4.30	3.44
Estimated risk of malpractice suit with poor outcome	4.10	3.11

ADDITIONAL RATIONALE

New code 62160 is more intense than 20938 (intracranial versus spinal) and requires less intraoperative work than 61795. The AANS/CNS consensus panel recommends the median RVW of 3.15 for CPT 62160. This value reasonably places this code between the reference codes 20938 and 61795.

FREQUENCY INFORMATION

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

64999 Unlisted procedure, nervous system

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: neurosurgery ~~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: neurosurgery Frequency: 1,200

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: neurosurgery Frequency: unknown

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

Limited

CPT Code: 62161 **Global: 090** **RUC Recommended RVW: 20.00**

CPT Descriptor: Neuroendoscopy, intracranial; with dissection of adhesions, fenestration of septum pellucidum or intraventricular cysts (including placement, replacement, or removal of ventricular catheter)

Survey Vignette (Typical Patient)
A 19-year-old male presents with a history of hydrocephalus complicated in the past by ventriculitis and intraventricular pseudocyst formation, previously treated with two ventriculo-peritoneal shunts, now complicated by infection of the peritoneal catheters. The shunts have been removed for treatment of the infection and a new shunt must be placed with the terminus in the right atrium of the heart. He undergoes neuroendoscopy where the pseudocyst walls are opened so that all the ventricles communicate and are drained by a single ventriculo-atrial shunt catheter.

CLINICAL DESCRIPTION OF SERVICE:
Pre- service work:
Day before surgery
- Plan a surgical approach which will allow entering the ventricular system with a flexible neuroendoscope and fenestrate the pseudocysts, all through a single burr hole
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Obtain informed consent
- Confirm, as necessary, with the operating room that all specialized equipment would be available
- Dictate a letter to the referring physician
- Call the referring physician to discuss the proposed surgery

Day of surgery
- Greet the patient in the pre-operation holding area and answers any final questions from the family.
- Review pre-operative work-up
- Review planned incisions and procedure
- Write pre-operative orders for peri-operative medications
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Verify CT and chest radiographs are available on the view box for reference during the procedure.
- Accompany patient to operating room
- Change into scrub clothes
- Review length and type of anesthesia with anesthesiologist
- Monitor patient positioning and draping, and assist with positioning as needed
- Review the chest radiograph film and report to make sure that there are no cardiac or pulmonary abnormalities
- After general anesthesia is induced, shave the patient's scalp at the site of the incision and prep the skin
- Scrub and gown
- Mark the incisions and supervise draping of the patient and the fluoroscopy tube.
- Supervise the connection of the neuroendoscope to the light source and the video camera.
- Confirm that the video camera is working properly and is in focus and oriented properly.

Intra- service work:
The skin is incised and hemostasis achieved with retraction and electrocautery. A power perforator is used to make a burr hole and hemostasis is achieved with bone wax. The dura is coagulated with bipolar coagulation and opened with sharp dissection. The cortex is inspected to make sure that there are no large cortical blood vessels directly in the area where a cortical incision will be made. The cortex is coagulated with bipolar coagulation and opened with sharp dissection. A 5mm peel-away trocar is introduced through the brain into the ventricle. The inner stylet of the trocar is removed and the flexible neuroendoscope is passed through the trocar into the ventricle. The walls of the pseudocyst are identified. Using various micro-instruments through the working channel of the neuroendoscope, the pseudocyst wall is perforated and the opening enlarged. The neurosurgeon then advances the neuroendoscope into the pseudocyst and the back wall of the pseudocyst is opened and enlarged with the micro-instruments. Bleeding is controlled with irrigation and bipolar electrocautery. The neuroendoscope is advanced to inspect the rest of the ventricular system and ensure that there is good communication of spinal fluid throughout the system. The neuroendoscope is carefully backed out until the tip of

the endoscope is straight and located in an area free of choroid plexus and loose pseudocyst wall. The trocar sheath is then advanced to the tip of the neuroendoscope and the length of the neuroendoscope relative to the trocar is noted. The neuroendoscope is removed and replaced with a ventricular catheter at exactly the same length as the neuroendoscope. The neurosurgeon takes a small sample of cerebral spinal fluid and sends it to pathology for analysis. The trocar is peeled away. The ventricular catheter is cut to the proper length and secured to the proximal portion of a one-way flow-control valve. The distal shunt tubing is passed from the scalp incision to a new incision in the neck using a shunt passer **(coded separately)**.. A branch of the external jugular vein is isolated in the neck and the distal shunt is passed into the venous system toward the right atrium. The location of the tip of the distal catheter is monitored by the neurosurgeon with intra-operative fluoroscopy until it is in the right atrium. The neurosurgeon consults with the anesthesiologist to make sure that there are no cardiac arrhythmias. The proximal portion of the catheter is cut to the proper length and secured to the distal port of the flow-controlled valve. The ventricular catheter is secured to the periosteum. The wounds are closed.

Post- service work:

Postop same-day work through discharge from recovery

- Apply dressing
- Write an OP note in the patient's record
- Monitor for abnormal neurological findings
- Sign OR forms, including pre- and postoperative diagnosis, operations performed
- Write orders for postop labs, films, medications, diet and patient activity
- 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 other hospital work – beginning on post-op day 1 until discharge day:

- Write orders for post-op labs, films, medications, diet, and patient activity
- Obtain a post-operative CT of the head and reviews the report and the films to ensure that all the ventricles are draining properly and that there are no new, unexpected findings
- Review the results of the cerebral spinal fluid analysis to ruleout new infection
- Review nursing/other staff patient chart notes
- Examine patient, check wounds and patient progress
- Chart patient progress notes
- Discuss patient progress with referring physician (verbal and written)
- Answer mother/family questions, nursing/other staff questions (verbal and written), insurance staff questions

Discharge day work:

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with mother/family
- Answer patient/family questions, nursing/other staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op office work – After discharge from hospital:

- Take telephone calls from mother/family regarding questions about persistent headache
- Write orders for medications and follow-up CT
- Review post-discharge CT
- Examine patient on tenth post-op day – remove sutures - check patient progress
- Examine patient as necessary within the 90-day global period - check patient progress
- Dictate patient progress notes for medical chart
- Answer mother/family questions, insurance staff questions
- Discuss patient progress with referring physician (verbal and written)

SURVEY DATA

Presenter(s): John A. Wilson, MD

Specialty(s): American Association of Neurological Surgeons/Congress of Neurological Surgeons

Sample Size: 110 **Resp n:** 27 **Resp %:** 25%

Sample Type: Panel (faxed to CNS endoscopy course participants and pediatric neurosurgeons)

	Low	25th pctl	Median	75th pctl	High
Survey RVW	15.00	**20.00**	24.00	26.00	32.00
Pre-Service			**85**		
Intra-Service	50	60	**90**	120	180

Post-Service	**Total Min**	**CPT code / # of visits**	
Day of Surgery:			
Immediate	**45**		
Other	**30**	99232	
After Day of Surgery:			
Critical Care	**0**		
Other Hospital	**38**	99231x2	**LOS = 4**
Dischg Day Mgmt	**36**	99238	
Office Visits	**61**	99213x2 99212x1	

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2002 RVW	Glob
62200	Ventriculocisternostomy, third ventricle;	18.32	090

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

TIME ESTIMATES (MEDIAN)	Svy CPT 62161	Ref CPT 62200
Pre-service time	85	81
Intra-service time	90	120
Same Day Immediate Post-service time	45	43
Same Day Other Post-service time	30	69
Post Total other hospital visit time (not same day)	38	
Discharge management time	36	36
Total office visit time	61	46

INTENSITY/COMPLEXITY MEASURES (mean)

TIME SEGMENTS		
Pre-service	4.17	3.83
Intra-service	4.50	4.17
Post-service	3.83	3.67
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	4.17	3.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.17	3.50
Urgency of medical decision making	4.00	3.67
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	4.50	4.00
Physical effort required	3.17	3.00
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	4.17	4.33
Outcome depends on the skill and judgment of physician	4.50	4.33
Estimated risk of malpractice suit with poor outcome	4.00	4.17

ADDITIONAL RATIONALE

New code 62161 is a unique procedure, making it difficult to find a key reference code for comparison. CPT 62200 (ventriculocisternostomy) is performed for different diagnoses and usually in different locations within the ventricular system. Both procedures entail dissection in the ventricles and communication to the subarachnoid space. The survey respondents judged all aspects of intensity/complexity of the survey code to be greater than the key reference code. Some of the difference in intensity/complexity may be attributed to the inherent differences between the endoscopic nature of the survey code and the reference code which requires a craniotomy. The work involved in opening and closing for either code would be significantly less intense than the work of the intracranial dissection. In the case of the reference code, that less intense work of a craniotomy would comprise a greater percentage of the overall intraservice time than a single burr hole which is done with the survey code. The AANS/CNS consensus panel recommends an RVW of 20.00, which is the 25th percentile of the survey responses. This value reasonably reflects the higher intensity of the new code compared 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)?

64999 Unlisted procedure, nervous system

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: neurosurgery ~~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: neurosurgery Frequency: 400

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: neurosurgery Frequency: unknown

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

Limited

CPT Code: 62162 **Global:** 090 **Recommended RVW:** ~~28.23~~
RUC Recommended RVW: 25.25

CPT Descriptor: Neuroendoscopy, intracranial; with fenestration or excision of colloid cyst, including placement of external ventricular catheter for drainage

Survey Vignette (Typical Patient)
A 21-year-old male with acute hydrocephalus secondary to a third ventricular colloid cyst undergoes neuroendoscopic excision of the colloid cyst.

CLINICAL DESCRIPTION OF SERVICE:

Pre- service work:

Day before surgery

- Plan a surgical approach which will allow entering the ventricular system, visualizing the colloid cyst and the attachment of the cyst to the roof of the third ventricle
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Obtain informed consent
- Confirm, as necessary, with the operating room that all specialized equipment would be available
- Dictate a letter to the referring physician
- Call the referring physician to discuss the proposed surgery

Day of surgery

- Greet the patient in the pre-operation holding area and answers any final questions from the family.
- Review pre-operative work-up
- Review planned incisions and procedure
- Write pre-operative orders for peri-operative medications
- Verify MRI is available on the view box for reference during the procedure.
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Accompany patient to operating room
- Change into scrub clothes
- Review length and type of anesthesia with anesthesiologist
- Monitor patient positioning and draping, and assist with positioning as needed
- After general anesthesia is induced, shave the patient's scalp at the site of the incision and prep the skin
- Scrub and gown
- Mark the incisions and supervise draping of the patient and the fluoroscopy tube.
- Supervise the connection of the neuroendoscope to the light source and the video camera.
- Confirm that the video camera is working properly and is in focus and oriented properly.

Intra- service work:

The skin is incised and hemostasis achieved with retraction and electrocautery. A power perforator is used to make a burr hole and hemostasis is achieved with bone wax. The dura is coagulated with bipolar coagulation and opened with sharp dissection. The cortex is inspected to make sure that there are no large cortical blood vessels directly in the area where a cortical incision will be made. The cortex is coagulated with bipolar coagulation and opened with sharp dissection. A 5mm peel-away trocar is introduced through the brain into the ventricle. The inner stylet of the trocar is removed and the neuroendoscope is passed through the trocar into the ventricle. The choroid plexus, the foramen of Monro, and the colloid cyst are identified. The neuroendoscope is advanced toward the colloid cyst. A small cutting suction catheter is passed through the working channel of the neuroendoscope until it touches the wall of the colloid cyst. While a small amount of suction is applied, the neurosurgeon gently twists the catheter until an opening is made. The contents of the colloid cyst are evacuated with the suction, shrinking the cyst. The cutting suction catheter is removed and the attachment of the cyst is visualized by the neurosurgeon. An electrocautery probe is passed through the working channel of the neuroendoscope. The wall of the cyst near its attachment is coagulated with the electrocautery. The electrocautery probe is removed and a micro-scissor is passed through the working channel of the neuroendoscope. The attachment is cut. The micro-scissor is removed and a micro-grasping forceps is passed through the working channel of the neuroendoscope. The shrunken cyst wall is grasped and the colloid cyst and neuroendoscope are removed together. After the colloid cyst and micro-grasping forceps are removed from the neuroendoscope, the neuroendoscope is passed back into the ventricle and the site of the cyst removal is

observed. Bleeding at the site is irrigated and observed until clear. The foramen of Monro is inspected to monitor for obstruction of the flow of spinal fluid from the lateral ventricles into the third ventricle. The neuroendoscope is removed and a ventricular catheter is placed into the lateral ventricle. This catheter is tunneled under the skin and pierces the skin remote from the incision. The neurosurgeon takes a small sample if cerebral spinal fluid and sends it to pathology for analysis. The ventricular catheter is cut to the proper length and secured to a closed extra-ventricular drainage system. The neurosurgeon looks to see that there is spontaneous flow of blood-tinged cerebral spinal fluid throughout the system. The wounds are closed.

Post- service work:

Postop same-day work through discharge from recovery

- Apply dressing
- Write an OP note in the patient's record
- Monitor for abnormal neurological findings
- Sign OR forms, including pre- and postoperative diagnosis, operations performed
- Write orders for postop labs, films, medications, diet and patient activity
- 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 other hospital work – beginning on post-op day 1 until discharge day:

- Write orders for post-op labs, films, medications, diet, and patient activity
- Obtain a post-operative CT of the head and reviews the report and the films to ensure that all the ventricles are draining properly and that there are no new, unexpected findings
- Review the results of the cerebral spinal fluid analysis to ruleout new infection
- Review nursing/other staff patient chart notes
- Examine patient, check wounds and patient progress
- Chart patient progress notes
- Remove catheter when spinal fluid is clear of blood and secure the wound
- Discuss patient progress with referring physician (verbal and written)
- Answer mother/family questions, nursing/other staff questions (verbal and written), insurance staff questions

Discharge day work:

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with mother/family
- Answer patient/family questions, nursing/other staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op office work – After discharge from hospital:

- Take telephone calls from mother/family regarding questions about persistent headache
- Write orders for medications and follow-up MRI
- Review post-discharge MRI
- Examine patient on tenth post-op day – remove sutures - check patient progress
- Examine patient as necessary within the 90-day global period - check patient progress
- Dictate patient progress notes for medical chart
- Answer mother/family questions, insurance staff questions
- Discuss patient progress with referring physician (verbal and written)

SURVEY DATA

Presenter(s): John A. Wilson, MD

Specialty(s): American Association of Neurological Surgeons/Congress of Neurological Surgeons

Sample Size: 110 **Resp n:** 22 **Resp %:** 20%

Sample Type: Panel (faxed to CNS endoscopy course participants and pediatric neurosurgeons)

	Low	25th pctl	Median	75th pctl	High
Survey RVW	22.00	25.25	**28.23**	30.00	50.00
Pre-Service			**108**		
Intra-Service	90	120	**148**	180	240

Post-Service	**Total Min**	**CPT code / # of visits**	
Day of Surgery:			
Immediate	**40**		
Other	**30**	99232	
After Day of Surgery:			
Critical Care	**0**		
Other Hospital	**68**	99232x1 99231x2	**LOS = 5**
Dischg Day Mgmt	**36**	99238	
Office Visits	**61**	99213x2 99212x1	

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2002 RVW	Glob
61510	Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma	28.45	90

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

TIME ESTIMATES (MEDIAN)	Svy CPT 62162	Ref CPT 61510
Pre-service time	108	105
Intra-service time	148	200
Same Day Immediate Post-service time	40	40
Same Day Other Post-service time	30	136
Post Total other hospital visit time (not same day)	68	
Discharge management time	36	36
Total office visit time	61	92

INTENSITY/COMPLEXITY MEASURES (mean)

TIME SEGMENTS		
Pre-service	4.10	3.89
Intra-service	4.20	3.89
Post-service	3.90	3.67
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3.60	3.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.60	3.44
Urgency of medical decision making	4.20	3.78
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	4.70	3.89
Physical effort required	4.00	3.56
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	4.70	4.00
Outcome depends on the skill and judgment of physician	4.80	4.11
Estimated risk of malpractice suit with poor outcome	4.70	4.00

ADDITIONAL RATIONALE

The key reference code 61510 describes an open craniotomy for a supratentorial tumor. This seems a logical choice as the survey code describes the endoscopic removal of a supratentorial tumor. The RVW suggested by the median response of the survey respondents is nearly the same as the reference code. Yet the intraservice time, hospital visit time, and total office visit time is less for the survey code. This difference can be accounted for by several factors. The reference code describes the removal of any supratentorial tumor except the meningioma. This encompasses a wide variety of pathology in many different locations that would utilize many different surgical approaches. In the spectrum of surgeries that 61510 would encompass, removal of a colloid cyst (new code 62162) is significantly more intense and complex than the average supratentorial tumor. The majority of surgeries coded with 61510 are for removal of tumors involving the hemispheres of the brain. 62162 is specific for the removal of a colloid cyst. A colloid cyst is located within the ventricular system in the roof of the 3rd ventricle. This is near the center of the brain, as opposed to the more superficial location of hemispheric tumors. Colloid cysts are immediately adjacent to, and may involve, the internal cerebral veins or the fornix, making their removal more difficult. Colloid cysts often cause hydrocephalus which may require the insertion of a ventricular drain. The insertion of a ventricular catheter (61107 RVW=5, modifier exempt) is included in 62162, but can be coded for separately with the reference code. We are recommending an RVW of 28.23 which is the survey median. This value reasonably reflects the balance between higher intensity and less time as compared with 61510. It also takes into account the inclusion of the often necessary insertion of a ventricular catheter.

FREQUENCY INFORMATION

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

64999 Unlisted procedure, nervous system

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: neurosurgery ~~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: neurosurgery Frequency: 80

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: neurosurgery Frequency: unknown

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

Limited

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION (Feb 2002)

CPT Code: 62163 **Global: 090** **Recommended RVW: ~~20.00~~**
RUC Recommended RVW: 15.50

CPT Descriptor: Neuroendoscopy, intracranial; with retrieval of foreign body

Survey Vignette (Typical Patient)
A 6-year-old male present with a history of resolved hydrocephalus and a lost ventricular catheter from a previous shunt attempt. The lost ventricular catheter is found and removed utilizing the neuroendoscope.

CLINICAL DESCRIPTION OF SERVICE:
Pre- service work:
Day before surgery

- Plan a surgical approach which will allow entering the ventricular system with a flexible neuroendoscope and retrieve the lost ventricular catheter, all through a single burr hole
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Obtain informed consent
- Confirm, as necessary, with the operating room that all specialized equipment would be available
- Dictate a letter to the referring physician
- Call the referring physician to discuss the proposed surgery

Day of surgery

- Greet the patient in the pre-operation holding area and answers any final questions from the family
- Review pre-operative work-up
- Review planned incisions and procedure
- Write pre-operative orders for peri-operative medications
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Verify CT and chest radiographs are available on the view box for reference during the procedure.
- Accompany patient to operating room
- Change into scrub clothes
- Review length and type of anesthesia with anesthesiologist
- Monitor patient positioning and draping, and assist with positioning as needed
- After general anesthesia is induced, shave the patient's scalp at the site of the incision and prep the skin
- Scrub and gown
- Mark the incisions and supervise draping of the patient and the fluoroscopy tube.
- Supervise the connection of the neuroendoscope to the light source and the video camera.
- Confirm that the video camera is working properly and is in focus and oriented properly.

Intra- service work:
The skin is incised and hemostasis achieved with retraction and electrocautery. A power perforator is used to make a burr hole and hemostasis is achieved with bone wax. The dura is coagulated with bipolar coagulation and opened with sharp dissection. The cortex is inspected to make sure that there are no large cortical blood vessels directly in the area where a cortical incision will be made. The cortex is coagulated with bipolar coagulation and opened with sharp dissection. A 5mm peel-away trocar is introduced through the brain into the ventricle. The inner stylet of the trocar is removed and the flexible neuroendoscope is passed through the trocar into the ventricle. The neurosurgeon orients herself to the intraventricular anatomy and finds the choroid plexus, the foramen of Monro, and the third ventricle. The neuroendoscope is advanced into the occipital horn of the lateral ventricle where the lost ventricular catheter is seen. The catheter is seen to be adherent to the choroid plexus. Using various micro-instruments through the working channel of the neuroendoscope, the catheter is freed from the surrounding scar tissue. Bleeding is controlled with irrigation and bipolar electrocautery. The catheter is grasped with micro-grasping forceps and the neuroendoscope and catheter together are removed from the brain. The neuroendoscope is replaced to inspect the rest of the ventricular system and ensure that there is good communication of spinal fluid throughout the system. The neuroendoscope is then removed. The wounds are closed.

Post- service work:

Postop same-day work through discharge from recovery

- Apply dressing
- Write an OP note in the patient's record
- Monitor for abnormal neurological findings
- Sign OR forms, including pre- and postoperative diagnosis, operations performed
- Write orders for postop labs, films, medications, diet and patient activity
- 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 other hospital work – beginning on post-op day 1 until discharge day:

- Write orders for post-op labs, films, medications, diet, and patient activity
- Obtain a post-operative CT of the head and reviews the report and the films to ensure that all the ventricles are draining properly and that there are no new, unexpected findings
- Review the results of the cerebral spinal fluid analysis to ruleout new infection
- Review nursing/other staff patient chart notes
- Examine patient, check wounds and patient progress
- Chart patient progress notes
- Discuss patient progress with referring physician (verbal and written)
- Answer mother/family questions, nursing/other staff questions (verbal and written), insurance staff questions

Discharge day work:

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with mother/family
- Answer patient/family questions, nursing/other staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op office work – After discharge from hospital:

- Take telephone calls from mother/family regarding questions about persistent headache
- Write orders for medications and follow-up CT
- Review post-discharge CT
- Examine patient on tenth post-op day – remove sutures - check patient progress
- Examine patient as necessary within the 90-day global period - check patient progress
- Dictate patient progress notes for medical chart
- Answer mother/family questions, insurance staff questions
- Discuss patient progress with referring physician (verbal and written)

SURVEY DATA

Presenter(s): John A. Wilson, MD

Specialty(s): American Association of Neurological Surgeons/Congress of Neurological Surgeons

Sample Size: 110 **Resp n:** 24 **Resp %:** 22%

Sample Type: Panel (faxed to CNS endoscopy course participants and pediatric neurosurgeons)

	Low	25th pctl	Median	75th pctl	High
Survey RVW	13.50	18.00	**20.00**	24.00	28.00
Pre-Service			**78**		
Intra-Service	30	49	**90**	90	180

Post-Service	**Total Min**	**CPT code / # of visits**	
Day of Surgery:			
Immediate	**30**		
Other	**19**	99231	
After Day of Surgery:			
Critical Care	**0**		
Other Hospital	**38**	99231x2	**LOS = 4**
Dischg Day Mgmt	**36**	99238	
Office Visits	**61**	99213x2 99212x1	

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2002 RVW	Glob
61570	Craniectomy or craniotomy; with excision of foreign body from brain	24.60	90

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

TIME ESTIMATES (MEDIAN)	Svy CPT 62163	Ref CPT 61570
Pre-service time	78	77
Intra-service time	90	190
Same Day Immediate Post-service time	30	33
Same Day Other Post-service time	19	180.5
Post Total other hospital visit time (not same day)	38	
Discharge management time	36	36
Total office visit time	61	57.5

INTENSITY/COMPLEXITY MEASURES (mean)

TIME SEGMENTS		
Pre-service	3.29	3.15
Intra-service	3.86	3.54
Post-service	3.21	3.08
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3.50	3.23
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.29	3.08
Urgency of medical decision making	3.14	3.15
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	4.21	3.38
Physical effort required	3.64	3.25
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	3.79	3.62
Outcome depends on the skill and judgment of physician	4.21	3.54
Estimated risk of malpractice suit with poor outcome	3.79	3.54

ADDITIONAL RATIONALE

In reviewing the survey responses for this new procedure, the AANS/CNS consensus panel identified a problem with the "typical patient" that was surveyed. Several survey respondents pointed out that the "typical" child would be sick and the foreign body would be infected. The child may often require an ICU stay along with IV and intra-thecal antibiotics to treat the ventriculitis. The consensus panel believes that because the typical patient did not describe an "infected" foreign body, the respondents may have underestimated the hospital stay. This procedure is essentially the same as the reference code 61570, except for the exposure and closure. We recommend the survey median RVW of 20.00. This value is less than the reference code and takes into account less intraoperative work and patient hospital follow-up.

FREQUENCY INFORMATION

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

64999 Unlisted procedure, nervous system

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: neurosurgery ~~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: neurosurgery 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: neurosurgery Frequency: unknown

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

Limited

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION **(Feb 2002)**

CPT Code: 62164 **Global: 090** **Recommended RVW: ~~29.50~~**
RUC Recommended RVW: 27.50

CPT Descriptor: Neuroendoscopy, intracranial; with excision of brain tumor, including placement of external ventricular catheter for drainage

Survey Vignette (Typical Patient)
A 56-year-old woman with a lymphoma in his right caudate nucleus undergoes a neuroendoscopic partial excision of the tumor.

CLINICAL DESCRIPTION OF SERVICE:
Day before surgery

- Plan a surgical approach which will allow entrance to the ventricular system, visualization of the tumor in the head of the caudate nucleus in the anterior right lateral ventricle, and excision of a portion of the tumor
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Obtain informed consent
- Confirm, as necessary, with the operating room that all specialized equipment would be available
- Dictate a letter to the referring physician
- Call the referring physician to discuss the proposed surgery

Day of surgery

- Greet the patient in the pre-operation holding area and answers any final questions from the family.
- Review pre-operative work-up
- Review planned incisions and procedure
- Write pre-operative orders for peri-operative medications
- Verify MRI is available on the view box for reference during the procedure.
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Accompany patient to operating room
- Change into scrub clothes
- Review length and type of anesthesia with anesthesiologist
- Monitor patient positioning and draping, and assist with positioning as needed
- After general anesthesia is induced, shave the patient's scalp at the site of the incision and prep the skin
- Scrub and gown
- Mark the incisions and supervise draping of the patient and the fluoroscopy tube.
- Supervise the connection of the neuroendoscope to the light source and the video camera.
- Confirm that the video camera is working properly and is in focus and oriented properly.

Intra- service work:
The skin is incised and hemostasis achieved with retraction and electrocautery. A power perforator is used to make a burr hole and hemostasis is achieved with bone wax. The dura is coagulated with bipolar coagulation and opened with sharp dissection. The cortex is inspected to make sure that there are no large cortical blood vessels directly in the area where a cortical incision will be made. The cortex is coagulated with bipolar coagulation and opened with sharp dissection. A 5mm peel-away trocar is introduced through the brain into the ventricle. The inner stylet of the trocar is removed and the neuroendoscope is passed through the trocar into the ventricle. The neurosurgeon orients herself to the intraventricular anatomy and finds the choroid plexus, the foramen of Monro, and the third ventricle. The neurosurgeon advances the neuroendoscope into the frontal horn of the right lateral ventricle and identifies a discoloration in the ependyma overlying the head of the caudate nucleus, which represents the tumor. In a relatively avascular area, the micro-cup forceps is inserted through the neuroendoscope and into the tumor. A portion of tumor tissue is excised and submitted for later pathological examination. This procedure is repeated several times until approximately one cubic centimeter of tumor tissue is removed. Hemostasis is achieved with a bipolar coagulation device introduced into the ventricle through the working channel of the neuroendoscope. Bleeding from the excision site clears after a period of gentle irrigation and observation. The neuroendoscope is removed. The wounds are closed.

Post- service work:

Postop same-day work through discharge from recovery

- Apply dressing
- Write an OP note in the patient's record
- Monitor for abnormal neurological findings
- Sign OR forms, including pre- and postoperative diagnosis, operations performed
- Write orders for postop labs, films, medications, diet and patient activity
- Discuss procedure outcome with patient/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 other hospital work – beginning on post-op day 1 until discharge day:

- Write orders for post-op labs, films, medications, diet, and patient activity
- Obtain a post-operative CT of the head and reviews the report and the films to ensure that all the ventricles are draining properly and that there are no new, unexpected findings
- Review the results of the cerebral spinal fluid analysis to ruleout new infection
- Review nursing/other staff patient chart notes
- Examine patient, check wounds and patient progress
- Chart patient progress notes
- Discuss patient progress with referring physician (verbal and written)
- Answer patient/family questions, nursing/other staff questions (verbal and written), insurance staff questions

Discharge day work:

- Examine patient, check wounds and patient progress
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient/family
- Answer patient/family questions, nursing/other staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op office work – After discharge from hospital:

- Take telephone calls from patient/family regarding questions about persistent headache
- Write orders for medications and follow-up MRI
- Review post-discharge MRI
- The report of the histopathological analysis of the tissue excised from the brain is reviewed and results discussed with the patient/family.
- Arrangements are made by the neurosurgeon for the patient to be seen by an oncologist and a radiation oncologist
- Examine patient on tenth post-op day – remove sutures - check patient progress
- Examine patient as necessary within the 90-day global period - check patient progress
- Dictate patient progress notes for medical chart
- Answer patient/family questions, insurance staff questions
- Discuss patient progress with referring physician and additional consults (verbal and written)

SURVEY DATA

Presenter(s): John A. Wilson, MD

Specialty(s): American Association of Neurological Surgeons/Congress of Neurological Surgeons

Sample Size: 110 **Resp n:** 24 **Resp %:** 22%

Sample Type: Panel (faxed to CNS endoscopy course participants and pediatric neurosurgeons)

	Low	25th pctl	Median	75th pctl	High
Survey RVW	18.00	27.50	**29.50**	30.50	35.00
Pre-Service			**90**		
Intra-Service	60	120	**165**	180	240

Post-Service	**Total Min**	**CPT code / # of visits**	
Day of Surgery:			
Immediate	**40**		
Other	**30**	99232	
After Day of Surgery:			
Critical Care	**0**		
Other Hospital	**98**	99232x2 99231x2	**LOS = 6**
Dischg Day Mgmt	**36**	99238	
Office Visits	**76**	99213x2 99212x2	

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2002 RVW	Glob
61510	Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma	28.45	90

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

TIME ESTIMATES (MEDIAN)	Svy CPT 62164	Ref CPT 61510
Pre-service time	90	105
Intra-service time	165	200
Same Day Immediate Post-service time	40	40
Same Day Other Post-service time	30	136
Post Total other hospital visit time (not same day)	98	
Discharge management time	36	36
Total office visit time	76	92

INTENSITY/COMPLEXITY MEASURES (mean)

TIME SEGMENTS		
Pre-service	4.29	3.93
Intra-service	4.64	4.07
Post-service	3.86	3.79
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	4.29	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.93
Urgency of medical decision making	3.86	3.86
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	4.86	4.07
Physical effort required	4.36	3.79
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	4.64	4.21
Outcome depends on the skill and judgment of physician	4.79	4.07
Estimated risk of malpractice suit with poor outcome	4.36	4.07

ADDITIONAL RATIONALE

New code 62164 and 61510 require similar total work. 61510 require more intraoperative time, but at a lower overall intensity due to the time required for the bone flap. Additionally, the new code includes the insertion of a ventricular catheter (61107 RVW=5, modifier exempt), whereas this can be coded for separately with the reference code. We recommend the survey median RVW of 29.50. This value takes into account the higher intraoperative intensity and the bundled insertion of a ventricular catheter.

FREQUENCY INFORMATION

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

64999 Unlisted procedure, nervous system

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: neurosurgery ~~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: neurosurgery 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: neurosurgery Frequency: unknown

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

Limited

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF WORK RECOMMENDATION **(Feb 2002)**

CPT Code: 62165 **Global: 090** **Recommended RVW: ~~23.00~~**
RUC Recommended RVW: 22.00

CPT Descriptor: Neuroendoscopy, intracranial; with excision of pituitary tumor, transnasal or trans-sphenoidal approach

Survey Vignette (Typical Patient)
A 62-year old female presents with a six-month history of progressive headaches and blurred vision. Her primary care physician had performed an MRI scan demonstrating a 1 cm pituitary tumor expanding the sella turcica. She undergoes a neuroendoscopic excision of the tumor.

CLINICAL DESCRIPTION OF SERVICE:
Day before surgery

- Patient history is reviewed, with an emphasis on vision and neuroendocrine status reports from ophthalmology and endocrinology consults

Day of surgery

- Review pre-operative laboratory tests, EKG and Chest x-ray
- Review pre-operative MRI
- Write pre-operative orders for peri-operative medications, including pre-operative steroids
- Greet the patient in the pre-operation holding area and answers any final questions from the family.
- Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family
- Obtain informed consent
- Confirm, as necessary, with the operating room that all specialized equipment would be available
- Verify MRI is available on the view box for reference during the procedure.
- Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite
- Accompany patient to operating room
- Change into scrub clothes
- Review length and type of anesthesia with anesthesiologist
- Monitor patient positioning and draping, and assist with positioning as needed
- After general anesthesia is induced, the Mayfield pin head holder is applied to the patient's head and the patient positioned in slight extension with the head turned.
- Cocainize the nasal mucosa and infiltrate with Marcaine with epinephrine.
- Place pharyngeal pack in the hypopharynx and the nose, mouth and face are prepared in sterile fashion.
- Supervise the connection of the neuroendoscope to the light source and the video camera.
- Confirm that the video camera is working properly and is in focus and oriented properly.

Intra- service work:
The nasal packs are removed and the endoscope is passed down the left nostril until the sphenoid ostium is visualized. A rongeur is used to open the sphenoid ostium under endoscopic visualization. The sphenoid mucosa is then stripped and bipolared for hemostasis. The sinus is irrigated with antibiotic solution. Endoscopic visualization is used to guide a small osteotome into place where the bone of the floor of the sella is removed, exposing the dura. The dura is coagulated by passing bipolar forceps down the right nostril. The dura is opened in a cruciate fashion with an 11 blade and the dural leaflets coagulated. The tumor capsule is visualized through the endoscope. Biopsy forceps are used to excise several pieces of the tumor which are sent to pathology. The tumor is then removed using a combination of curettage and suction. Once the tumor is removed, the endoscope is released from its clamp and passed through the hole in the dura, into the sella. Using the 30 degree scope, the diaphragma sella is visualized. The endoscope is turned within the cavity to identify any additional tumor remnants. A small dissector is passed through the endoscope and additional tumor remnant(s) are removed with suction. Endoscopic bipolar forceps are used to assist with hemostasis within the sella and endoscopic irrigation is applied. The endoscope is withdrawn into the nasal sinus and clamped there to provide visualization during reconstruction of the sella floor. The dural defect is gently packed with Gelfoam until all bleeding has stopped. The sphenoid sinus is packed with Vaseline impregnated gauze. The endoscope is withdrawn and the hypopharyngeal pack removed. The Mayfield headholder is removed and the patient awakened and extubated for transport to recovery.

Post- service work:

Postop same-day work through discharge from recovery

- Write an OP note in the patient's record
- Monitor patient's vision and for development of diabetes insipidus
- Sign OR forms, including pre- and postoperative diagnosis, operations performed
- Write orders for postop labs, films, medications, diet and patient activity
- Discuss post-op management with endocrinology consult
- Discuss procedure outcome with patient/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 other hospital work – beginning on post-op day 1 until discharge day:

- Write orders for post-op labs, films, medications, diet, and patient activity
- Monitor for CSF leakage, changing nasal drip pads several times throughout the day
- Monitor electrolytes and serum and urine osmolality
- Review nursing/other staff patient chart notes
- Examine patient, check wounds and patient progress
- Chart patient progress notes
- Discuss patient progress with referring physician (verbal and written)
- Answer patient/family questions, nursing/other staff questions (verbal and written), insurance staff questions

Discharge day work:

- The nasal packing is removed
- Examine patient, check patient progress, looking for signs of infection, signs of CSF leakage, endocrine abnormalities, visual abnormalities
- Review nursing/other staff patient chart notes
- Review post-discharge wound care and activity limitations with patient/family
- Answer patient/family questions, nursing/other staff questions
- Write orders for post-discharge labs, films, and medications
- Chart patient discharge notes

Post-op office work – After discharge from hospital:

- Write orders for medications and follow-up MRI
- The report of the histopathological analysis is reviewed and results discussed with the patient/family.
- Arrangements are made by the neurosurgeon for the patient to be seen by an oncologist and a radiation oncologist
- Examine patient nasal sinuses and home record of intake and output is reviewed
- Review post-discharge MRI
- Examine patient as necessary within the 90-day global period - check patient progress
- Dictate patient progress notes for medical chart
- Answer patient/family questions, insurance staff questions
- Discuss patient progress with referring physician and additional consults (verbal and written)

SURVEY DATA

Presenter(s): John A. Wilson, MD

Specialty(s): American Association of Neurological Surgeons/Congress of Neurological Surgeons

Sample Size: 110 **Resp n:** 13 **Resp %:** 12%

Sample Type: Panel (faxed to CNS endoscopy course participants and pediatric neurosurgeons)

	Low	25th pctl	Median	75th pctl	High
Survey RVW	20.50	22.00	**23.00**	24.00	32.00
Pre-Service			**85.00**		
Intra-Service	112	135	**180**	180	210

Post-Service	Total Min	CPT code / # of visits	
Day of Surgery:			
Immediate	**45**		
Other	**19**	99232	
After Day of Surgery:			
Critical Care	**0**		
Other Hospital	**68**	99231x2	**LOS = 4**
Dischg Day Mgmt	**36**	99238	
Office Visits	**61**	99213x2 99212x1	

KEY REFERENCE SERVICE(S):

CPT	Descriptor	2002 RVW	Glob
61548	Hypophysectomy or excision of pituitary tumor, transnasal or transseptal approach, nonstereotactic	21.53	90

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

TIME ESTIMATES (MEDIAN)	Svy CPT 62165	Ref CPT 61548
Pre-service time	85	83
Intra-service time	180	165
Same Day Immediate Post-service time	45	31
Same Day Other Post-service time	19	114
Post Total other hospital visit time (not same day)	38	
Discharge management time	36	36
Total office visit time	61	46

INTENSITY/COMPLEXITY MEASURES (mean)

TIME SEGMENTS		
Pre-service	4.08	4.08
Intra-service	4.62	4.17
Post-service	3.92	3.83
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	4.15	3.92
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.92	3.92
Urgency of medical decision making	3.69	3.58
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	4.69	4.17
Physical effort required	4.31	4.00
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	4.54	4.33
Outcome depends on the skill and judgment of physician	4.69	4.17
Estimated risk of malpractice suit with poor outcome	4.46	4.17

ADDITIONAL RATIONALE

New code 62165 is essentially the same work as 61548 with the addition of the use of a neuroendoscope which requires additional preservice time and additional intraservice time. The intensity of 62165 is greater than the reference code, requiring significantly more technical skill. The survey median RVW of 23.00 is recommended. This value reasonably reflects these comparisons.

FREQUENCY INFORMATION

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

64999 Unlisted procedure, nervous system

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: neurosurgery ~~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: neurosurgery 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: neurosurgery Frequency: unknown

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

Limited

	A	B	C	D	E	F	G	H	I
1			CPT:	62160		62161		62162	
2	**Neuroendoscopy Procedure PE Details**		DESCRIPTOR:	Neuroendoscopy, intracranial, for placement or replacement of ventricular catheter and attachment to shunt system or external drainage		Neuroendoscopy, intracranial; with dissection of adhesions, fenestration of septum pellucidum or intraventricular cysts, including placement, replacement, or removal of ventricular catheter		Neuroendoscopy, intracranial; with fenestration or excision of colloid cyst, including placement of external ventricular catheter for drainage	
3			GLOBAL:	ZZZ		90		90	
4		CMS Code	CMS Desc	NonFac	Facility	NonFac	Facility	NonFac	Facility
5	TOTAL CLINICAL LABOR TIME	130	RN/LPN/MA	--	6	--	159	--	174
6	PRE-service time	130	RN/LPN/MA	--	6	--	60	--	75
7	SERVICE time	130	RN/LPN/MA	--	0	--	0	--	0
8	POST-service time	130	RN/LPN/MA	--	0	--	99	--	99
9	PRE-SERVICE	CMS Code	CMS Desc	--		--		--	
10	BEGINS after consultation when a decision to perform surgery was made.			--		--		--	
11	Complete pre-service diagnostic & referral forms (5/5)	130	RN/LPN/MA	--	0	--	5	--	5
12	Coordinate pre-surgery services, review test/exam results (10/20)	130	RN/LPN/MA	--	0	--	20	--	20
13	OV before surgery: Review test and exam results (0/0)	130	RN/LPN/MA	--	0	--	0	--	0
14	Schedule space and equipment in facility (0/8)	130	RN/LPN/MA	--	3	--	8	--	8
15	Provide pre-service education/obtain consent (10/20)	130	RN/LPN/MA	--	3	--	20	--	20
16	Follow-up phone calls & prescriptions (10/7)	130	RN/LPN/MA	--	0	--	7	--	7
17	Other Clinical Activity (please specify)								
18	Additional pre-service for difficult procedures	130	RN/LPN/MA	--	0	--	0	--	15
19	ENDS with admission to site of service			--		--		--	
20	SERVICE PERIOD	CMS Code	CMS Desc	--		--		--	
21	BEGINS with admission to site of service			--		--		--	
22	Other Clinical Activity (please specify)			--	0	--	0	--	0
23	End: Patient leaves site of service			--		--		--	
24	POST-SERVICE Period	CMS Code	CMS Desc	--		--		--	
25	Start: Patient leaves site of service			--		--		--	
26	Conduct phone calls/call in prescriptions			--	0	--	0		0
27	assemble previous test reports/results;assist physician during exam; assist with dressings, wound			--		--		--	
28	99211 16 minutes			--	0	--	0	--	0
29	99212 27 minutes			--	0	--	1	--	1
30	99213 36 minutes			--	0	--	2	--	2
31	99214 53 minutes			--	0	--	0	--	0
32	99215 63 minutes			--	0	--	0	--	0
33	*Total Office Visit Time:*	130	RN/LPN/MA	--	0	--	99	--	99
34				--		--		--	
35	Conduct phone calls between office visits	130	RN/LPN/MA	--	0	--	0	--	0
36	Other Activity (please specify)			--		--		--	
37	End: at completion of global period			--		--		--	
38	MEDICAL SUPPLIES	CMS Code	CMS Desc	--		--		--	
39	AANS/CNS-Std Office Visit Package:								
40	Exam table paper - 7 feet	11111	foot	--	0	--	21	--	21
41	Pillow case, disposable - 1 item	11112	item	--	0	--	3	--	3
42	Gloves, non-sterile - 2 pair	11302	pair	--	0	--	6	--	6
43	Patient gown, disposable - 1 item	11107	item	--	0	--	3	--	3
44	Thermometer probe cover, disposable - 1 item	11509	item	--	0	--	3	--	3
45									
46	AANS/CNS Post-op Incision Care Items - general neurosurgery								
47	gloves, non-sterile	pair	11302	--	0	--	1	--	1
48	swab, alcohol	item	11302	--	0	--	2	--	2
49	Gauze,Sterile 4 x 4	item	31505	--	0	--	2	--	2
50	steri-strips	strip	31513	--	0	--	12	--	12
51	tape	inch	31514	--	0	--	12	--	12
52	staple removal kit	item	31702	--	0	--	1	--	1
53	Betadine	ml	52301	--	0	--	20	--	20
54	tincture benzoin swab	item	52308	--	0	--	1	--	1
55	suture removal kit	item	31703	--	0	--	1	--	1
56	patient education book	item	11115	--	0	--	0	--	0
57									
58	Equipment	CMS Code	CMS Desc	--		--		--	
59	Exam Table	item	E11001	--	0	--	1	--	1

	A	B	C	J	K	L	M	N	O
1			CPT:	62163		62164		62165	
2	**Neuroendoscopy Procedure PE Details**		DESCRIPTOR:	Neuroendoscopy, intracranial; with retrieval of foreign body		Neuroendoscopy, intracranial; with excision of brain tumor, including placement of external ventricular catheter for drainage		Neuroendoscopy, intracranial; with excision of pituitary tumor, transnasal or trans-sphenoidal approach	
3			GLOBAL:	90		90		90	
4		CMS Code	CMS Desc	NonFac	Facility	NonFac	Facility	NonFac	Facility
5	**TOTAL CLINICAL LABOR TIME**	130	RN/LPN/MA	--	159	--	206	--	179
6	**PRE-service time**	130	RN/LPN/MA	--	60	--	75	--	75
7	**SERVICE time**	130	RN/LPN/MA	--	0	--	0	--	0
8	**POST-service time**	130	RN/LPN/MA	--	99	--	131	--	104
9	**PRE-SERVICE**	**CMS Code**	**CMS Desc**	--		--		--	
10	**BEGINS after consultation when a decision to perform surgery was made.**			--		--		--	
11	Complete pre-service diagnostic & referral forms (5/5)	130	RN/LPN/MA	--	5	--	5	--	5
12	Coordinate pre-surgery services, review test/exam results (10/20)	130	RN/LPN/MA	--	20	--	20	--	20
13	OV before surgery: Review test and exam results (0/0)	130	RN/LPN/MA	--	0	--	0	--	0
14	Schedule space and equipment in facility (0/8)	130	RN/LPN/MA	--	8	--	8	--	8
15	Provide pre-service education/obtain consent (10/20)	130	RN/LPN/MA	--	20	--	20	--	20
16	Follow-up phone calls & prescriptions (10/7)	130	RN/LPN/MA	--	7	--	7	--	7
17	**Other Clinical Activity (please specify)**								
18	Additional pre-service for difficult procedures	130	RN/LPN/MA	--	0	--	15	--	15
19	**ENDS with admission to site of service**			--		--		--	
20	**SERVICE PERIOD**	**CMS Code**	**CMS Desc**	--		--		--	
21	**BEGINS with admission to site of service**			--		--		--	
22	**Other Clinical Activity (please specify)**			--	0	--	0	--	0
23	**End: Patient leaves site of service**			--		--		--	
24	**POST-SERVICE Period**	**CMS Code**	**CMS Desc**	--		--		--	
25	**Start: Patient leaves site of service**			--		--		--	
26	Conduct phone calls/call in prescriptions			--	0	--	0	--	0
27	assemble previous test reports/results;assist physician during exam, assist with dressings, wound			--		--		--	
28	99211 16 minutes			--	0	--	0	--	0
29	99212 27 minutes			--	1	--	2	--	1
30	99213 36 minutes			--	2	--	2	--	2
31	99214 53 minutes			--	0	--	0	--	0
32	99215 63 minutes			--	0	--	0	--	0
33	***Total Office Visit Time:***	130	RN/LPN/MA	--	99	--	126	--	99
34				--		--		--	
35	Conduct phone calls between office visits	130	RN/LPN/MA	--	0	--	5	--	5
36	**Other Activity (please specify)**			--		--		--	
37	**End: at completion of global period**			--		--		--	
38	**MEDICAL SUPPLIES**	**CMS Code**	**CMS Desc**	--		--		--	
39	**AANS/CNS-Std Office Visit Package:**								
40	Exam table paper - 7 feet	11111	foot	--	21	--	2821	--	21
41	Pillow case, disposable - 1 item	11112	item	--	3	--	4	--	3
42	Gloves, non-sterile - 2 pair	11302	pair	--	6	--	8/8	--	6
43	Patient gown, disposable - 1 item	11107	item	--	3	--	4	--	3
44	Thermometer probe cover, disposable - 1 item	11509	item	--	3	--	4	--	3
45									
46	**AANS/CNS Post-op Incision Care Items - general neurosurgery**								
47	gloves, non-sterile	pair	11302	--	1	--	1	--	1
48	swab, alcohol	item	11302	--	2	--	2	--	2
49	Gauze,Sterile 4 x 4	item	31505	--	2	--	2	--	2
50	steri-strips	strip	31513	--	12	--	12	--	12
51	~~tape~~	inch	31514	--	12	--	12	--	12
52	staple removal kit	item	31702	--	1	--	1	--	1
53	Betadine	ml	52301	--	20	--	20	--	20
54	tincture benzoin swab	item	52308	--	1	--	1	--	1
55	suture removal kit	item	31703	--	1	--	1	--	1
56	patient education book	item	11115	--	0	--	0	--	0
57									
58	Equipment	CMS Code	CMS Desc	--		--		--	
59	Exam Table	item	E11001	--	1	--	1	--	1

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Percutaneous Lysis of Epidural Adhesions

CPT revised code 62263 and created a new code to allow for the reporting of percutaneous lysis of epidural adhesions using solution injections that can occur over a three day eriod as well as those that tale place over only one day. Epidural adhesions are a common source of chronic low back pain and CPT 62263 was approved for *Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, spring-wound catheter) including radiologic localization (includes contrast when administered)* for CPT 2000. Since that time, the evolution of this technique has resulted in modification and simplification where the procedure can be performed on a one-day basis where the catheter is removed after injecting the drugs rather than leaving it in the patient.

62263
The RUC examined the survey results for 62263 and accepted the recommended value of 6.14. This value is the same as the current value and is supported by a survey median value of 6.10. This median value is essentially identical to the current value and the presenters stated that the CPT changes did not affect the physician work. The RUC agreed to no change in the work RVU for this code since it was originally valued by the RUC in 1999. **The RUC recommends a work relative value of 6.14 for code 62263.**

62264
The RUC examined code 62264, *Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, spring-wound catheter) including radiologic localization (includes contrast when administered) multiple adhesiolysi sessions; 1 day,* and developed a building block consistent with what was used in 1999 to value code 62263 *Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, spring-wound catheter) including radiologic localization (includes contrast when administered)* (work RVU 6.14). The RUC determined that code 62264 was equivalent to code 62319 *Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal) (work RVU 1.87),* plus work for epidurography, injection of a neurolytic agent and half of a discharge day visit. The RUC determined that this code is typically performed on a hospital outpatient basis and developed the following recommendation as follows:

CPT Code	Description	RVU
62319	Insert and manipulate catheter, inject contrast/steriod	1.87
72275	Epidurography	.76
62282	Inject neurolytic agent	½ of 2.33= 1.16
99238	Discharge day management	½ of 1.28 = .64
	Recommended RVU	**4.43**

The RUC agreed that these building block values accurately value the procedure and placed the code in proper rank order with code 62263.

The RUC recommends a work relative value of 4.43 for code 62264. The RUC also noted that since the work of epidurography is included in the recommended value, epidurography should not be separately billed in conjunction with this code and recommends that CPT add appropriate language to clarify this issue.

At the May, 2002 CPT Pannel meeitng, clarifying languange was added.

Practice Expense

The RUC refined the practice expense inputs for codes 62263 to be consistent with the building blocks included in the physician work recommendations. The practice expense inputs for 62264 include pre-service time and minimal post-service time.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation

Injection of contrast during fluoroscopic guidance and localization is an inclusive component of codes 62270-62273, 62280-62282, 62310-62319. Fluoroscopic guidance and localization is reported by code 76005, unless a formal contrast study (myelography, epidurography, or arthrography) is performed, in which case the use of fluoroscopy is included in the supervision and interpretation codes.

For radiologic supervision and interpretation of epidurography, use 72275. Code 72275 is only to be used when an epidurogram is performed, recorded, and a formal radiologic report is issued.

Code 62263 describes a catheter-based treatment involving targeted injection of various substances (eg, hypertonic saline, steroid, anesthetic) via an indwelling epidural catheter. Code 62263 includes percutaneous insertion and removal of an epidural catheter (remaining in place over a several-day period), for the administration of multiple injections of a neurolytic agent(s) performed during serial treatment sessions (ie, spanning two or more treatment days). If required, adhesions or scarring may also be lysed by mechanical means. Code 62263 is NOT reported for each adhesiolysis treatment, but should be reported ONCE to describe the entire series of injections/infusions spanning two or more treatment days. For endoscopic lysis of adhesions, use 0027T.

Code 62264 describes multiple adhesiolysis treatment sessions performing on the same day. Adhesions or scarring may be lysed by injections of neurolytic agent(s). If required, adhesions or scarring may also be lysed mechanically using a percutaneously-deployed catheter.

Codes 62263 and 62264X include the procedure of injection of contrast for epidurography (72275) and fluoroscopic guidance and localization (76005). ~~Do not report code 72275 nor code 76005 for the fluoroscopic guidance and localization performed during the subsequent session(s) of an adhesiolysis procedure. When required, epidurography (72275) should be reported only if arthrography involving multiplanar imaging is performed, interpreted, recorded, and a formal radiologic report is issued. Code 72275 includes fluoroscopic guidance and localization. Therefore, code 76005 should not be reported in addition to code 72275.~~

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
~~For codes 62318 and 62319, use code 01996 for subsequent daily management of epidural or subarachnoid catheter drug administration.~~ (For daily hospital management of continuous epidural or subarachnoid drug administration performed in conjunction with codes 62318-62319, **see Evaluation and Management** services) (For endoscopic lysis of epidural adhesions, use Category III code 0027T)				
▲62263	AD1	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, ~~spring wound~~ catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days	010	6.14 (no change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
• 62264	AD2	1 day (Do not report 62264 with 62263) **(62263 includes 72275 and 76005)**	010	4.43
77275 Epidurography, radiological supervision and interpretation (For injection procedure, see 62263, 62264~~X~~, 0027T, 62280 62281 – 62282, 62310 62311 62318 – 62319, 64479 64480 64483 – 64484)				
76005 Fluoroscopic guidance andlocalization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve or sacroiliac joint), including neurolytic agent destruction *(Injection of contrast during fluoroscopic guidance and localization is an inclusive component of codes 62270 62272 - 62273, 62280 62281 - 62282, 62310 62311 62318 - 62319)* *(Fluoroscopic guidance for subarachnoid puncture for diagnostic radiographic myelography is included in supervision and interpretation codes 72240, 72255, 72265, 72270)* *(For epidural or subarachnoid needle or catheter placement and injection, see codes 62270 62272 - 62273, 62280 62281 - 62282, 62310 62311 62318 – 62319)* *(For sacroiliac joint arthrography, see 27096, 73542. If formal arthrography is not performed, recorded, and a formal radiologic report is not issued, use 76005 for fluoroscopic guidance for sacroiliac joint injections)*				

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
(For paravertebral facet joint injection, see 64470 64472 64475 – 64476. For transforaminal epidural needle placement and injection, see 64479– 64484) *(For destruction by neurolytic agent, see 64600-64680)* (For percutaneous lysis of epidural adhesions, codes 62263, 62264, 0027T, include flouroscopic guidance and localization. ~~If formal arthrography is performed, recorded, and a formal radiologic report is issued, use 72275.)~~				
● 0027T		Endoscopic lysis of epidural adhesions with direct visualization using mechanical means (eg, spinal endoscopic catheter system) or solution injection (eg, normal saline) including radiologic localization and epidurography	N/A	N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 62263 Tracking Number: AD1 Global Period: 010 **Recommended RVW:** 6.14

CPT Descriptor: Percutaneous lysis of epidural adhesions using solution injection (eg hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered) multiple adhesiolysis sessions; 2 or more days

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35-year-old male has severe pain (rated 8/10) located in the right lower back and radiates down the outside of the right leg to the top of the foot and the big toe after multiple back operations over a 10-year period. Various systemic medications (oral narcotic and non-narcotic) and physical therapy have failed to provide significant long-term pain relief. A catheter is placed percutaneously in the epidural space; and epidurogram is performed to identify the areas of scar, nerve constriction, and possible nerve inflammation and degree of fluid flow (or lack thereof) in the epidural space; and the epidural adhesions are lysed.

[Please note that the catheter is left in place for additional adhesiolysis sessions over the next one or more days. This service encompasses 2 or more days and has a global period of 10 days.]

Description of Pre-Service Work: Review of records and any pertinent imaging studies (e.g., spine MRI); examine patient for evidence of a single nerve root or spinal nerve dysfunction; communicating with other professionals, patient, and family; and obtaining consent. The pre-operative work also includes dressing, scrubbing, and waiting before the procedure, preparing the patient and needed equipment for the procedure, positioning the patient on the x-ray table, and draping of the catheter puncture site.

Description of Intra-Service Work: The skin is locally anesthetized. The introduction needle is directed into the epidural space at the proper vertebral level or the caudal epidural space, under x-ray fluoroscopy. A flexible, directable catheter is introduced through the needle into the epidural space. The catheter tip is carefully maneuvered in the epidural space around bands of scar tissue until it is in the focal scar tissue at the target spinal nerve-nerve root. A contrast injection is performed to confirm needle tip or catheter location and determine degree of free flow liquid in the epidural space (e.g., determine areas of scarring in the epidural space). This injection also is used with temporary fluorogram monitor views to evaluate the nerve roots and spinal nerves in the area and any focal constriction or swelling of the nerve. The free flow of dye through the epidural space adjacent to this target spinal nerve-nerve root is also determined. A decision on the number, type, and quantity of injections/infusions is made. For the typical patient described above, an injection is given at this point of hyaluronidase, local anesthetic, and steroid, followed 30 minutes later by an injection of hypertonic (10%) saline. The catheter exit site is dressed for sterility and secured and the patient is admitted to the hospital for two days. At 12-24 hours and at 24-48 hours later, injections are repeated, using local anesthetic, hyaluronidase, steroid, and hypertonic saline. Also, at each series of injections, a repeat epidural contrast injection is performed with temporary fluorogram monitor views to verify correct catheter placement. Also evaluated is the surrounding epidural space, including the gradual opening of constricted scar areas around the target nerves/nerve roots. After the third series of injections, the catheter is removed and a sterile dressing applied.

Description of Post-Service Work: The patient is closely observed for one to two hours after each injection/infusion, for any new/ unexpected neurologic defects. The physician communicates findings with the patient and other professionals (including written and telephone reports and orders). Additionally, two follow-up office visits are scheduled within the 10-day global period to monitor the patient for clinical response to the procedure and for wound care.

SURVEY DATA:

Presenter(s) Karl E. Becker, MD and Norman A. Cohen. MD of ASA, and Laxmaiah Manchikanti, MD of ASIP

Specialty(s): A joint survey by ASA, AAPMR and ASIPP

Sample Size: 58 Response Rate: 55% Convenience 0.5% Panel Median RVW: 6.10

Type of Sample (Circle One): random, **panel, convenience**. Explanation of sample size:
Convenience: One hundred surveys were distributed during a society meeting, 55 were returned.
Panel: 600 e-mails sent to physicians directing them to a website

25th Percentile RVW: 6.00 75th Percentile RVW: 6.30 Low: 5.00 High: 8.91

Median Pre-Service Time: 40.0 Median Intra-Service Time: 30.0

25th Percentile Intra-Svc Time: 30.0 75th Percentile Intra-Svc Time: 50.0 Low: 15.0 High: 90.0

Median Post-Service Time: 20.0

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	20	
Critical Care:		
Other Hospital Visits:	38	99231, 2 visits
Discharge Day Mgmt.:	36	99238, 1 visit
Office Visits:	30	99212, 2 visits

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
64561	Percutaneous implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)	010	6.74

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: 62263**	**Key Reference CPT Code: 64561 RUC**
Median Pre-Time	40	45
Median Intra-Time	30	70
Median Immediate Post-service Time	20	30
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		18
Median of Aggregate Office Visit Times		38

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	4.19	4.39
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.20	4.18
Urgency of medical decision making	3.22	3.30

Technical Skill/Physical Effort (Mean)

Technical skill required	4.31	4.52
Physical effort required	4.09	4.39

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.22	4.04
Outcome depends on the skill and judgement of physician	4.39	4.57
Estimated risk of malpractice suit with poor outcome	4.35	4.57

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service
Time Segments (Mean)		
Pre-Service intensity/complexity	3.74	4.46
Intra-Service intensity/complexity	4.05	4.54
Post-Service intensity/complexity	3.37	4.04

ADDITIONAL RATIONALE

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

The specialties believe that the median RVW from survey data validates and is essentially identical to the current RVW for this procedure. The specialties reached their final conclusion after evaluation of the results of this survey and consideration of the similarities and dissimilarities of this procedure with the key reference services. Furthermore, the specialties recognize that approximately 85% of the procedures previously reported under this code (62263) will now be reported with the new code 6226X. The specialties believe that the current RVW for this code accurately reflects the work involved and that this current RVW should be retained.

FREQUENCY INFORMATION

How was this service previously reported? 62263 (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 AANS/CNS ____Commonly __X__Sometimes ____Rarely

Specialty AAPM ____Commonly __X__Sometimes ____Rarely

Specialty NASS ____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 ASA Frequency 500 old, 75 new

Specialty AANS/CNS Frequency 500 old, 75 new

Specialty AAPM Frequency 500 old, 75 new

Specialty NASS Frequency 500 old, 75 new

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 ASA Frequency 250 old, 40 new

Specialty AANS/CNS Frequency 250 old, 40 new

Specialty AAPM Frequency 250 old, 40 new

Specialty NASS Frequency 250 old, 40 new

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 62264 Tracking Number: AD2 Global Period: 010 ~~**Recommended RVW: 5.2**~~
RUC Recommended RVW: 4

CPT Descriptor: Percutaneous lysis of epidural adhesions using solution injection (eg hypertonic saline, enzyme) or mechanical means (eg catheter) including radiologic localization (includes contrast when administered) multiple adhesiolysis sessions; 1 day

(Do not report 6226X with 62263)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old white male with intermittent severe intractable low back pain with radiation into the right lower extremity associated with numbness, tingling and weakness for over 12 years which started following a work related injury. Subsequently, he underwent various modalities of treatments, initially conservative management with medication, subsequently physical therapy followed by lumbar laminectomy followed by lumbar fusion with hardware with intermittent conservative management with physical therapy and continuous medication management, but continued pain problems with significant deterioration of his physical and functional status leading to disability. At this time, he is on significant amounts of narcotics, anxiolytics, as well as other drugs with interrelated depression, generalized anxiety disorder and significant functional limitations. Following his presentation to a multidisciplinary pain management program, he was diagnosed to be negative for facet joint mediated pain. Subsequently, an epidurogram showed significant filling defects. His MRI also showed significant scar tissue on the right side occupying L5 and S1 nerve roots. He failed to respond significantly to transforaminal epidural steroid injections even though diagnosis was confirmed by blocking right L5 and S1 nerve roots and also failed to respond to high volume caudal epidural steroid injection. The patient is scheduled for a one-day percutaneous lysis of epidural adhesions.
[Please note that this service is a 1-day procedure and has a global period of 10 days]

Description of Pre-Service Work: The procedure is performed in a sterile operating room under appropriate sterile precautions utilizing fluoroscopy and a specially designed needle, as well as a spring-wire catheter. After the initial evaluation, the patient is transferred to the holding area, where appropriate preparation is carried out, including preoperative evaluation, checking of vital signs and establishing of IV access, as well as administering of antibiotic. An appropriate detailed consent is obtained from all patients.

Description of Intra-Service Work: After the appropriate preparation and consent, the patient is taken to the operating room or a sterile procedure room where preparation is carried out with povidone-iodine prep. Draping is carried out to cover the patient, extending into the midthoracic or cervical region, even if the procedure is performed in the lumbosacral region. Appropriate monitoring is carried out, with monitoring of BP and pulse and pulse oximetry. Sedation is slowly administered. The fluoroscope is adjusted over the lumbosacral region for AP and lateral views. A physician scrubbed and in sterile gown and gloves, infiltrates the area for needle insertion with local anesthetic. Following this, an RK needle is introduced into the epidural space under fluoroscopic utilization. Once the needle placement is confirmed to be in the epidural space, a lumbar epidurogram is carried out utilizing approximately 2 to 5 mL of contrast. Finding the filling defects by examining the contrast flow into the nerve roots is the purpose of the epidurogram. Intravascular or subarachnoid placement of the needle or contrast is avoided; if such malpositioning occurs, the needle is repositioned. After appropriate determination of epidurography, a Racz catheter, which is a spring-guided, reinforced catheter, is slowly passed through the RK needle to the area of the filling defect or the site of pathology determined by MRI, CT, or patient symptoms. Following the positioning of the catheter into the appropriate area, adhesiolysis is carried out by mechanical means. After completion of the adhesiolysis, a repeat epidurogram is carried out by additional injection of contrast. If appropriate adhesiolysis is completed, nerve root filling as well as epidural filling will be noted. At this time, variable doses of local anesthetic and steroid are injected. Five to 10 mL of 2% lidocaine hydrochloride or 5 to 10 mL of 0.25% bupivacaine are used for the local anesthetic. Additionally, hyaluronidase may be injected at this time. Deposteroid consisting of either 6

to 12 mg of Celestone or 40 to 80 mg of Depomedrol or another steroid is injected in the operating room or recovery room. Following completion of the injection, the catheter is taped utilizing bio-occlusive dressing; and the patient is turned to the supine position and transferred to the recovery room.

Description of Post-Service Work: The patient is very closely monitored for any potential complications or side effects. If no complications are observed and the patient reports good pain relief without any motor weakness, hypertonic saline neurolysis is carried out at this time by injection of variable doses of 10% sodium chloride solution. This may be carried out by an infusion pump or repeat injections in doses of 2 mL to 3 mL, ranging from 6 to 10 mL total, followed by injection of steroid (if it was not injected in operating room). The catheter is flushed with normal saline and removed and checked for intactness. The wound is also checked at this time. The patient is ambulated if all parameters are satisfactory, IV access is removed and the patient is discharged home with appropriate instructions. A follow-up phone call is made to the patient within 48 hours. Patients are also instructed to report if they develop any symptomatology with infection, numbness, weakness, etc.

SURVEY DATA:

Presenter(s): Karl E. Becker, MD and Norman A. Cohen, MD of ASA, and Laxmaiah Manchikanti, MD of ASIPP

Specialty(s): A joint survey by ASA, AAPMR and ASIPP

Sample Size: 59 Response Rate: (%): 56% Convenience 0.5% Panel Median RVW: 5.20

Type of Sample (Circle One): random, **panel, convenience.** Explanation of sample size:
Convenience: One hundred surveys were distributed at a society meeting, 56 were returned.
Panel: 600 e-mails sent to physicians directing them to a website

25th Percentile RVW: 5.10 75th Percentile RVW: 5.50 Low: 4.80 High: 7.00

Median Pre-Service Time: 40.0 Median Intra-Service Time: 30.0

25th Percentile Intra-Svc Time: 26.25 75th Percentile Intra-Svc Time: 48.75 Low: 15.0 High: 90.0

Median Post-Service Time: 20.0

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	20	
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:	18	1/99238
Office Visits:		

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
64561	Percutaneous implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)	010	6.74

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: 6226X**	**Key Reference CPT Code: 64561 RUC**
Median Pre-Time	40	45
Median Intra-Time	30	70
Median Immediate Post-service Time	20	30
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time	18	18
Median of Aggregate Office Visit Times		38

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.15	4.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.16	4.10
Urgency of medical decision making	3.31	3.29

Technical Skill/Physical Effort (Mean)

Technical skill required	4.23	4.48
Physical effort required	4.02	4.29

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.18	4.10
Outcome depends on the skill and judgement of physician	4.29	4.52
Estimated risk of malpractice suit with poor outcome	4.19	4.43

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service
Time Segments (Mean)		
Pre-Service intensity/complexity	3.57	4.24
Intra-Service intensity/complexity	3.97	4.43
Post-Service intensity/complexity	3.38	4.00

ADDITIONAL RATIONALE

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

The specialties agreed with the median RVW from survey data. The specialties reached their final conclusion after evaluation of the results of this survey and consideration of the similarities and dissimilarities of this procedure with the key reference service and with CPT code 62263. Furthermore, the decrement in RVU's between 6226X and 62263 accurately reflects the difference in work between these two codes, where about 5/6 of the total work is in the initial pre-service work and the primary day of service and the post service work.

FREQUENCY INFORMATION

How was this service previously reported? 62263 (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 AANS/CNS ____Commonly __X__Sometimes ____Rarely

Specialty AAPM ____Commonly __X__Sometimes ____Rarely

Specialty NASS ____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 ASA Frequency 425

Specialty AANS/CNS Frequency 425

Specialty AAPM Frequency 425

Specialty NASS Frequency 425

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 ASA Frequency 212

Specialty AANS/CNS Frequency 212

Specialty AAPM Frequency 212

Specialty NASS Frequency 212

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

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AMA/Specialty Society RVS Update Committee Recommendation

		Epidurolysis Codes			
Clinical Labor		62263		62264	
Epidurolysis Codes	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Percutaneous lysis of epidural adhesions using solution injection (eg hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered) multiple adhesiolysis sessions; 2 or more days		Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (eg, catheter), including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions, 1 day	
LOCATION		**In Office**	**Out Office**	**In Office**	**Out Office**
GLOBAL PERIOD		**10**	**10**	**10**	**10**
TOTAL CLINICAL LABOR TIME		**218**	**97**	**127**	**40**
PRE-SERVICE					
Start: Following visit when decision for surgery or procedure made					
Complete pre-service diagnostic & referral forms	RN/LPN/MTA	6	6	6	6
Coordinate pre-surgery services	RN/LPN/MTA	3	3	3	3
Schedule space and equipment in facility	RN/LPN/MTA		8		8
Provide pre-service education/obtain consent	RN/LPN/MTA	10	9	10	9
Follow-up phone calls & prescriptions	RN/LPN/MTA	5	5	5	5
TOTAL PRE-SERVICE TIME	RN/LPN/MTA	**24**	**31**	**24**	**31**
End:When patient enters office/facility for surgery/procedure					
SERVICE PERIOD					
Start: When patient enters office/facility for surgery/procedure		(3 days)			
Pre-service services					
Review charts	RN/LPN/MTA	3		2	
Greet patient and provide gowning	RN/LPN/MTA	9		3	
Obtain vital signs	RN/LPN/MTA	15		5	
Prepare room, equipment,supplies	RN/LPN/MTA	5		5	
Prepare and position patient/ monitor patient/ set up IV	RN/LPN/MTA	5		5	
Sedate/apply anesthesia	RN/LPN/MTA	2		2	
intra-service					
Assist physician in performing procedure. RN for conscious sedation and blend to assist physician	RN	30		30	
	RN/LPN/MTA	20		20	
Post-Service					
Monitor pt. following service/check tubes, monitors, drains--conscious sedation monitoring.	RN	40		20	
Clean room/equipment by physician staff	RN/LPN/MTA	3		3	
Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	RN/LPN/MTA	8		5	
Discharge day management 99238 -- 12 minutes 99239 --15 minutes	RN/LPN/MTA		12		6
RN SERVICE PERIOD TIME	RN	**70**		**50**	
RN/LPN/MTA SERVICE PERIOD TIME	RN/LPN/MTA	**70**	**12**	**50**	**6**
TOTAL SERVICE TIME		**140**	**12**	**100**	**6**
End: Patient leaves office					
POST-SERVICE Period					
Start: Patient leaves office/facility					
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 or outpatient care					
List Number and Level of Office Visits					
99211 16 minutes					
99212 27 minutes	RN/LPN/MTA	2	2		
99213 36 minutes					
99214 53 minutes					
99215 63 minutes					
Other					
Total Office Visit Time	RN/LPN/MTA	54	54		
Conduct phone calls between office visits	RN/LPN/MTA			3	3
TOTAL POST SERVICE PERIOD TIME	RN/LPN/MTA	**54**	**54**	**3**	**3**
End: with last office visit before end of global period					

AMA/Specialty Society RVS Update Committee Recommendation

Clinical Labor		62263		62264	
Epidurolysis Codes	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Percutaneous lysis of epidural adhesions using solution injection (eg hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered) multiple adhesiolysis sessions; 2 or more days		Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions, 1 day	
LOCATION		In Office	Out Office	In Office	Out Office
MEDICAL SUPPLIES					
Basic Injection Package		1		1	
Minimum Supply Package for Visits (Multi-specialty)		3	2	1	
Conscious Sedation Package		1		1	
Skin marking pen	11524	1		1	
Towel, sterile	14004	4		4	
18 gauge filter needle	71014	3		1	
IV extension tube	91109	1		1	
Synnge 5cc	91411	3		1	
Synnge 10cc	91407	6		2	
RK Needle		1		1	
Racz Catheter	$185	1		1	
PROCEDURE SPECIFIC EQUIPMENT					
Stretcher	E11002	120		60	
Suction machine, Gomco	E30001	2		2	
Radiographic/fluoroscopy room	E51005	30		30	
3 Channel ECG machine	E55002	170		90	
Pulse oximeter	E55003	30		30	
X-ray View Box 4 panel	E51001	5		5	
Mayo Stand	$585.00	30		30	
Exam Table	E11001	54	54		

CPT Code: 62263

Specialty Society('s): ASA, NASS, AAPM, AANS/CNS, ASIPP

AMA/Specialty Society Update Process
RUC Summary of Recommendation
010 or 090 Day Global Periods
In Office Direct Inputs

Sample Size: 58 Response Rate: (%): 55% Global Period: 010

Tracking Number: AD1 Reference Code 1 64561 Reference Code 2 _____

Geographic Practice Setting %: Rural ____ Suburban 50 Urban 50

Type of Practice %:
15 Solo Practice
40 Single Specialty Group
25 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:

Multi-specialty RVS practice expense committee, consisting of practitioners involved in both in-office and out-of-office interventional pain management in multiple practice settings in widespread geographic areas, reviewed practice expense data and provided the following consensus information. The Committee included members of the following organizations: ASA, NASS, AAPM, AANS/CNS, ASIPP

Please describe the clinical activities of your staff:

Staff Time: Our recommended staff time takes into account RN, LPN and MA time spent: 1) in the office with the patient prior to the procedures in preparing the necessary paperwork, scheduling, education, pre-op care instructions and pre-procedure follow-up; 2) in the office procedure room prior to, during, and after the procedures, including the provision of IV sedation/analgesia and monitoring; 3) in the office post-procedure room monitoring the patient, providing post-op home care instructions and coordinating post-op follow-up and prescriptions; 4) in the office providing post-op visit care.

Supplies: In-office supplies are fairly standard and include PEAC recommended supplies and supplies particular to this procedure.

Equipment: In-office equipment includes regular office equipment as recommended by PEAC and additional equipment specific to a fluoroscopy room.

CPT Code: 62263
Specialty Society('s): ASA, AAPMR, ASIPP

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

Sample Size: 58 Response Rate: (%): 55% Global Period: 010

Tracking Number: AD1 Reference Code 1 64561 Reference Code 2: _____

Geographic Practice Setting %: Rural____ Suburban 50 Urban 50

Type of Practice %:
____Solo Practice
25 Single Specialty Group
25 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:

Multi-specialty RVS practice expense committee, consisting of practitioners involved in both in-office and out-office interventional pain management in multiple practice settings in widespread geographic areas, reviewed practice expense data and provided the following consensus information. The Committee included members of the following organizations: ASA, NASS, AAPM, AANS/CNS, ASIPP

Please describe the clinical activities of your staff:

Staff Time: Our recommended staff time takes into account RN, LPN and MA time spent: 1) in the office with the patient prior to the procedure in preparing the necessary paperwork, scheduling, education, pre-op care instructions and pre-procedure follow-up; 2) in the hospital or facility assisting in post-op care and visits over three days; 3) providing post-op home care instructions, coordinating post-op follow-up, calling in prescriptions phone calls and care for 2 post-op visits.

Supplies: In-office supplies are fairly standard and include PEAC recommended supplies and supplies particular to this procedure.

Equipment: None

CPT Code: 62264

Specialty Society('s): ASA, NASS, AAPM, AANS/CNS, ASIPP

AMA/Specialty Society Update Process
RUC Summary of Recommendation
010 or 090 Day Global Periods
In Office Direct Inputs

Sample Size: 59 Response Rate: (%): 56% Global Period: 010

Tracking Number: AD2 Reference Code 1 64561 Reference Code 2 _____

Geographic Practice Setting %: Rural ____ Suburban 50 Urban 50

Type of Practice %:
15 Solo Practice
40 Single Specialty Group
25 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:

Multi-specialty RVS practice expense committee, consisting of practitioners involved in both in-office and out-of-office interventional pain management in multiple practice settings in widespread geographic areas, reviewed practice expense data and provided the following consensus information. The Committee included members of the following organizations: ASA, NASS, AAPM, AANS/CNS, ASIPP

Please describe the clinical activities of your staff:

Staff Time: Our recommended staff time takes into account RN, LPN and MA time spent: 1) in the office with the patient prior to the procedures in preparing the necessary paperwork, scheduling, education, pre-op care instructions and pre-procedure follow-up; 2) in the office procedure room prior to, during, and after the procedures, including the provision of IV sedation/analgesia and monitoring; 3) in the office post-procedure room monitoring the patient, providing post-op home care instructions and coordinating post-op follow-up and prescriptions; 4) in the office providing post-op visit care.

Supplies: In-office supplies are fairly standard and include PEAC recommended supplies and supplies particular to this procedure.

Equipment: In-office equipment includes regular office equipment as recommended by PEAC and additional equipment specific to a fluoroscopy room.

CPT Code: 62264
Specialty Society('s): ASA, AAPMR, ASIPP

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

Sample Size: 59 Response Rate: (%): 56% Global Period: 010

Tracking Number: AD2 Reference Code 1 64561 Reference Code 2: _____

Geographic Practice Setting %: Rural____ Suburban 50 Urban 50

Type of Practice %:
_____Solo Practice
25 Single Specialty Group
25 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:

Multi-specialty RVS practice expense committee, consisting of practitioners involved in both in-office and out-office interventional pain management in multiple practice settings in widespread geographic areas, reviewed practice expense data and provided the following consensus information. The Committee included members of the following organizations: ASA, NASS, AAPM, AANS/CNS, ASIPP

Please describe the clinical activities of your staff:

Staff Time: Our recommended staff time takes into account RN, LPN and MA time spent: 1) in the office with the patient prior to the procedure in preparing the necessary paperwork, scheduling, education, pre-op care instructions and pre-procedure follow-up; 2) in the office assisting in post-op care and visits over three days; 3) providing post-op home care instructions, coordinating post-op follow-up, calling in prescriptions, phone calls; 4) providing care in the office for 1 post-op visit.

Supplies: In-office supplies are fairly standard and include PEAC recommended supplies and supplies particular to this procedure.

Equipment: None

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Nerve Block and Daily Management of Continuous Drug Administration

CPT revised this family of codes and created new codes to reflect new procedures to differentiate between codes describing single injections and codes for the continuous administration of local anesthetic via a catheter for post-operative pain control.

64416

The RUC examined the survey data for this code and agreed that the survey median value of 3.50 accurately reflected the work involved in this code. The presenters clarified that the catheter is put in place for 72 hours and therefore 3 hospital visits involving analgesic management are typically included in the provision of this code. This also places the code in proper rank order when compared to other injection codes such as reference code 62318 *Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic* (work RVU 2.01). **The RUC recommends a work relative value of 3.50 for code 64416.**

64447

Code 64447 describes femoral nerve injections which are becoming more common for post-op pain control. The RUC reached its final conclusion after evaluation of the survey results and consideration of the similarities and dissimilarities of this procedure with the reference service. The presenters believe that the work is more difficult than reference service 64450 *Injection, anesthetic agent; other peripheral nerve or branch* (work RVU 1.27) and less than 64425 *Injection, anesthetic agent; ilioinguinal, iliohypogastric nerves* (work RVU 1.75). The intensity and complexity measures support this analysis in that these measures for 64447 in aggregate fall halfway between those for the key reference service. Given that the times are approximately the same for the proposed code and the key reference services, the RUC agreed that the intensity measures support a value midway between the two reference services and therefore concluded that the survey 25th percentile of 1.50 was an appropriate value for this code. **The RUC recommends a work relative value of 1.50 for code 64447.**

64448

Code 64448 is very similar to code 64448 *brachial plexus, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration* (RUC recommendation 3.50), except that this code should be valued slightly less since the potential complications from this code are somewhat less and the insertion of the block is slightly easier. Therefore a value of 3.00 would place this code in proper rank order in comparison to code 64446. this value is also the survey median value. **The RUC recommends a work relative value of 3.00 for code 64448.**

64446

The specialties presented a building block approach in support of the survey data. The presenters stated that that a value of 3.25 accurately reflects the work involved in this procedures and it is a value in between the survey median of 2.90 and the building block value of 3.73. The presenters stated that the median value underestimated the work involved in this procedure since this 10 day global period code was compared to reference code with a 000 day global period. This value of 3.25 would also place the code in proper rank order within the family. **The RUC recommends a work relative value of 3.25 for code 64446.**

64415, 64445, and 64450

The specialty presented work neutrality calculations for these three codes based on estimated frequency, however, the resulting adjustments were of no consequence to the work RVUs for these codes. The Specialties computations are attached to the recommendation. The RUC recommends that CMS review these calculations and determine any necessary work neutrality adjustment since the RUC's intent is for these coding changes to be work neutral.

Practice Expense

Since these codes are vary rarely performed in the office setting (less than 1%), the RUC agreed to assigned a status of N/A to the office setting for codes 64416, 64447, and 64446. For the facility setting, zero direct inputs were assigned since these codes are always performed in conjunction with a surgery performed in the facility, and do not involve any direct expenses for the anesthesiologist.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
62318		*Injection, including catheter placement,continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic*	000	2.04 (no change)
62319		*Lumbar, sacral (caudal)* (For daily hospital management of continuous epidural or subarachnoid drug administration performed in conjunction with codes 62318-62319, **see Evaluation and Management** services)	000	1.87 (no change)
64400		*Injection, anesthetic agent; trigeminal nerve, any division or branch*	000	1.11 (no change)
▲64415	AE1	Brachial plexus, single	000	1.48 (no change)
●64416	AE2	Brachial plexus, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration (Do not report 01996 in addition to 64416)	010	3.50
●64447	AE3	femoral nerve, single (Do not report 01996 in addition to 64447)	000	1.50

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 64448	AE4	femoral nerve, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration (Do not report 01996 in addition to 64448)	010	3.00
64400		*Injection, anesthetic agent; trigeminal nerve, any division or branch*	*000*	1.11 (no change)
▲64445	AE5	sciatic nerve, single	000	1.48 (no change)
●64446	AE6	sciatic nerve, continuous infusion by catheter, (including catheter placement) including daily management for anesthetic agent administration (Do not report 01996 in addition to 64446)	010	3.25
▲64450		Injection, anesthetic agent; other peripheral nerve or branch	000	1.27 (no change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Base Unit
▲*01996*		Daily hospital management of epidural or subarachnoid continuous drug administration (Report code 01996 for daily hospital management of continuous epidural or subarachnoid drug administration performed following insertion of an epidural or subarachnoid catheter placed primarily for anesthesia administration during an operative session, but retained for post-operative pain management)	N/A	3 (No Change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 64416 Tracking Number: AE2 Global Period: 010 ~~**Recommended RVW: 3.73**~~
RUC recommended RVW: 3

CPT Descriptor: Injection, anesthetic agent; brachial plexus, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration
(Do not report 01996 in addition to 64416)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 36-year-old male suffered traumatic amputation of his thumb and forefinger on the right hand in an auto accident. He has had these digits replanted under a general anesthetic and five hours of surgery. The digits are ischemic in appearance and cold with poor capillary filling despite a good surgical repair and anastomoses of the digital arteries. A continuous brachial plexus block using a catheter placed in the brachial plexus at the axilla and the infusion of local anesthetic is planned to provide pain relief and to provide vasodilatation of the arterial supply to the hand and digits in an effort to improve survival of the re-implanted digits.

Description of Pre-Service Work: The patient's medical record is reviewed, the patient is interviewed and examined and informed consent is obtained. Particular attention is paid to history of epilepsy, evidence of infection, and bleeding disorders as these increase the risk of complication from the procedure.

Description of Intra-Service Work: After obtaining informed consent, the patient is sedated lightly, if necessary, with a small amount of midazolam. His right arm is abducted at the shoulder and flexed at the elbow with his hand positioned above his right shoulder. The axilla is prepped with a betadine solution and an 18 or 20 gauge 2-inch angiocath-type catheter is inserted into the brachial plexus sheath after anesthetizing the skin with a small amount of local anesthetic. The proper location of the needle is ascertained with the use of a nerve stimulator, the elicitation of paresthesias, or the loss of resistance technique. The needle is removed and the plastic sleeve or cannula left in position. Next an epidural-type plastic catheter is inserted through the sleeve into the brachial plexus sheath and fixed in place with tape or suture. An axillary block using the injection of about 30-40 ml of local anesthetic (usually 1 to 1.5% lidocaine, 0.25 to 0.375% bupivacaine or 1 to 1.5% mepivacaine) is now performed after using a small test dose of the local anesthetic and frequent aspiration during the injection. The density and function of the block is then assessed over the next 30 minutes as well as signs and symptoms of local anesthetic toxicity. A continuous infusion of local anesthetic is now started (0.25% bupivacaine at 5-10 ml/hr.)

Description of Post-Service Work: A procedure note is dictated and medical record requirements are completed. Over the next several days, the continued efficacy and function of the block is evaluated and adjustments in the infusion made as necessary. In addition to the usual complications of an axillary block, infection, injury to the axillary artery with hematoma formation and vascular insufficiency, systemic local anesthetic toxicity are all possible complications of the continuous catheter technique. The patient is evaluated for these issues on each visit. Typically, the patient will be seen a second time on the day of the procedure and the infusion will continue for at least two subsequent days.

SURVEY DATA:

Presenter(s): Karl E. Becker, MD, Norm Cohen, MD, Samuel Hassenbusch, MD

Specialty(s): ASA, AANS/CNS, AAPM and NASS

Sample Size: 30 Response Rate: (%): 0.7% Median RVW: 3.5

Type of Sample (Circle One): **random,** panel, convenience. Explanation of sample size: Approximatly 4,000 e-mails sent out directing physicians to a website.

25th Percentile RVW: 3.0 75th Percentile RVW: 5.0 Low: 2.0 High: 6.0

Median Pre-Service Time: 30.0 Median Intra-Service Time: 30.0

25th Percentile Intra-Svc Time: 20.0 75th Percentile Intra-Svc Time: 30.0 Low: 10.0 High: 60.0

Median Post-Service Time: 20.0

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	20	
Critical Care:		
Other Hospital Visits:	57	99231, 3 visits
Discharge Day Mgmt.:		
Office Visits:		

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
62318	Injection, including catheter placement continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic	000	2.04
62319	lumbar, sacral (caudal)	000	1.87

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including 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: 6441X	Key Reference CPT Code: 62318 RUC	Key Reference CPT Code: 62319 RUC
Median Pre-Time	30.0	50	48
Median Intra-Time	30.0	40	30
Median Immediate Post-service Time	20.0	66 (Total post service time)	66 (Total post service time)
Median of Aggregate Critical Care Times			
Median of Aggregate Other Hospital Visit Times			
Median Discharge Day Management Time			
Median of Aggregate Office Visit Times			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.0	1.83	3.5
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.0	1.83	3.5
Urgency of medical decision making	2.90	2.0	3.5

Technical Skill/Physical Effort (Mean)

Technical skill required	3.73	3.0	4.25
Physical effort required	3.31	2.5	3.88

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.38	3.0	3.88
Outcome depends on the skill and judgement of physician	3.62	2.83	3.86
Estimated risk of malpractice suit with poor outcome	3.48	2.67	4.0

INTENSITY/COMPLEXITY MEASURES	CPT Code 6441X	Reference Service 62318	Reference Service 62319
Time Segments (Mean)			
Pre-Service intensity/complexity	2.90	2.0	3.5
Intra-Service intensity/complexity	3.48	2.17	3.86
Post-Service intensity/complexity	3.07	2.0	3.63

ADDITIONAL RATIONALE

FREQUENCY INFORMATION

How was this service previously reported? 64415 and 99231for follow-up (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 ASA ____Commonly __X__Sometimes ____Rarely

Specialty AANS/CNS ____Commonly ____Sometimes _X___Rarely

Specialty AAPM ____Commonly __X__Sometimes ____Rarely

Specialty NASS ____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 ASA	Frequency 1,800
Specialty AANS/CNS	Frequency 45
Specialty AAPM	Frequency 450
Specialty NASS	Frequency 45

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 ASA	Frequency 600
Specialty AANS/CNS	Frequency 15
Specialty AAPM	Frequency 150
Specialty NASS	Frequency 15

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

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 64446 Tracking Number: AE6 Global Period: 010 ~~**Recommended RVW: 3.73**~~
RUC Recommended RVW: 3.25

CPT Descriptor: Injection, anesthetic agent; sciatic nerve, continuous infusion by catheter, (including catheter placement) including daily management for anesthetic agent administration
(Do not report 01996 in addition to 6444X3)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: : A 30-year-old male smashes his left foot in an automobile accident. He undergoes major reconstruction of his left foot and ankle under general anesthesia. In order to provide post-operative pain control, a continuous sciatic nerve block is performed at the end of surgery. This block will decrease post-op pain, allow earlier ambulation, and lessen the amount of post-op analgesic medication required.

Description of Pre-Service Work: The patient's medical record is reviewed, the patient is interviewed and examined and informed consent is obtained. Particular attention is paid to history of epilepsy, evidence of infection, and bleeding disorders as these increase the risk of complication from the procedure.

Description of Intra-Service Work: In the post-anesthesia recovery room or in the operating room after surgery on the foot and ankle is completed, the patient is placed in the right lateral position and the thigh flexed on the hip to 45 degrees. The greater femoral trochanter and ischial tuberosity are marked and a line drawn from the popliteal fossa to midway between the two landmarks. A 20 gauge insulated needle is introduced vertically to the skin, just medial to the upper end of the marked line to determine the depth of the sciatic nerve. A brisk motor response in the ankle, foot or toes is noted with less than 0.4 mA stimulation. Next an insulated Tuohy needle is advanced from approximately 5 cm cephalad and angled to intersect the tip of the first needle. Nerve stimulation is again noted, and a catheter then advanced through the Tuohy needle 50 to 100 mm. The electrical connection is then transferred to the catheter and nerve stimulation again noted. The Tuohy needle is removed, the catheter sutured in place, a bacterial filter is attached and 15-20 ml of 0.5% bupivacaine injected through the catheter. Block of the sciatic nerve is then accessed over the next 15-30 minutes and an infusion of 0.375% bupivacaine at 0.1 ml/kg/hr (~7 ml/hr) started. Required infusion rates typically range from 2 to 12 ml/hr. Occasionally bolus injections (10-15 ml) are required. The infusion is usually stopped at about 48 hours post op. The complications of a continuous sciatic nerve block include possible infection, injury to the sciatic nerve with neuralgia, and systemic local anesthetic toxicity. Fortunately these complications are rare.

Description of Post-Service Work: : Over the next several days, the continued efficacy and function of the block is evaluated and adjustments in the infusion made as necessary. A procedure note is dictated and medical record entries are made after each visit. Typically, the patient will be seen a second time on the day of the procedure and the infusion will continue for at least two subsequent days.

SURVEY DATA:

Presenter(s): Karl E. Becker, MD, Norm Cohen, MD, Samuel Hassenbusch, MD

Specialty(s): ASA, AANS/CNS, AAPM and NASS

Sample Size: 22 Response Rate: (%): 0.5% Median RVW: 2.90

Type of Sample (Circle One): **random,** panel, convenience. Explanation of sample size:Approximatly 4,000 e-mails sent out directing physicians to a website.

25th Percentile RVW: 2.50 75th Percentile RVW: 3.94 Low: 1.45 High: 6.0

Median Pre-Service Time: 15.0 Median Intra-Service Time: 27.5

25th Percentile Intra-Svc Time: 10.0 75th Percentile Intra-Svc Time: 30.0 Low: 10.0 High: 60.0

Median Post-Service Time: 15.0

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	15	
Critical Care:		
Other Hospital Visits:	57	99231, 3 visits
Discharge Day Mgmt.:		
Office Visits:		

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
64445	Injection, anesthetic agent; sciatic nerve	000	1.48

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including 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: 6444X3**	**Key Reference CPT Code: 64445 Harvard**
Median Pre-Time	15.0	8
Median Intra-Time	27.5	16
Median Immediate Post-service Time	15.0	8
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.05	2.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.09	2.83
Urgency of medical decision making	2.95	2.83

Technical Skill/Physical Effort (Mean)

Technical skill required	3.50	3.08
Physical effort required	3.23	2.83

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3..23	3.0
Outcome depends on the skill and judgement of physician	3.41	3.08

Estimated risk of malpractice suit with poor outcome	3.32	2.92

INTENSITY/COMPLEXITY MEASURES	CPT Code 6444X3	Reference Service 64445
Time Segments (Mean)		
Pre-Service intensity/complexity	3.05	2.83
Intra-Service intensity/complexity	3.5	3.08
Post-Service intensity/complexity	3.0	2.75

ADDITIONAL RATIONALE

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

The specialty societies recommend using a building block approach to value the new continuous sciatic nerve injection code. The components of the building block include the RVUw for the single sciatic injection, the increment in RVUw between 62311 and 62319, which serves as a proxy for the increase in work from a single to a continuous injection code, and the value of the post procedure visits, since the proposed code is a 10 day global and the single injection code is a 0 day global. Since the RUC recently valued both 62311 and 62319, the specialty societies believe that this produces a reasonable approximation of the increased work performed when conside the value for a new continuous block code. Placement of a continuous sciatic catheter is somewhat more invo. than placing a continuous epidural or subarachnoid catheter due to multiple needle placements and the requirement for suturing the catheter in place. The specialty societies believe that the building block approach presented here closely approximates the true work value for the proposed code and justifies an RVUw greater than the survey median.

Building Block Component	RVUw
64445 - sciatic nerve, single	1.48
Single vs Catheter differential (62319 - 62311)	0.33
99231 - 3 visits	1.92
Building Block RVUw	3.73

The proposed RVUw of 3.73 is less than the 75th percentile survey results.

FREQUENCY INFORMATION

How was this service previously reported? __64445 and 99231 for follow-up__ (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 ASA	____Commonly	__X__Sometimes	_____Rarely
Specialty AANS/CNS	____Commonly	_____Sometimes	_X___Rarely
Specialty AAPM	____Commonly	__X__Sometimes	_____Rarely
Specialty NASS	____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 ASA	Frequency 2,400
Specialty AANS/CNS	Frequency 60
Specialty AAPM	Frequency 450
Specialty NASS	Frequency 60

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 ASA	Frequency 800
Specialty AANS/CNS	Frequency 20
Specialty AAPM	Frequency 150
Specialty NASS	Frequency 20

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 64447 Tracking Number: AE3 Global Period: 000 ~~**Recommended RVW:1.51**~~
RUC Recommended RVU = 1.50

CPT Descriptor: Injection, anesthetic agent; femoral nerve, single

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old male undergoes a right anterior cruciate ligament repair under general anesthesia. In order to provide post-operative pain control and increase mobility in his knee, a femoral nerve block is performed. This block will allow earlier discharge from the recovery room, decreased post-op pain and earlier ambulation.

Description of Pre-Service Work: The patient's medical record is reviewed, the patient is interviewed and examined and informed consent is obtained. Particular attention is paid to history of epilepsy, evidence of infection, and bleeding disorders as these increase the risk of complication from the procedure.

Description of Intra-Service Work: In the post-anesthesia recovery room or in the operating room prio to general anesthesia, the patient's right groin is prepped with a betadine solution and a 22 gauge short-bevel 4 cm needle inserted approximately 1 cm lateral to the femoral artery and 1 cm caudad from the inguinal ligament after anesthetizing the skin with a small amount of local anesthetic. The proper location of the needle is ascertained with the use of a nerve stimulator, the elicitation of paresthesias, the loss of resistance technique, or with a field block technique. Next, between 15 and 30 ml of 0.25% to 0.5% bupivacaine with epinephrine 1:200,000 is injected carefully and with frequent aspiration to avoid the possibility of intravascular injection. The density and function of the block is then assessed. Onset of block may take 30-40 minutes. Postoperative analgesia typically lasts 12 to 24 hours. The complications of a femoral nerve block include possible infection, injury to the femoral artery with hematoma formation, systemic local anesthetic toxicity and nerve injury. Persistent quadriceps weakness suggests neural injury

Description of Post-Service Work: A procedure note is dictated and medical record requirements are completed. The patient is reevaluated in the post-operative care unit to evaluate the efficacy of the block.

SURVEY DATA:

Presenter(s): Karl E. Becker, MD, Norm Cohen, MD, Samuel Hassenbusch, MD

Specialty(s): ASA, AANS/CNS, AAPM and NASS

Sample Size: 30 Response Rate: (%): 0.7% Median RVW: 1.90

Type of Sample (Circle One): **random,** panel, convenience. Explanation of sample size: Approximatly 4,000 e-mails sent out directing physicians to a website.

25th Percentile RVW: 1.50 75th Percentile RVW: 2.15 Low: 1.27 High: 4.0

Median Pre-Service Time: 25.0 Median Intra-Service Time: 15.0

25th Percentile Intra-Svc Time: 15.0 75th Percentile Intra-Svc Time: 25.0 Low: 10.0 High: 40.0

Median Post-Service Time: 12.50

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	12.5	
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
64425	Injection, anesthetic agent; ilioinguinal, iliohypogastric nerves	000	1.75
64450	other peripheral nerve or branch	000	1.27

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including 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: 6444X1	Key Reference CPT Code: 64425 Harvard	Key Reference CPT Code: 64450 Harvard
Median Pre-Time	25.0	8	10
Median Intra-Time	15.0	15	17
Median Immediate Post-service Time	12.5	8	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	2.73	3.0	2.43
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.67	3.0	2.43
Urgency of medical decision making	2.93	3.11	2.71

Technical Skill/Physical Effort (Mean)

Technical skill required	3.27	3.56	3.14
Physical effort required	3.07	3.33	2.71

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.0	3.22	2.71
Outcome depends on the skill and judgement of physician	3.33	3.56	3.14

Estimated risk of malpractice suit with poor outcome	2.97	3.11	2.57

INTENSITY/COMPLEXITY MEASURES	CPT Code 6444X1	Reference Service 64425	Reference Service 64450
Time Segments (Mean)			
Pre-Service intensity/complexity	2.68	2.88	2.57
Intra-Service intensity/complexity	3.11	2.57	2.43
Post-Service intensity/complexity	2.64	3.25	3.0

ADDITIONAL RATIONALE

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

The specialties disagree with the median RVW from the survey data. They believe that the 25th percentile survey value comes closer to accurately defining the work value for the procedure The specialties reached their final conclusion after evaluation of the results of this survey and consideration of the similarities and dissimilarities of this procedure with the key reference service. The specialties believe that the work is more difficult than reference service 64450 and less than 64425. The intensity and complexity measures support this analysis in that these measures for 6444X1 in aggregate fall halfway between those for the key reference service. Given that the times are approximately the same for the proposed code and the key reference services, the specialties believe that the intensity measures support a value midway between the two reference services. The average of the work values for 64425 and 64450 is 1.51. Thus, the specialties recommend 1.51 as the value for the new code 6444X1.

FREQUENCY INFORMATION

How was this service previously reported? 64450 (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 ASA	X Commonly	___ Sometimes	___ Rarely
Specialty AANS/CNS	___ Commonly	___ Sometimes	X Rarely
Specialty AAPM	___ Commonly	X Sometimes	___ Rarely
Specialty NASS	___ 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 ASA	Frequency 45,000
Specialty AANS/CNS	Frequency 900
Specialty AAPM	Frequency 9,000
Specialty NASS	Frequency 900

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 ASA	Frequency 15,000
Specialty AANS/CNS	Frequency 300
Specialty AAPM	Frequency 3,000
Specialty NASS	Frequency 300

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

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 64448 Tracking Number: AE4 Global Period: 010 ~~**Recommended RVW: 3.76**~~
RUC Recommended RVW: 3.00

CPT Descriptor: Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration
(Do not report 01996 in addition to 6444X2)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old male undergoes a right total knee replacement (CPT code 27447) under general anesthesia. In order to provide post-operative pain control and increased mobility in his knee, a continuous femoral nerve block is performed. This block will allow earlier discharge from the recovery room, decreased post-op pain, earlier ambulation, improved range of motion of the knee and enhanced rehabilitation.

Description of Pre-Service Work: The patient's medical record is reviewed, the patient is interviewed and examined and informed consent is obtained. Particular attention is paid to history of epilepsy, evidence of infection, and bleeding disorders as these increase the risk of complication from the procedure.

Description of Intra-Service Work: In the post-anesthesia recovery room or in the operating room prior to general anesthesia, the patient's right groin is prepped with a betadine solution and a 22-gauge short-bevel 10 cm insulated needle is inserted into an 18 gauge long plastic cannula. The femoral nerve is located approximately 1 cm lateral to the femoral artery and 1 cm caudad from the inguinal ligament after anesthetizing the skin with a small amount of local anesthetic. The proper location of the needle is ascertained with the use of a nerve stimulator or with the elicitation of paresthesias, or both. The plastic cannula is then advanced over the needle into the "sheath" of the femoral nerve. Next, between 20 and 30 ml of 0.25% to 0.5% bupivacaine with epinephrine 1:200,000 is injected carefully through the cannula and with frequent aspiration to avoid the possibility of intravascular injection. A 20-gauge epidural catheter is threaded through the cannula and the cannula removed. The catheter is sutured in place and sterilely dressed. Bupivacaine 0.25 to 0.125% at 0.14 ml/kg/hr (~10 ml/hr) is then infused. The complications of a femoral nerve block include possible infection, injury to the femoral artery with hematoma formation, systemic local anesthetic toxicity and nerve injury from direct trauma, intraneural injection or compressive-ischemic injury. Persistent quadriceps weakness suggests neural injury

Description of Post-Service Work: Over the next several days, the continued efficacy and function of the block is evaluated and adjustments in the infusion made as necessary. A procedure note is dictated and medical record entries are made after each visit. Typically, the patient will be seen a second time on the day of the procedure and the infusion will continue for at least two subsequent days.

SURVEY DATA:

Presenter(s): Karl E. Becker, MD, Norm Cohen, MD, Samuel Hassenbusch, MD

Specialty(s): ASA, AANS/CNS, AAPM and NASS

Sample Size: 22 Response Rate: (%): 0.5% Median RVW: 3.0

Type of Sample (Circle One): **random,** panel, convenience. Explanation of sample size:Approximatly 4,000 e-mails sent out directing physicians to a website.

25th Percentile RVW: 2.43 75th Percentile RVW: 3.0 Low: 1.50 High: 6.0

Median Pre-Service Time: 23.5 Median Intra-Service Time: 25.0

25th Percentile Intra-Svc Time: 10.0 75th Percentile Intra-Svc Time: 30.0 Low: 10.0 High: 60.0

Median Post-Service Time: 15.0

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	15	
Critical Care:		
Other Hospital Visits:	57	99231, 3 visits
Discharge Day Mgmt.:		
Office Visits:		

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
62318	Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic	000	2.04

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including 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: 6444X2	Key Reference CPT Code: 62318 RUC
Median Pre-Time	23.5	50
Median Intra-Time	25.0	40
Median Immediate Post-service Time	15.0	66 (total post service time)
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.95	2.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.0	2.70
Urgency of medical decision making	3.05	2.80

Technical Skill/Physical Effort (Mean)

Technical skill required	3.55	3.30
Physical effort required	3.27	3.20

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.09	2.90
Outcome depends on the skill and judgement of physician	3.5	3.30
Estimated risk of malpractice suit with poor outcome	3.18	3.0

INTENSITY/COMPLEXITY MEASURES	CPT Code 6444X2	Reference Service 62318
Time Segments (Mean)		
Pre-Service intensity/complexity	3.09	2.90
Intra-Service intensity/complexity	3.5	3.40
Post-Service intensity/complexity	3.14	3.0

ADDITIONAL RATIONALE

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

FREQUENCY INFORMATION

How was this service previously reported? 64450 and 99231 for follow-up visits (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 ASA _____Commonly _X_Sometimes _____Rarely

Specialty AANS/CNS _____Commonly ____Sometimes _X___Rarely

Specialty AAPM _____Commonly __X_ Sometimes _____Rarely

Specialty NASS _____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 ASA Frequency 7,500

Specialty AANS/CNS Frequency 75

Specialty AAPM Frequency 600

Specialty NASS Frequency 75

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 ASA Frequency 2,500

Specialty AANS/CNS Frequency 25

Specialty AAPM Frequency 200

Specialty NASS Frequency 25

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

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Since these codes are very rarely performed in the office setting, the committee agreed to assign a status of N/A to the office setting.
For the facility setting, zero inputs were assigned.

FAMILY 1--Nerve Block Codes

Clinical Labor		64416		64448		64446		64447	
Nerve Block Codes	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Injection, anesthetic agent; brachial plexus, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration		Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration		Injection, anesthetic agent; sciatic nerve, continuous infusion by catheter, (including catheter placement) including daily management for anesthetic agent administration		Injection, anesthetic agent; femoral nerve, single	
LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office
GLOBAL PERIOD		10	10	10	10	10	10	0	0
TOTAL CLINICAL LABOR TIME									
PRE-SERVICE									
Start: Following visit when decision for surgery or procedure made									
End:When patient enters office/facility for surgery/procedure									
SERVICE PERIOD									
Start: When patient enters office/facility for surgery/procedure									
Pre-service services									
Intra-service									
Post-Service									
End: Patient leaves office									
POST-SERVICE Period									
Start: Patient leaves office/facility									
End: with last office visit before end of global period									
MEDICAL SUPPLIES									
Medical EQUIPMENT									

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Ophthalmic Diagnostic Endoscopy

CPT code 66990 was developed to describe an endoscopic method of diagnosis, which is used in combination with many anterior and posterior segment eye procedures.

66990

The RUC reviewed the survey results for 66990, *Use of ophthalmic endoscope*. A consensus panel was surveyed by the specialty society to obtain survey results. The consensus panel agreed that there was no pre or post service time associated with this code. The median recommended relative work value was 1.70. The RUC then reviewed the reference code, 31233 *Nasal/sinus endoscopy, diagnostic with maxillary sinusoscopy (via inferior meatus or canine fossa puncture)* (RVU = 2.18). This code was selected because it is a 0-day global with 15 minutes of pre time, 20 minutes of intra-service time and 15 minutes of post service time. Additionally, 31233, like 66990, involves using an endoscope to inspect a cavity followed by a diagnosis. To value 66990, the RUC removed the amount of work associated with the 30 minutes of pre and post service for 31233 (0.67) from the relative work value of this code (2.18) and obtained a value of 1.51. **The RUC recommends a work relative value of 1.51 for 66990.**

Practice Expense

Because this code is only performed out-of-office, there are no practice expense inputs associated with this code.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
+●66990	J1	Use of ophthalmic endoscope (List separately in addition to code for primary procedure) **(66990 may be used only with codes 65820, 65875, 65920, 66985, 66986, 67038, 67039, 67040)**	ZZZ	1.51

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 66990 Tracking Number: Global Period: ZZZ **Recommended RVW:** ~~1.7WRVU~~
RUC Recommendation: 1.51

CPT Descriptor:
Use of ophthalmic endoscope(List separately in addition to code **for** primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:A 72yo male, sixteen months post-op phacoemulsification who had a posterior chamber lens inserted in the sulcus at the time of surgery due to a broken posterior capsule, presents with glare, poor vision and multiple images due to a "sunset syndrome". A repositioning of the intraocular lens is performed. During the procedure ophthalmic endoscopy is performed to aid in planning and ensuring adequate capsular support

Description of Pre-Service Work:
The ophthalmic endoscope is checked to ensure adequate focusing, visualization and illumination.

Description of Intra-Service Work: Two stab incisions are made with a #75 blade at the supero-nasal and temporal surgical limbus. Using a blunt cannula, the anterior segment is filled with viscoelastic material. The viscoelastic is then gently injected under the iris and in front of the implant to allow visualization of the capsular bag. The sulcus is examined 360 degrees. The zonules are noted to be absent below but intact above. The lower haptic of the intraocular lens is noted to be subluxated into the anterior vitreous. A repositioning is planned based on the anatomy. After the intraocular lens is repositioned and rotated, the endoscope is then reinserted to ensure that there is adequate capsular support for the implant before the completion of the surgical procedure.

Description of Post-Service Work: None

SURVEY DATA:

Presenter(s)Stephen Kamenetzky,MD, AAO Technical Advisor, Martin Uram, MD
Specialty(s):
Sample Size: 11 Response Rate: (%): 100% Median RVW: 1.7WRVU

Type of Sample (Circle One): Panel Explanation of sample size A previous attempt to survey this code was performed in December of 2001. A survey was sent out to 100 ophthalmologists listed by the manufacturer as users of the endoscope. There were 11 respondents. The recommended median WRVU was 7.9WRVU. It was apparent that the surveyed physicians were unable to separate the additional work of the endoscopy from the reference service. The feasibility of performing a selected panel survey at the annual meeting of the American Glaucoma Society was rejected because of the lack of a statistically significant number of attendees familiar with the procedure. It was then elected to convened a conference call of the eleven members of the AAO Health Policy Committee to serve a panel. All eleven were familiar with the service and six had personally used the ophthalmic endoscope. The AAO Health Policy Committee functioned as a consensus panel.
25th Percentile RVW: 75th Percentile RVW: Low: High:

Median Pre-Service Time: ~~5 minutes~~ 0 minutes Median Intra-Service Time: 20 minutes

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

Median Post-Service Time:	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	0	
Critical Care:	0	
Other Hospital Visits:	0	
Discharge Day Mgmt.:	0	
Office Visits:	0	

CPT Code: 66990

KEY REFERENCE SERVICE:

CPT Code 65870 CPT Descriptor Severing of adhesions of anterior segment of eye, incisional technique(with or without air or liquid injection); posterior synechiae
Global90 days Work RVU 6.54

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: 66990	Key Reference CPT Code: 65870
Median Pre-Time	~~5~~ 0	21
Median Intra-Time	20	33
Median Immediate Post-service Time	0	27
Median of Aggregate Critical Care Times	0	
Median of Aggregate Other Hospital Visit Times	0	
Median Discharge Day Management Time	0	
Median of Aggregate Office Visit Times	0	92

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	2
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2	2
Urgency of medical decision making	1	1

Technical Skill/Physical Effort (Mean)

Technical skill required	4	2
Physical effort required	2	2

Psychological Stress (Mean)

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

INTENSITY/COMPLEXITY MEASURES	New/Revis CPT Code: 66990	Key Reference CPT Code: 65870
Time Segments (Mean)		
Pre-Service intensity/complexity	na	
Intra-Service intensity/complexity	3	3
Post-Service intensity/complexity		

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. As with most add on codes, the AAO had a great deal of difficulty in using the usual RUC survey process to arrive at an appropriate WRVU. It was felt that the reference service most approximated what was done at the time of surgery but that the add on code had no post work and little pre-work. In addition, the new code under consideration was more like a diagnostic procedure rather than a surgical one in that the add on did not include any of the work of the body of the base procedure. Within ophthalmology there are other codes which describe a diagnostic visualizaton of an ocular tissue. 92020, gonioscopy with a WRVU of 0.37 WRVU is a commonly performed procedure. However, it is not an intraocular procedure, requires less time(10 IST), and is in no way as technically demanding. Breaking out the pre-post work **(using [fill in the factor we used to remove pre and post time-we should show the math or someone will ask]** of the reference code would result in a value of 2.44WRVU but the AAO panel felt that this value was too high. A search for comparable codes in other specialties was undertaken. Diagnostic maxillary sinus endoscopy, 31233 with 2.1 WRVU, seemed like a good cross walk. This is a 000- global with 15 minutes of pre time, 20 minutes IST and 15 min. of post service time. It is a two dimensional viewing of a body cavity through an ostium and requires more technical skill than a direct visualization. Breaking out the difference in pre-post work would lead to a value of 1.7WRVU.

FREQUENCY INFORMATION

How was this service previously reported? 66999(unlisted) (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 ophtlalmology ____Commonly ____Sometimes ___X__Rarely

Specialty ____Commonly ____Sometimes ____Rarely

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

Specialty ophthalmology Frequency 1500

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 ophthalmologhy Frequency 750__

Specialty ____ Frequency ____

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

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
February 2002
Bone Density Studies

As part of the overall project to move physician services described by HCPCS Level II G codes into CPT, the CPT Editorial Panel revised CPT code 76070 *Computed tomography bone mineral density study, one or more sites; axial skeleton (eg, hips, pelvis, spine)* (work RVU = 0.25) and created code 76071 *Computed tomography bone mineral density study, one or more sites; appendicular skeleton (peripheral (eg, radius, wrist, heel))* to better differentiate these services. The RUC considered survey data from radiology and determined that the survey median of 0.22 was appropriate for the new code 76071. The total time of twenty minutes is comparable to the total time for reference service 76076 *Dual energy x-ray absorptiometry (DEXA), bone density study, one or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)* (work RVU = 0.22). This is also the current work value assigned by CMS to G code G0132 *Computerized tomography bone mineral density study, one or more sites; appendicular skeleton (peripheral) (e.g. radius, wrist, heel)* (work RVU = 0.22). **The RUC, therefore, recommends a work RVU of 0.22 for CPT code 76071.**

The RUC also reviewed the direct practice expense inputs for 76071 and made one adjustment to the specialty society recommendation by eliminating the staff time to escort the patient back to the waiting area. The revised inputs are attached to this recommendation. The RUC recommends no direct practice expense inputs when the service is performed in a facility setting.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲76070	AF1	~~Computerized axial~~ Computed tomography bone mineral density study, one or more sites; axial skeleton (eg, hips, pelvis, spine)	XXX	0.25 (no change)
~~G0131~~		~~Computerized tomography bone mineral density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)~~	XXX	N/A
●76071	AF2	appendicular skeleton (peripheral (eg, radius, wrist, heel))	XXX	0.22
~~G0132~~		~~Computerized tomography bone mineral density study, one or more sites; appendicular skeleton (peripheral) (e.g. radius, wrist, heel)~~	XXX	N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:	76071	Tracking Number:	AF2	Global Period:	XXX	Recommended RVW:	0.22

CPT Descriptor: Computed tomography bone mineral density study, one or more sites; appendicular skeleton (peripheral (eg, radius, wrist, heel))

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year old menopausal woman with a family history of osteoporosis, considering estrogen therapy. Lumbar spine hardware prevents obtaining a CT bone mineral density study of the spine.

Description of Pre-Service Work:

- **Review of clinical data (e.g. patient history) and other pertinent radiologic studies.**

Description of Intra-Service Work:

- **Calibration and quality control (e.g. measurement of phantom) of device**
- **Assure anatomic markings are appropriately displayed and are in proper position.**
- **Appropriate CT sections are obtained in the area of interest**

Description of Post-Service Work:

- **Assure quantitative data are valid**
- **Interpretation of data; generation of written report**
- **Communication of report to referring physician and/or patient.**

CPT Code: 76071

SURVEY DATA:

Presenter(s) Bibb Allen, Jr., M.D., ACR RUC advisor

Specialty(s) American College of Radiology

Sample Size: 25 Response Rate: (%): 14 (56%) Median RVW: 0.22

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

25th Percentile RVW: 0.22 75th Percentile RVW: 0.22 Low: 0.22 High: 0.22

Median Pre-Service Time: 3.00 Median Intra-Service Time: 12.00

25th Percentile Intra-Service Time: 10.00 75th Percentile Intra-Svc Time: 14.00 Low: 8.00 High: 16.00

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	5.00	
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
76076	Dual energy x-ray absorptiometry (DEXA), bone density study, one or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)	0.22

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)	New/Revis. CPT Code: 7607X1	Key Reference CPT Code: 76076
Median Pre-Time	3.00	5
Median Intra-Time	12.00	5
Median Immediate Post-service Time	5.00	10
Median of Aggregate Critical Care Times	N/A	
Median of Aggregate Other Hospital Visit Times	N/A	
Median Discharge Day Management Time	N/A	
Median of Aggregate Office Visit Times	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	3.00	1.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	1.00
Urgency of medical decision making	1.00	1.00

Technical Skill/Physical Effort (Mean)

Technical skill required	1.00	1.00
Physical effort required	1.00	1.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.00	1.00
Outcome depends on the skill and judgement of physician	1.00	1.00
Estimated risk of malpractice suit with poor outcome	1.00	1.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	1.00	1.00
Intra-Service intensity/complexity	2.00	1.00
Post-Service intensity/complexity	3.00	1.00

ADDITIONAL RATIONALE

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

The ACR surveyed a small group (25) of physicians who indicated that they perform CT for bone density study. The ACR convened a consensus panel to review and further develop recommendations. The panel represented different geographic distributions, practice types and practice sizes. The panel recommends a median RVU of 0.22.

FREQUENCY INFORMATION

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

G0132 (Computerized tomography bone mineral density study, one or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)

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

Specialty Radiology ___ Commonly ___ Sometimes X Rarely

Specialty _____ ___ Commonly ___ Sometimes ___ Rarely

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

Specialty Radiology Frequency It is estimated that this procedure would be performed less than 1,500 times 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 Radiology Frequency It is estimated that this procedure would be performed less than 600 times per year.

Specialty _____ Frequency _____

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

		76071	
	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Computed tomography (bone mineral density study), one or more sites; appendicular skeleton (peripheral (eg, radius, wrist, heel))	
LOCATION		**In Office**	**Out Office**
GLOBAL PERIOD		XXX	
TOTAL CLINICAL LABOR TIME		29	
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		**3**	**RT**
Obtain vital signs			
Provide pre-service education/obtain consent		**5**	**RT**
Prepare room, equipment,supplies		**3**	**RT**
Prepare and position patient/ monitor patient/ set up IV			
Sedate/apply anesthesia			
Intra-service			
Assist physician in performing procedure/ *Acquire images/post processing*		**15**	**RT**
Post-Service			
Monitor pt. following service/check tubes, monitors, drains			
Clean room/equipment by physician staff		**3**	**RT**
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 or outpatient care			
List Number and Level of Office Visits			
99211 16 minutes			
99212 27 minutes			
99213 36 minutes			
99214 53 minutes			
99215 63 minutes			
Other			
Total Office Visit Time		0	0
Conduct phone calls between office visits			
Other Activity (please specify)			
End: with last office visit before end of global period			

		76071
	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	[illegible]
LOCATION		In Office	Out Office
MEDICAL SUPPLIES			
Laser paper	73420	1 sheet	
Equipment			
Peripheral QCT (Norland, $55,000)			

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Obstetric Ultrasound

Codes 76801, 76802, 76811, 76812 and 76817 were developed to reflect the advances in ultrasound technology, which now enable physicians to evaluate and measure fetal characteristics and organ systems in much greater detail than was possible several years ago.

Codes 76805 and 76810

The RUC reviewed the specialty societies' recommendations for 76805 *Ultrasound, pregnant uterus, B scan and/or real time with image documentation;, complete (complete fetal and maternal evaluation) , after first trimester (> or =14 weeks 0 days), transabdominal approach; single or first gestation* and 76810 ~~*complete (complete fetal and maternal evaluation), multiple gestation, after the first trimester*~~ *each additional gestation (List separately in addition to code for primary procedure performed)*. The RUC agreed that the physician work for 76805 has not changed as a result. Currently, for a multiple gestation, physicians would code 76810 separately, which was valued at 1.97 RVUs. Because the descriptor of 76810 (work RVU = 1.97) once regardless of the number of gestations. Because the descriptor of 76810 has changed, for a multiple gestation, physicians would code 76805 for a single gestation and 76810 for each additional gestation. Therefore, code 76810 has been reduced to a relative work value of 0.98 (half of its original RVU = 1.97), to reflect this change in the CPT language and global period to ZZZ. **The RUC recommends a work relative value of 0.99 for 76805 and 0.98 for 76810.**

Codes 76801 and 76802

The RUC reviewed the specialty societies' recommendations for 76801 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 days), transabdominal approach; single or first gestation* and 76802 *each additional gestation (List separately in addition to code for primary procedure performed).* These codes reflect ultrasound performed in the first trimester, which the specialties agreed was important to track.. The RUC reviewed the specialty societies' survey data and the survey median relative work value of a 0.99. The RUC agreed that the work of 76801 is identical to the work value of 76805. Code 76801 had previously been reported under 76805. For 76802, the RUC accepted the survey median relative work value of 0.83. The RUC understands that the work of reviewing ultrasound for multiple gestation is less in the first trimester then the 2nd or 3rd trimester (CPT code 76810, work RVU = 0.98). **The RUC recommends a work relative value of 0.99 for 76801 and 0.83 for 76802.**

Code 76815

The RUC assessed the specialty societies' recommendation for 76815 *Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume ~~or emergency in the delivery room~~), one or more fetuses*. The RUC felt that the survey data supported the contention that this coding change was editorial and did not change the work of the service. This code is valued identical to CPT 76856 (work RVU = 0.69). **The RUC recommends a work relative value of 0.65 for 76815.**

Code 76816

The RUC examined the specialty societies' recommendation for 76816 *Ultrasound, pregnant uterus, real time with image documentation, follow-up ~~or repeat~~ (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus*. The specialty society felt that this code had been undervalued in the past because it was valued less than 76815, which is a limited scan while 76816 reflect the same services as described in 76805 (RVU = 0.99). Therefore, the RUC felt that the specialty societies' recommendation of 0.85, the survey median, was appropriate. **The RUC recommends a work relative value of 0.85 for 76816.**

Codes 76811 and 76812

The RUC examined the specialty societies recommendations for 76811 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation* and 76812 *each additional gestation (List separately in addition to code for primary procedure performed)*. The specialty societies explained that these codes reflected the work performed in 76805 plus *a detailed anatomic evaluation of the fetal brain/ventricles, face, heart/outflow tracts and chest anatomy, abdominal organ specific anatomy, number/length/architecture of limbs and detailed evaluation of the umbilical cord and placenta and other fetal anatomy as clinically indicated.* This is new work made possible by the advances in the technology of the new ultrasound machines. This service is infrequently utilized and is mostly performed by maternal-fetal specialists. Therefore, the RUC felt that the specialty societies' recommendations of 1.90 for 76811 and 1.78 for 76812, both the survey medians, were appropriate. A patient with a multiple pregnancy typically has had a prior ultrasound study and/or other more extensive records, which must be reviewed, adding to pre-service work. In the intra-service period, the examination of the uterus and adnexa is not repeated, but additional intra-service work other than the evaluation of the additional fetus must be performed. The chorionic membranes, amniotic membranes, and placenta must be closely examined to determine whether the pregnancy is di-chorionic or mono-chorionic and di-amniotic or mono-amniotic. Accurate determination of these factors is important to assessing risk for development of complications such twin-twin transfusion syndrome. Additional post-service work is also

required – documentation is more extensive and discussion with the patient and, if applicable, her referring physician is lengthier. **The RUC recommends a work relative value of 1.9 for 76811 and 1.78 for 76812.**

Code 76817

The RUC reviewed the specialty societies' data and recommendation for 76817 *Ultrasound, pregnant uterus, real time with image documentation, transvaginal.* The RUC agreed with the specialty that this new service requires more time and is more intense than both codes 76856 *Ultrasound, pelvic (nonobstetric), B-scan and/or real time with image documentation; complete* (work RVU = 0.69) and 76830 *Ultrasound, transvaginal* (work RVU=0.69) and suggests the use of the specialty society's survey 75th percentile(work RVU= 0.75) **The RUC recommends a work relative value of 0.75 for 76817.**

Practice Expense

The RUC reviewed the practice expense inputs for the obstetric ultrasound codes. The specialty society explained that these were the standard practice expense inputs for ultrasound developed by the PEAC. Questions were also raised about the ultrasound room vs. the ultrasound machine. If typically the service were performed in a radiology office or unit at the hospital, than an ultrasound room would be the appropriate equipment. If the service were typically performed in an obstetrician's office, then the ultrasound machine would be more appropriate. The specialties have indicated that the ultrasound room is the typical site of service. The modified practice expense inputs are attached to these recommendations.

CPT Descriptor

Codes 76801 and 76802 include determination of the number of gestational sacs and fetuses, gestational sac/fetal measurements appropriate for gestation (<14 weeks 0 days), survey of visible fetal and placental anatomic structure, qualitative assessment of amniotic fluid volume/gestational sac shape and examination of the maternal uterus and adnexa.

Codes 76805 and 76810 include determination of number of fetuses and amniotic/chorionic sacs, measurements appropriate for gestational age (> or = 14 weeks 0 days), survey of intracranial/spinal/abdominal anatomy, 4 chambered heart, umbilical cord insertion site, placenta location and amniotic fluid assessment and, when visible, examination of maternal adnexa.

Codes 76811 and 76812 include all elements of codes 76805 and 76810 plus detailed anatomic evaluation of the fetal brain/ventricles, face, heart/outflow tracts and chest anatomy, abdominal organ specific anatomy, number/length/architecture of limbs and detailed evaluation of the umbilical cord and placenta and other fetal anatomy as clinically indicated.

Report should document the results of the evaluation of each element described above or the reason for non visualization.

Code 76815 represents a focused "quick look" exam limited to the assessment of one or more of the elements listed in code 76815.

Code 76816 describes an examination designed to reassess fetal size and interval growth or reevaluate one or more anatomic abnormalities of a fetus previously demonstrated on ultrasound, and should be coded once for each fetus requiring reevaluation using modifier '–59' for each fetus after the first.

Code 76817 describes a transvaginal obstetric ultrasound performed separately or in addition to one of the transabdominal examinations described above. For transvaginal examinations performed for non-obstetrical purposes, use code 76830.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●76801	BE1	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 days), transabdominal approach; single or first gestation	XXX	0.99

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
✚●76802	BE2	each additional gestation (List separately in addition to code for primary procedure performed) (Use 76802 in conjunction with 76801)	ZZZ	0.83
▲76805	BE3	Ultrasound, pregnant uterus, B scan and/or real time with image documentation;, complete (complete fetal and maternal evaluation) , after first trimester (> or =14 weeks 0 days), transabdominal approach; single or first gestation	XXX	0.99 (no change)
▲✚76810	BE4	~~complete (complete fetal and maternal evaluation), multiple gestation, after the first trimester~~ each additional gestation (List separately in addition to code for primary procedure performed) (Use 76810 in conjunction with code 76805)	ZZZ	0.98
●76811	BE5	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation	XXX	1.90

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●✚76812	BE6	each additional gestation (List separately in addition to code for primary procedure performed) (Use 76812 in conjunction with code 76811)	ZZZ	1.78
▲76815	BE7	Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume ~~or emergency in the delivery room~~), one or more fetuses (Use 76815 only once per exam and not per element)	XXX	0.65 (no change)
▲76816	BE8	Ultrasound, pregnant uterus, real time with image documentation, follow-up ~~or repeat~~ (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus (Report 76816 with modifier '-59' for each additional fetus examined in a multiple pregnancy)	XXX	0.85

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●76817	BE9	Ultrasound, pregnant uterus, real time with image documentation, transvaginal (For non-obstetrical transvaginal ultrasound, use 76830) (If transvaginal examination is done in addition to transabdominal obstetrical ultrasound exam, use 76817 in addition to appropriate transabdominal exam code)	XXX	0.75

Non-obstetrical

76830	Ultrasound, transvaginal (For obstetrical transvaginal ultrasound, see 76817) (If transvaginal examination is done in addition to transabdominal non-obstetrical ultrasound exam, use 76830 in addition to appropriate transabdominal exam code)
76831	*Hysterosonography, with or without color flow Doppler* *(For introduction of saline or contrast for hysterosonography, use 58340)* *(76855 has been deleted. To report, see 93975-93979)*
76856	*Ultrasound, pelvic (nonobstetric), B-scan and/or real time with image documentation; complete*
76857	*limited or follow-up (e.g., for follicles)*

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:	76801	Tracking Number:	BE1	Global Period:	XXX	**Recommended RVW:**	0.99

CPT Descriptor: Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 days), transabdominal approach; single or first gestation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 34-year-old female who conceived on oral contraceptive pills presents to the ER with vaginal bleeding. She states that her last menstrual period was eight weeks ago and has a positive pregnancy test. Physical exam reveals that the uterus is 12 weeks size. An ultrasound is ordered to evaluate first trimester bleeding and determine the gestational age. Ultrasound shows a single intrauterine fetus with crown-rump length consistent with 11 weeks gestation. Both ovaries are visualized and normal. An intramural uterine myoma measuring 1.5 cm in diameter is present.

Pre-service Work

- Review of clinical information
- Review of pertinent prior imaging studies

Intra-service Work

- Supervision of the sonographer performing the examination
- Interpretation of the examination including the following key elements:
  - -Determination of the number of gestational sacs and fetuses
  - -Fetal measurements
  - -Survey of visible fetal anatomy
  - -Assessment of the umbilical cord and placenta when visible
  - -Qualitative assessment of the amniotic fluid volume
  - -Evaluation of maternal uterus and adnexa
- Prepare report for the medical record

Post-service Work

- Discuss findings with the patient and referring physician when appropriate
- Review and sign the prepared report

SURVEY DATA:

Presenter(s): George Hill, MD, ACOG and Bibb Allen, Jr., M.D., ACR

Specialty(s): American College of Obstetricians and Gynecologists and American College of Radiology

Sample Size: 290 Response Rate: (%): 64 (22%) Median RVW: 0.99

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

25th Percentile RVW: 0.73 75th Percentile RVW: 0.99 Low: 0.35 High: 1.33

Median Pre-Service Time: 5.00 Median Intra-Service Time: 15.00

25th %tile Intra-Svc Time: 10.00 75th %tile Intra-Svc Time: 20.0 Low: 4.00 High: 30.00

-

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	7.00	
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
76856	Ultrasound, pelvic (nonobstetric), B-scan and/or real time with image documentation; complete	XXX	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 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:
Median Pre-Time	5.00	
Median Intra-Time	15.00	(20) Harvard total time
Median Immediate Post-service Time	7.00	
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	3.31	2.86
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.04	2.64
Urgency of medical decision making	3.57	2.79

Technical Skill/Physical Effort (Mean)

Technical skill required	3.96	2.79
Physical effort required	2.63	2.50

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.52	2.57
Outcome depends on the skill and judgement of physician	3.37	2.79
Estimated risk of malpractice suit with poor outcome	4.02	2.79

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.11	2.36
Intra-Service intensity/complexity	2.89	2.82
Post-Service intensity/complexity	2.44	2.55

ADDITIONAL RATIONALE

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

The American College of Obstetricians and Gynecologists (ACOG), in cooperation with the Society for Maternal Fetal Medicine, disseminated the RUC survey instrument via U.S. Mail to a selected panel of obstetricians and maternal fetal medicine subspecialists who perform the procedure. The American College of Radiology (ACR) mailed the survey to a random sample of ACR members. ACOG and ACR staff tabulated the responses from both societies. A panel of ACOG and ACR physicians reviewed the data and developed the consensus recommendation.

The ACOG/ACR panel felt that 76801 requires significantly more work than the reference service (76856). While 76856 includes a complete evaluation of the pelvic organs, 76801 includes not only examination of maternal pelvic structures such as the uterus and adnexa, but also evaluation of the fetus. Survey respondents reported significantly more time for 76801 and consistently rated it higher on measures of mental effort and judgement, technical skill/physical effort, and psychological stress. Therefore ACOG and ACR recommend adoption of the survey median RVW of 0.99.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 76805

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

Specialty Radiology X Commonly ___ Sometimes ___ Rarely

Specialty Ob-Gyn X Commonly ___ Sometimes ___ Rarely

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

Specialty Radiology Frequency Unavailable

Specialty Ob-gyn Frequency Unavailable

Code-specific national frequency data for obstetric ultrasound services are unavailable. National birth certificate data indicate that in 2000 approximately 2.7 million ultrasound procedures were performed during pregnancies that resulted in live births (**National Vital Statistics Report**, Vol. 50, No. 5, Feb. 12, 2002). An unknown percentage of these procedures would be coded using 76801.

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 <500

Specialty Ob-gyn Frequency <1000

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:	76802	Tracking Number:	BE2	Global Period:	ZZZ	**Recommended RVW:**	0.83

CPT Descriptor: Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure performed)

(Use 76802 in conjunction with 76801)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient described in 76801 is found to have twins. In addition to the work described above, the crown-rump length is also measured on the additional fetus. Two placenta sites are evaluated and a thick dividing membrane is seen indicating that they are dichorionic placentas.

Intra-service Work

- Supervision of the sonographer performing the examination
- Interpretation of the examination including the following key elements:
  - -Determination of the number of membranes and placentas and type of zygote
  - -Fetal measurements
  - -Survey of visible fetal anatomy
  - -Assessment of the umbilical cord and placenta when visible
  - -Qualitative assessment of the amniotic fluid volume
  - -Evaluation of maternal uterus and adenexa
- Prepare report for the medical record

SURVEY DATA:

Presenter(s): George Hill, MD, ACOG and Bibb Allen, Jr., M.D., ACR

Specialty(s): American College of Obstetricians and Gynecologists and American College of Radiology

Sample Size: 290 Response Rate: (%): 57 (20%) Median RVW: 0.83

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

25th Percentile RVW: 0.40 75th Percentile RVW: 0.99 Low: 0.12 High: 1.98

Median Pre-Service Time: 0 Median Intra-Service Time: 10.00

25th Percentile Intra-Service Time: 7.00 75th Percentile Intra-Svc Time: 20.0 Low: 1.00 High: 30.00

Median Post-Service Time:

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

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
76856	Ultrasound, pelvic (nonobstetric), B-scan and/or real time with image documentation; complete	XXX	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 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:
Median Pre-Time		
Median Intra-Time	10.00	20 Harvard total time
Median Immediate Post-service Time		
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.41	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.07	2.91
Urgency of medical decision making	3.39	3.00
Technical skill required	3.98	2.91
Physical effort required	2.48	2.64

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.59	2.55
Outcome depends on the skill and judgement of physician	3.27	3.00
Estimated risk of malpractice suit with poor outcome	3.89	2.91

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.20	2.65
Intra-Service intensity/complexity	3.14	2.80
Post-Service intensity/complexity	3.20	2.50

ADDITIONAL RATIONALE

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

The American College of Obstetricians and Gynecologists (ACOG), in cooperation with the Society for Maternal Fetal Medicine, disseminated the RUC survey instrument via U.S. Mail to a selected panel of obstetricians and maternal fetal medicine subspecialists who perform the procedure. The American College of Radiology (ACR) mailed the survey to a random sample of ACR members. ACOG and ACR staff tabulated the responses from both societies. A panel of ACOG and ACR physicians reviewed the data and developed the consensus recommendation.

The ACOG/ACR panel felt that 76802 requires more work than the reference service (76856). Survey respondents reported significantly more time for 76802 and consistently rated it higher on measures of mental effort and judgement, technical skill/physical effort, and psychological stress. Therefore ACOG and ACR recommend adoption of the survey median RVW of 0.83.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 76805

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

Specialty Radiology X Commonly ___ Sometimes ___ Rarely

Specialty Ob-gyn X Commonly ___ Sometimes ___ Rarely

Specialty Radiology Frequency Unavailable

Specialty Ob-gyn Frequency Unavailable

Code-specific national frequency data for obstetric ultrasound services are unavailable. National birth certificate data indicate that in 2000 approximately 2.7 million ultrasound procedures were performed during pregnancies that resulted in live births (**National Vital Statistics Report**, Vol. 50, No. 5, Feb. 12, 2002). Approximately 2.9% of births are twins and another 0.18% are higher order multiples, so 76802 will represent a very small percentage of all obstetric ultrasounds performed.

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 <100

Specialty Ob-gyn Frequency <100

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 76805 Tracking Number: BE3 Global Period: XXX **Recommended RVW:** ~~1.00~~ **RUC Recommended 0.99**

CPT Descriptor: Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or =14 weeks 0 days), transabdominal approach; single or first gestation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35-year-old pregnant female with menstrual age of 24 weeks is large for dates. An ultrasound is ordered to evaluate the gestational age and assess the fetus. Ultrasound determinations of gestational age are consistent with 28 week gestation. Fetal evaluation including a survey of intracranial, spinal and abdominal anatomy, 4-chamber view of the heart and umbilical cord insertion is normal. The placenta location is anterior and away from the cervical os, and the amniotic fluid is normal. Both ovaries are visualized and normal.

Description of Pre-Service Work:

- Review of clinical information
- Review of pertinent prior imaging studies

Description of Intra-Service Work:

- Supervision of the sonographer performing the examination
- Interpretation of the examination including the following key elements:
  - -Determination of the number of fetuses amniotic/chorionic sacs
  - -Survey of intracranial, spinal and abdominal anatomy
  - -Evaluate the 4-chamber heart view
  - -Assessment of the umbilical cord insertion site
  - -Assessment of the amniotic fluid volume
  - -Evaluation of maternal adnexa when visible
- Prepare report for the medical record

Description of Post-Service Work

- Discuss findings with the patient and referring physician when appropriate
- Review and sign the prepared report

SURVEY DATA:

Presenter(s): George Hill, MD, ACOG, Bibb Allen, Jr., M.D., ACR RUC advisor

Specialty(s): American College of Obstetricians and Gynecologists, American College of Radiology

Sample Size: 290 Response Rate (%): 46 (16%) Median RVW: 1.00

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

25th Percentile RVW: 0.99 75th Percentile RVW: 1.50 Low: 0.50 High: 2.00

Median Pre-Service Time: 5.00 Median Intra-Service Time: 15.00

25th %tile Intra-Srvc Time: 15.00 75th %tile Intra-Srvc Time: 25.00 Low: 0.00 High: 30.00

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	6.00	
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
76856	Ultrasound, pelvic (nonobstetric), B-scan and/or real time with image documentation; complete	XXX	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 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:
Median Pre-Time	5.00	
Median Intra-Time	15.00	20 (Harvard total time)
Median Immediate Post-service Time	6.00	
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.59	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.27	3.00
Urgency of medical decision making	3.27	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	3.73	3.00
Physical effort required	2.97	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.24	3.00
Outcome depends on the skill and judgement of physician	3.59	3.00
Estimated risk of malpractice suit with poor outcome	4.03	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.53	3.00
Intra-Service intensity/complexity	3.47	3.00
Post-Service intensity/complexity	2.88	3.00

ADDITIONAL RATIONALE

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

The American College of Obstetricians and Gynecologists (ACOG), in cooperation with the Society for Maternal Fetal Medicine, disseminated the RUC survey instrument via U.S. Mail to a selected panel of obstetricians and maternal fetal medicine subspecialists who perform the procedure. The American College of Radiology (ACR) mailed the survey to a random sample of ACR members. ACOG and ACR staff tabulated the responses from both societies. A panel of ACOG and ACR physicians reviewed the data and developed the consensus recommendation.

The ACOG/ACR panel determined that the survey median of 1.00 RVW was appropriate for 76805. This value seemed reasonable in comparison to the reference service (76856) because 76805 includes evaluation of the fetus, placenta, umbilical cord, and amniotic fluid, in addition to the uterus and maternal adnexa. The higher total time from the survey, as well as higher ratings of intensity/complexity confirm the difference in RVW.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 76805

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

Specialty Radiology X Commonly ___ Sometimes ___ Rarely

Specialty Ob-gyn X Commonly ___ Sometimes ___ Rarely

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

Specialty Radiology Frequency Unavailable

Specialty Ob-gyn Frequency Unavailable

Code-specific national frequency data for obstetric ultrasound services are unavailable. National birth certificate data indicate that in 2000 approximately 2.7 million ultrasound procedures were performed during pregnancies that resulted in live births (**National Vital Statistics Report**, Vol. 50, No. 5, Feb. 12, 2002). An unknown percentage of these procedures would be coded using 76805.

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 800 (1999)

Specialty Ob-gyn Frequency 3852 (1999)

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

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:	76810	Tracking Number:	BE4	Global Period:	ZZZ	Recommended RVW:	0.97
						RUC Recommended	0.98

CPT Descriptor: Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or =14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure performed)

(Use 76810 in conjunction with code 76805)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient described in 76805 is found to have twins. In addition to the work described above, ultrasound evaluation of gestational age is performed on the second fetus. Fetal evaluation of the second fetus including a survey of intracranial, spinal and abdominal anatomy, 4-chamber view of the heart and umbilical cord insertion is normal. Two placenta sites are identified and a thick dividing membrane is seen indicating that they are dichorionic placentas.

Intra-service Work

- Supervision of the sonographer performing the examination
- Interpretation of the examination of the additional fetus including the following key elements:
  - -Assessment of the amniotic/chorionic membranes and number/type of placentas
  - -Survey of intracranial, spinal and abdominal anatomy
  - -Evaluate the 4-chamber heart view
  - -Assessment of the umbilical cord insertion site
  - -Assessment of the amniotic fluid volume
  - -Evaluation of maternal adnexa when visible
- Prepare report for the medical record

SURVEY DATA:

Presenter(s): George Hill, MD, ACOG and Bibb Allen, Jr., M.D., ACR

Specialty(s): American College of Obstetricians and Gynecologists and American College of Radiology

Sample Size: 290 Response Rate (%): 55 (19%) Median RVW: 0.99

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

25th Percentile RVW: 0.80 75th Percentile RVW: 1.21 Low: 0.20 High: 3.20

Median Pre-Service Time: 0 Median Intra-Service Time: 20.00

25th %tile Intra-Svc Time: 12.00 75th %tile Intra-Svc Time: 20.00 Low: 0.00 High: 45.00

Median Post-Service Time:

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

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
76856	Ultrasound, pelvic (nonobstetric), B-scan and/or real time with image documentation; complete	XXX	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 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:_
Median Pre-Time		
Median Intra-Time	20.00	20 (Harvard total time)
Median Immediate Post-service Time		
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.80	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.57	3.00
Urgency of medical decision making	3.73	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	4.35	3.00
Physical effort required	2.91	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.93	3.00
Outcome depends on the skill and judgment of physician	3.61	3.00

Estimated risk of malpractice suit with poor outcome	4.47	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.67	3.00
Intra-Service intensity/complexity	3.81	3.00
Post-Service intensity/complexity	3.00	3.00

ADDITIONAL RATIONALE

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

The American College of Obstetricians and Gynecologists (ACOG), in cooperation with the Society for Maternal Fetal Medicine, disseminated the RUC survey instrument via U.S. Mail to a selected panel of obstetricians and maternal fetal medicine subspecialists who perform the procedure. The American College of Radiology (ACR) mailed the survey to a random sample of ACR members. ACOG and ACR staff tabulated the responses from both societies. A panel of ACOG and ACR physicians reviewed the data and developed the consensus recommendation.

The ACR/ACOG panel felt that the additional time and higher ratings of complexity/intensity in comparison to the reference service (76856) reported by the survey respondents justified the median RVW of 0.99. In addition, the panel concluded that the physician work required to evaluate an additional fetus after the first trimester is equivalent to the work of 76805. First, a patient with a multiple pregnancy typically has had a prior ultrasound study and/or other more extensive records which must be reviewed, adding to pre-service work. In the intra-service period, the examination of the uterus and adnexa is not repeated, but additional intra-service work other than the evaluation of the additional fetus must be performed. The chorionic membranes, amniotic membranes, and placenta must be closely examined to determine whether the pregnancy is di-chorionic or mono-chorionic and di- or mono-amniotic. Accurate determination of these factors is important to assessing risk for development of complications such twin-twin transfusion syndrome. Additional post-service work is also required – documentation is more extensive and discussion with the patient and, if applicable, her referring physician is lengthier. The current RVW assigned to 76810 is 1.97. The code will now become an add-on to 76805. ACOG and ACR recommend adoption of **0.97 RVW** for 76810 to maintain at a constant level the RVW for ultrasound after the first trimester of a twin pregnancy. Higher order multiple pregnancies are rare.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 76810

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

Specialty Radiology X Commonly ___ Sometimes ___ Rarely

Specialty Ob-gyn X Commonly ___ Sometimes ___ Rarely

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

Specialty Radiology Frequency Unavailable

Specialty Ob-gyn Frequency Unavailable

Code-specific national frequency data for obstetric ultrasound services are unavailable. National birth certificate data indicate that in 2000 approximately 2.7 million ultrasound procedures were performed during pregnancies that resulted in live births. Approximately 2.9% of births are twins and another 0.18% are higher order multiples, so 76810 will represent a very small percentage of all obstetric ultrasounds performed (**National Vital Statistics Report**, Vol. 50, No. 5, Feb. 12, 2002).

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 24 (1999)

Specialty Ob-gyn Frequency 143 (1999)

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:	76811	Tracking Number:	BE5	Global Period:	XXX	Recommended RVW:	1.90

CPT Descriptor: Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 37-year-old female in her fourth pregnancy presents for sonography at 18 weeks gestation. Her past obstetric history is significant for a miscarriage, delivery of a normal child, and a child with a skeletal defect (short rib-polydactyly) who died shortly after birth. She has had a serum triple screen that showed an increased risk for Down syndrome over her age-related risk of 1:224 to 1:70. She would like to avoid the risk of amniocentesis and requests determination of whether the fetus has a recurrence of a skeletal dysplasia or Down syndrome.

Pre-service Work

- Review of clinical information
- Review of pertinent prior imaging studies

Intra-service Work

- Supervision of the sonographer performing the examination
- Interpretation of the examination including the following key elements:
  - -All components of 76805
  - -Complete evaluation of intracranial, facial and spinal anatomy face
  - -Complete evaluation the heart, outflow tracts and chest anatomy
  - -Complete evaluation of abdominal organs
  - -Complete evaluation of the extremities (number, length and architecture)
  - -Assessment of the umbilical cord insertion site and placenta
  - -Assessment of the amniotic fluid volume
  - -Evaluation of maternal adnexa when visible
- Prepare report for the medical record

Post-Service Work

- Discuss findings with the patient and referring physician when appropriate
- Review and sign the prepared report

SURVEY DATA:

Presenter(s): George Hill, MD, ACOG and Bibb Allen, Jr., M.D., ACR RUC advisor

Specialty(s): American College of Obstetricians and Gynecologists and American College of Radiology

Sample Size: 290 Response Rate: (%): 56 (19%) Median RVW: 1.90

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

25th Percentile RVW: 1.50 75th Percentile RVW: 2.00 Low: 0.89 High: 5.50

Median Pre-Service Time: 10.00 Median Intra-Service Time: 30.00

25th Percentile Intra-Srvc Time: 22.50 75th Percentile Intra-Svc Time: 30.00 Low: 5.00 High: 110.00

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Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	12.00	
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
76856	Ultrasound, pelvic (nonobstetric), B-scan and/or real time with image documentation; complete	XXX	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 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:
Median Pre-Time	10.00	
Median Intra-Time	30.00	20 (Harvard total time)
Median Immediate Post-service Time	12.00	
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	4.72	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.57	3.00
Urgency of medical decision making	4.15	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	4.77	3.00
Physical effort required	3.11	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.32	3.00
Outcome depends on the skill and judgement of physician	4.49	3.00
Estimated risk of malpractice suit with poor outcome	4.85	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.19	3.00
Intra-Service intensity/complexity	4.56	3.00
Post-Service intensity/complexity	3.56	3.00

ADDITIONAL RATIONALE

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

The American College of Obstetricians and Gynecologists (ACOG), in cooperation with the Society for Maternal Fetal Medicine, disseminated the RUC survey instrument via U.S. Mail to a selected panel of obstetricians and maternal fetal medicine subspecialists who perform the procedure. The American College of Radiology (ACR) mailed the survey to a random sample of ACR members. ACOG and ACR staff tabulated the responses from both societies. A panel of ACOG and ACR physicians reviewed the data and developed the consensus recommendation

The survey median of 1.90 is reasonable and appropriate. Survey respondents estimated that this procedure requires more than twice as much time as 76856. During the pre-service period, review of clinical information and previous imaging studies is more extensive. During the intra-service period more anatomic elements are examined and the evaluation/interpretation of these images demands a higher level of skill and more extensive fund of knowledge. The patient is also at higher risk. Survey data show higher assessments of mental effort judgment, technical skill, and psychological stress in comparison to 76805.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 76805

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

Specialty Radiology X Commonly ___ Sometimes ___ Rarely

Specialty Ob-Gyn X Commonly ___ Sometimes ___ Rarely

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

Specialty Radiology Frequency Unavailable

Specialty Ob-gyn Frequency Unavailable

Code-specific national frequency data for obstetric ultrasound services are unavailable. National birth certificate data indicate that in 2000 approximately 2.7 million ultrasound procedures were performed during pregnancies that resulted in live births (**National Vital Statistics Report**, Vol. 50, No. 5, Feb. 12, 2002). This procedure will be performed to detect congenital anomalies. Approximately 10% of pregnancies can be considered at elevated risk of anomalies of fetal development.

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 <500

Specialty Ob-gyn Frequency <500

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:	76812	Tracking Number:	BE6	Global Period:	ZZZ	**Recommended RVW:**	1.78

CPT Descriptor: Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation (List separately in addition to code for primary procedure performed)

(Use 76812 in conjunction with code 76811)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient described in 76811 is found to have twins. In this procedure the same measurements and anatomic assessment is carried out on the additional fetus. Two placenta sites are evaluated and a thick dividing membrane is seen indicating that they are dichorionic placenta.

Intra-service Work

- Supervision of the sonographer performing the examination
- Interpretation of the examination including the following key elements:
  - -All components of 76810
  - -Complete evaluation of intracranial, facial and spinal anatomy face
  - -Complete evaluation the heart, outflow tracts and chest anatomy
  - -Complete evaluation of abdominal organs
  - -Complete evaluation of the extremities (number, length and architecture)
  - -Assessment of the umbilical cord insertion site and placenta
  - -Assessment of the amniotic fluid volume
  - -Evaluation of maternal adnexa when visible
- Prepare report for the medical record

SURVEY DATA:

Presenter(s): George Hill, MD, ACOG and Bibb Allen, Jr., M.D., ACR

Specialty(s): American College of Obstetricians and Gynecologists and American College of Radiology

Sample Size: 290 Response Rate: (%): 55 (19%) Median RVW: 1.78

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

25th Percentile RVW: 1.25 75th Percentile RVW: 2.00 Low: 0.50 High: 4.00

Median Pre-Service Time: 0 Median Intra-Service Time: 25.00

25th Percentile Intra-Srvc Time: 20.00 75th Percentile Intra-Svc Time: 29.75 Low: 3.00 High: 90.00

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Median Post-Service Time:

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

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
76856	Ultrasound, pelvic (nonobstetric), B-scan and/or real time with image documentation; complete	XXX	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 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:
Median Pre-Time		
Median Intra-Time	25.00	23 (Harvard)
Median Immediate Post-service Time		
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.54	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.35	3.13
Urgency of medical decision making	4.02	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	3.91	3.11
Physical effort required	3.33	3.13

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.37	3.00
Outcome depends on the skill and judgement of physician	4.52	3.00

Estimated risk of malpractice suit with poor outcome	4.85	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	1.00	3.00
Intra-Service intensity/complexity	4.38	3.00
Post-Service intensity/complexity	4.25	3.00

ADDITIONAL RATIONALE

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

The American College of Obstetricians and Gynecologists (ACOG), in cooperation with the Society for Maternal Fetal Medicine, disseminated the RUC survey instrument via U.S. Mail to a selected panel of obstetricians and maternal fetal medicine subspecialists who perform the procedure. The American College of Radiology (ACR) mailed the survey to a random sample of ACR members. ACOG and ACR staff tabulated the responses from both societies. A panel of ACOG and ACR physicians reviewed the data and developed the consensus recommendation.

The ACR/ACOG panel felt that the additional time and higher ratings of complexity/intensity in comparison to the reference service (76856) reported by the survey respondents justified the median RVW of 1.78. In addition, the panel concluded that the physician work required to evaluate an additional fetus after the first trimester is nearly equivalent to the work of 76811. First, a patient with a multiple pregnancy typically has had a prior ultrasound study and/or other more extensive records which must be reviewed, adding to pre-service work. In the intra-service period, the examination of the uterus and adnexa is not repeated, but additional intra-service work other than the evaluation of the additional fetus must be performed. The chorionic membranes, amniotic membranes, and placenta must be closely examined to determine whether the pregnancy is di-chorionic or mono-chorionic and di-amniotic or mono-amniotic. Accurate determination of these factors is important to assessing risk for development of complications such twin-twin transfusion syndrome. Additional post-service work is also required – documentation is more extensive and discussion with the patient and, if applicable, her referring physician is lengthier. Therefore, ACOG and ACR recommend adoption of the survey median of 1.78.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed), 76810

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

Specialty Radiology X Commonly ___ Sometimes ___ Rarely

Specialty Ob-Gyn X Commonly ___ Sometimes ___ Rarely

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

Specialty Radiology Frequency Unavailable

Specialty Ob-gyn Frequency Unavailable

Code-specific national frequency data for obstetric ultrasound services are unavailable. National birth certificate data indicate that in 2000 approximately 2.7 million ultrasound procedures were performed during pregnancies that resulted in live births (**National Vital Statistics Report**, Vol. 50, No. 5, Feb. 12, 2002). Approximately 2.9% of births are twins and another 0.18% are higher order multiples, so 76812 will represent a very small percentage of all obstetric ultrasounds performed. This procedure will be performed to detect congenital anomalies. Approximately 10% of pregnancies can be considered at elevated risk of anomalies of fetal development.

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

Specialty Ob-gyn Frequency <50

Specialty Radiology Frequency <50

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:	76815	Tracking Number:	BE7	Global Period:	XXX	Recommended RVW:	0.65

CPT Descriptor: Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), one or more fetuses

Use 76815 only once per exam and not per element)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 32-year-old obese term pregnant female presents in labor. The presenting part is difficult to evaluate by physical examination. Ultrasound is ordered to determine fetal position. A limited evaluation reveals a single fetus in cephalic presentation. No additional determinations were made.

Pre-service Work

- Review of clinical information
- Review of pertinent prior imaging studies

Intra-service Work

- Supervision of the sonographer performing the examination
- Interpretation of the examination limited to focused "quick look" assessment of one or more of the key elements:
    - Fetal position
    - Fetal heart beat
    - Placental location
    - Qualitative amniotic fluid volume
- Prepare report for the medical record

Post-Service Work

- Discuss findings with the patient and referring physician when appropriate
- Review and sign the prepared report

SURVEY DATA:

Presenter(s): George Hill, MD, ACOG and Bibb Allen, Jr., M.D., ACR RUC advisor

Specialty(s): American College of Obstetricians and Gynecologists, American College of Radiology

Sample Size: 290 Response Rate: (%): 59 (20%) Median RVW: 0.65

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

25th Percentile RVW: 0.50 75th Percentile RVW: 0.68 Low: 0.20 High: 2.00

Median Pre-Service Time: 5.00 Median Intra-Service Time: 5.50

25th %tile Intra-Srvc Time: 5.00 75th %tile Intra-Svc Time: 10.00 Low: 2.00 High: 20.00

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Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	5.00	
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

CPT Code: _____

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
76856	Ultrasound, pelvic (nonobstetric), B-scan and/or real time with image documentation; complete	XXX	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 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:
Median Pre-Time	5.00	
Median Intra-Time	5.50	(20) Harvard total time
Median Immediate Post-service Time	5.00	
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 Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.65	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.82	2.78
Urgency of medical decision making	3.57	2.89

Technical Skill/Physical Effort (Mean)

Technical skill required	3.65	2.89
Physical effort required	2.29	2.89

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.45	2.67
Outcome depends on the skill and judgment of physician	2.98	2.89
Estimated risk of malpractice suit with poor outcome	3.90	2.89

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.41	2.63
Intra-Service intensity/complexity	2.76	2.75
Post-Service intensity/complexity	2.47	2.63

ADDITIONAL RATIONALE

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

The American College of Obstetricians and Gynecologists (ACOG), in cooperation with the Society for Maternal Fetal Medicine, disseminated the RUC survey instrument via U.S. Mail to a selected panel of obstetricians and maternal fetal medicine subspecialists who perform the procedure. The American College of Radiology (ACR) mailed the survey to a random sample of ACR members. ACOG and ACR staff tabulated the responses from both societies. A panel of ACOG and ACR physicians reviewed the data and developed the consensus recommendation.

The ACOG/ACR panel determined that the survey median of 0.65 RVW accurately reflected the small difference in work between 76815 and the reference service (76856). The limited obstetric ultrasound (76815) takes somewhat less time than 76856. The smaller amount of time is partially offset by the circumstances under which 76815 is often performed. Frequently 76815 is performed on an emergent basis to provide critical information for an immediate treatment decision. Accordingly, respondents rated 76815 higher on measures of urgency of me decision making, technical skill, and risk.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed), 76815

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

Specialty Radiology X Commonly ___ Sometimes ___ Rarely

Specialty Ob-Gyn X Commonly ___ Sometimes ___ Rarely

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

Specialty Radiology Frequency Unavailable

Specialty Ob-gyn Frequency Unavailable

Code-specific national frequency data for obstetric ultrasound services are unavailable. National birth certificate data indicate that in 2000 approximately 2.7 million ultrasound procedures were performed during pregnancies that resulted in live births (**National Vital Statistics Report**, Vol. 50, No. 5, Feb. 12, 2002). An unknown percentage of these procedures would be coded using 76815.

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 99 (1999)

Specialty Ob-gyn Frequency 1663 (1999)

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:	76816	Tracking Number:	BE8	Global Period:	XXX	**Recommended RVW:**	0.85

CPT Descriptor: Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus

(Report 76816 with modifier '-59' for each additional fetus examined in a multiple pregnancy)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 26-year-old pregnant female with a menstrual age of 22 weeks has been previously evaluated by ultrasound examination and was noted to have a fetus that was small for gestational age (19 weeks by ultrasound). A follow-up ultrasound examination is ordered four weeks later to assess for interval growth of the fetus. Ultrasound measurements indicate a 23 week gestational age suggesting normal interval growth of the fetus. No additional determinations were made.

Pre-service Work

- Review of clinical information
- Review of pertinent prior imaging studies

Intra-service Work

- Supervision of the sonographer performing the examination
- Interpretation of the examination limited to the following elements:
  - -Focused assessment of fetal size by measuring BPD, abdominal circumference, femur length, or other appropriate measurement; **or**
  - -Detailed re-examination of a specific organ or system known or suspected to be abnormal
- Comparison of this examination to a prior study to evaluate interval change, which in this vignette, is fetal growth
- Prepare report for the medical record

Post-Service Work

- Discuss findings with the patient and referring physician when appropriate
- Review and sign the prepared report

Review and sign the prepared report

SURVEY DATA:

Presenter(s): George Hill, MD, ACOG and Bibb Allen, Jr., M.D., ACR

Specialty(s): American College of Obstetricians and Gynecologists and American College of Radiology

Sample Size: 290 | Response Rate: (%): 50 (17%) | Median RVW: 0.85

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

25th Percentile RVW: 0.70 | 75th Percentile RVW: 0.91 | Low: 0.45 | High: 1.92

Median Pre-Service Time: 6.00 | Median Intra-Service Time: 15.00

25th %tile Intra-Service Time: 8.00 | 75th %tile Intra-Svc Time: 25.00 | Low: 0.00 | High: 25.00

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Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	10.00	
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
76856	Ultrasound, pelvic (nonobstetric), B-scan and/or real time with image documentation; complete	XXX	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 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:_
Median Pre-Time	6.00	
Median Intra-Time	15.00	(20) Harvard total time
Median Immediate Post-service Time	10.00	
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.38	3.11
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.36	3.00
Urgency of medical decision making	3.31	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	3.95	3.13
Physical effort required	2.36	3.13

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.64	3.13
Outcome depends on the skill and judgment of physician	3.11	3.13
Estimated risk of malpractice suit with poor outcome	4.21	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.33	2.75
Intra-Service intensity/complexity	3.42	2.75
Post-Service intensity/complexity	2.33	2.75

ADDITIONAL RATIONALE

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

The American College of Obstetricians and Gynecologists (ACOG), in cooperation with the Society for Maternal Fetal Medicine, disseminated the RUC survey instrument via U.S. Mail to a selected panel of obstetricians and maternal fetal medicine subspecialists who perform the procedure. The American College of Radiology (ACR) mailed the survey to a random sample of ACR members. ACOG and ACR staff tabulated the responses from both societies. A panel of ACOG and ACR physicians reviewed the data and developed the consensus recommendation.

The ACOG/ACR panel noted that 76816 requires about 50 percent more time that the reference service (76856). Although 76816 includes an examination focused primary on previously identified abnormal findings, the examination of the abnormality(s) may typically be quite extensive. In addition, the physician must also explicitly compare the images obtained in this study with the findings of previous studies. Therefore, the survey median of 0.85 RVW is reasonable.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 76816

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

Specialty Radiology X Commonly ___ Sometimes ___ Rarely

Specialty Ob-Gyn 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.

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 Unavailable

Specialty Ob-gyn Frequency Unavailable

Code-specific national frequency data for obstetric ultrasound services are unavailable. National birth certificate data indicate that in 2000 approximately 2.7 million ultrasound procedures were performed during pregnancies tl resulted in live births (**National Vital Statistics Report**, Vol. 50, No. 5, Feb. 12, 2002). An unknown percentage these procedures would be coded using 76816.

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 58 (1999)

Specialty Ob-gyn Frequency 1266 (1999)

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:	76817	Tracking Number:	BE9	Global Period:	XXX	Recommended RVW:	0.76

CPT Descriptor: Ultrasound, pregnant uterus, real time with image documentation, transvaginal

(For non-obstetrical transvaginal ultrasound, use 76830)

(If transvaginal examination is done in addition to transabdominal obstetrical ultrasound exam, use 76817 in addition to appropriate transabdominal exam code)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 31-year-old female in her second pregnancy presents. Her first pregnancy was complicated by preterm rupture of the membranes at 28 weeks gestation. A fetal scan for anatomy was performed at 18 weeks and was normal. She is seen at 22 weeks of pregnancy for transvaginal ultrasound determination of cervical length and determination of the presence of cervical funneling.

Pre-service Work

- Review of clinical information
- Review of pertinent prior imaging studies
- Inform patient of transvaginal technique

Intra-service Work

- Supervision of the sonographer performing the examination
- Interpretation of the examination including the following elements:
  - -Evaluation of the fetus and placenta
  - -Evaluation of the maternal uterus and adnexa
  - -Evaluation of characteristics of cervix including length and structure
- Prepare report for the medical record

Post-service Work

- Discuss findings with the patient and referring physician when appropriate
- Review and sign the prepared report

SURVEY DATA:

Presenter(s): George Hill, MD, ACOG and Bibb Allen, Jr., M.D., ACR

Specialty(s), American College of Obstetricians and Gynecologists and American College of Radiology

Sample Size: 290 Response Rate: (%): 58 (20%) Median RVW: 0.69

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

25th Percentile RVW: 0.60 75th Percentile RVW: 0.75 Low: 1.35 High: 1.40

Median Pre-Service Time: 5.00 Median Intra-Srvc Time: 10.00

25th %tile Intra-Srvc Time: 9.00 75th %tile Intra-Srvc Time: 25.00 Low: 5.00 High: 25.00

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	8.00	
Critical Care:		
Other Hospital Visits:		
Discharge Day Mgmt.:		
Office Visits:		

: _____

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
76856	Ultrasound, pelvic (nonobstetric), B-scan and/or real time with image documentation; complete	XXX	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 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:**
Median Pre-Time	5.00	
Median Intra-Time	10.00	20 (Harvard total time)
Median Immediate Post-service Time	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	3.22	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.06	2.67
Urgency of medical decision making	3.59	2.67

Technical Skill/Physical Effort (Mean)

Technical skill required	3.98	3.17
Physical effort required	2.53	2.67

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.67	2.50
Outcome depends on the skill and judgement of physician	3.35	3.00
Estimated risk of malpractice suit with poor outcome	4.10	3.50

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.70	2.40
Intra-Service intensity/complexity	3.45	3.00
Post-Service intensity/complexity	2.95	2.40

ADDITIONAL RATIONALE

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

The American College of Obstetricians and Gynecologists (ACOG), in cooperation with the Society for Maternal Fetal Medicine, disseminated the RUC survey instrument via U.S. Mail to a selected panel of obstetricians and maternal fetal medicine subspecialists who perform the procedure. The American College of Radiology (ACR) mailed the survey to a random sample of ACR members. ACOG and ACR staff tabulated the responses from both societies. A panel of ACOG and ACR physicians reviewed the data and developed the consensus recommendation.

The ACOG/ACR panel did not believe that the survey median RVW of 0.69 reflected the difference in physician work demonstrated by respondents' assessments of time and intensity. Survey respondents reported that 76817 requires more time, demands a higher level of technical skill, and entails more psychological stress due to risk. Therefore, ACOG and ACR recommend adoption of the 75th percentile RVW of 0.76.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 76805, 76810, 76815, 76816, 76830

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

Specialty Radiology X Commonly ___ Sometimes ___ Rarely

Specialty Ob-Gyn X Commonly ___ Sometimes ___ Rarely

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

Specialty Radiology Frequency Unavailable

Specialty Ob-gyn Frequency Unavailable

Code-specific national frequency data for obstetric ultrasound services are unavailable. National birth certificate data indicate that in 2000 approximately 2.7 million ultrasound procedures were performed during pregnancies that resulted in live births (**National Vital Statistics Report**, Vol. 50, No. 5, Feb. 12, 2002). An unknown percentage of these procedures would be coded using 76817.

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 Unavailable

Specialty Ob-gyn Frequency Unavailable

Do many physicians perform this service across the United States?

X Yes No

		76801		76802		76805	
	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 days), transabdominal approach; single or first gestation		Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure performed) (Use 768X2 in conjunction with 768X1)		Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or =14 weeks 0 days), transabdominal approach; single or first gestation	
LOCATION		**In Office**	**Out Office**	**In Office**	**Out Office**	**In Office**	**Out Office**
GLOBAL PERIOD							
TOTAL CLINICAL LABOR TIME		**38**		**10**		**47**	
PRE-SERVICE							
Start: Following visit when decision for surgery or procedure made							
Complete pre-service diagnostic & referral forms							
Coordinate pre-surgery services							
Schedule space and equipment in facility							
Office visit before surgery/procedure: Review test and exam results							
Provide pre-service education/obtain consent							
Follow-up phone calls & prescriptions							
Other Clinical Activity (please specify)							
Retrieve prior images for comparison		**3**	**RDMS**	**0**	**RDMS**	**3**	**RDMS**
End:When patient enters office/facility for surgery/procedure							
SERVICE PERIOD							
Start: When patient enters office/facility for surgery/procedure							
Pre-service services							
Review charts							
Greet patient and provide gowning		**3**	**RDMS**	**0**	**RDMS**	**3**	**RDMS**
Obtain vital signs							
Provide pre-service education/obtain consent							
Prepare room, equipment,supplies		**3**	**RDMS**	**0**	**RDMS**	**3**	**RDMS**
Prepare and position patient/ monitor patient/ set up IV		**3**	**RDMS**	**0**	**RDMS**	**3**	**RDMS**
Sedate/apply anesthesia							
Intra-service							
Assist physician in performing procedure/ *Acquire images*		**18**	**RDMS**	**10**	**RDMS**	**27**	**RDMS**
Post-Service							
Monitor pt. following service/check tubes, monitors, drains							
Clean room/equipment by physician staff		**3**	**RDMS**	**0**	**RDMS**	**3**	**RDMS**
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							
Coordination of Care							
Discharge day management 99238 – 6 minutes 99239 –9 minutes							
Other Clinical Activity (please specify) **Process and hang films**		**5**		**0**		**5**	
End: Patient leaves office							
POST-SERVICE Period							
Start: Patient leaves office/facility							
Conduct phone calls/call in prescriptions							

		76801		76802		76805	
	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 days), transabdominal approach; single or first gestation		Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure performed) (Use 768X2 in conjunction with 768X1)		Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or =14 weeks 0 days), transabdominal approach; single or first gestation	
LOCATION		**In Office**	**Out Office**	**In Office**	**Out Office**	**In Office**	**Out Office**
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 or outpatient care							
List Number and Level of Office Visits							
99211 16 minutes	16						
99212 27 minutes	27						
99213 36 minutes	36						
4 53 minutes	53						
5 63 minutes	63						
Other							
Total Office Visit Time		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							
MEDICAL SUPPLIES							
Aquasonic gel	71001	60 cc		30 cc		60 cc	
Disinfectant	On CMS's list, but no supply code given	10 cc				10 cc	
Film jacket	73405	1				1	
Film, 14X17	73402	2		1		3	
Film, 8X10 color	73403	2		1		2	
Gloves, non-sterile	11302	1				1	
Patient's wipes		2				2	
Pillow case, disposable	11112	1				1	
Processor chemicals		1				1	
Probe lubricant (KY Jelly)							
Equipment			**Minutes used**		**Minutes used**		**Minutes used**
Ultrasound room		1	27	1	10	1	36
Film alternator	On CMS's list, but no supply code given	1	5	1	5	1	5
Laser printer		1	5	1	5	1	5

		76810		76811		76812	
	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or =14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure performed) (Use 76810 in conjunction with code 76805)		Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation		Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation (List separately in addition to code for primary procedure performed) (Use 768X4 in conjunction with code 768X3)	
LOCATION		**In Office**	**Out Office**	**In Office**	**Out Office**	**In Office**	**Out Office**
GLOBAL PERIOD							
TOTAL CLINICAL LABOR TIME		**20**		**79**		**53**	
PRE-SERVICE							
Start: Following visit when decision for surgery or procedure made							
Complete pre-service diagnostic & referral forms							
Coordinate pre-surgery services							
Schedule space and equipment in facility							
Office visit before surgery/procedure: Review test and exam results							
Provide pre-service education/obtain consent							
Follow-up phone calls & prescriptions							
Other Clinical Activity (please specify)							
Retrieve prior images for comparison		**0**	**RDMS**	**3**	**RDMS**	**0**	**RDMS**
End:When patient enters office/facility for surgery/procedure							
SERVICE PERIOD							
Start: When patient enters office/facility for surgery/procedure							
Pre-service services							
Review charts							
Greet patient and provide gowning		**0**	**RDMS**	**3**	**RDMS**	**0**	**RDMS**
Obtain vital signs							
Provide pre-service education/obtain consent							
Prepare room, equipment,supplies		**0**	**RDMS**	**3**	**RDMS**	**0**	**RDMS**
Prepare and position patient/ monitor patient/ set up IV		**0**	**RDMS**	**3**	**RDMS**	**0**	**RDMS**
Sedate/apply anesthesia							
Intra-service							
Assist physician in performing procedure/ *Acquire images*		**20**	**RDMS**	**59**	**RDMS**	**53**	**RDMS**
Post-Service							
Monitor pt. following service/check tubes, monitors, drains							
Clean room/equipment by physician staff		**0**	**RDMS**	**3**	**RDMS**	**0**	**RDMS**
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							
Coordination of Care							
Discharge day management 99238 -- 6 minutes 99239 --9 minutes							
Other Clinical Activity (please specify) **Process and hang films**		**0**		**5**		**0**	
End: Patient leaves office							
POST-SERVICE Period							
Start: Patient leaves office/facility							
Conduct phone calls/call in prescriptions							

		76810		76811		76812	
	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or =14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure performed) (Use 76810 in conjunction with code 76805)		Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation		Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation (List separately in addition to code for primary procedure performed) (Use 768X4 in conjunction with code 768X3)	
LOCATION		**In Office**	**Out Office**	**In Office**	**Out Office**	**In Office**	**Out Office**
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 or outpatient care							
List Number and Level of Office Visits							
99211 16 minutes	16						
99212 27 minutes	27						
99213 36 minutes	36						
4 53 minutes	53						
5 63 minutes	63						
Other							
Total Office Visit Time		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							
MEDICAL SUPPLIES							
Aquasonic gel	71001	**30 cc**		**60 cc**		**30 cc**	
Disinfectant	On CMS's list, but no supply code given			**10 cc**			
Film jacket	73405			**1**			
Film, 14X17	73402	**2**		**4**		**3**	
Film, 8X10 color	73403	**1**		**2**		**2**	
Gloves, non-sterile	11302			**1**			
Patient's wipes				**2**			
Pillow case, disposable	11112			**1**			
Processor chemicals				**1**			
Probe lubricant (KY Jelly)							
Equipment			**Minutes used**		**Minutes used**		**Minutes used**
Ultrasound room		**1**	**20**	**1**	**68**	**1**	**47**
Film alternator	On CMS's list, but no supply code given	**1**	**5**	**1**	**5**	**1**	**5**
Laser printer		**1**	**5**	**1**	**5**	**1**	**5**

		76815		76816		76817	
	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), one or more fetuses Use 76815 only once per exam and not per element)		Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus (Report 76816 with modifier '-59' for each additional fetus examined in a multiple pregnancy)		Ultrasound, pregnant uterus, real time with image documentation, transvaginal (For non-obstetrical transvaginal ultrasound, use 76830) (If transvaginal examination is done in addition to transabdominal obstetrical ultrasound exam, use 768X5 in addition to appropriate transabdominal exam code)	
LOCATION		**In Office**	**Out Office**	**In Office**	**Out Office**	**In Office**	**Out Office**
GLOBAL PERIOD							
TOTAL CLINICAL LABOR TIME		**28**		**38**		**32**	
PRE-SERVICE							
Start: Following visit when decision for surgery or procedure made							
Complete pre-service diagnostic & referral forms							
Coordinate pre-surgery services							
Schedule space and equipment in facility							
Office visit before surgery/procedure: Review test and exam results							
Provide pre-service education/obtain consent							
Follow-up phone calls & prescriptions							
Other Clinical Activity (please specify)							
Retrieve prior images for comparison		**3**	**RDMS**	**3**	**RDMS**	**3**	**RDMS**
End:When patient enters office/facility for surgery/procedure							
SERVICE PERIOD							
Start: When patient enters office/facility for surgery/procedure							
Pre-service services							
Review charts							
Greet patient and provide gowning		**3**	**RDMS**	**3**	**RDMS**	**3**	**RDMS**
Obtain vital signs							
Provide pre-service education/obtain consent							
Prepare room, equipment,supplies		**3**	**RDMS**	**3**	**RDMS**	**3**	**RDMS**
Prepare and position patient/ monitor patient/ set up IV		**3**	**RDMS**	**3**	**RDMS**	**3**	**RDMS**
Sedate/apply anesthesia							
Intra-service							
Assist physician in performing procedure/ *Acquire images*		**8**	**RDMS**	**18**	**RDMS**	**12**	**RDMS**
Post-Service							
Monitor pt. following service/check tubes, monitors, drains							
Clean room/equipment by physician staff		**3**	**RDMS**	**3**	**RDMS**	**3**	**RDMS**
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							
Coordination of Care							
Discharge day management 99238 -- 6 minutes 99239 --9 minutes							
Other Clinical Activity (please specify) **Process and hang films**		**5**		**5**		**5**	
End: Patient leaves office							
POST-SERVICE Period							
Start: Patient leaves office/facility							
Conduct phone calls/call in prescriptions							

		76815		76816		76817	
	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), one or more fetuses (Use 76815 only once per exam and not per element)		Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus (Report 76816 with modifier '-59' for each additional fetus examined in a multiple pregnancy)		Ultrasound, pregnant uterus, real time with image documentation, transvaginal (For non-obstetrical transvaginal ultrasound, use 76830) (If transvaginal examination is done in addition to transabdominal obstetrical ultrasound exam, use 768X5 in addition to appropriate transabdominal exam code)	
LOCATION		**In Office**	**Out Office**	**In Office**	**Out Office**	**In Office**	**Out Office**
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 or outpatient care							
List Number and Level of Office Visits							
99211 16 minutes	16						
99212 27 minutes	27						
99213 36 minutes	36						
4 53 minutes	53						
5 63 minutes	63						
Other							
Total Office Visit Time		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							
MEDICAL SUPPLIES							
Aquasonic gel	71001	**60 cc**		**60 cc**			
Disinfectant	On CMS's list, but no supply code given	**10 cc**		**10 cc**		**10 cc**	
Film jacket	73405	**1**		**1**		**1**	
Film, 14X17	73402	**3**		**2**		**3**	
Film, 8X10 color	73403	**2**				**1**	
Gloves, non-sterile	11302	**1**		**1**		**1**	
Patient's wipes		**2**		**2**		**2**	
Pillow case, disposable	11112	**1**		**1**		**1**	
Processor chemicals		**1**		**1**		**1**	
Probe lubricant (KY Jelly)						**30 cc**	
Equipment			**Minutes used**		**Minutes used**		**Minutes used**
Ultrasound room		**1**	**17**	**1**	**27**	**1**	**25**
Film alternator	On CMS's list, but no supply code given	**1**	**5**	**1**	**5**	**1**	**5**
Laser printer		**1**	**5**	**1**	**5**	**1**	**5**

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Measurement of Post-Voiding Residual Urine/Bladder Capacity by Ultrasound

Code 51798 represents a new code to CPT as a transition from a G code. Code G00050 *Measurement of post voiding residual urine and/or bladder capacity by ultrasound* (Work RVU=0.00) was eliminated to signify that it is no longer associated with imaging. Code 51798 was then surveyed by urology and found that it typically is preformed by a urologist although no physician work was assigned to this code by CMS. Based on the median of their survey results, the specialty requested, a work relative value of 0.58. The RUC reviewed the specialty's request and noted that the most appropriate reference code was code 76857 *Ultrasound, pelvic (nonobstetric), B-scan and/or real time with image documentation; limited or follow-up (eg, for follicles)* (Work RVU=0.38) rather than code 76942 *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation* (Work RVU=0.67). Based on the specialty society's 25th percentile survey results and the similarities in work of code 76857 and 51798, **the RUC recommends a relative work value of 0.38, and physician time equal to the specialty society's surveyed 25th percentile.**

Practice Expense
The RUC reviewed in great detail the practice expense inputs in both the facility and non-facility settings for code 51798, and agreed to lower the clinical labor time for the codes since much of the work is performed by the physician. The RUC recommends 30 minutes of clinical labor time in the office and 13 minutes in the facility setting. The RUC also recommends some basic medical supplies and equipment in the office setting, as shown in the practice expense summary form attached to the recommendation for this service.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 51798	AA1	Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging	XXX	0.38
G 00050		~~Measurement of post-voiding residual urine and/or bladder capacity by ultrasound~~	XXX	N/A

	A	B	C	D	E	F	G
1		CMS Code	Unit of Measure	Invoice Quantity	Price	51798 - Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging	
2	**LOCATION**					In Office	Out Office
3	**GLOBAL PERIOD**					XXX	XXX
4	**TOTAL CLINICAL LABOR TIME**	1130				30	13
5	**PRE-SERVICE**						
6	**Start: Following visit when decision for surgery or procedure made**						
7	Complete pre-service diagnostic & referral forms					3	3
8	Coordinate pre-surgery services					3	3
9	Schedule space and equipment in facility (for out of office only)						
10	Office visit before surgery/procedure: Review test and exam results						
11	Provide pre-service education/obtain consent					1	1
12	Follow-up phone calls & prescriptions					0	3
13	Other Clinical Activity (please specify)						
14	**End:When patient enters office for surgery/procedure**						
15	**TOTAL PRE-SERVICE CLINICAL TIME**					7	10
16	**SERVICE PERIOD**						
17	**Start: When patient enters office for surgery or procedure**						
18	**Pre-service services**						
19	Review charts						
20	Greet patient and provide gowning					3	
21	Obtain vital signs					3	
22	Provide pre-service education/obtain consent						
23	Prepare room, equipment,supplies					5	
24	Prepare and position patient/ monitor patient/ set up IV					3	
25	Sedate/apply anesthesia						
26	**Intra-service**						
27	Assist physician in performing procedure						
28	**Post-Service**						
29	Monitor pt following service/check tubes, monitors, drains						
30	Clean room/equipment by physician staff					3	
31	Assist with ICU or hospital visits (for out of office only)						
32	Complete diagnostic forms, lab & X-ray requisitions					3	
33	Review/read X-ray, lab, and pathology reports						
34	Check dressings & wound/ home care instructions/coordinate office visits/prescriptions					3	
35	Coordination of care by staff in office (for out of office only)						3
36	Other Clinical Activity (please specify)						
37	**End: Patient leaves office**						
38	**TOTAL INTRA-SERVICE CLINICAL TIME**					23	3
39	**POST-SERVICE Period**						
40	**Start: Patient leaves office**						
41	Conduct phone calls/call in prescriptions						
42	*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 or outpatient care						
43	*List Number and Level of Office Visits*						
44	99211 16 minutes						
45	99212 27 minutes						
46	99213 36 minutes						
47	99214 53 minutes						
48	99215 63 minutes						
49	Other						
50	***Total Office Visit Time***					0	0
51	Conduct phone calls between office visits						
52	Other Activity (please specify)						
53	**End: with last office visit before end of global period**						
54	**TOTAL POST-SERVICE CLINICAL TIME**					0	0
55							
56							
57							
58							
59	***Supplies***						

	A	B	C	D	E	F	G
1		CMS Code	Unit of Measure	Invoice Quantity	Price	51798 - Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging	
2	LOCATION					In Office	Out Office
3	GLOBAL PERIOD					XXX	XXX
60	aquasonic gel	71001	ml	10	0.27	1	
61	cleansing solution, Transeptic (diagnostic ultrasound; 0800-0078	new	oz.	1	$4.50	1	
62	condom	11514	item	1	$0.34		
63	drape, sheet	11106	item	1	$0.26	1	
64	minimum visit package (multi-specialty)		package	1	$1.31	1	
65	printer paper, thermal (diagnostic ultrasound; 0800-0042	new	foot	1	$0.69	1	
66	Paper towel	11118	item	1	$0.01		
67	transducer wipe	11520	item	1	$0.09	1	
68							
69	***Equipment:***						
70	bladder scanner with dedicated rolling cart (Diagnostic Ultrasound; BVI-3000)	new			$11,445.00	1	
71	Power Table	E11003			$6,939.00	1	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 51798 Tracking Number: AA1 Global Period: XXX ~~Recommended RVW: .58~~
RUC Recommended RVW: 0.38

CPT Descriptor: Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 70-year-old man complains of progressive decrease in force of urinary flow, urgency, frequency and nocturia times five. As a part of his urologic evaluation a residual urine volume needs to be determined. With the patient supine on the exam table a dedicated ultrasound machine is used to measure the residual urine immediately after the patient voids. The residual urine volume is measured at 655 ml, therefore the patient is asked to go to the bathroom again to try to empty more completely. He is then rescanned and the urine volume is measured at 608 mls.

Pre-service work:

- Ask patient to empty bladder completely in bathroom.
- Have the patient disrobe to allow examination of pubic area
- Position and drape patient in a supine position on exam table
- Turn on ultrasound machine, select gender appropriate mode

Description of Intra-Service Work:

- Palpate the abdominal area to identify the pubic bone
- Apply ultrasound jelly to suprapubic area
- The suprapubic area is repeatedly scanned, typically 3 to 6 times
- If the volume is high, as in the vignette, the patient is asked to void again and the procedure is repeated.
- The jelly is cleaned off of the patients abdominal area

Description of Post-Service Work:

- The machine notes the scan with the largest volume
- The bladder image is printed out along with the volume of urine in milliliters

SURVEY DATA:

Presenter(s) James B. Regan, M.D., Jeffrey A. Dann, M.D.

Specialty(s): American Urological Association

Sample Size: 100 Response Rate: (%): 30 Median RVW .58

Type of Sample: Mixed- panel, random

Explanation of sample size: **A random sample of general urologists was surveyed.**

	Low	25th %	Median	75 %	High
Survey RVW	0.25	0.38	0.58	0.76	1.5
Pre-Service Time	0	**5.00**	~~11~~	15	35
Intra-Service Time	0	**4.00**	8	10	60

KEY REFERENCE SERVICE:

CPT	Descriptor	2002 RVW	% RESP	GLOB
76942	**Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation**	**0.67**	**40%**	**XXX**
74430	**Cystography, minimum of three views, radiological supervision and interpretation**	**0.32**	27%	**XXX**

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: 51798**	**Key Reference CPT Code: 76942**
Median Pre-Time (SAME DAY EVAL)	5	
Median Intra-Time	4	
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	**2.44**	**2.78**
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	**2.33**	**2.5**
Urgency of medical decision making	**2.78**	**2.67**

Technical Skill/Physical Effort (Mean)

Technical skill required	**2.44**	**2.94**

Physical effort required	2.11	2.61

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.67	2.39
Outcome depends on the skill and judgement of physician	2.61	2.61
Estimated risk of malpractice suit with poor outcome	1.72	2.11

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.00	2.11
Intra-Service intensity/complexity	1.89	2.11
Post-Service intensity/complexity	2.11	2.44

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation:
Our RUC recommendations are based on survey responses from urologists located across the country, including urologists from single-specialty, multi-specialty and academic practices. Once responses are compiled, a panel of urologists comprised of a representative sample of the above described group convenes to examine the data associated with each code and determine the final RUC recommendations. In the survey instrument a question was added asking the respondents to tell us what percentage of the time the Urologist performed this procedure. The response indicated that the physician performed the scan 75% of the time, (median).

FREQUENCY INFORMATION

How was this service previously reported: The CMS code of G0050 has been used in the past to identify this procedure

(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: **American Urological Association** **XXX 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 Urological Association** Frequency: **625,000 +**

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 Urological Association** Frequency: **625,097**

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

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Speech and Language Hearing Procedures

The new codes 92612-92617 were developed in order to fully capture the endoscopic work involved with swallowing and laryngeal sensory testing. The practice inputs for codes 92601-92611 were assessed, modified and approved by the Health Care Professional Advisory Committee (HCPAC) because there was no physician work associated with these codes.

92612, 92613, 92614, 92615, 92616 and 92617

New codes 92612, 92614, and 92616 involve placement of a flexible fiberoptic endoscope into the nasal cavity to a place where videotaping of swallowing and/or sensory reflex can be recorded. New codes 92613, 92615, and 92617 involve the review of these videotapes by the physician to assess and report findings and recommendations to the PCP and/or patient or caregiver (eg, changes in diet and/or non-oral forms of alimentation).

After reviewing the survey data collected for these six codes, The RUC concluded that the relationship (ie, relative ranking) between the procedure codes (92612, 92614, 92616) and between the interpretation/report codes (92613, 92615, 92617) was reasonable. However, the RUC felt that the survey respondents – using "magnitude estimation" - overestimated the RVWs.

To develop our recommendations for these codes, the RUC reviewed the new interpretation/report codes, specifically, 92617. In comparing 92617 with reference code 93314, the RUC noted that the intensity/complexity measures for intra-service time and for mental effort/judgment is significantly higher (see 92617 summary form). However, clinically, the RUC believed 92617 is slightly less *total* work than 93314 *Echo transesophageal* (RVW=1.25). We also looked at the level of physician work and decision making in relationship to E/M 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* (RVW=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" (RVW=1.34). The RUC believes that new code 92617 requires a level of physician judgment necessary to evaluate the (new) patient history and procedure tapes to formulate recommendations comparable to the work of a level four established patient office visit. Based on all of these comparisons, The RUC recommends an RVW of 1.10 for 92617. For the other two interpretation/report codes, the RUC recommends values that maintain the median survey RVW relationship between the codes, setting 92617 at 1.10:

Survey Median RVW:	92613=2.25	92615=2.00	92617=2.50
Ratio:	92613=0.90	92615=0.80	92617=*1.00*
Recommended RVW:	**92613=0.99**	**92615=0.88**	**92617=1.10**

Next, the RUC considered the specialty society's recommendations for 92612, 92614 and 92616. The specialty society reviewed the "total" value for the procedures and their corresponding interpretation/report. The specialty society believes that endoscopic evaluation of swallowing and interpretation/report (92612/92613) is the same total work as 31579 *Laryngoscopy with stroboscopy* (RVW=2.26). Using the RVW of 2.26, we subtracted 0.99 RVUs (the recommendation for 92613) to arrive at an RVW of 1.27 for 92612. Similar to the development of the recommendation for the three interpretation/report codes, the specialty society recommends values that maintain the median survey RVW relationship between the codes, setting 92612 at 1.27:

Survey Median RVW:	92612=2.50	92614=2.71	92616=3.70
Ratio:	92612=*1.00*	92614=1.08	92616=1.48
Recommended RVW:	**92612=1.27**	**92614=1.38**	**92616=1.88**

This results in the following "total" work values for the procedure/report code pairs:
92612/92613 = 2.26 92614/92615 = 2.26 92616/92617 = 2.98

This relationship makes sense: 1) Compared to 92614/92615, 92612/92613 requires more time for administration of food, but is less intense. Combined, the pairs represent similar total work. 2) Pair 92616/92617 combines both pair 92612/92613 and pair 92614/92615, however *some* of the procedure pre/post work is the same (eg, pre-service exam or post-service discussion) and *some* of the procedure intra-service work is not doubled (eg, application of anesthetic/decongestant, insertion of endoscope). The specialty society recommends these values for 92612, 92614 and 92616, however the RUC believes that the work performed in 92612 and 92614 is comparable and therefore should be valued the same. **The RUC recommends the following work relative values:**

Code	Work Relative Value
92612	**1.27**
92613	**0.99**
92614	**1.27**
92615	**0.88**
92616	**1.88**
92617	**1.10**

Practice Expense

The RUC then reviewed the practice expense inputs for 92612-92617. The RUC questioned the time allotted for education/instruction/counseling and felt 5 minutes was appropriate for this practice expense input for codes 92612, 92614 and 92616. Additionally, the RUC questioned the pre-service time for 92613, 92615 and 92617 and felt that there was no pre-service time associated with these codes. **The RUC recommends these modified practice expense inputs for 92612-92617.**

Special Otorhinolaryngologic Services

CPT Code (•New)	Track-ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
~~92525~~		~~Evaluation of swallowing and oral function for feeding~~ (92525 has been deleted. To report see 92610-92611 for specific evaluation)	XXX	N/A

Audiologic Function Tests with Medical Diagnostic Evaluation

CPT Code (•New)	Track-ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲92597		Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech (To report augmentative and alternative communication device services, see 92605-92608)	XXX	N/A

Other Procedures

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
~~92598~~		~~Modification of voice prosthetic or augmentative/alternative communication device to supplement oral speech~~ (92598 has been deleted)	XXX	N/A
~~92599~~		~~Unlisted otorhinolaryngological service or procedure~~ (92599 has been deleted. To report use 92700)	XXX	N/A

Evaluative and Therapeutic Services

Codes 92601 and 92603 describe postoperative analysis and fitting of previously placed external devices, connection to the cochlear implant, and programming of the stimulator. Codes 92602 and 92604 describe subsequent sessions for measurements and adjustment of the external transmitter and reprogramming of the internal stimulator

For placement of cochlear implant, use 69930

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●92601	BF1	Diagnostic analysis of cochlear implant, patient under 7 years of age; with programming	XXX	0 (PE inputs submitted by the HCPAC)

CPT Code (•New)	Track-ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
●92602	BF2	subsequent reprogramming (Do not report 92602 in addition to 92601) (For aural rehabilitation services following cochlear implant, including evaluation of rehabilitation status, use 92507)	XXX	0 (PE inputs submitted by the HCPAC)
●92603	BF3	Diagnostic analysis of cochlear implant, age 7 years or older; with programming	XXX	0 (PE inputs submitted by the HCPAC)
●92604	BF4	subsequent reprogramming (Do not report 92604 in addition to 92603)	XXX	0 (PE inputs submitted by the HCPAC)
●92605	BF5	Evaluation for prescription of non-speech generating augmentative and alternative communication device	XXX	0 (PE inputs submitted by the HCPAC)
●92606	BF6	Therapeutic service(s) for the use of non-speech-generating device, including programming and modification	XXX	0 (PE inputs submitted by the HCPAC)

CPT Code (•New)	Track-ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
●92607	BF7	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour (For evaluation for prescription of a non-speech-generating device, use 92605)	XXX	0 (PE inputs submitted by the HCPAC)
+●92608	BF8	each additional 30 minutes (List separately in addition to code for primary procedure) (Use 92608 in conjunction with 92607)	XXX	0 (PE inputs submitted by the HCPAC)
●92609	BF9	Therapeutic services for the use of speech-generating device, including programming and modification (For therapeutic service(s) for the use of a non-speech-generating device, use 92606)	XXX	0 (PE inputs submitted by the HCPAC)

CPT Code (•New)	Track-ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
●92610	BF10	Evaluation of oral and pharyngeal swallowing function (For motion fluoroscopic evaluation of swallowing function, use 92611) (For flexible endoscopic examination use 92612-92617)	XXX	0 (PE inputs submitted by the HCPAC)
●92611	BF11	Motion fluoroscopic evaluation of swallowing function (For radiological supervision and interpretation, use 74230) (For evaluation of oral and pharyngeal swallowing function, use 92610) ~~(For therapeutic service(s) for the use of non-speech generating device, use 92606)~~	XXX	0 (PE inputs to be submitted by the HCPAC)

CPT Code (•New)	Track-ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
●92612	BF12	Flexible fiberoptic endoscopic evaluation of swallowing; by cine or video recording (If flexible fiberoptic or endoscopicevaluation of swallowing is preferred without cine or video recording, use 92700)	XXX	1.27
●92613	BF13	physician interpretation and report only (To report an evaluation of oral and pharyngeal swallowing function, use 92610) (To report motion fluoroscopic evaluation of swallowing function, use 92611)	XXX	0.99
●92614	BF14	Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording;	XXX	1.27
●92615	BF15	Physician interpretation and report ~~(To report an evaluation of oral and pharyngeal swallowing function, use 92610) (To report motion fluoroscopic evaluation of swallowing function, use 92611)~~	XXX	0.88

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●92616	BF16	Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording;	XXX	1.88
●92617	BF17	physician interpretation and report (~~To report an evaluation of oral and phayngeal swallowing function, use 92610~~) (~~To report motion fluoroscopic evaluation of swallowing function, use 92611~~)	XXX	1.10

Other Procedures

92700		Unlisted otorhinolaryngological service or procedure		N/A

CPT Code: 92612 **Global:** XXX **Recommended RVW:** 1.27

Descriptor: Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording;

(If flexible fiberoptic or endoscopic evaluation of swallowing is performed without cine or video recording, use 92700)

SURVEY Vignette (Typical Patient)

A 60-year old man diagnosed with aortic root aneurysm underwent coronary artery bypass grafting times one. The postoperative course was difficult, with prolonged ventilation via endotracheal tube. The patient's nutrition and hydration were maintained via total parenteral nutrition. On postoperative day seven the process of weaning from the ventilator was initiated and the endotracheal tube removed. An oral diet was ordered and initiated. The patient was noted to cough and choke during feeding, indicating that food and/or liquid were entering the airway (aspiration). The findings of the bedside examination did not allow for complete and confident management of the patient's oral intake, so a flexible fiberoptic endoscopic evaluation of swallowing (FEES) was scheduled to directly assess pharyngeal swallowing function.

Clinical Description Of Service:

PRE SERVICE

The physician first examines the patient's right and left nasal cavities with a headlight prior to administering both topical nasal anesthesia and topical nasal decongestion to the side of the nasal cavity where the scope will be passed. A cotton-tipped applicator containing anesthesia and decongestant is administered under direct visualization into the side of the nasal cavity where the endoscope will be placed. In addition, the lips, oral cavity and oropharynx are examined with some type of illumination so that any anatomic abnormalities of these areas that might adversely affect the endoscopic swallowing evaluation are noted. As a safety measure, adjustments in the sequence, volumes and types of administered food will be made prior to commencement of the food administration trials.

While the physician is waiting for the anesthesia and decongestant to take effect, the solid and liquid foods that will be administered are prepared. Based on the physician's exam of the lips, mouth and throat, necessary adjustments are made in food consistency, volume, and technique of delivery (spoon, straw, sippy cup).

INTRA SERVICE

The physician passes a flexible endoscope via the nasal cavity into widest portion of the oropharynx, noting anatomic and vocal fold movement abnormalities. Abnormalities are noted as they may immediately affect how the food administration trials are delivered. During the examination, the physician must:

1. position the endoscope so that the epiglottis is at the inferior aspect of the monitor displaying a real-time image of the laryngopharynx. This positioning ensures proper visual orientation and recognition of the effects of the various swallowing safety maneuvers;
2. keep the tip of the endoscope lens unobstructed and free of debris to permit detection of laryngeal penetration and aspiration;
3. slightly withdraw the tip of the endoscope during the actual swallow to avoid entering the trachea when the larynx elevates;
4. adjust the position of the endoscope tip during the various swallowing maneuvers to avoid missing instances of aspiration; and
5. periodically bring the tip of the endoscope into the most posterior and inferior aspects of the hypopharynx to obtain key information regarding reflux of administered food and function of the cricopharyngeus muscle.

POST SERVICE

The patient's nasal cavity is re-examined with a nasal speculum and a headlight to make sure that no trauma has occurred to the nasal mucosa. Any points of bleeding or abrasion are immediately addressed. The physician has a cursory discussion of whether the patient can upgrade, downgrade, or simply maintain their current diet. Final medical diagnoses and final results of the test await the physician's interpretation and report.

SURVEY DATA

Presenter(s): James Denneny, III, MD; Jonathan Aviv, MD; Dana Thompson, MD

Specialty(s): American Academy of Otolaryngology – Head and Neck Surgery

Sample Size: 54 **Resp n:** 32 **Resp %:** 59%

Sample Type: Random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	1.50	2.26	2.50	3.26	4.00
Pre-Service Time			10		
Intra-Service Time	5	14	15	20	30
Post-Service Time			7		

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'02 RVW	Glob
31579	Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy	2.26	000

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

	Svy CPT	Ref CPT
TIME ESTIMATES (MEDIAN)		(hvd)
Pre-service	10	24
Intra-service	15	27
Post-service	7	15
INTENSITY/COMPLEXITY MEASURES (mean)	32	66
TIME SEGMENTS		
Pre-service	2.76	2.38
Intra-service	3.95	3.62
Post-service	2.81	2.81
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3.90	3.52
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.52	3.05
Urgency of medical decision making	3.95	2.71
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	3.90	3.62
Physical effort required	3.33	2.86
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	3.29	2.38
Outcome depends on the skill and judgment of physician	4.24	3.90
Estimated risk of malpractice suit with poor outcome	3.33	3.14

RATIONALE:

RVW Recommendation Rationale for 92612, 92613, 92614, 92615, 92616, 92617

In January 2001, the Centers for Medicare and Medicaid Services implemented a series of G-codes for use with Medicare patient claims because CPT 92520 and/or 92525 did not distinguish between endoscopic assessment of airway protection and acoustic and aerodynamic assessments of voice function:

> ***Federal Register.*** **November 1, 2000 (pp65426).**
> **C. Other Changes to the 2001 Physician Fee Schedule and Clarification of CPT Definitions**
> For the 2001 physician fee schedule, we are establishing or revising several alpha-numeric HCPCS codes for reporting certain services that are not clearly described by existing CPT codes.
> *Evaluation of swallowing function*
> We are proposing the following new codes to describe the evaluation of swallowing function. These codes will replace the more general CPT 92525, *Evaluation of swallowing and oral function for feeding,* which represents a combination of these separate examinations. Our contractors requested the more precise coding to improve claims review for evaluation of dysphagia. The new codes are described as follows:
> G0193 Endoscopy study of swallowing function, often referred to as fiberoptic endoscopic evaluation of swallowing (FEES).
> G0194 *Sensory testing during endoscoping study of swallowing.* This service, often referred to as fiberoptic endoscopic evaluation of swallowing with testing, will be coded as an add-on code to G0193.
> The creation of these two codes does not imply coverage. Coverage of G0193 and G0194 remains at the discretion of the contractor processing the Medicare claim. These codes will be priced by contractors.
> Note that CPT 31575 (laryngoscopy, flexible fiberoptic, diagnostic) and CPT 31579 (laryngoscopy, flexible or rigid fiberoptic, with stroboscopy) should not be used for evaluations of swallowing.

In 2001, AAO-HNS and ASHA submitted a proposal to the CPT Editorial Panel for new codes to replace the temporary G-codes. The outcome of the Panel actions included six new codes; three primary procedure codes for endoscopic evaluation; and three interpretation/report codes:

92612	Flexible fiberoptic endoscopic evaluation of swallowing;
92613	physician interpretation and report only
92614	Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing;
92615	physician interpretation and report only
92616	Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal testing;
92617	physician interpretation and report only

New codes 92612, 92614, and 92616 involve placement of a flexible fiberoptic endoscope into the nasal cavity to a place where videotaping of swallowing and/or sensory reflex can be recorded. New codes 92613, 92615, and 92617 involve the review of these videotapes by the physician to assess and report findings and recommendations to the PCP and/or patient or caregiver (eg, changes in diet and/or non-oral forms of alimentation).

After reviewing the survey data collected for these six codes, we concluded that the relationship (ie, relative ranking) between the procedure codes (92612, 92614, 92616) and between the interpretation/report codes (92613, 92615, 92617) was reasonable. However, we felt that the survey respondents – using "magnitude estimation" - overestimated the RVWs.

To develop our recommendations for these codes, we looked first at the new interpretation/report codes, specifically, 92617. In comparing 92617 with reference code 93314, we noted that the intensity/complexity measures for intra-service time and for mental effort/judgment is significantly higher (see 92617 summary form). However, clinically, we believe 92617 is slightly less *total* work than 93314 *Echo transesophageal* (RVW=1.25). We also looked at the level of physician work and decision making in relationship to E/M 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" (RVW=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" (RVW=1.34). We believe new code X10 requires a level of physician judgment necessary to evaluate the (new) patient history and procedure tapes to formulate recommendations

comparable to the work of a level four established patient office visit. Based on all of these comparisons, we recommend an RVW of 1.10 for 92617. For the other two interpretation/report codes, we recommend values that maintain the median survey RVW relationship between the codes, setting 92617 at 1.10:

Survey Median RVW:	92613=2.25	92615=2.00	92617=2.50
Ratio:	92613=0.90	92615=0.80	92617=*1.00*
Recommended RVW:	**92613=0.99**	**92615=0.88**	**92617=1.10**

Next, we considered the "total" value for the procedures and their corresponding interpretation/report. We believe that endoscopic evaluation of swallowing and interpretation/report (92612/92613) is the same total work as 31579 *Laryngoscopy with stroboscopy* (RVW=2.26). Using the RVW of 2.26, we subtracted 0.99 rvu's (the recommendation for 92613) to arrive at an RVW of 1.27 for 92612. Similar to the development of the recommendation for the three interpretation/report codes, we recommend values that maintain the median survey RVW relationship between the codes, setting 92612 at 1.27:

Survey Median RVW:	92612=2.50	92614=2.71	92616=3.70
Ratio:	*92612=1.00*	92614=1.08	92616=1.48
Recommended RVW:	**92612=1.27**	**92614=1.38**	**92616=1.88**

This results in the following "total" work values for the procedure/report code pairs:
92612/92613 = 2.26 92614/92615 = 2.26 92616/92617 = 2.98

This relationship makes sense: 1) Compared to 92614/92615, 92612/92613 requires more time for administration of food, but is less intense. Combined, the pairs represent similar total work. 2) Pair 92616/92617 combines both pair 92612/92613 and pair 92614/92615, however *some* of the procedure pre/post work is the same (eg, pre-service exam or post-service discussion) and *some* of the procedure intra-service work is not doubled (eg, application of anesthetic/decongestant, insertion of endoscope).

FREQUENCY INFORMATION

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

Prior to April 1, 2001, reported as 31575 PLUS 92525.
After April 1, 2001, reported as G0193

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: Otolaryngology ~~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: Otolaryngology Frequency: Unknown, not common

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: Otolaryngology Frequency: Unknown, not common

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

Limited to most medical centers and a few community-based physicians

CPT Code: 92613 **Global:** XXX **Recommended RVW:** 0.99

Descriptor: Flexible fiberoptic endoscopic evaluation of swallowing; physician interpretation and report only

(To report an evaluation of oral and pharyngeal swallowing function, use 92610)
(To report motion fluoroscopic evaluation of swallowing function, use 92611)

SURVEY Vignette (Typical Patient)

A 60-year old man diagnosed with aortic root aneurysm underwent coronary artery bypass grafting times one. The postoperative course was difficult, with prolonged ventilation via endotracheal tube. The patient's nutrition and hydration were maintained via total parenteral nutrition. On postoperative day seven the process of weaning from the ventilator was initiated and the endotracheal tube removed. An oral diet was ordered and initiated. The patient was noted to cough and choke during feeding, indicating that food and/or liquid were entering the airway (aspiration). The findings of the bedside examination did not allow for complete and confident management of the patient's oral intake, so a flexible fiberoptic endoscopic evaluation of swallowing (FEES) was scheduled to directly assess pharyngeal swallowing function.

Clinical Description Of Service:

PRE SERVICE

The physician cues up the videotape of the patient in question and obtains the endoscopic evaluation of swallowing form.

INTRA SERVICE

The physician reviews the videotape containing the endoscopic swallowing evaluation for the following items:

1. Anatomic abnormalities of the laryngopharyngeal structures such as tumors (solid, cystic, vascular), areas of edema, exudate and mucosal irregularity. The videotape therefore must be rewound to the beginning of the exam in order to review the appearance of the nasopharyngeal and superior oropharyngeal regions.
2. Evidence of vocal fold paresis or paralysis during the swallowing evaluation. The portion of the examination where this is best visualized is during the pre-food administration period.
3. Laryngeal elevation. The physician forwards to portions of the videotaped exam where active swallowing is taking place.
4. Laryngeal penetration and aspiration. The physician advances the videotape to the food administration portion of the exam to determine whether there is penetration and aspiration.
5. Cricopharyngeal function. The portion of the swallow where the endoscope tip is placed into a posterior view of the laryngopharynx must be reviewed thoroughly. At this juncture, information about cricopharyngeal contraction and relaxation can be determined.

POST SERVICE

The physician confirms penetration and aspiration and records the determination on the endoscopy for swallowing forms. Any medical diagnoses made during the videotape review are noted (eg., vocal fold paralysis, edema of posterior larynx, tumor of laryngeal surface of epiglottis). Watershed recommendations such as suggesting a significant dietary change in either direction (commencement of feeding in a previously non-orally alimenting patient or cessation of taking food by mouth in a previously oral alimenting patient) are noted and explained to the patient and/or their care givers in great detail.

Prescriptions that might be necessary subsequent to physician review (eg., proton-pump inhibitor medications (anti-acids)) must be called in, or written for the patient.

SURVEY DATA

Presenter(s): James Denneny, III, MD; Jonathan Aviv, MD; Dana Thompson, MD

Specialty(s): American Academy of Otolaryngology-Head and Neck Surgery

CPT: 92613

Sample Size: 54 **Resp n:** 32 **Resp %:** 59%

Sample Type: Random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	0.60	1.40	2.25	2.59	3.75
Pre-Service Time			3		
Intra-Service Time	3	10	10	15	30
Post-Service Time			10		

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'02 RVW	Glob
93314	Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); image acquisition, interpretation and report only	1.25	XXX

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

	Svy CPT	Ref CPT
TIME ESTIMATES (MEDIAN)		
Pre-service	3	
Intra-service	10	
Post-service	10	
INTENSITY/COMPLEXITY MEASURES (mean)	23	25(pr)
TIME SEGMENTS		
Pre-service	1.29	1.57
Intra-service	3.86	2.57
Post-service	3.86	2.43
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3.86	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.43	2.67
Urgency of medical decision making	4.71	2.83
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	1.86	1.86
Physical effort required	1.00	1.00
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	1.43	1.43
Outcome depends on the skill and judgment of physician	3.57	4.86
Estimated risk of malpractice suit with poor outcome	2.57	2.71

RATIONALE:

RVW Recommendation Rationale for 92612, 92613, 92614, 92615, 92616, 92617

In January 2001, the Centers for Medicare and Medicaid Services implemented a series of G-codes for use with Medicare patient claims because CPT 92520 and/or 92525 did not distinguish between endoscopic assessment of airway protection and acoustic and aerodynamic assessments of voice function:

> ***Federal Register.*** **November 1, 2000 (pp65426).**
> **C. Other Changes to the 2001 Physician Fee Schedule and Clarification of CPT Definitions**
> For the 2001 physician fee schedule, we are establishing or revising several alpha-numeric HCPCS codes for reporting certain services that are not clearly described by existing CPT codes.
> *Evaluation of swallowing function*
> We are proposing the following new codes to describe the evaluation of swallowing function. These codes will replace the more general CPT 92525, *Evaluation of swallowing and oral function for feeding,* which represents a combination of these separate examinations. Our contractors requested the more precise coding to improve claims review for evaluation of dysphagia. The new codes are described as follows:
> G0193 Endoscopy study of swallowing function, often referred to as fiberoptic endoscopic evaluation of swallowing (FEES).
> G0194 *Sensory testing during endoscoping study of swallowing.* This service, often referred to as fiberoptic endoscopic evaluation of swallowing with testing, will be coded as an add-on code to G0193.
> The creation of these two codes does not imply coverage. Coverage of G0193 and G0194 remains at the discretion of the contractor processing the Medicare claim. These codes will be priced by contractors.
> Note that CPT 31575 (laryngoscopy, flexible fiberoptic, diagnostic) and CPT 31579 (laryngoscopy, flexible or rigid fiberoptic, with stroboscopy) should not be used for evaluations of swallowing.

In 2001, AAO-HNS and ASHA submitted a proposal to the CPT Editorial Panel for new codes to replace the temporary G-codes. The outcome of the Panel actions included six new codes; three primary procedure codes for endoscopic evaluation; and three interpretation/report codes:

92612	Flexible fiberoptic endoscopic evaluation of swallowing;
92613	physician interpretation and report only
92614	Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing;
92615	physician interpretation and report only
92616	Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal testing;
92617	physician interpretation and report only

New codes 92612, 92614, and 92616 involve placement of a flexible fiberoptic endoscope into the nasal cavity to a place where videotaping of swallowing and/or sensory reflex can be recorded. New codes 92613, 92615, and 92617 involve the review of these videotapes by the physician to assess and report findings and recommendations to the PCP and/or patient or caregiver (eg, changes in diet and/or non-oral forms of alimentation).

After reviewing the survey data collected for these six codes, we concluded that the relationship (ie, relative ranking) between the procedure codes (92612, 92614, 92616) and between the interpretation/report codes (92613, 92615, 92617) was reasonable. However, we felt that the survey respondents – using "magnitude estimation" - overestimated the RVWs.

To develop our recommendations for these codes, we looked first at the new interpretation/report codes, specifically, 92617. In comparing 92617 with reference code 93314, we noted that the intensity/complexity measures for intra-service time and for mental effort/judgment is significantly higher (see 92617 summary form). However, clinically, we believe 92617 is slightly less *total* work than 93314 *Echo transesophageal* (RVW=1.25). We also looked at the level of physician work and decision making in relationship to E/M 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" (RVW=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" (RVW=1.34). We believe new code X10 requires a level of physician judgment necessary to evaluate the (new) patient history and procedure tapes to formulate recommendations

comparable to the work of a level four established patient office visit. Based on all of these comparisons, we recommend an RVW of 1.10 for 92617. For the other two interpretation/report codes, we recommend values that maintain the median survey RVW relationship between the codes, setting 92617 at 1.10:

Survey Median RVW:	92613=2.25	92615=2.00	92617=2.50
Ratio:	92613=0.90	92615=0.80	92617=*1.00*
Recommended RVW:	**92613=0.99**	**92615=0.88**	**92617=1.10**

Next, we considered the "total" value for the procedures and their corresponding interpretation/report. We believe that endoscopic evaluation of swallowing and interpretation/report (92612/92613) is the same total work as 31579 *Laryngoscopy with stroboscopy* (RVW=2.26). Using the RVW of 2.26, we subtracted 0.99 rvu's (the recommendation for 92613) to arrive at an RVW of 1.27 for 92612. Similar to the development of the recommendation for the three interpretation/report codes, we recommend values that maintain the median survey RVW relationship between the codes, setting 92612 at 1.27:

Survey Median RVW:	92612=2.50	92614=2.71	92616=3.70
Ratio:	*92612=1.00*	92614=1.08	92616=1.48
Recommended RVW:	**92612=1.27**	**92614=1.38**	**92616=1.88**

This results in the following "total" work values for the procedure/report code pairs:
92612/92613 = 2.26 92614/92615 = 2.26 92616/92617 = 2.98

This relationship makes sense: 1) Compared to 92614/92615, 92612/92613 requires more time for administration of food, but is less intense. Combined, the pairs represent similar total work. 2) Pair 92616/92617 combines both pair 92612/92613 and pair 92614/92615, however *some* of the procedure pre/post work is the same (eg, pre-service exam or post-service discussion) and *some* of the procedure intra-service work is not doubled (eg, application of anesthetic/decongestant, insertion of endoscope).

FREQUENCY INFORMATION

1. How was this service previously reported (if unlisted code, please ensure that the medicare frequency for this unlisted code is reviewed)?
No way to report.

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: Otolaryngology ~~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: Otolaryngology Frequency: Unknown, will be tied to 925X3

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: Otolaryngology Frequency: Unknown, will be tied to 925X3

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

Limited to most medical centers and a few community-based physicians

CPT Code: 92614 **Global:** XXX ~~**Recommended RVW:** 1.38~~
RUC Recommendation:1.27

Descriptor: Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording;

Typical patient: A 64-year-old man developed a stroke and was hospitalized immediately. The patient could not move the left side of his body, was choking, hoarse, and unable to swallow. Full workup, including MRI of the brain, revealed the patient to have sustained a stroke. The patient was unable to eat and swallow without choking and coughing uncontrollably. The patient required a diagnostic test of his ability to protect his airway both from ingestants and secretions so that he would sustain his nutrition and not have a respiratory arrest nor develop aspiration pneumonia.

Clinical Description Of Service:

PRE SERVICE
The physician first examines the patient's right and left nasal cavities with a headlight prior to administering topical nasal decongestion to the less narrow side of the nasal cavity. A cotton-tipped applicator containing decongestant medication is placed under direct visualization into the side of the nasal cavity where the endoscope will be passed.

While the physician is waiting for the decongestant to take effect, the sensory device from where the air pulse is administered is calibrated. Once this has been accomplished the machine is calibrated and the sensory testing procedure can commence.

INTRA SERVICE
Endoscopic sensory testing takes place by passing the sensory endoscope via the nasal cavity into the hypopharynx and bringing the tip of the endoscope to within 3 mm of the tissue surface. Both the right side and the left side are always tested. Air pulses of varying strengths (mm Hg) and pulse durations (msec) are then administered to the arytenoid mucosa innervated by the internal branch of the superior laryngeal nerve in order to elicit the laryngeal adductor reflex. The foot pedal is depressed at least one time at suprathreshold values (10 mm Hg) in order to clear debris from the endoscope tip prior to each air pulse delivery sequence. Once a clear image is seen, the endoscope is then directed towards the mucosa of the arytenoids and sensory testing generally begins by administering a 10 mm Hg, 50 msec air pulse to the tissues, in order to elicit the laryngeal adductor reflex. Depending on the response of the patient to this initial pulse one of two things must then be carried out by the physician:

1) If the adductor reflex is not elicited, a **continuous** air pulse mode of one thousand milliseconds (200 times as long as the standard 50 msec pulse) is then administered to the tissues. The endoscope is brought towards the tissue target. At the instant the continuous pulse is emanating from the endoscope tip, the tip must be at the precise location on the arytenoid mucosa. Subsequently, the physician immediately withdraws the tip of the endoscope from the arytenoid mucosa, because elicitation of the airway protective reflex typically results in elicitation of the swallow reflex, which in turn causes the larynx to begin elevating upwards towards the tongue base. Whether or not the airway protective reflex is then elicited, one then proceeds with testing of the contralateral side. If the reflex is not elicited on both sides, the patient does not have intact airway protective reflexes and all testing then stops. In general, if bilateral absent laryngeal adductor reflexes are noted, no food administration trials are then given.
2) If the adductor reflex is elicited, the air pulse strength is then reduced to 3.0 mm Hg and a pulse given. If the adductor reflex is elicited, then the patient is noted to have a normal airway protective reflex and the contralateral side is then tested. If the reflex is not elicited at 3.0 mm Hg, the pulse strength is then increased to 6.0 mm Hg. If the reflex occurs at 6.0 mm Hg, the dial is then reduced in 1.0 mm Hg increments and another pulse given. Where the pulse strength switches from positive (reflex intact) to negative (reflex absent) is noted.

POST SERVICE

The patient's nasal cavity is re-examined with a nasal speculum and a headlight to make sure that no trauma has occurred to the nasal mucosa. Any points of bleeding or abrasion are immediately addressed. The physician gives a cursory description of the airway reflexes to the patient with final interpretation pending review of the videotape.

SURVEY DATA

Presenter(s): James Denneny, III, MD; Jonathan Aviv, MD; Dana Thompson, MD

Specialty(s): American Academy of Otolaryngology – Head and Neck Surgery
Sample Size: 54 **Resp n:** 31 **Resp %:** 57%
Sample Type: Random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	1.25	2.33	2.71	3.00	4.00
Pre-Service Time			8		
Intra-Service Time	5	10	15	18	30
Post-Service Time			5		

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'02 RVW	Glob
31579	Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy	2.26	000

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

	Svy CPT	Ref CPT
TIME ESTIMATES (MEDIAN)		(hvd)
Pre-service	8	24
Intra-service	15	27
Post-service	5	15
INTENSITY/COMPLEXITY MEASURES (mean)	28	66
TIME SEGMENTS		
Pre-service	2.61	2.22
Intra-service	4.09	3.22
Post-service	2.65	2.52
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	4.04	3.43
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.83	3.09
Urgency of medical decision making	3.78	2.70
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	4.39	3.35
Physical effort required	3.17	2.74
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	2.87	2.22
Outcome depends on the skill and judgment of physician	4.35	3.96
Estimated risk of malpractice suit with poor outcome	2.96	2.83

RATIONALE:

RVW Recommendation Rationale for 92612, 92613, 92614, 92615, 92616, 92617

In January 2001, the Centers for Medicare and Medicaid Services implemented a series of G-codes for use with Medicare patient claims because CPT 92520 and/or 92525 did not distinguish between endoscopic assessment of airway protection and acoustic and aerodynamic assessments of voice function:

> ***Federal Register.*** **November 1, 2000 (pp65426).**
> **C. Other Changes to the 2001 Physician Fee Schedule and Clarification of CPT Definitions**
> For the 2001 physician fee schedule, we are establishing or revising several alpha-numeric HCPCS codes for reporting certain services that are not clearly described by existing CPT codes.
> *Evaluation of swallowing function*
> We are proposing the following new codes to describe the evaluation of swallowing function. These codes will replace the more general CPT 92525, *Evaluation of swallowing and oral function for feeding,* which represents a combination of these separate examinations. Our contractors requested the more precise coding to improve claims review for evaluation of dysphagia. The new codes are described as follows:
> G0193 Endoscopy study of swallowing function, often referred to as fiberoptic endoscopic evaluation of swallowing (FEES).
> G0194 *Sensory testing during endoscoping study of swallowing.* This service, often referred to as fiberoptic endoscopic evaluation of swallowing with testing, will be coded as an add-on code to G0193.
> The creation of these two codes does not imply coverage. Coverage of G0193 and G0194 remains at the discretion of the contractor processing the Medicare claim. These codes will be priced by contractors.
> Note that CPT 31575 (laryngoscopy, flexible fiberoptic, diagnostic) and CPT 31579 (laryngoscopy, flexible or rigid fiberoptic, with stroboscopy) should not be used for evaluations of swallowing.

In 2001, AAO-HNS and ASHA submitted a proposal to the CPT Editorial Panel for new codes to replace the temporary G-codes. The outcome of the Panel actions included six new codes; three primary procedure codes for endoscopic evaluation; and three interpretation/report codes:

92612	Flexible fiberoptic endoscopic evaluation of swallowing;
92613	physician interpretation and report only
92614	Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing;
92615	physician interpretation and report only
92616	Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal testing;
92617	physician interpretation and report only

New codes 92612, 92614, and 92616 involve placement of a flexible fiberoptic endoscope into the nasal cavity to a place where videotaping of swallowing and/or sensory reflex can be recorded. New codes 92613, 92615, and 92617 involve the review of these videotapes by the physician to assess and report findings and recommendations to the PCP and/or patient or caregiver (eg, changes in diet and/or non-oral forms of alimentation).

After reviewing the survey data collected for these six codes, we concluded that the relationship (ie, relative ranking) between the procedure codes (92612, 92614, 92616) and between the interpretation/report codes (92613, 92615, 92617) was reasonable. However, we felt that the survey respondents – using "magnitude estimation" - overestimated the RVWs.

To develop our recommendations for these codes, we looked first at the new interpretation/report codes, specifically, 92617. In comparing 92617 with reference code 93314, we noted that the intensity/complexity measures for intra-service time and for mental effort/judgment is significantly higher (see 92617 summary form). However, clinically, we believe 92617 is slightly less *total* work than 93314 *Echo transesophageal* (RVW=1.25). We also looked at the level of physician work and decision making in relationship to E/M 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" (RVW=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" (RVW=1.34). We believe new code X10 requires a level of physician judgment necessary to evaluate the (new) patient history and procedure tapes to formulate recommendations

comparable to the work of a level four established patient office visit. Based on all of these comparisons, we recommend an RVW of 1.10 for 92617. For the other two interpretation/report codes, we recommend values that maintain the median survey RVW relationship between the codes, setting 92617 at 1.10:

Survey Median RVW:	92613=2.25	92615=2.00	92617=2.50
Ratio:	92613=0.90	92615=0.80	92617=*1.00*
Recommended RVW:	**92613=0.99**	**92615=0.88**	**92617=1.10**

Next, we considered the "total" value for the procedures and their corresponding interpretation/report. We believe that endoscopic evaluation of swallowing and interpretation/report (92612/92613) is the same total work as 31579 *Laryngoscopy with stroboscopy* (RVW=2.26). Using the RVW of 2.26, we subtracted 0.99 rvu's (the recommendation for 92613) to arrive at an RVW of 1.27 for 92612. Similar to the development of the recommendation for the three interpretation/report codes, we recommend values that maintain the median survey RVW relationship between the codes, setting 92612 at 1.27:

Survey Median RVW:	92612=2.50	92614=2.71	92616=3.70
Ratio:	*92612=1.00*	92614=1.08	92616=1.48
Recommended RVW:	**92612=1.27**	**92614=1.38**	**92616=1.88**

This results in the following "total" work values for the procedure/report code pairs:
92612/92613 = 2.26 92614/92615 = 2.26 92616/92617 = 2.98

This relationship makes sense: 1) Compared to 92614/92615, 92612/92613 requires more time for administration of food, but is less intense. Combined, the pairs represent similar total work. 2) Pair 92616/92617 combines both pair 92612/92613 and pair 92614/92615, however *some* of the procedure pre/post work is the same (eg, pre-service exam or post-service discussion) and *some* of the procedure intra-service work is not doubled (eg, application of anesthetic/decongestant, insertion of endoscope).

FREQUENCY INFORMATION

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

Prior to April 1, 2001, reported as 31575 PLUS 92520.
After April 1, 2001, reported as G0194

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: Otolaryngology ~~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: Otolaryngology Frequency: Unknown, not common

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: Otolaryngology Frequency: Unknown, not common

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

Limited to some medical centers and a few community-based physicians

CPT Code: 92615 **Global:** XXX **Recommended RVW:** 0.88

Descriptor: Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing; physician interpretation and report only

~~(To report an evaluation of oral and pharyngeal swallowing function, use 926X10)~~
~~(To report motion fluoroscopic evaluation of swallowing function, use 926X11)~~

SURVEY Vignette (Typical Patient)

A 64-year-old man developed a stroke and was hospitalized immediately. The patient could not move the left side of his body, was choking, hoarse, and unable to swallow. Full workup, including MRI of the brain, revealed the patient to have sustained a stroke. The patient was unable to eat and swallow without choking and coughing uncontrollably. The patient required a diagnostic test of his ability to protect his airway both from ingestants and secretions so that he would sustain his nutrition and not have a respiratory arrest nor develop aspiration pneumonia.

Clinical Description Of Service:

PRE SERVICE

The physician cues up the video tape of the patient in question and obtains the sensory testing form. If necessary, the physician uses a calculator.

INTRA SERVICE

Several key items are noted during the physician review of the videotape containing the sensory testing findings:

1. Anatomic abnormalities of the laryngopharyngeal structures such as tumors (solid, cystic, vascular), areas of edema, exudate and mucosal irregularity. The video tape therefore must be rewound to the beginning of the exam in order to review the appearance of the nasopharyngeal and superior oropharyngeal regions.
2. Evidence of vocal fold paresis or paralysis during the sensory testing. As sensory testing depends on intact vocal fold movements (opening and closing), sensory testing often unmasks subtle vocal fold movement disorders not generally seen during a cursory examination of the larynx. Generally, a frame by frame, or at least a slow motion, analysis of the sensory findings must be observed on the videotape machine in order to clearly make these diagnoses.
3. Symmetry of the sensory testing results. The review of the videotape must include sequences of both the right and left sides that were tested. Distinct differences between the right and left sides of the laryngopharynx can herald site of lesion findings in the brain or skull base.
4. Determination of presence or absence of the laryngeal adductor reflex. In order to make this assessment the tape must be forwarded to the threshold points – the lowest air pulse pressures where the reflex was elicited for both the right and left sides of the laryngopharynx.

POST SERVICE

If the airway protective reflexes are noted to be absent after review of the videotape, a notation of "absent laryngeal adductor reflex" is made on the sensory testing form and recommendations regarding non-oral forms of alimentation are then discussed with the patient and their caregivers.

If the airway protective reflexes are intact, the particular sensory threshold is calculated by determining the mean of the lowest detected pressures that elicited the adductor reflex on each side. This value is noted on the sensory testing form.

Final notation of the key intraservice items are entered on the sensory testing forms. Any medical diagnoses made during the videotape review are noted (eg., vocal fold paralysis, edema of posterior larynx, tumor of laryngeal surface of epiglottis) and then discussed with the patient and their caregivers.

SURVEY DATA

Presenter(s): James Denneny, III, MD; Jonathan Aviv, MD; Dana Thompson, MD

Specialty(s): American Academy of Otolaryngology – Head and Neck Surgery

Sample Size: 54 **Resp n:** 31 **Resp %:** 57%

Sample Type: Random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	0.52	1.25	2.00	2.75	3.50
Pre-Service Time			2		
Intra-Service Time	4	8	10	15	25
Post-Service Time			10		

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'02 RVW	Glob
93314	Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); image acquisition, interpretation and report only	1.25	XXX

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

	Svy CPT	Ref CPT
TIME ESTIMATES (MEDIAN)		
Pre-service	2	
Intra-service	10	
Post-service	10	
INTENSITY/COMPLEXITY MEASURES (mean)	22	25(pr)
TIME SEGMENTS		
Pre-service	1.29	1.29
Intra-service	3.00	2.57
Post-service	3.86	2.43
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	3.14	2.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.43	2.57
Urgency of medical decision making	3.86	2.57
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	1.86	1.86
Physical effort required	1.00	1.00
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	1.29	1.43
Outcome depends on the skill and judgment of physician	4.14	4.86
Estimated risk of malpractice suit with poor outcome	2.00	2.71

RATIONALE:

RVW Recommendation Rationale for 92612, 92613, 92614, 92615, 92616, 92617

In January 2001, the Centers for Medicare and Medicaid Services implemented a series of G-codes for use with Medicare patient claims because CPT 92520 and/or 92525 did not distinguish between endoscopic assessment of airway protection and acoustic and aerodynamic assessments of voice function:

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> For the 2001 physician fee schedule, we are establishing or revising several alpha-numeric HCPCS codes for reporting certain services that are not clearly described by existing CPT codes.
> *Evaluation of swallowing function*
> We are proposing the following new codes to describe the evaluation of swallowing function. These codes will replace the more general CPT 92525, *Evaluation of swallowing and oral function for feeding,* which represents a combination of these separate examinations. Our contractors requested the more precise coding to improve claims review for evaluation of dysphagia. The new codes are described as follows:
> G0193 Endoscopy study of swallowing function, often referred to as fiberoptic endoscopic evaluation of swallowing (FEES).
> G0194 *Sensory testing during endoscoping study of swallowing.* This service, often referred to as fiberoptic endoscopic evaluation of swallowing with testing, will be coded as an add-on code to G0193.
> The creation of these two codes does not imply coverage. Coverage of G0193 and G0194 remains at the discretion of the contractor processing the Medicare claim. These codes will be priced by contractors.
> Note that CPT 31575 (laryngoscopy, flexible fiberoptic, diagnostic) and CPT 31579 (laryngoscopy, flexible or rigid fiberoptic, with stroboscopy) should not be used for evaluations of swallowing.

In 2001, AAO-HNS and ASHA submitted a proposal to the CPT Editorial Panel for new codes to replace the temporary G-codes. The outcome of the Panel actions included six new codes; three primary procedure codes for endoscopic evaluation; and three interpretation/report codes:

92612	Flexible fiberoptic endoscopic evaluation of swallowing;
92613	physician interpretation and report only
92614	Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing;
92615	physician interpretation and report only
92616	Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal testing;
92617	physician interpretation and report only

New codes 92612, 92614, and 92616 involve placement of a flexible fiberoptic endoscope into the nasal cavity to a place where videotaping of swallowing and/or sensory reflex can be recorded. New codes 92613, 92615, and 92617 involve the review of these videotapes by the physician to assess and report findings and recommendations to the PCP and/or patient or caregiver (eg, changes in diet and/or non-oral forms of alimentation).

After reviewing the survey data collected for these six codes, we concluded that the relationship (ie, relative ranking) between the procedure codes (92612, 92614, 92616) and between the interpretation/report codes (92613, 92615, 92617) was reasonable. However, we felt that the survey respondents – using "magnitude estimation" - overestimated the RVWs.

To develop our recommendations for these codes, we looked first at the new interpretation/report codes, specifically, 92617. In comparing 92617 with reference code 93314, we noted that the intensity/complexity measures for intra-service time and for mental effort/judgment is significantly higher (see 92617 summary form). However, clinically, we believe 92617 is slightly less *total* work than 93314 *Echo transesophageal* (RVW=1.25). We also looked at the level of physician work and decision making in relationship to E/M 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" (RVW=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" (RVW=1.34). We believe new code X10 requires a level of physician judgment necessary to evaluate the (new) patient history and procedure tapes to formulate recommendations

comparable to the work of a level four established patient office visit. Based on all of these comparisons, we recommend an RVW of 1.10 for 92617. For the other two interpretation/report codes, we recommend values that maintain the median survey RVW relationship between the codes, setting 92617 at 1.10:

Survey Median RVW:	92613=2.25	92615=2.00	92617=2.50
Ratio:	92613=0.90	92615=0.80	92617=*1.00*
Recommended RVW:	**92613=0.99**	**92615=0.88**	**92617=1.10**

Next, we considered the "total" value for the procedures and their corresponding interpretation/report. We believe that endoscopic evaluation of swallowing and interpretation/report (92612/92613) is the same total work as 31579 *Laryngoscopy with stroboscopy* (RVW=2.26). Using the RVW of 2.26, we subtracted 0.99 rvu's (the recommendation for 92613) to arrive at an RVW of 1.27 for 92612. Similar to the development of the recommendation for the three interpretation/report codes, we recommend values that maintain the median survey RVW relationship between the codes, setting 92612 at 1.27:

Survey Median RVW:	92612=2.50	92614=2.71	92616=3.70
Ratio:	*92612=1.00*	92614=1.08	92616=1.48
Recommended RVW:	**92612=1.27**	**92614=1.38**	**92616=1.88**

This results in the following "total" work values for the procedure/report code pairs:
92612/92613 = 2.26 92614/92615 = 2.26 92616/92617 = 2.98

This relationship makes sense: 1) Compared to 92614/92615, 92612/92613 requires more time for administration of food, but is less intense. Combined, the pairs represent similar total work. 2) Pair 92616/92617 combines both pair 92612/92613 and pair 92614/92615, however *some* of the procedure pre/post work is the same (eg, pre-service exam or post-service discussion) and *some* of the procedure intra-service work is not doubled (eg, application of anesthetic/decongestant, insertion of endoscope).

FREQUENCY INFORMATION

1. How was this service previously reported (if unlisted code, please ensure that the medicare frequency for this unlisted code is reviewed)?
No way to report.

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: Otolaryngology ~~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: Otolaryngology Frequency: Unknown, will be tied to 925X6

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: Otolaryngology Frequency: Unknown, will be tied to 925X6

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

Limited to most medical centers and a few community-based physicians

CPT Code: 92616 **Global:** XXX **Recommended RVW:** 1.88

Descriptor: Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal testing by cine or video recording;

SURVEY Vignette (Typical Patient)

A 59-year-old woman developed a stroke and was hospitalized immediately. The patient could not move the left side of her body, was choking, hoarse, and unable to swallow. Full workup, including MRI of the brain, revealed the patient to have sustained a stroke. The patient was unable to eat and swallow without choking and coughing uncontrollably. The patient required a diagnostic test of her ability to protect her airway both from ingestants and secretions so that she would sustain her nutrition and not have a respiratory arrest nor develop aspiration pneumonia. The patient also required endoscopic evaluation of pharyngeal swallowing function to determine appropriate nutritional intake.

Clinical Description Of Service:

PRE SERVICE

The physician first examines the patient's right and left nasal cavities with a headlight prior to administering topical nasal decongestion to the less narrow side of the nasal cavity. A cotton-tipped applicator containing decongestant is administered under direct visualization into the side of the nasal cavity where the endoscope will be placed. In addition, the lips, oral cavity and oropharynx are examined with some type of illumination so that any anatomic abnormalities of these areas that might adversely affect the endoscopic swallowing evaluation are noted. As a safety measure, adjustments in the sequence, volumes and types of administered food will be made prior to commencement of the food administration trials.

In addition, while the physician is waiting for the decongestant to take effect, the sensory device from where the air pulse is administered is calibrated. Once calibration has been completed, the solid and liquid foods that will be administered are prepared. Based on the physician's exam of the lips, mouth and throat, necessary adjustments are made in food consistency, volume, and technique of delivery (spoon, straw, sippy cup).

INTRA SERVICE

During scope passage via the nasal cavity, the physician must first note anatomic abnormalities and vocal fold movement abnormalities. Abnormalities are noted as they may immediately affect how the food administration trials are delivered.

Endoscopic sensory testing takes place by passing the sensory endoscope via the nasal cavity into the hypopharynx and bringing the tip of the endoscope to within 3 mm of the tissue surface. Both the right side and the left side are always tested. Air pulses of varying strengths (mm Hg) and pulse durations (msec) are then administered to the arytenoid mucosa innervated by the internal branch of the superior laryngeal nerve in order to elicit the laryngeal adductor reflex. The foot pedal is depressed at least one time at suprathreshold values (10 mm Hg) in order to clear debris from the endoscope tip prior to each air pulse delivery sequence. Once a clear image is seen, the endoscope is then directed towards the mucosa of the arytenoids and sensory testing generally begins by administering a 10 mm Hg, 50 msec air pulse to the tissues, in order to elicit the laryngeal adductor reflex. Depending on the response of the patient to this initial pulse one of two things must then be carried out by the physician:

1) If the adductor reflex is not elicited, a **continuous** air pulse mode of one thousand milliseconds (200 times as long as the standard 50 msec pulse) is then administered to the tissues. The endoscope is brought towards the tissue target. At the instant the continuous pulse is emanating from the endoscope tip, the tip must be at the precise location on the arytenoid mucosa. Subsequently, the physician immediately withdraws the tip of the endoscope from the arytenoid mucosa, because elicitation of the airway protective reflex typically results in elicitation of the swallow reflex, which in turn causes the larynx to begin elevating upwards towards the tongue base. Whether or not the airway protective reflex is then elicited, one then proceeds with testing of the contralateral side. If the reflex is not elicited on both sides, the patient does not have intact airway protective reflexes and all testing then stops. In general, if bilateral absent laryngeal adductor reflexes are noted, no food administration trials are then given.
2) If the adductor reflex is elicited, the air pulse strength is then reduced to 3.0 mm Hg and a pulse given. If the adductor reflex is elicited, then the patient is noted to have a normal airway protective reflex and the contralateral side is then tested. If the reflex is not elicited at 3.0 mm Hg, the pulse strength is then increased to 6.0 mm Hg. If the reflex occurs at 6.0 mm Hg, the dial is then reduced in 1.0 mm Hg

increments and another pulse given. Where the pulse strength switches from positive (reflex intact) to negative (reflex absent) is noted.

If it is determined from the sensory test that the patient has intact airway protective reflexes then the food administration trials commence. During the examination, the physician must:

1. position the endoscope so that the epiglottis is at the inferior aspect of the monitor displaying a real-time image of the laryngopharynx. This positioning ensures proper visual orientation and recognition of the effects of the various swallowing safety maneuvers;
2. keep the tip of the endoscope lens unobstructed and free of debris to permit detection of laryngeal penetration and aspiration;
3. slightly withdraw the tip of the endoscope during the actual swallow to avoid entering the trachea when the larynx elevates;
4. adjust the position of the endoscope tip during the various swallowing maneuvers to avoid missing instances of aspiration; and
5. periodically bring the tip of the endoscope into the most posterior and inferior aspects of the hypopharynx to obtain key information regarding reflux of administered food and function of the cricopharyngeus muscle.

POST SERVICE

The patient's nasal cavity is re-examined with a nasal speculum and a headlight to make sure that no trauma has occurred to the nasal mucosa. Any points of bleeding or abrasion are immediately addressed. The physician gives the patient or caregiver a cursory description of the airway reflexes and whether the patient can upgrade, downgrade, or simply maintain their current diet. Final medical diagnoses and final results of the test await the physician's interpretation and report.

SURVEY DATA

Presenter(s): James Denneny, III, MD; Jonathan Aviv, MD; Dana Thompson, MD

Specialty(s): American Academy of Otolaryngology – Head and Neck Surgery

Sample Size: 54 **Resp n:** 32 **Resp %:** 54%

Sample Type: Random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	2.00	3.00	3.70	4.54	5.30
Pre-Service Time			10		
Intra-Service Time	10	20	25	30	45
Post-Service Time			10		

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'02 RVW	Glob
31579	Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy	2.26	000

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

	Svy CPT	Ref CPT
TIME ESTIMATES (MEDIAN)		(hvd)
Pre-service	10	24
Intra-service	25	27
Post-service	10	15
	45	66

INTENSITY/COMPLEXITY MEASURES (mean)

TIME SEGMENTS

Pre-service	3.14	2.14
Intra-service	4.48	3.05
Post-service	3.19	2.38

MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	4.33	3.24
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	2.90
Urgency of medical decision making	4.14	2.43
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	4.52	3.14
Physical effort required	3.52	2.43
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	3.19	2.00
Outcome depends on the skill and judgment of physician	4.38	4.00
Estimated risk of malpractice suit with poor outcome	3.19	2.71

RATIONALE:

RVW Recommendation Rationale for 92612, 92613, 92614, 92615, 92616, 92617

In January 2001, the Centers for Medicare and Medicaid Services implemented a series of G-codes for use with Medicare patient claims because CPT 92520 and/or 92525 did not distinguish between endoscopic assessment of airway protection and acoustic and aerodynamic assessments of voice function:

> ***Federal Register.*** **November 1, 2000 (pp65426).**
> **C. Other Changes to the 2001 Physician Fee Schedule and Clarification of CPT Definitions**
> For the 2001 physician fee schedule, we are establishing or revising several alpha-numeric HCPCS codes for reporting certain services that are not clearly described by existing CPT codes.
> *Evaluation of swallowing function*
> We are proposing the following new codes to describe the evaluation of swallowing function. These codes will replace the more general CPT 92525, *Evaluation of swallowing and oral function for feeding,* which represents a combination of these separate examinations. Our contractors requested the more precise coding to improve claims review for evaluation of dysphagia. The new codes are described as follows:
> G0193 Endoscopy study of swallowing function, often referred to as fiberoptic endoscopic evaluation of swallowing (FEES).
> G0194 *Sensory testing during endoscoping study of swallowing.* This service, often referred to as fiberoptic endoscopic evaluation of swallowing with testing, will be coded as an add-on code to G0193.
> The creation of these two codes does not imply coverage. Coverage of G0193 and G0194 remains at the discretion of the contractor processing the Medicare claim. These codes will be priced by contractors.
> Note that CPT 31575 (laryngoscopy, flexible fiberoptic, diagnostic) and CPT 31579 (laryngoscopy, flexible or rigid fiberoptic, with stroboscopy) should not be used for evaluations of swallowing.

In 2001, AAO-HNS and ASHA submitted a proposal to the CPT Editorial Panel for new codes to replace the temporary G-codes. The outcome of the Panel actions included six new codes; three primary procedure codes for endoscopic evaluation; and three interpretation/report codes:

92612 Flexible fiberoptic endoscopic evaluation of swallowing;
92613 physician interpretation and report only
92614 Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing;
92615 physician interpretation and report only
92616 Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal testing;
92617 physician interpretation and report only

New codes 92612, 92614, and 92616 involve placement of a flexible fiberoptic endoscope into the nasal cavity to a place where videotaping of swallowing and/or sensory reflex can be recorded. New codes 92613, 92615, and 92617 involve the review of these videotapes by the physician to assess and report findings and recommendations to the PCP and/or patient or caregiver (eg, changes in diet and/or non-oral forms of alimentation).

After reviewing the survey data collected for these six codes, we concluded that the relationship (ie, relative ranking) between the procedure codes (92612, 92614, 92616) and between the interpretation/report codes (92613, 92615, 92617) was reasonable. However, we felt that the survey respondents – using "magnitude estimation" - overestimated the RVWs.

To develop our recommendations for these codes, we looked first at the new interpretation/report codes, specifically, 92617. In comparing 92617 with reference code 93314, we noted that the intensity/complexity measures for intra-service time and for mental effort/judgment is significantly higher (see 92617 summary form).

However, clinically, we believe 92617 is slightly less *total* work than 93314 *Echo transesophageal* (RVW=1.25). We also looked at the level of physician work and decision making in relationship to E/M 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" (RVW=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" (RVW=1.34). We believe new code X10 requires a level of physician judgment necessary to evaluate the (new) patient history and procedure tapes to formulate recommendations comparable to the work of a level four established patient office visit. Based on all of these comparisons, we recommend an RVW of 1.10 for 92617. For the other two interpretation/report codes, we recommend values that maintain the median survey RVW relationship between the codes, setting 92617 at 1.10:

Survey Median RVW:	92613=2.25	92615=2.00	92617=2.50
Ratio:	92613=0.90	92615=0.80	92617=*1.00*
Recommended RVW:	**92613=0.99**	**92615=0.88**	**92617=1.10**

Next, we considered the "total" value for the procedures and their corresponding interpretation/report. We believe that endoscopic evaluation of swallowing and interpretation/report (92612/92613) is the same total work as 31579 *Laryngoscopy with stroboscopy* (RVW=2.26). Using the RVW of 2.26, we subtracted 0.99 rvu's (the recommendation for 92613) to arrive at an RVW of 1.27 for 92612. Similar to the development of the recommendation for the three interpretation/report codes, we recommend values that maintain the median survey RVW relationship between the codes, setting 92612 at 1.27:

Survey Median RVW:	92612=2.50	92614=2.71	92616=3.70
Ratio:	*92612=1.00*	92614=1.08	92616=1.48
Recommended RVW:	**92612=1.27**	**92614=1.38**	**92616=1.88**

This results in the following "total" work values for the procedure/report code pairs:
92612/92613 = 2.26 92614/92615 = 2.26 92616/92617 = 2.98

This relationship makes sense: 1) Compared to 92614/92615, 92612/92613 requires more time for administration of food, but is less intense. Combined, the pairs represent similar total work. 2) Pair 92616/92617 combines both pair 92612/92613 and pair 92614/92615, however *some* of the procedure pre/post work is the same (eg, pre-service exam or post-service discussion) and *some* of the procedure intra-service work is not doubled (eg, application of anesthetic/decongestant, insertion of endoscope).

FREQUENCY INFORMATION

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

Prior to April 1, 2001, reported as 31575 PLUS 92525 PLUS 92529-59.
After April 1, 2001, reported as G0193 PLUS G0194

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: Otolaryngology ~~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: Otolaryngology Frequency: Unknown, not common

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: Otolaryngology Frequency: Unknown, not common

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

Limited to some medical centers and a few community-based physicians

CPT Code: 92617 **Global:** XXX **Recommended RVW:** 1.10

Descriptor: Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal testing; physician interpretation and report only

~~(To report an evaluation of oral and pharyngeal swallowing function, use 926X10)~~
~~(To report motion fluoroscopic evaluation of swallowing function, use 926X11)~~

SURVEY Vignette (Typical Patient)
A 59-year-old woman developed a stroke and was hospitalized immediately. The patient could not move the left side of her body, was choking, hoarse, and unable to swallow. Full workup, including MRI of the brain, revealed the patient to have sustained a stroke. The patient was unable to eat and swallow without choking and coughing uncontrollably. The patient required a diagnostic test of her ability to protect her airway both from ingestants and secretions so that she would sustain her nutrition and not have a respiratory arrest nor develop aspiration pneumonia. The patient also required endoscopic evaluation of pharyngeal swallowing function to determine appropriate nutritional intake.

Clinical Description Of Service:

PRE SERVICE
The physician cues up the videotape of the patient in question and obtains a sensory testing form and an endoscopic evaluation of swallowing form. If necessary, a calculator is available.

INTRASERVICE
Several key items are noted during the physician review of the videotape containing the sensory testing and evaluation of swallowing findings:

1. Anatomic abnormalities of the laryngopharyngeal structures such as tumors (solid, cystic, vascular), areas of edema, exudate and mucosal irregularity. The videotape therefore must be rewound to the beginning of the exam in order to review the appearance of the nasopharyngeal and superior oropharyngeal regions.
2. Evidence of vocal fold paresis or paralysis during the sensory testing. As sensory testing depends on intact vocal fold movements (opening and closing), sensory testing often unmasks subtle vocal fold movement disorders not generally seen during a cursory examination of the larynx. Generally, a frame by frame, or at least a slow motion, analysis of the sensory findings must be observed on the videotape machine in order to clearly make these diagnoses.
3. Symmetry of the sensory testing results. The review of the videotape must include sequences of both the right and left sides that were tested. Distinct differences between the right and left sides of the laryngopharynx can herald site of lesion findings in the brain or skull base.
4. Determination of presence or absence of the laryngeal adductor reflex. In order to make this assessment the tape must be forwarded to the threshold points – the lowest air pulse pressures where the reflex was elicited for both the right and left sides of the laryngopharynx.
5. Laryngeal elevation. The physician forwards to portions of the videotaped exam where active swallowing is taking place.
6. Laryngeal penetration and aspiration. The physician advances the videotape to the food administration portion of the exam to determine whether there is penetration and aspiration.
7. Cricopharyngeal function. The portion of the swallow where the endoscope tip is placed into a posterior view of the laryngopharynx must be reviewed thoroughly. At this juncture, information about cricopharyngeal contraction and relaxation can be determined.

POST SERVICE

If the airway protective reflexes are absent, then a notation of "ABSENT Laryngeal Adductor Reflex" is made on the sensory testing form. Recommendations regarding non-oral forms of alimentation are then discussed with the patient and their caregivers.

If the airway protective reflexes are intact, the particular sensory threshold is calculated by determining the mean of the lowest detected pressures that elicited the adductor reflex on each side. This value is noted on the sensory testing form.

> Any medical diagnoses made during the videotape review are noted (eg., vocal fold paralysis, edema of posterior larynx, tumor of laryngeal surface of epiglottis). Confirmation of penetration and aspiration is made on the endoscopy for swallowing forms. Watershed recommendations such as suggesting a significant dietary change in either direction (commencement of feeding in a previously non-orally alimenting patient or cessation of taking food by mouth in a previously oral alimenting patient) are noted and then discussed with the patient and their caregivers.

Prescriptions that might be necessary subsequent to physician review (eg., proton-pump inhibitor medications (anti-acids)) must be called in, or written for the patient.

SURVEY DATA

Presenter(s): James Denneny, III, MD; Jonathan Aviv, MD; Dana Thompson, MD

Specialty(s): American Academy of Otolaryngology – Head and Neck Surgery

CPT: 92617

Sample Size: 54 **Resp n:** 32 **Resp %:** 59%

Sample Type: Random

	Low	25th pctl	Median	75th pctl	High
Survey RVW	1.40	1.59	2.50	3.30	4.40
Pre-Service Time			3		
Intra-Service Time	5	10	15	20	35
Post-Service Time			10		

KEY REFERENCE SERVICE(S):

CPT	Descriptor	'02 RVW	Glob
93314	Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); image acquisition, interpretation and report only	1.25	XXX

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

	Svy CPT	Ref CPT
TIME ESTIMATES (MEDIAN)		
Pre-service	3	
Intra-service	15	
Post-service	10	
INTENSITY/COMPLEXITY MEASURES (mean)	28	25(pr)
TIME SEGMENTS		
Pre-service	1.29	1.33
Intra-service	4.71	2.43
Post-service	3.57	2.71
MENTAL EFFORT AND JUDGMENT		
The number of possible diagnosis and/or the number of management options that must be considered	4.43	2.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.57	2.57
Urgency of medical decision making	4.57	2.71
TECHNICAL SKILL/PHYSICAL EFFORT		
Technical skill required	2.00	1.86
Physical effort required	1.00	1.00
PSYCHOLOGICAL STRESS		
The risk of significant complications, morbidity and/or mortality	1.43	1.43
Outcome depends on the skill and judgment of physician	4.14	4.86
Estimated risk of malpractice suit with poor outcome	2.57	2.71

RATIONALE:

RVW Recommendation Rationale for 92612, 92613, 92614, 92615, 92616, 92617

In January 2001, the Centers for Medicare and Medicaid Services implemented a series of G-codes for use with Medicare patient claims because CPT 92520 and/or 92525 did not distinguish between endoscopic assessment of airway protection and acoustic and aerodynamic assessments of voice function:

> ***Federal Register*. November 1, 2000 (pp65426).**
> **C. Other Changes to the 2001 Physician Fee Schedule and Clarification of CPT Definitions**
> For the 2001 physician fee schedule, we are establishing or revising several alpha-numeric HCPCS codes for reporting certain services that are not clearly described by existing CPT codes.
> *Evaluation of swallowing function*
> We are proposing the following new codes to describe the evaluation of swallowing function. These codes will replace the more general CPT 92525, *Evaluation of swallowing and oral function for feeding,* which represents a combination of these separate examinations. Our contractors requested the more precise coding to improve claims review for evaluation of dysphagia. The new codes are described as follows:
> G0193 Endoscopy study of swallowing function, often referred to as fiberoptic endoscopic evaluation of swallowing (FEES).
> G0194 *Sensory testing during endoscoping study of swallowing.* This service, often referred to as fiberoptic endoscopic evaluation of swallowing with testing, will be coded as an add-on code to G0193.
> The creation of these two codes does not imply coverage. Coverage of G0193 and G0194 remains at the discretion of the contractor processing the Medicare claim. These codes will be priced by contractors.
> Note that CPT 31575 (laryngoscopy, flexible fiberoptic, diagnostic) and CPT 31579 (laryngoscopy, flexible or rigid fiberoptic, with stroboscopy) should not be used for evaluations of swallowing.

In 2001, AAO-HNS and ASHA submitted a proposal to the CPT Editorial Panel for new codes to replace the temporary G-codes. The outcome of the Panel actions included six new codes; three primary procedure codes for endoscopic evaluation; and three interpretation/report codes:

92612 Flexible fiberoptic endoscopic evaluation of swallowing;
92613 physician interpretation and report only
92614 Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing;
92615 physician interpretation and report only
92616 Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal testing;
92617 physician interpretation and report only

New codes 92612, 92614, and 92616 involve placement of a flexible fiberoptic endoscope into the nasal cavity to a place where videotaping of swallowing and/or sensory reflex can be recorded. New codes 92613, 92615, and 92617 involve the review of these videotapes by the physician to assess and report findings and recommendations to the PCP and/or patient or caregiver (eg, changes in diet and/or non-oral forms of alimentation).

After reviewing the survey data collected for these six codes, we concluded that the relationship (ie, relative ranking) between the procedure codes (92612, 92614, 92616) and between the interpretation/report codes (92613, 92615, 92617) was reasonable. However, we felt that the survey respondents – using "magnitude estimation" - overestimated the RVWs.

To develop our recommendations for these codes, we looked first at the new interpretation/report codes, specifically, 92617. In comparing 92617 with reference code 93314, we noted that the intensity/complexity measures for intra-service time and for mental effort/judgment is significantly higher (see 92617 summary form). However, clinically, we believe 92617 is slightly less *total* work than 93314 *Echo transesophageal* (RVW=1.25). We also looked at the level of physician work and decision making in relationship to E/M 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" (RVW=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" (RVW=1.34). We believe new code X10 requires a level of physician judgment necessary to evaluate the (new) patient history and procedure tapes to formulate recommendations comparable to the work of a level four established patient office visit. Based on all of these comparisons, we recommend an RVW of 1.10 for 92617. For the other two interpretation/report codes, we recommend values that maintain the median survey RVW relationship between the codes, setting 92617 at 1.10:

Survey Median RVW:	92613=2.25	92615=2.00	92617=2.50
Ratio:	92613=0.90	92615=0.80	92617=*1.00*
Recommended RVW:	**92613=0.99**	**92615=0.88**	**92617=1.10**

Next, we considered the "total" value for the procedures and their corresponding interpretation/report. We believe that endoscopic evaluation of swallowing and interpretation/report (92612/92613) is the same total work as 31579 *Laryngoscopy with stroboscopy* (RVW=2.26). Using the RVW of 2.26, we subtracted 0.99 rvu's (the recommendation for 92613) to arrive at an RVW of 1.27 for 92612. Similar to the development of the recommendation for the three interpretation/report codes, we recommend values that maintain the median survey RVW relationship between the codes, setting 92612 at 1.27:

Survey Median RVW:	92612=2.50	92614=2.71	92616=3.70
Ratio:	*92612=1.00*	92614=1.08	92616=1.48
Recommended RVW:	**92612=1.27**	**92614=1.38**	**92616=1.88**

This results in the following "total" work values for the procedure/report code pairs:
92612/92613 = 2.26 92614/92615 = 2.26 92616/92617 = 2.98

This relationship makes sense: 1) Compared to 92614/92615, 92612/92613 requires more time for administration of food, but is less intense. Combined, the pairs represent similar total work. 2) Pair 92616/92617 combines both pair 92612/92613 and pair 92614/92615, however *some* of the procedure pre/post work is the same (eg, pre-service exam or post-service discussion) and *some* of the procedure intra-service work is not doubled (eg, application of anesthetic/decongestant, insertion of endoscope).

FREQUENCY INFORMATION

1. How was this service previously reported (if unlisted code, please ensure that the medicare frequency for this unlisted code is reviewed)?
No way to report.

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: Otolaryngology ~~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: Otolaryngology Frequency: Unknown, will be tied to 925X9

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: Otolaryngology Frequency: Unknown, will be tied to 925X9

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

Limited to most medical centers and a few community-based physicians

	A	B	C	D	E	F	G	H	I	J	K
1			CPT	92612		92614		92616		92613	
2	Tab 13 925XX PE Details (April 2002)		Descriptor	Flex fib endo eval of swallowing;		Flex fib endo eval, laryngeal sensory testing;		Flex fib endo eval of swallowing and laryngeal sensory testing;		Flex fib endo eval of swallowing; review/report only	
3			Global	XXX		XXX		XXX		XXX	
4		CMS Code	CMS Desc	NonFac	Facility	NonFac	Facility	NonFac	Facility	NonFac	Facility
5	TOTAL CLINICAL LABOR TIME	033 / 037	RN/SP	59	0	56	0	77	0	0	0
6	PRE-SERVICE	CMS Code	CMS Desc								
7	Collate/prepare X-ray, lab, and pathology reports - calls to answer questions about procedure	033 / 037	RN/SP	5	0	5	0	5	0	0	0
8	SERVICE PERIOD (stds in red)	CMS Code	CMS Desc								
9	BEGINS with admission to site of service										
10	Pre-service services										
11	Greet patient and provide gowning (peac std=3)	033 / 037	RN/SP	3	0	3	0	3	0	0	0
12	Obtain vital signs (Vitals 0=0; 1-3=3; 4-6=5)	033 / 037	RN/SP	3	0	3	0	3	0	0	0
13	Provide pre-service education/obtain consent	033 / 037	RN/SP	5	0	5	0	5	0	0	0
14	Prepare room, equipment,supplies (99213=2)	033 / 037	RN/SP	10	0	11	0	16	0	0	0
15	Apply anesthesia / decongestant / postion patient	033 / 037	RN/SP	4	0	4	0	4	0	0	0
16	Intra-service										
17	Assist physician in performing procedure	033 / 037	RN/SP	15	0	12	0	25	0	0	0
18	Post-Service										
19	Monitor pt./ vitals (Vitals 0=0, 1-3=3; 4-6=5)	033 / 037	RN/SP	3	0	3	0	3	0	0	0
20	Clean room/equipment by physician staff (99213=3)	033 / 037	RN/SP	4	0	3	0	6	0	0	0
21	Complete diagnostic forms, lab & X-ray requisitions	033 / 037	RN/SP	2	0	2	0	2	0	0	0
22	Education/instruction/counseling	033 / 037	RN/SP	5	0	5	0	5	0	0	0
23	End: Patient leaves site of service										
24	POST-SERVICE										
25	Other clinical activity - after patient leaves office	033 / 037	RN/SP	0	0	0	0	0	0	0	0
26	MEDICAL SUPPLIES	CMS Code	CMS Desc								
27	Other Supplies (please specify)										
28	disk for video system	New	item	1	0	1	0	1	0	0	0
29	defog-- see attached for pricing	New	ml	1	0	1	0	1	0	0	0
30	Polaroid film, type 667	75010	exposure	3	0	3	0	3	0	0	0
31	lidocaine jelly 30ml package	51301	ml	5	0	0	0	0	0	0	0
32	xylocaine w/ epinephrine 1%, 20ml	51504	ml	5	0	0	0	0	0	0	0
33	afrin		item	1	0	1	0	1	0	0	0
34	cotton tipped applicators	31103	item	2	0	0	0	0	0	0	0
35	suction canister, disposable	93604	item	1	0	1	0	1	0	0	0
36	tubing, non-latex see attached for pricing	New	foot	6	0	6	0	6	0	0	0
37	tubing, non-latex, with tip- see attached sheet for pricing	New	item	1	0	1	0	1	0	0	0
38	tongue depressor	11511	item	1	0	1	0	1	0	0	0
39	disposable endosheath	31119	item	1	0	0	0	0	0	0	0
40	gloves, non-stenle	11302	pair	1	0	1	0	1	0	0	0
41	chux	11102	item	1	0	1	0	1	0	0	0
42	gauze, non-stenle, 4" x 4"	31518	item	3	0	3	0	3	0	0	0
43	tubing, suction, 6' with yankauer tip	93606	item	1	0	1	0	1	0	0	0
44	emesis basin	11506	item	1	0	1	0	1	0	0	0
45	straw, drinking see attached sheet for pricing	see CMS files	item	3	0	0	0	3	0	0	0
46	spoons, plastic see attached sheet for pring	New	item	2	0	0	0	2	0	0	0
47	cups, drinking plastic see attached sheet for pricing	New	item	6	0	0	0	6	0	0	0
48	apple sauce- see attached sheet for pricing	New	oz	3	0	0	0	3	0	0	0
49	apple juice- see attached sheet for pricing	New	oz	21	0	0	0	21	0	0	0
50	thicket pack- see attached sheet for pricing	New	pack	3	0	0	0	3	0	0	0
51	graham crackers- see attached sheet for pricing	New	pack	1	0	0	0	1	0	0	0
52	Equipment	CMS Code	CMS Desc								
53	fiberoptic exam light	E11006		1	0	1	0	1	0	0	0
54	reclining exam chair with headrest	E11011		1	0	1	0	1	0	0	0
55	suction machine, Gomco	E30001		1	0	1	0	1	0	0	0
56	DIGITAL video system with photo documentation (for scope) (camera, monitor, ETC)- see attached sheet for pricing	New		1	0	1	0	1	0	0	0
57	xenon light source - cable - see attached sheet for pricing	New		1	0	1	0	1	0	0	0
58	Olympus fiberoptic endoscope	E13101		1	0	0	0	0	0	0	0
59	Pentax fiberoptic endoscope- see attached sheet for pricing	New		0	0	1	0	1	0	0	
60	Sensory box (Pentax AP4000 @ $6,800) see attached sheet for pricing	New		0	0	1	0	1	0	0	0
61	Review Station: AG7300 SVHS,17in.	E52013		0	0	0	0	0	0	1	0

	A	B	C	L	M	N	O
1			CPT	92615		92617	
2	**Tab 13 925XX PE Details (April 2002)**		Descriptor	Flex fib endo eval, laryngeal sensory testing; review/report only		Flex fib endo eval of swallowing and laryngeal sensory testing; review/report only	
3			Global	XXX		XXX	
4		CMS Code	CMS Desc	NonFac	Facility	NonFac	Facility
5	**TOTAL CLINICAL LABOR TIME**	033 / 037	RN/SP	0	0	0	0
6	**PRE-SERVICE**	CMS Code	CMS Desc				
7	Collate/prepare X-ray, lab, and pathology reports - calls to answer questions about procedure	033 / 037	RN/SP	0	0	0	0
8	**SERVICE PERIOD** (stds in red)	CMS Code	CMS Desc				
9	**BEGINS with admission to site of service**						
10	**Pre-service services**						
11	Greet patient and provide gowning (peac std=3)	033 / 037	RN/SP	0	0	0	0
12	Obtain vital signs (Vitals 0=0; 1-3=3; 4-6=5)	033 / 037	RN/SP	0	0	0	0
13	Provide pre-service education/obtain consent	033 / 037	RN/SP	0	0	0	0
14	Prepare room, equipment,supplies (99213=2)	033 / 037	RN/SP	0	0	0	0
15	Apply anesthesia / decongestant / postion patient	033 / 037	RN/SP	0	0	0	0
16	**Intra-service**						
17	Assist physician in performing procedure	033 / 037	RN/SP	0	0	0	0
18	**Post-Service**						
19	Monitor pt./ vitals (Vitals 0=0; 1-3=3; 4-6=5)	033 / 037	RN/SP	0	0	0	0
20	Clean room/equipment by physician staff (99213=3)	033 / 037	RN/SP	0	0	0	0
21	Complete diagnostic forms, lab & X-ray requisitions	033 / 037	RN/SP	0	0	0	0
22	Education/instruction/counseling	033 / 037	RN/SP	0	0	0	0
23	**End: Patient leaves site of service**						
24	**POST-SERVICE**						
25	Other clinical activity - after patient leaves office	033 / 037	RN/SP	0	0	0	0
26	**MEDICAL SUPPLIES**	CMS Code	CMS Desc				
27	**Other Supplies (please specify)**						
28	disk for video system	New	item	0	0	0	0
29	defog-- see attached for pricing	New	ml	0	0	0	0
30	Polaroid film, type 667	75010	exposure	0	0	0	0
31	lidocaine jelly 30ml package	51301	ml	0	0	0	0
32	xylocaine w/ epinephrine 1%, 20ml	51504	ml	0	0	0	0
33	afrin		item	0	0	0	0
34	cotton tipped applicators	31103	item	0	0	0	0
35	suction canister, disposable	93604	item	0	0	0	0
36	tubing, non-latex see attached for pricing	New	foot	0	0	0	0
37	tubing, non-latex, with tip- see attached sheet for pricing	New	item	0	0	0	0
38	tongue depressor	11511	item	0	0	0	0
39	disposable endosheath	31119	item	0	0	0	0
40	gloves, non-sterile	11302	pair	0	0	0	0
41	chux	11102	item	0	0	0	0
42	gauze, non-sterile, 4" x 4"	31518	item	0	0	0	0
43	tubing, suction, 6' with yankauer tip	93606	item	0	0	0	0
44	emesis basin	11506	item	0	0	0	0
45	straw, drinking see attached sheet for pricing	see CMS files	item	0	0	0	0
46	spoons, plastic see attached sheet for pricing	New	item	0	0	0	0
47	cups, drinking plastic see attached sheet for pricing	New	item	0	0	0	0
48	apple sauce- see attached sheet for pricing	New	oz	0	0	0	0
49	apple juice- see attached sheet for pricing	New	oz	0	0	0	0
50	thicket pack- see attached sheet for pricing	New	pack	0	0	0	0
51	graham crackers- see attached sheet for pricing	New	pack	0	0	0	0
52	**Equipment**	CMS Code	CMS Desc				
53	fiberoptic exam light	E11006		0	0	0	0
54	reclining exam chair with headrest	E11011		0	0	0	0
55	suction machine, Gomco	E30001		0	0	0	0
56	DIGITAL video system with photo documentation (for scope) (camera, monitor, ETC)- see attached sheet for pricing	New		0	0	0	0
57	xenon light source - cable - see attached sheet for pricing	New		0	0	0	0
58	Olympus fiberoptic endoscope	E13101		0	0	0	0
59	Pentax fiberoptic endoscope- see attached sheet for pricing	New		0	0	0	0
60	Sensory box (Pentax AP4000 @ $6,800) see attached sheet for pricing	New		0	0	0	0
61	Review Station, AG7300 SVHS,17in	E52013		1	0	1	0

New ENT Supplies & Equipment				
Item	**Code(s)**	**Manufacturer**	**Item Number**	**Price**
Insert eartip with sound tube	92552, 92553, 92555-57			
Caloric Irrigator	92543	Medical Calibration Ser	n/a	$ 4,875.00
Rotation Chair	92546	Neuro Kinetics	n/a	$ 91,059.00
SMR Unit/cabinet with Suction (stainless steel with 2 otoscopes)	40800 to 41114	Global Surgical	n/a	$ 3,195.00
Guarded needle tip for electrocautery	40800 to 41114			
Suture, chromic	40800 to 41114			
straw, drinking	92612, 92614, 92616	Generic	n/a	$ 0.02
spoon, plastic	92612, 92614, 92616	Generic	n/a	$ 0.04
cup, drinking plastic	92612, 92614, 92616	Generic	n/a	$ 0.06
apple sauce (per ounce)	92612, 92614, 92616	Generic	n/a	$ 0.05
apple juice (per ounce)	92612, 92614, 92616	Generic	n/a	$ 0.03
graham crackers (per pack)	92612, 92614, 92616	Generic	n/a	$ 0.66
Defog	92612, 92614, 92616	DERO	2161671	$ 4.98
Pontacaine/Afrin (Oxymetazoline)	92612, 92614, 92616	Mayo Pharmacy	n/a	$ 1.95
Yankauer Suction Tip	92612, 92614, 92616	SHER	104370	$ 0.71
Thick It	92612, 92614, 92616	Hormel	50420	$ 0.24
Digital video system with xenon light source	92612, 92614, 92616	Storz	n/a	$ 26,901.00
Pentax fiberoptic endoscope	92612, 92614, 92616	Pentax	FNL 7R P3 (2.5ml)	$ 6,100.00
Sensory box	92612, 92614, 92616	Pentax	AP4000	$ 6,800.00
Tubing, non-latex , 1/4 inch (per foot)	92612, 92614, 92616, 40800 to 41114	Global Surgical	n/a	$ 1.00

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2002

Percutaneous Cardiac Procedures

The CPT Editorial Panel created two codes to describe percutaneous transcatheter closure of cardiac defects, 93580 *Percutaneous transcatheter closure of congenital interartrial communication (ie, fontan fenestration, atrial septal defect) with implant* and 93581 *Percutaneous transcatheter closure of a congenital ventricular septal defect with implant.* The RUC reviewed survey data from more than 30 pediatric cardiologists and compared the survey data to the current CPT codes that describe these services performed via open technique.

The RUC compared CPT code 33641 *Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch* (work RVU = 21.39) with new CPT code 93580 and determined that the pre, intra, and immediate post-service time is essentially the same for both services. Only Harvard time was available for this reference service. The RUC determined that an increment of 3.39 was appropriate to capture the post day of procedure work included in the open code, therefore, the survey's 25th percentile of 18.00 appeared reasonable. **The RUC recommends a work RVU of 18.00 for CPT code 93580.**

The RUC compared CPT code 33681 *Closure of ventricular septal defect, with or without patch* (work RVU = 30.61) with new CPT code 93581 and determined that the pre and immediate post-service time is essentially the same for both services. The new percutaneous procedure requires approximately 30 minutes additional intra-service time, however the work value for this service does not include the extensive post day of procedure time included in the open procedure code. 99681 includes six 99231, one discharge day management, two 99213 and one 99214 office visits. The RUC computed a work relative value for 93581 of 24.43 by backing out the post-operative visits from 33681, while allowing for additional intra-service time for the new procedure. The work RVU recommendation of 24.43 is slightly less than the 25th percentile of the survey data from pediatric cardiology. The RUC agreed that this maintained an appropriate relationship between 93580 and 93581. **The RUC recommends a work RVU of 24.43 for CPT code 93581.**

The RUC did note that the specialty should continue to review the appropriateness of a 000 day global for these services and consider reviewing these codes again in the future, if a different global period (ie, 010 or 090) appear more appropriate.

The RUC recommended that the practice expense inputs (pre and post clinical staff time) be modified to be consistent with the cardiac catheterization direct inputs, as approved by the PEAC at their January 2002 meeting. The revised recommendations are attached to this recommendation. This service is not performed in the office setting.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●93580	L1	Percutaneous transcatheter closure of interatrial communication (ie, fontan fenestration, atrial septal defect) with implant (Percutaneous transcatheter closure of atrial septal defect includes a right heart catheterization procedure. 93580 includes injection of contrast for atrial and ventricular angiograms. Codes 93501, 93529-93533, 93539, 93543, 93555 should not be reported separately in addition to code 93580).	000	18.00
●93581	L2	Percutaneous transcatheter closure of a congenital ventricular septal defect with implant (Percutaneous transcatheter closure of ventricular septal defect (ie, fontan fenestration) includes a right heart catheterization procedure. 93581 includes injection of contrast for atrial and ventricular angiograms. Codes 93501, 93529-93533, 93539, 93543, 93555 should not be reported separately in addition to code 93581). For echocardiographic services performed in addition to 93580, 93581 see 93303-93317, as appropriate)	000	24.43

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

ACC/AAP

CPT Code: 93580 Tracking Number: L1 Global Period: 000 **Recommended RVW:** 18

CPT Descriptor:

Percutaneous transcatheter closure of congenital interatrial communication (ie, fontan fenestration, atrial septal defect) with implant

(Percutaneous transcatheter closure of atrial septal defect includes a right heart catheterization procedure. Code 93580 includes injection of contrast for atrial and ventricular angiograms. Codes 93501, 93529-93533, 93539, 93543, 93555 should not be reported separately in addition to code 9356X1)

(For echocardiographic services performed in addition to 93580, 93581 see 93303-93317 and 93662 as appropriate)

Note: cardiac catheterization is done first and cannot be billed separately.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

The typical patient has atrial defects amenable to device closure include congenital atrial septal defects (ASDs), surgically created fenestrations in atrial baffles (e.g. fenestrated Fontan or in patches to partially close ASDs in selected circumstances) and leaks in surgically created baffles or patches. Patients range from infants to adults. The pre-, intra-, and postservice physician work for infant and adults does not vary and is, for the most part consistent.

Description of Pre-Service Work:

The preservice work includes history and physical examination of the patient, review of non-invasive testing including chest x-ray, echocardiogram, MRI, and electrocardiogram. The procedure, expected results and potential complications are discussed with the patient and/or the patient's parents. Informed consent is obtained.

Description of Intra-Service Work:

Trans-esophageal echocardiography (TEE) or intracardiac echocardiography (ICE) may be required (separately reported). General anesthesia (separately reported) is commonly used when TEE is required; otherwise conscious sedation is usually employed. The patient is heparinized and the ACT is maintained >200 seconds throughout the case. Prophylactic antibiotics are given. A combined right heart catheterization and left heart catheterization through existing septal opening including angiography (93529 or 93533, 93542 or 93543 and 93555) is performed to delineate the anatomy and physiology.

Using an end-hole catheter, wedge or preformed catheter such as a multipurpose catheter, the atrial defect is crossed from right to left atrium. The catheter is then advanced into the left upper pulmonary vein. This catheter is exchanged for a sizing balloon over a guide wire. The balloon is positioned across the defect and inflated at low pressure to measure the "stretched" diameter. Device size is based on this measurement. In patients with fenestrated Fontans, and in some with right-to-left shunts through the atrial defect, right-sided pressures and saturations are re-measured while temporarily balloon occluding the defect to insure that device closure will be hemodynamically tolerated.

A long sheath and dilator are then advanced over the wire and positioned in the left atrium. The device is then deployed across the atrial opening. The position of the device must be evaluated by echocardiography and fluoroscopy prior to release. If the device is in good position, the release mechanism is activated and the device position checked again. Abnormal placement or an inappropriate sized device may have to be removed if there a large leak, potential encroachment on cardiac structures, or risk of embolization, and a second device placed.

After device position is confirmed using TEE or angiography, the catheters and sheaths are removed and hemostasis achieved.

Description of Post-Service Work:

The patient is observed in the recovery room and then transferred to the regular hospital room. The results are reviewed with the patient/patient's parents and a report is generated which includes interpretation of hemodynamic findings and outcome of device implantation.

SURVEY DATA:

Presenter(s) Michael Freed, MD, FACC, FAAP and James Maloney, MD, FACC

Specialty(s): Pediatric Cardiology and Cardiology

Sample Size: 80 Response Rate: (%): 41 (51%)Median RVW: 21.50

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

Physicians who perform atrial and ventricular septal closures are currently using products from one of thr manufacturers upon receiving certification. Names of these certified physicians were provided to ACC/AAP.

25th Percentile RVW: 18 75th Percentile RVW: 25 Low: 8.28 High: 45.20

Day Before Pre-Service Time: 60 minutes
Median Pre-Service Time: 30 Median Intra-Service Time: 120

25th Percentile Intra-Svc Time: 90 75th Percentile Intra-Svc Time: 150 Low: 60 High: 180

Median Post-Service Time:	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	60	
Critical Care:	N/A	N/A
Other Hospital Visits:	N/A	N/A
Discharge Day Mgmt.:	N/A	N/A
Office Visits:	N/A	N/A

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW	Global
92986	Percutaneous balloon valvuloplasty; aortic valve	21.8	090

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)	CPT Code: 9356X1	Key Reference CPT Code: 92986
Median Pre-Time	30	
Median Intra-Time	120	470 total time Harvard data
Median Immediate Post-service Time	60	
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	4.00	3.29
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.05	3.41
Urgency of medical decision making	3.56	3.82

Technical Skill/Physical Effort (Mean)

Technical skill required	4.71	4.00
Physical effort required	3.80	3.35

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.46	4.06
Outcome depends on the skill and judgement of physician	4.71	4.12

Estimated risk of malpractice suit with poor outcome	4.51	3.94

INTENSITY/COMPLEXITY MEASURES	CPT Code 9356X1	Reference Service 1 93986
Time Segments (Mean)		
Pre-Service intensity/complexity	3.56	3.00
Intra-Service intensity/complexity	4.56	3.76
Post-Service intensity/complexity	3.41	3.29

ADDITIONAL RATIONALE

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

The American College of Cardiology Cardiovascular RUC Committee, representing cardiology and the cardiology subspecialties, and the American Academy of Pediatrics Committee on Coding and Reimbursement met by phone conference to discuss the recommended work RVU.

Following the review of the survey data, the ACC and AAP recommend a work RVU of 18 for the new percutaneous closure of congenital atrial communication code (9356X1). The most commonly used reference procedure was balloon dilation of aortic valve (92986), which has a work RVU of 21.8 but has a global period of 90 days.

The 18 work RVUs are the 25th percentile of the survey results (median RVU was 21.50). We think this value is reasonable given the intensity/complexity and risk of this procedure in comparison to the reference procedure. The code also includes the cardiac catheterization procedure which is not billed separately.

FREQUENCY INFORMATION

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

33641, 33999, 93315, 93529, 93530, 93531, 93532, 93533, 93539, 93543, 93555, 93799

Reporting codes 93529 through 93533, 93539, 93543, 93555 inaddition to the code for the service proposed here, would represent unbundling. 100% of services performed using current codes that would now be coded using the proposed new code would be replaced under this proposal.

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 Cardiology ____ ____Commonly ____Sometimes __X__Rarely

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

Specialty Pediatric Cardiology Frequency 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 Pediatric Cardiology Frequency 25

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

ACC/AAP

RUC Rec.: 24.43

CPT Code: 93581 Tracking Number: L2 Global Period: 000 Recommended RVW: ~~25~~

CPT Descriptor:

Percutaneous transcatheter closure of a congenital ventricular septal defect with implant

(Percutaneous transcatheter closure of ventricular septal defect includes a right heart catheterization procedure. Code 93581 includes injection of contrast for atrial and ventricular angiograms. Codes 93501, 93529-93533, 93539, 93543, 93555 should not be reported separately in addition to code 93581)

(For echocardiographic services performed in addition to 93580, 93581, see 93303-93317 and 93662, as appropriate)

Note: cardiac catheterization is done first and cannot be billed separately.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

The patient is one with a ventricular septal defect appropriate for device closure. The defect is congenital and unoperated or residual following attempted surgical closure. Patients range from infants to adults. The physician work is comparable whether the patient is an infant or an adult.

Description of Pre-Service Work:

The pre-service work includes history and physical examination of the patient, review of non-invasive testing including chest x-ray, echocardiogram, MRI, and electrocardiogram. The procedure, expected results and potential complications are discussed with the patient and/or the patient's parents. Informed consent is obtained.

Description of Intra-Service Work:

Most VSD closures are performed using general anesthesia (separately reported). Trans-esophageal or intracardiac echocardiography is almost always used (separately reported). The patient is prepped and draped.

Percutaneous access is obtained in the femoral vein and artery and sheaths are placed. The patient is heparinized and the ACT is maintained > 200 seconds throughout the case. Prophylactic antibiotics are given.

Depending on the location of the VSD, in more than fifty percent of patients, additional venous access will be required in the other femoral vein or the internal jugular vein. A right and left heart catheterization, including angiography is performed to define the anatomy and physiology of the defect(s).

Device closure of VSDs involves crossing the VSD, sizing the defect, and then delivering the device. Multiple options to cross the defect are available and depend on the anatomy and location of the defect. Usually the VSD is crossed from left to right ventricle rather than right-to-left from the trabeculated right ventricle. From the left ventricle, the VSD can be crossed using a retrograde approach from the femoral artery or antegrade using the catheter in the femoral vein. The latter is accomplished by performing a transseptal (atrial septum) puncture (Brockenbrough) to enter the left atrium. The catheter is then passed from the left atrium to the left ventricle. The VSD can be crossed using a flow- directed, balloon-tipped wedge catheter or more commonly, preformed catheters are used to aim a guidewire, which is then advanced through the defect into the right ventricle and then into a pulmonary artery or retrograde through the tricuspid valve in the right atrium. This wire is then snared from

the venous side. The venous site from which the wire is snared will depend on how one intends to deliver the device. Devices are occasionally delivered retrograde from an artery. Mid- and apical muscular defects are most easily closed using the internal jugular vein. Anterior muscular defects and residual membranous and cono-ventricular defects are most easily closed from the femoral vein. At the completion of this stage, there is an exchange-length guidewire entering the body at one site, passing through the VSD and exiting the body at another site.

An angiographic catheter is passed over the wire for selective contrast injections in the defect to define the commonly complex anatomy. Following this, a balloon-tipped catheter (over the wire) is pulled through or inflated in the defect to determine the "stretched" diameter. With this information, the appropriate device can be chosen. A long sheath and dilator are advanced over the guidewire and positioned across the VSD. The guidewire and dilator are removed and the device is delivered. Angiography, using a retrograde left ventricular catheter, is performed during delivery to insure correct positioning of the device. Following delivery, angiography is performed to confirm device position and hemodynamics are repeated to determine residual shunting.

If there is a large leak, potential encroachment on cardiac structures or risk of embolization, the device may have to be removed and a second device placed. Occasionally (10 to 15 percent of the time), multiple devices must be placed to close separate muscular defects that cannot be covered with a single device.

Description of Post-Service Work:

Following the procedure, the patient is observed in the recovery room and then admitted to the ICU or to a general hospital room. The results are discussed with the patient and/or his or her parents. If uncomplicated, the patient can be discharged the following day. A report is generated which includes interpretation of hemodynamic findings and outcome of device implantation.

SURVEY DATA:

Presenter(s) Michael Freed, MD, FACC, FAAP and James Maloney, MD, FACC

Specialty(s): Pediatric Cardiology and Cardiology

Sample Size: 80 Response Rate: (%): 27 (34%) Median RVW: 28

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

Physicians who perform atrial and ventricular septal closures are currently using products from one of three manufacturers upon receiving certification. Names of these certified physicians were provided to ACC/AAP.

25th Percentile RVW: 25 75th Percentile RVW: 30 Low: 11 High: 56.40
Day Before Pre-Service Time: 60 minutes
Median Pre-Service Time: 30 Median Intra-Service Time: 180

25th Percentile Intra-Svc Time: 180 75th Percentile Intra-Svc Time: 207.50 Low: 60 High: 240

Median Post-Service Time:	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	60	

Critical Care:	N/A	N/A
Other Hospital Visits:	N/A	N/A
Discharge Day Mgmt.:	N/A	N/A
Office Visits:	N/A	N/A

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW	Global
92986	Percutaneous balloon valvuloplasty; aortic valve	21.8	090

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)	CPT Code 9356X2:	Key Reference CPT Code: 92986
Median Pre-Time	30	
Median Intra-Time	180	470 total time Harvard data
Median Immediate Post-service Time	60	
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	4.52	3.39
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.56	3.44
Urgency of medical decision making	4.44	3.89

Technical Skill/Physical Effort (Mean)

Technical skill required	5.00	3.94

Physical effort required	4.74	3.67
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.93	4.28
Outcome depends on the skill and judgement of physician	4.93	4.28
Estimated risk of malpractice suit with poor outcome	4.70	3.89

INTENSITY/COMPLEXITY MEASURES	CPT Code 9356X2	Reference Service 92986
Time Segments (Mean)		
Pre-Service intensity/complexity	4.52	3.28
Intra-Service intensity/complexity	5.00	3.94
Post-Service intensity/complexity	4.07	3.22

ADDITIONAL RATIONALE

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

The American College of Cardiology Cardiovascular RUC Committee, representing cardiology and the cardiology subspecialties, and the American Academy of Pediatrics Committee on Coding and Reimbursement met by phone conference to discuss the recommended work RVU.

Following the review of the survey data, the ACC and AAP recommend a work RVU of 25 for the new percutaneous closure of congenital ventricular septal defect code (9356X2). The most commonly used reference procedure was balloon dilation of the aortic valve (92986), which has a work RVU of 21.8 but has a global period of 90 days.

The 25 work RVUs are the 25th percentile of the survey results (median RVU was 28). We think this value is reasonable given the intensity/complexity and risk of this procedure in comparison to the reference procedure. The code also includes the cardiac catheterization procedure which is not billed separately. Lastly, survey respondents indicated that the ventricular approach is considerably more difficult than the atrial approach (survey on code 9356X1 with a recommendation of 18 work RVUs).

FREQUENCY INFORMATION

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

The current codes do not relate to actual procedure. The CPT codes currently being used to report this service are:

33681, 33999, 93315, 93529, 93530, 93531, 93532, 93533, 93542, 93543, 93555, 93799

Reporting codes 93529 through 93533, 93542, 93543, 93555 in addition to the code for the service proposed here, would represent unbundling. 100% of services performed using current codes that would now be coded using the proposed new code would be replaced under this proposal.

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 Cardiology ____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 Pediatric Cardiology Frequency 200

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 Cardiology Frequency 0

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

AMA/Specialty Society Update Process
PEAC Summary of Recommendation
000 Day Global Period
Out of Office Direct Inputs

ACC/AAP - Code 93580

CPT Long Descriptor:
Percutaneous transcatheter closure of congenital interatrial communication (ie, fontan fenestration, atrial septal defect) with implant

(Percutaneous transcatheter closure of atrial septal defect (ie, fontan fenestration, atrial septal defect) includes a right heart catheterization procedure. Code 93580 includes injection of contrast for atrial and ventricular angiograms. Codes 93501, 93529-93533, 93539, 93543, 93555 should not be reported separately in addition to code 935680)

(For echocardiographic services performed in addition to 93580, 93581, see 93303-93317 and 93662 as appropriate)

Note: cardiac catheterization is done first and cannot be billed separately.

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 College of Cardiology Cardiovascular RUC Committee, representing cardiology and the cardiology subspecialties, and the American Academy of Pediatrics Committee on Coding and Reimbursement met by phone conference to discuss the recommended direct practice expense inputs. We are recommending 45 minutes of clinical staff time, which is consistent with our recommendation to the PEAC for the cardiac catheterization family.

Please describe the clinical activities of your staff:

Pre-Service:

Complete pre-service diagnostic and referral forms

Obtain medical records including films, stress tests, echocardiograms, previous catheterization, interventional and surgical reports Coordinate pre-surgery services

Coordinate scheduling in facility

Follow-up phone calls and prescriptions

Provide pre-service education, review consent and answer questions

Intra-Service:

None

Post-Service:

Follow-up phone calls with patient/family

Verify prescriptions

Inquire re: late complications (hematoma, site pain or swelling, etc.)

Coordinate care by staff in office

See Attached Spreadsheet for Clinical Labor, Medical Supplies, and Medical Equipment.

We are not providing any recommendation for these services in a non-facility setting because this is an inpatient procedure.

AMA/Specialty Society Update Process
PEAC Summary of Recommendation
000 Day Global Period
Out of Office Direct Inputs

ACC/AAP - Code 93581

CPT Long Descriptor:

Percutaneous transcatheter closure of a congenital ventricular septal defect with implant

(Percutaneous transcatheter closure of ventricular septal defect includes a right heart catheterization procedure. Code 93581 includes injection of contrast for atrial and ventricular angiograms. Codes 93501, 93529-93533, 93539, 93543, 93555 should not be reported separately in addition to code 93581)

(For echocardiographic services performed in addition to 93580, 93581, see 93303-93317 and 93662, as appropriate)

Note: cardiac catheterization is done first and cannot be billed separately.

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 College of Cardiology Cardiovascular RUC Committee, representing cardiology and the cardiology subspecialties, and the American Academy of Pediatrics Committee on Coding and Reimbursement met by phone conference to discuss the recommended direct practice expense inputs. We are recommending 45 minutes of clinical staff time, which is consistent with our recommendation to the PEAC for the cardiac catheterization family.

Please describe the clinical activities of your staff:

Pre-Service:

Complete pre-service diagnostic and referral forms

Obtain medical records including films, stress tests, echocardiograms, previous catheterization, interventional and surgical reports Coordinate pre-surgery services

Coordinate scheduling in facility

Follow-up phone calls and prescriptions

Provide pre-service education, review consent and answer questions

Intra-Service:

None

Post-Service:

Follow-up phone calls with patient/family

Verify prescriptions

Inquire re: late complications (hematoma, site pain or swelling, etc.)

Coordinate care by staff in office

See Attached Spreadsheet for Clinical Labor, Medical Supplies, and Medical Equipment.

We are not providing any recommendation for these services in a non-facility setting because this is an inpatient procedure.

		93580		93581	
	CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Percutaneous transcatheter closure of congenital interatrial communicatio n (ie., fontan fenestration, atrial septal defect) with implant		Percutaneous transcatheter closure of a congenital ventricular septal defect with implant	
LOCATION		**In Office**	**Out Office**	**In Office**	**Out Office**
GLOBAL PERIOD		**000**	**000**	**000**	**000**
TOTAL CLINICAL LABOR TIME	**RN/LPN/MTA**	**n/a**	**38**	**n/a**	**38**
PRE-SERVICE					
Start: Following visit when decision for surgery or procedure made					
Complete pre-service diagnostic & referral forms	**RN/LPN/MTA**		**5**		**5**
Coordinate pre-surgery services (obtain medical records, coordinate pre procedure testing)	**RN/LPN/MTA**		**10**		**10**
Schedule space and equipment in facility	**RN/LPN/MTA**		**5**		**5**
Office visit before surgery/procedure: Review test and exam results			**0**		**0**
Provide pre-service education/obtain consent	**RN/LPN/MTA**		**12**		**12**
Follow-up phone calls & prescriptions	**RN/LPN/MTA**		**3**		**3**
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		0	0
Greet patient and provide gowning		0	
Obtain vital signs		0	0
Provide pre-service education/obtain consent		0	0
Prepare room, equipment,supplies		0	0
Prepare and position patient/ monitor patient/ set up IV		0	0
Sedate/apply anesthesia		0	0
Intra-service		0	0
Assist physician in performing procedure		0	0
Post-Service		0	0
Monitor pt. following service/check tubes, monitors, drains		0	0
Clean room/equipment by physician staff		0	0
Complete diagnostic forms, lab & X-ray requisitions		0	0
Review/read X-ray, lab, and pathology reports		0	
Check dressings & wound/ home care instructions /coordinate office visits /prescriptions		0	0
Coordination of care by staff in office			
Other Clinical Activity (inform patient/family of results, follow-up phone calls)	**RN/LPN/MTA**	3	3
End: Patient leaves office			

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Refilling of Implantable Infusion Pumps

The specialty societies that were scheduled to present code 95590 *Refilling and maintenance of implantable pump or reservoir for drug delivery; spinal (intrathecal, epidural) or brain (intraventricular),* requested that the code be presented to the RUC in September. This postponement would allow the specialties to resolve several issues with CMS prior to the RUC presentation.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 95590	AJ1	Refilling and maintenance of implantable pump or reservoir for drug delivery; spinal (intrathecal, epidural) or brain (intraventricular) (For analysis and/or reprogramming of implantable infusion pump, see 62367-62368) (For refill and maintenance of implanted infusion pump or reservoir for systemic drug therapy (eg, chemotherapy or insulin, use 96530)	XXX	No RUC Recommendation
▲96530	AJ2	Refilling and maintenance of an implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial) (For refilling and maintenance of an implantable infusion pump for spinal or brain drug infusion, use 95590)	XXX	0.00 (No Change)

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Laser Treatment for Inflammatory Skin Diseases

Three new codes were created to more appropriately describe the use of laser treatment for skin diseases. The RUC reviewed the survey data determined that despite the specialty society's amended recommendations, the values were still too high. The RUC used the following reference service codes to assign relative work values to these proposed codes that were properly ranked:

CPT code 11402, *Excision, benign lesion except skin tag, trunk, arms, legs, 1.1 – 2.0 cm* (work RVU=1.61)
CPT code 12001, *Simple repair of superfacial wounds of scalp, neck, external genitalia, 2.5 cm or less* (work RVU = 1.70)
CPT code 11406, *Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs; lesion diameter over 4.0 cm* (work RVU=2.76)

Each of these reference codes has a 010-day global period. Therefore, the RUC agreed to remove one of the office visits (CPT code 99212 with a 0.45 work RVU) from each of the reference codes and recalculate the RVU values for the new codes accordingly.

The RUC recommends a work relative value of 1.15 RVUs for CPT code 96920.
The RUC recommends a work relative value of 1.17 RVUs for CPT code 96921.
The RUC recommends a work relative value of 2.10 RVUs for CPT code 96922.

Practice Expense

The RUC reviewed the practice expenses and agreed to delete the following practice expenses: 1) Monitor patient following service/check tubes, monitors and drains; 2) Complete diagnostic forms, lab and x-ray acquisition and 3) Review/read X-ray, lab and pathology reports. This would reduce the 9 minutes from the practice expense times for each code. Lidocaine Jelly (30 mL) was removed from the list of supplies for CPT code 96920 and 96921. The Pulse Dye Laser was deleted from the list of equipment. Revised practice expense inputs are attached to the recommendations.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 96920	BG1	Laser treatment for inflammatory skin diseases, (psoriasis); total area less than 250 sq cm	000	1.15
● 96921	BG2	250 sq cm to 500 sq cm	000	1.17
● 96922	BG3	over 500 sq cm	000	2.10

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 96920 **Tracking Number:** **Global Period:** 000 **RUC Recommended RVW:** ~~1.81~~ 1.15

CPT Code Descriptor: **Laser treatment for inflammatory skin disease, (psoriasis); total area less than 250 sq cm**

CLINICAL DESCRIPTION OF SERVICE:

Typical Patient/Service: The patient is a 35-year-old Caucasian male with a 10-year history of stable moderate plaque psoriasis, which worsens during the winter months. There is a family history of psoriasis. Physical findings include inflamed, scaly, somewhat tender lesions present on the extensor surfaces of elbows and knees, hips, sacrum, and scalp involving 10% of the body surface area, or about 1500 square centimeters. Current therapies include daily use of both moderate-potency topical corticosteroid ointment and calcipotriene ointment. A corticosteroid lotion is used daily on the scalp; topical tar preparations are added when necessary.

These therapies have produced a partial improvement response of approximately 80% plaque clearance, leaving less than 250 square centimeters of chronic plaques resistant to topical therapy. The patient continues to suffer from significant erythema, induration, pruritus, and desquamation of thick scales from these non-responsive areas. The severity of the disease is documented and the decision is made to utilize laser treatment for recurrent psoriatic plaques. Activities of daily living and quality of life are negatively impacted by the presence of symptomatic lesions.

Description of Pre-Service Work: The physician reviews treatment options including systemic therapy, phototherapy, additional topical therapy and laser treatment. He reviews chart, and confirms the area of treatment with the patient and obtains informed consent for the laser treatment. He verifies positioning of patient and checks laser equipment.

Description of Intra Service Work: The affected area draped and the lesion site(s) prepped with a clarifying agent such as mineral oil or other moisturizing agent. Physician assesses the redness of the lesions and any erythema. Pain or blistering from previous therapy or treatment methodology is also assessed. The physician determines the laser dosage level from an assessment of the minimum erythema dosage of laser light on normal skin. The physician treats area of inflamed lesions or plaque with the laser. The physician monitors for pain as well as skin surface reaction throughout the process.

Description of Post Service Work:
Physician discusses follow-up assessment. Physician discusses pain management, dressings if required and care of the treated area.

SURVEY DATA:

Presenter(s)_____

Specialty(s): American Academy of Dermatology_____

Sample Size: 75 Response Rate: (%): 36 (27 responses) Median RVW: 2.85

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

Explanation of sample size: Sent to all dermatologists on record currently performing this procedure

25th Percentile RVW: 1.81 75th Percentile RVW: 3.0 Low: .98 High: 7.6

Median Pre-Service Time: 5 Median Intra-Service Time: 17

25th Percentile Intra-Svc Time: 10 75th Percentile Intra-Svc Time: 20 Low: 5 High: 90

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

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
11403	**Excision, benign lesion, trunk arms or legs lesion diameter 2.1 to 3.0**	**010**	**1.92**

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: 96920	Key Ref CPT Code: 11403
Median Pre-Time	5 min	7
Median Intra-Time	17 min	31
Median Immediate Post-service Time	5 min	7
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	14

CPT 96920

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	2.6	2.6
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.9	2.3
Urgency of medical decision making	2.3	2.1

Technical Skill/Physical Effort (Mean)

Technical skill required	3.4	3.0
Physical effort required	2.8	2.4

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.0	2.7
Outcome depends on the skill and judgement of physician	3.6	3.0
Estimated risk of malpractice suit with poor outcome	2.9	2.6

INTENSITY/COMPLEXITY MEASURES	**CPT Code 96920**	**Reference Service 1 11403**

Time Segments (Mean)

Pre-Service intensity/complexity	2	2
Intra-Service intensity/complexity	3	3
Post-Service intensity/complexity	2	2

ADDITIONAL RATIONALE

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

Survey results consistently support physician and clinical staff time required for the typical patient.
However, in light of the range and lack of consistency in suggested RVW level by survey respondents, the American Academy of Dermatology's Coding and Reimbursement Task Force members recommend use of the 25th percentile as the appropriate RVW. The use of the 25th percentile is also supported by the RVW for survey respondent's pre-dominant choice of reference code. In order to establish appropriate placement and valuation, the Task Force also reviewed these new codes which are defined by size of treatment area in the context of the other laser codes which are site specific and lesion specific, such as destruction of anal lesion(s) (CPT46917 and destruction of penile lesion(s) (CPT 54057). The primary areas of treatment of the new code are elbows, knees feet, hands, scalp, forearms and back.

FREQUENCY INFORMATION

How was this service previously reported? N/A (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 Dermatology ____ 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 Dermatology _____ Frequency 5000

Specialty _____ Frequency _____

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

Specialty Dermatology _____ Frequency 2500

Specialty _____ Frequency _____

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 96921____ Tracking Number: __ Global Period: 000_ RUC Recommended RVW: ~~2.00~~ 1.17

CPT Code Descriptor: Laser treatment for inflammatory skin disease, (psoriasis); total area 250 sq cm to 500 sq cm

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CLINICAL DESCRIPTION OF SERVICE:

Typical Patient/Service: The patient is a 35-year-old Caucasian male with a 10-year history of stable moderate plaque psoriasis, which worsens during the winter months. There is a family history of psoriasis. Physical findings include inflamed, scaly, somewhat tender lesions present on the extensor surfaces of elbows and knees, hips, sacrum, and scalp involving 10% of the body surface area, or about 1500 square centimeters. Current therapies include daily use of both moderate-potency topical corticosteroid ointment and calcipotriene ointment. A corticosteroid lotion is used daily on the scalp; topical tar preparations are added when necessary.

These therapies have produced a partial improvement response of approximately 80% plaque clearance, leaving 250 to 500 square centimeters of chronic plaques resistant to topical therapy. The patient continues to suffer from significant erythema, induration, pruritus, and desquamation of thick scales from these non-responsive areas. The severity of the disease is documented and the decision is made to utilize laser treatment for recurrent psoriatic plaques. Activities of daily living and quality of life are negatively impacted by the presence of symptomatic lesions.

Description of Pre-Service Work: The physician reviews treatment options including systemic therapy, phototherapy, additional topical therapy and laser treatment. He reviews chart, and confirms the area of treatment with the patient and obtains informed consent for the laser treatment. He verifies positioning of patient and checks laser equipment.

Description of Intra Service Work: The patient is positioned, the affected area draped and the lesion site(s) prepped with a clarifying agent such as mineral oil or other moisturizing agent. Physician assesses the redness of the Lesions and any erythema. Pain or blistering from previous therapy or treatment methodology is also assessed. The physician determines the laser dosage level from an assessment of the minimum erythema dosage of laser light on normal skin. The physician treats each lesion or plaque with the laser. The physician monitors for pain as well as skin surface reaction throughout the process.

Description of Post Service Work:
Physician discusses follow-up assessment. Physician discusses pain management, dressings if required and care of the treated area.

SURVEY DATA:

Presenter(s)_____

Specialty(s): American Academy of Dermatology_____

Sample Size: 75 Response Rate: (%): 36 (27 responses) Median RVW: 3.0

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

Explanation of sample size: Sent to all dermatologists on record currently performing this procedure

25th Percentile RVW: 2.0 75th Percentile RVW: 3.25 Low: .98 High: 12.0

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

25th Percentile Intra-Svc Time: 16.25 75th Percentile Intra-Svc Time: 21.75 Low: 10 High: 120

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

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
11403	Excision, benign lesion, trunk arms or legs lesion diameter 2.1 to 3.0	010	1.92

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: 96921	Key Ref CPT Code: 11403
Median Pre-Time	5 min	7
Median Intra-Time	20 min	31
Median Immediate Post-service Time	5 min	7
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	14

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	2.6	2.6
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3	2.3
Urgency of medical decision making	2.3	2.1

Technical Skill/Physical Effort (Mean)

Technical skill required	3.4	3.0
Physical effort required	2.8	2.4

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.0	2.7
Outcome depends on the skill and judgement of physician	3.6	3.0
Estimated risk of malpractice suit with poor outcome	2.9	2.6

INTENSITY/COMPLEXITY MEASURES	CPT Code 96921	Reference Service 1 11403
Time Segments (Mean)		
Pre-Service intensity/complexity	2	2
Intra-Service intensity/complexity	3	3
Post-Service intensity/complexity	2	2

ADDITIONAL RATIONALE

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

Survey results consistently support physician and clinical staff time required for the typical patient.
However, in light of the range and lack of consistency in suggested RVW level by survey respondents, the American Academy of Dermatology's Coding and Reimbursement Task Force members recommend use of the 25th percentile as the appropriate RVW. The use of the 25th percentile is also supported by the RVW for survey respondent's pre-dominant choice of reference code. In order to establish appropriate placement and valuation, the Task Force also reviewed these new codes which are defined by size of treatment area in the context of the other laser codes which are site specific and lesion specific, such as destruction of anal lesion(s) (CPT46917 and destruction of penile lesion(s) (CPT 54057). The primary areas of treatment of the new code are elbows, knees feet, hands, scalp, forearms and back.

FREQUENCY INFORMATION

How was this service previously reported? __N/A_____ (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___Dermatology_____ ____ 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 __Dermatology_____ Frequency_____5000_____

Specialty _____ Frequency_____

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

Specialty __Dermatology _____ Frequency__2500_____

Specialty _____ Frequency_____

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 96922____ Tracking Number: Global Period: 000_ RUC Recommended RVW: ~~2.79~~ 2.10

CPT Code Descriptor: Laser treatment for inflammatory skin disease, (psoriasis); over 500 sq cm

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CLINICAL DESCRIPTION OF SERVICE:

Typical Patient/Service: The patient is a 35-year-old Caucasian male with a 10-year history of stable moderate plaque psoriasis, which worsens during the winter months. There is a family history of psoriasis. Physical findings include inflamed, scaly, somewhat tender lesions present on the extensor surfaces of elbows and knees, hips, sacrum, and scalp involving 10% of the body surface area, or about 1500 square centimeters. Current therapies include daily use of both moderate-potency topical corticosteroid ointment and calcipotriene ointment. A corticosteroid lotion is used daily on the scalp; topical tar preparations are added when necessary.

These therapies have produced a partial improvement response of approximately 80% plaque clearance, leaving over 500 square centimeters of chronic plaques resistant to topical therapy. The patient continues to suffer from significant erythema, induration, pruritus, and desquamation of thick scales from these non-responsive areas. The severity of the disease is documented and the decision is made to utilize laser treatment for recurrent psoriatic plaques. Activities of daily living and quality of life are negatively impacted by the presence of symptomatic lesions.

Description of Pre-Service Work: The physician reviews treatment options including systemic therapy, phototherapy, additional topical therapy and laser treatment. He reviews chart, and confirms the area of treatment with the patient and obtains informed consent for the laser treatment. He verifies positioning of patient and checks laser equipment.

Description of Intra Service Work: The patient is positioned, the affected area draped and the lesion site(s) prepped with a clarifying agent such as mineral oil or other moisturizing agent. Physician assesses the redness of the Lesions and any erythema. Pain or blistering from previous therapy or treatment methodology is also assessed. The physician determines the laser dosage level from an assessment of the minimum erythema dosage of laser light on normal skin. The physician treats each lesion or plaque with the laser. The physician monitors for pain as well as skin surface reaction throughout the process.

Description of Post Service Work:
Physician discusses follow-up assessment. Physician discusses pain management, dressings if required and care of the treated area

SURVEY DATA:

Presenter(s)_____

Specialty(s): American Academy of Dermatology_____

Sample Size: 75 Response Rate: (%): 36 (27 responses) Median RVW: 3.0

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

Explanation of sample size: Sent to all dermatologists on record currently performing this procedure

25th Percentile RVW: 2.79 75th Percentile RVW: 3.4 Low: .98 High: 16.0

Median Pre-Service Time: 5 Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 24 75th Percentile Intra-Svc Time: 30 Low 20 High: 150

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

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	Global	Work RVU
11403	**Excision, benign lesion, trunk arms or legs lesion diameter 2.1 to 3.0**	**010**	**1.92**

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: 96922	Key Ref CPT Code: 11403
Median Pre-Time	5 min	7
Median Intra-Time	30 min	31
Median Immediate Post-service Time	5 min	7
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	14

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	2.6	2.6
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3	2.3
Urgency of medical decision making	2.3	2.1

Technical Skill/Physical Effort (Mean)

Technical skill required	3.4 3.0	3.4 3.0
Physical effort required	2.8	2.8

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.0	2.7
Outcome depends on the skill and judgement of physician	3.6	3.0
Estimated risk of malpractice suit with poor outcome	2.9	2.6

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2	2
Intra-Service intensity/complexity	3	3
Post-Service intensity/complexity	2	2

ADDITIONAL RATIONALE

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

Survey results consistently support physician and clinical staff time required for the typical patient.
However, in light of the range and lack of consistency in suggested RVW level by survey respondents, the American Academy of Dermatology's Coding and Reimbursement Task Force members recommend use of the 25th percentile as the appropriate RVW. The use of the 25th percentile is also supported by the RVW for survey respondent's pre-dominant choice of reference code. In order to establish appropriate placement and valuation, the Task Force also reviewed these new codes which are defined by size of treatment area in the context of the other laser codes which are site specific and lesion specific, such as destruction of anal lesion(s) (CPT46917 and destruction of penile lesion(s) (CPT 54057). The primary areas of treatment of the new code are elbows, knees feet, hands, scalp, forearms and back.

FREQUENCY INFORMATION

How was this service previously reported? __N/A_____ (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__Dermatology_____ ____ 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 __Dermatology_____ Frequency_____500

Specialty _____ Frequency_____

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

Specialty __Dermatology _____ Frequency__250_____

Specialty _____ Frequency_____

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

AAD SUBMISSION 04/03/02		FAMILY 1							
AMA RUC Facilitation Com. Changes		96920		96921		96922			
	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Laser treatment for inflammatory skin disease (psoriasis);total area less than 250 sq cm		Laser treatment for inflammatory skin disease (psoriasis); 250 to 500 sq cm		Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm			
LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office		
GLOBAL PERIOD		0	0	0	0	0	0		
TOTAL CLINICAL LABOR TIME		50		53		63			
PRE-SERVICE									
Start: Following visit when decision for surgery or procedure made									
Complete pre-service diagnostic & referral forms									
Coordinate pre-surgery services									
Schedule space and equipment in facility									
Office visit before surgery/procedure: Review test and exam results									
Provide pre-service education/obtain consent									
Follow-up phone calls & prescriptions									
Other Clinical Activity (please specify)									
End:When patient enters office/facility for surgery/procedure									
SERVICE PERIOD									
Start: When patient enters office/facility for surgery/procedure									
Pre-service services									
Review charts		5		5		5			
Greet patient and provide gowning		3		3		3			
Obtain vital signs		3		3		3			
Provide pre-service education/obtain consent		5		5		5			
Prepare room, equipment,supplies		5		5		5			
Prepare and position patient/ monitor patient/ set up IV		5		5		5			
Sedate/apply anesthesia									
Intra-service									
Assist physician in performing procedure		17		20		30			
Post-Service									
Monitor pt. following service/check tubes, monitors, drains		0		0		0			
Clean room/equipment by physician staff		2		2		2			
Complete diagnostic forms, lab & X-ray requisitions		0		0		0			
Review/read X-ray, lab, and pathology reports		0		0		0			
Check dressings & wound/ home care instructions /coordinate office visits /prescriptions		5		5		5			
Coordination of Care									
Discharge day management 99238 -- 6 minutes 99239 --9 minutes									
Other Clinical Activity (please specify)									
End: Patient leaves office									
POST-SERVICE Period									
Start: Patient leaves office/facility									
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 or outpatient care									
List Number and Level of Office Visits									
99211 16 minutes	16								
99212 27 minutes	27								
99213 36 minutes	36								
99214 53 minutes	53								
99215 63 minutes	63								
Other									
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									

AMA RUC Facilitation Com. Changes		96920		96921		96922			
	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Laser treatment for inflammatory skin disease (psoriasis);total area less than 250 sq cm		Laser treatment for inflammatory skin disease (psoriasis); 250 to 500 sq cm		Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm			
LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office		
MEDICAL SUPPLIES								PRICE	COST
M/S Minimum Supply Package *		1		1		1			
TOWELS	11106	1		1		1			
SHEET 40X72		1		1		1		0.23	
SANI WIPE	11113	3		3		3		0.24	
PAPER TOWEL	11118	6		6		6		0.06	
gown, staff impervious, disposable	11304	2		2		2		1.38	
GLOVES LATEX	11302	2		2		2		0.04	
PROTECTIVE EYEWEAR	11309	2		2		2		5.5	
SKIN MARKING PEN	11524	1		1		1		1.65	
ALCOHOL SWABS	31101	6		6		6			
COTTON BALLS	31102	6		6		6		0.006	
VASELINE	31107	1		1		1		1.19	
SUNSCREEN, 4 OZ	31108	1		1		1		3.79	
MINERAL OIL, 3.5 OZ	31109	1		1		1		0.95	
TAPE MICROPORE	31514	1		1		1		0.015	
GAUZE 4X4, 10 PAK	31508	1		1		1		0.12	
Steri-strips (6 per pak)	31513	1		1		1		1.79	
PROFESSIONAL TOWEL	31111	1		1		1		0.18	
LIDOCAINE JELLY, 30 ML	51301	0		0		0		0	0
BACITRACIN, oz	52101	1		1		1		2	
ALCOHOL	53003	1		1		1			
BLAND EMOLLIENT Eucerin cream	53023	1		1		1		0.84	
ice bag	11130	1		1		1		1.5	
UV BLOCKING GOGGLES	111247	1		1		1			$4/PR
CHUX - FLOOR OR CHAIR COVER	11102	2		2		2		0.05	
Laser tip, Disposable		1		1		1			
Oil Immersion	75135	1		1		1		0.15	
Equipment								PRICE	COST
Power Table	E11003							6995	
EXAM LAMP	E30006							1850	
Pulse Dye Laser	E30011	DELETED	NOT	TYPICAL	EQUIP				
Excimer Laser								155000	
Digital Camera Pkg	PEAC 8/01							3000	
Optical Fibers (4)								3,236	
Gas Cylinders (4)								8,000	
Filter Modules								480	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2002

Mandated Physician On-Call

CPT created two new codes to allow the reporting of hospital mandated on call service. The RUC reviewed these codes in detail over the course of two meetings. No specialty societies were interested in developing a recommendation for these codes. The RUC concluded that mandated on-call services are typically arrangements between hospitals and physicians and cover a wide range of scenarios. Therefore, the current methodology for developing relative value recommendations does not allow for valuing such services. However, the RUC is cognizant that obtaining reimbursement for mandated on-call services is an issue for some specialties.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•99026	C1	Hospital mandated on call service; in-hospital, each hour	XXX	No Recommendation
•99027	C2	out-of-hospital, each hour	XXX	No Recommendation
(For physician standby services requiring prolonged physician attendance, use 99360, as appropriate. Time spent performing separately reportable procedure(s) or service(s) should not be included in the time reported as mandated on call service) *99360 Physician standby service, requiring prolonged physician attendance, each 30 minutes (eg, operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG)*				

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February and April 2002

Pediatric Intensive Care/Neonatal Intensive Care Codes

The CPT Editorial Panel created new codes to describe pediatric critical care services. In addition, the Panel revised the existing neonatal critical care services to better define these services. The RUC reviewed survey data from more than 50 neonatologists.

The RUC reviewed the survey time data for the initial pediatric intensive care (PICU) services and determined that the total time of 240 minutes was comparable to the total time for four hours of critical care services, 99291 (work RVU = 4.00). The RUC, therefore, determined that the 25th percentile of the survey was appropriate for 99293 *Initial pediatric critical care, 31 days up through 24 months of age, per day, for the evaluation and management of a critically ill infant or young child.* **The RUC recommends a work relative value of 16.00 for 99293.**

The RUC reviewed the survey time data for the subsequent PICU services and determined that the total time of 140 minutes was comparable to two hours of critical care services, 99291 (work RVU = 4.00). Therefore, the RUC agreed that the 25th percentile of the survey was appropriate for 99294 *Subsequent pediatric critical care, 31 days up through 24 months of age, per day, for the evaluation and management of a critically ill infant or young child.* **The RUC recommends a work relative value of 8.00 for 99294.**

The RUC discussed the coding revisions made to CPT codes 99295, 99296, and 99297 and determined that additional data needed to be collected prior to the April RUC meeting, in order to appropriately value these services. These codes were referred to a facilitation committee. The facilitation committee requested that:

- The specialty society re-survey 99295 and 99296 prior to the April RUC meeting. It became clear that the survey respondents may have been confused regarding the inclusion of procedural time (ie, the respondents may have only included face-to-face critical care time in their estimates).

- The specialty society should ask the survey respondents to list the procedures typically performed, along with identification of critical care and other time spent per date of service.

The specialty society collected additional data, as requested by the RUC, and presented this data at the April 2002 RUC meeting. The survey results indicated that CPT code 99295 *Initial neonatal critical care, per day, for the evaluation and management of a critically ill neonate 30 days of age or less* typically includes 265 minutes of critical care evaluation and management physician time. The RUC agreed that this was equivalent to 1 unit of 99291 *Critical care, initial hour* (work RVU = 4.00) and 6 units of 99292 *Critical Care, each subsequent half hour* (work RVU = 2.00), for a total of 16.00 critical care work. In addition, the RUC reviewed the survey time that specifically identified the separate procedures that are included in this service and typically performed. The RUC agreed that each service and concluded that it was appropriate to add the physician time and work for procedure codes 36510 *Catheterization of umbilical vein for diagnosis or therapy; newborn* (work RVU = 1.09) and 36660 *Catheterization, umbilical artery, newborn, for diagnosis or therapy* (work RVU = 1.40). The RUC added the critical care time and work to the procedure time and work to arrive at 18.49 work RVUs (16.00 + 1.09 + 1.40 = 18.49) and 325 total minutes (265 + 30 + 30 = 325). **The RUC recommends a work value of 18.49 for CPT code 99295.**

The additional specialty society data, reviewed in April, indicated that the physician critical care time related to CPT code 99296 *Subsequent neonatal critical care, per day, for the evaluation and management of a critically ill neonate 30 days of age or less* was 130 minutes. This would equate to one unit of 99291 and two units of 99292, for a total of 8.00 work related to critical care services. The specialty also indicated that it would recommend the relative value of 8.00, which does not represent a change from the current value for this service, to retain relativity between this service and new code 99294, which describes services performed after 30 days of age. **The RUC recommends a work value of 8.00 for CPT code 99296.**

The RUC reviewed CPT codes 99298 *Subsequent ~~neonatal~~ intensive care, per day, for the evaluation and management of the recovering very low birthweight infant (present body weight less than 1500 grams)* and 99299 *Subsequent intensive care, per day, for the evaluation and management of the recovering low birthweight infant (present body weight of 1500-2500 grams).* The RUC determined that the changes made to 99298 were editorial in nature and would not reflect a change in work. The RUC reviewed survey data from 55 neonatologists and agreed that the 25th percentile of 2.50 was appropriate. **The RUC recommends a work value of 2.75 for 99298 and 2.50 for 99299.**

Practice Expense Inputs:

These services are all performed in a facility. The RUC recommends no direct practice expense inputs related to these services.

Critical Care

Critical care services provided to infants 31 days up through 24 months of age ~~older than one month of age at the time of admission to an intensive care unit~~ are reported with pediatric critical care codes 99293 and 99294.~~critical care codes 99291 and 99292.~~ The pediatric critical care codes are reported as long as the infant/young child qualifies for critical care services during the hospital stay. Critical care services provided to neonates (30 days of age or less ~~at the time of admission to an intensive care unit~~) are reported with the neonatal critical care codes 99295 and 99296, ~~99297, and 99298~~. The neonatal critical care codes are reported as long as the neonate qualifies for critical care services ~~during the hospital stay~~ through the 30th postnatal day. The reporting of the pediatric and neonatal critical care services is not based on time~~,~~ or the type of unit (eg, pediatric or neonatal critical care unit) ~~or~~ and it is not dependent upon the type of provider delivering the care. For additional instructions on reporting these services, see the Neonatal ~~Intensive Care~~ & Pediatric Critical Care section and codes ~~99295-99298~~ 99293-99296.

Neonatal ~~Intensive Care~~ and Pediatric Critical Care Services

The following codes (99293-99296) are used to report services provided by a physician directing the care of a critically ill ~~newborn~~ neonate/infant ~~(or managing the continuing intensive care of the very low birth weight (VLBW) infant). Once the neonate is no longer considered to be critically ill and attains a body weight which exceeds 1500 grams, the codes for Subsequent Hospital Care (99231-99233) should be utilized.~~ The same definitions for critical care services apply for the adult, child, and neonate.

These initial day neonatal critical care code~~s~~ (99295) ~~are to~~ can be used in addition to codes 99360, 99436 or 99440 as appropriate, when the physician is present for the delivery and newborn resuscitation is required. Other procedures performed as a necessary part of the resuscitation (eg, endotracheal intubation) are also reported separately.

~~The same definitions for critical care services apply for the adult, child and neonate. The neonatal critical care codes, however are global 24-hour codes and not reported as hourly services. Services for a patient who is not critically ill but happens to be in a critical care unit are reported using other appropriate E/M codes.~~

~~The neonatal critical care c~~Codes ~~(~~99295, 99296~~, 99297, 99298)~~ are ~~applied to neonates (30 days of age or less) admitted to an intensive care unit. These codes will be applicable as long as the child qualifies for critical care services during this hospital stay. Infants admitted to an intensive care unit older than one month of age would be coded with hourly critical care code (99291,99292) if they qualify for critical care services. These neonatal codes are not applied based upon the type of unit (eg, pediatric or neonatal critical care unit) in which the child receives care nor the type of provider delivering the care.~~ used to report services provided by a physician directing the care of a critically ill neonate through the first 30 days of life. They represent care starting with the date of

admission (99295) and subsequent day(s) (99296) and may be reported only once per day, per patient. Once the neonate is no longer considered to be critically ill the Intensive Low Birth Weight Services codes for those with present body weight of less than 2500 grams (99298, 99299) or the codes for Subsequent Hospital Care (99231-99233) for those with present body weight over 2500 grams should be utilized.

Codes 99293-99294 are used to report services provided by a physician directing the care of a critically ill infant or young child from 31 days of postnatal age up through 24 months of age. They represent care starting with the date of admission (99293) and subsequent day(s) (99294) and may be reported by a single physician only once per day, per patient in a given setting. The critically ill or critically injured child older than two years when admitted to an intensive care unit would be reported with hourly critical care service codes (99291, 99292). Once an infant is no longer considered to be critically ill but continues to require intensive care, the Intensive Low Birth Weight Services codes (99298, 99299) should be used to report services for infants with present body weight of less than 2500 grams. When the present body weight of those infants exceeds 2500 grams, the Subsequent Hospital Care (99231-99233) codes should be utilized.

Care rendered under 99293-99296 includes management, monitoring and treatment of the patient including respiratory, pharmacologic control of the circulatory system, enteral and parenteral nutritional ~~maintenance~~, metabolic and hematologic maintenance, ~~pharmacologic control of the circulatory system,~~ parent/family counseling, case management services, and personal direct supervision of the health care team in the performance of cognitive and procedural activities.

~~In addition to those services~~ The pediatric and neonatal critical care codes include those procedures listed above for the ~~adult and pediatric~~ hourly critical care codes (99291, 99292)~~,~~. In addition, the following procedures are also included in the bundled (global) pediatric and neonatal critical care service codes (99293-99296): umbilical venous (36510) and umbilical arterial (36620) catheters, central (36488, 36490) or peripheral vessel catheterization (36000), other arterial catheters (36140, 36620), oral or nasogastric tube placement (43752), endotracheal intubation (31500), lumbar puncture (62270), suprapubic bladder aspiration (51000), bladder catheterization (53670), initiation and management of mechanical ventilation (94656, 94657) or continuous positive airway pressure (CPAP) (94660), surfactant administration, intravascular fluid administration (90780, 90781), transfusion of blood components (36430, 36440), vascular punctures (36420, 36600), invasive or non-invasive electronic monitoring of vital signs, bedside pulmonary function testing (94375), and/or monitoring or interpretation of blood gases or oxygen saturation (94760-94762). Any services performed which are not listed above should be reported separately.

For additional instructions, see descriptions listed for 99293-~~9929~~99296.

CPT Code (•New)	Track-ing Number	CPT Descriptor	Global Period	Work RVU Recommen-dation
● 99293	AK1	Initial pediatric critical care, 31 days up through 24 months of age, per day, for the evaluation and management of a critically ill infant or young child	XXX	16.00 (approved at the Feb 2002 RUC meeting)
● 99294	AK2	Subsequent pediatric critical care, 31 days up through 24 months of age, per day, for the evaluation and management of a critically ill infant or young child	XXX	8.00 (approved at the Feb 2002 RUC meeting)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲99295	AK3	Initial neonatal ~~intensive~~ critical care, per day, for the evaluation and management of a critically ill neonate ~~and infant~~ 30 days of age or less This code is reserved for the date of admission for neonates who are critically ill. Critically ill neonates require cardiac and/or respiratory support (including ventilator or nasal CPAP when indicated), continuous or frequent vital sign monitoring, laboratory and blood gas interpretations, follow-up physician re-evaluations, and constant observation by the health care team under direct physician supervision. Immediate preoperative evaluation and stabilization of neonates with life threatening surgical or cardiac conditions are included under this code. Neonates with life threatening surgical or cardiac conditions are included under this code. Care for neonates who require an intensive care setting but who are not critically ill is reported using the initial hospital care codes (99221-99223).	XXX	18.49 (Approved at the April 2002 RUC meeting)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
99296	AK4	Subsequent neonatal ~~intensive~~ critical care, per day, for the evaluation and management of a critically ill ~~and unstable~~ neonate ~~or infant~~ 30 days of age or less A critically ill ~~and unstable~~ neonate will require cardiac and/or respiratory support (including ventilator or nasal CPAP when indicated), continuous or frequent vital sign monitoring, laboratory and blood gas interpretations, follow-up physician re-evaluations throughout a 24-hour period, and constant observation by the health care team under direct physician supervision. ~~In addition, most will require frequent ventilator changes, intravenous fluid alterations, and/or early initiation of parenteral nutrition. Neonates in the immediate post-operative period or those who become critically ill and unstable during the hospital stay will commonly qualify for this level of care. This code encompasses intensive care provided on dates subsequent to the admission date.~~	XXX	8.00 (no change from current work RVU) (Approved at the April RUC meeting)
~~▲99297~~		~~Subsequent neonatal intensive care, per day, for the evaluation and management of a critically ill though stable neonate or infant~~ ~~Critically ill though stable neonates require cardiac and/or respiratory support (including ventilator and nasal CPAP when indicated), continuous or frequent vital sign monitoring, laboratory and blood gas interpretations, follow-up physician re-evaluations throughout a 24-hour period, and constant observation by the health care team under direct physician supervision. Neonates at this level of care commonly would be expected to require less frequent ventilator changes in respiratory, cardiovascular and fluid and electrolyte therapy, intravenous fluid alterations and/or early initiation of parenteral nutrition as those included under code 99296.~~ ~~This code encompasses intensive care provided on dates subsequent to the admission date.~~ (99297 has been deleted. To report, use 99296)	XXX	N/A

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Intensive (Non-Critical) Low Birth Weight Services Codes 99298-99299 are used to report services subsequent to the day of admission provided by a physician directing the continuing intensive care of the low birth weight (LBW) or very low birth weight (VLBW) infant who no longer meets the definition of critically ill. They represent subsequent day(s) of care and may be reported only once per day, per patient. Low birth weight services are reported for those neonates less than 2500 grams who do not meet the definition of critical care but continue to require intensive observation and frequent services and interventions only available in an intensive care setting. The level and frequency of services required for the LBW and the VLBW infant exceed those available in less intensive hospital areas or medical floors. Codes 99298-99299 are global 24-hour codes with the same services bundled as outlined under codes 99293-99296. For additional instructions, see descriptions listed for 99298-99299.				
▲99298	AK5	Subsequent ~~neonatal~~ intensive care, per day, for the evaluation and management of the recovering very low birthweight infant (present body weight less than 1500 grams) Infants with present body weight less than 1500 grams ~~Very low birthweight neonates~~ who are no longer critically ill continue to require intensive cardiac and respiratory monitoring, continuous and/or frequent vital sign monitoring, heat maintenance, enteral and/or parenteral nutritional adjustments, laboratory and oxygen monitoring, and constant observation by the health care team under direct physician supervision. ~~Neonates of this level of care would be expected to require infrequent changes in respiratory, cardiovascular and/or fluid and electrolyte therapy as those included under 99296 or 99297.~~ ~~This code encompasses intensive care provided on days subsequent to the admission date.~~	XXX	2.75 (No change in current work value)

● 99299	AK6	Subsequent intensive care, per day, for the evaluation and management of the recovering low birthweight infant (present body weight of 1500-2500 grams) Infants with present body weight of 1500-2500 grams who are no longer critically ill continue to require intensive cardiac and respiratory monitoring, continuous and/or frequent vital sign monitoring, heat maintenance, enteral and/or parenteral nutritional adjustments, laboratory and oxygen monitoring, and constant observation by the health care team under direct physician supervision.	XXX	2.50 (approved at the Feb 2002 RUC meeting)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

RUC Rec RVW: 16.00

CPT Code: **99293** Tracking Number: **AK1** Global Period: **XXX** Recommended RVW: ~~18.00~~

CPT Descriptor: **Initial pediatric critical care, 31 days up to 2 years of age, per day, for the evaluation and management of a critically ill infant or young child**

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A six-month-old female, former 28-week gestational age premature infant, now with chronic lung disease (bronchopulmonary dysplasia) following her neonatal course is admitted to the PICU from home with respiratory distress and impending respiratory failure. She had been stable on a low flow of nasal oxygen until 2 days prior to admission when she developed a fever, cough, and increased oxygen requirement. She gradually developed tachypnea, wheezing and retractions despite increased bronchodilator therapy at home (in addition to her daily diuretics, supplemental oxygen and maintenance bronchodilator therapy for her CLD).
In the ER she was found to have an oxygen saturation of 83% on 1L of nasal cannula O_2. An ABG revealed acute and chronic hypercarbia and hypoxia. A CXR revealed bilateral diffuse pneumonia, as well as hyperinflation. She was transferred to the PICU for evaluation and management by the pediatric intensivist. Despite aggressive therapy to treat her pulmonary disease, she progressed to respiratory failure requiring intubation and mechanical ventilation. Central venous and arterial access was obtained by the pediatric intensivist after numerous attempts at peripheral arterial and venous catheterization were unsuccessful due to scarring from line placement during her NICU stay. Arterial blood pressure and central venous pressure monitoring revealed hypotension and intravascular volume depletion. Blood, urine, and respiratory cultures were obtained and broad-spectrum antibiotic coverage was instituted for presumed sepsis. The patient's hypotension responded to treatment with fluid boluses and low doses of pressors. Her respiratory failure worsened and she developed acute respiratory distress syndrome (ARDS), circulatory failure and fluid and electrolyte disturbances that required high frequency oscillatory ventilation and increased inotropic support for 7 days. She was eventually converted back to conventional ventilation and weaned to extubation. The pediatric intensivist spent many hours throughout the child's admission coordinating the activities of other subspecialists, nursing staff, respiratory therapists, nutritionists and social workers involved, as well as, providing daily communications to the family and the patient's primary care physician.

Description of Pre-Service Work: Preparing to see the patient includes obtaining and reviewing the results of any lab work and/or radiologic studies, reviewing the care flow sheet and discussing the patient's status with the bedside nurse, and communicating with other health professionals, as appropriate.

Description of Intra-Service Work: A complete examination of the head, eyes, nose, mouth, chest, lungs, heart, abdomen, genitals, rectum, joints, spine, extremities, and a neurologic appraisal of movement, reflexes, cranial nerves, and degree of arousal and activity. All attached monitors and tubes are checked for secure placement and proper function.

Description of Post-Service Work: Post-service work includes all coordination of care, documentation, and telephone calls with the patient, family members, or other health professionals including writing the daily TPN orders after recovery and/or writing new feeding orders, ordering daily laboratory and imaging studies, as necessary, documenting care changes in the patient's chart and verbally with the nursing staff, speaking with the family in person or by telephone, and updating the referring physician.

SURVEY DATA:

Presenter(s): Steve Krug, MD, FAAP, Rich Molteni, MD, FAAP, and David Jaimovich, MD, FAAP

Specialty(s): American Academy of Pediatrics

AAP 99293 Jan-Feb 2002 RUC
Sample Size: **51** Response Rate: (%): **69% (n=35)** Median RVW: **18.00**

Type of Sample (Circle One): random (panel) convenience

Explanation of sample size: We sent surveys out to those physician members most experienced with the service of pediatric critical care. The results of those surveys were compiled and discussed by an expert panel until consensus was reached.

25th Percentile RVW: **16.00** 75th Percentile RVW: **20.92** Low: **10.00** High: **27.00**

Median Pre-Service Time: **30 minutes** Median Intra-Service Time: **180 minutes**

25th Percentile Intra-Service Time: **180 minutes** 75th Percentile Intra-Service Time: **240 minutes**

Low: **90 minutes** High: **420 minutes**

Median Post-Service Time:	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	**30 minutes**	
Critical Care:	N/A	
Other Hospital Visits:	N/A	
Discharge Day Mgmt.:	N/A	
Office Visits:	N/A	

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	4.00

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: 99293X1	Key Reference CPT Code: 99291
Median Pre-Time	30	15
Median Intra-Time	180	45
Median Immediate Post-service Time	30	15
Median of Aggregate Critical Care Times	N/A	N/A
Median of Aggregate Other Hospital Visit Times	N/A	N/A
Median Discharge Day Management Time	N/A	N/A
Median of Aggregate Office Visit Times	N/A	N/A

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.51	3.80
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.49	3.77
Urgency of medical decision making	4.83	4.60

Technical Skill/Physical Effort (Mean)

Technical skill required	4.77	4.00
Physical effort required	4.57	3.83

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.71	4.14
Outcome depends on the skill and judgement of physician	4.86	4.17
Estimated risk of malpractice suit with poor outcome	4.34	3.74

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.71	3.09
Intra-Service intensity/complexity	4.86	4.09
Post-Service intensity/complexity	3.74	3.23

ADDITIONAL RATIONALE

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

Our expert panel reviewed the survey data and concluded that the survey median accurately reflected the physician work of providing initial pediatric critical care.

FREQUENCY INFORMATION

How was this service previously reported? **99291-99292**
(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** __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: **Pediatrics** Frequency: **Critically ill infants and young children (31 days to 2 years of age) comprise a third of the patients admitted to pediatric intensive care units. Infants and critically ill children make up a large proportion of inpatients in most major tertiary hospitals (37%). For example, at Hope Children's Hospital in Chicago, the average number of annual admits to the PICU is 1,700.**

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 150**

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: **99294** Tracking Number: **AK2** Global Period: **XXX** **RUC Rec. RVW: 8.00** ~~**Recommended RVW: 9.00**~~

CPT Descriptor: **Subsequent pediatric critical care, 31 days up to 2 years of age, per day, for the evaluation and management of a critically ill infant or young child**

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 1½-year-old male, who was in his usual state of health, now presented with acute respiratory distress to the emergency department. The patient's ongoing medications included home nebulized bronchodilator therapy and low dose steroids for significant reactive airway disease. After evaluation and failure to clear with bronchodilator therapy in the ED he was admitted to the Pediatric ICU with increasing respiratory distress and impending respiratory failure. Over the next few hours he demonstrated increasing oxygen requirements, tachypnea, cough, and a mild rash. He was placed on bronchodilator therapy, constant cardiopulmonary, blood pressure, and oxygen saturation monitoring, IV infusions, antibiotics, chest radiographs, blood gases, and intravenous steroids. He was placed on a 100% nonrebreather mask and multiple laboratory examinations for bacterial and viral studies were performed. His response to therapy was variable over the first 12 hours and he then gradually deteriorated. The patient's deteriorating clinical state was discussed extensively with the family including the need to intubate the patient for ventilatory support. He required endotracheal intubation and mechanical ventilation for respiratory failure. His chest x-ray at that time showed a diffuse, interstitial pattern consistent with progressive diffuse alveolar disease. The patient was placed on IV continuous sedation of Fentanyl and Midazolam to assist with ventilator/patient asynchrony. The patient's family and primary care physician were contacted daily for daily updates and therapeutic planning. The patient continued to show a deteriorating state of oxygenation and ventilation over the first 48 hours, and increasing lung congestion consistent with noncardiogenic pulmonary edema. Initially this was treated with diuretic therapy and increasing the mechanical ventilatory support with positive expiratory pressure. The patient had associated glucose and electrolyte abnormalities, which were treated with additional diuretic therapy and changes in intravenous solutions. Nutritional support was provided in the form of hyperalimentation. Over the next 72 hours he continued to require increased FIO_2 to 80% and increasing ventilatory support resulting in high airway pressures, necessitating placement on high frequency oscillatory ventilation. Due to the child's unstable condition he required 1:1 nursing care. An arterial line and central venous pressure monitoring line were placed to closely monitor the patient's hemodynamics and his intravascular fluid status. During the course of high frequency oscillation, progressive anemia from blood obtained for laboratory tests and from hemodilution was treated with packed red blood cell transfusions. Over the course of the first week of high frequency oscillation the patient developed improvement of his chest radiograph and decrease in oxygen requirements to less than 50%. By the end of the second week his respiratory status had improved and he was transferred to conventional mechanical ventilation with moderate settings on pressure regulated volume control. The family was given daily updates and discussion about his progress. His primary physician received daily calls with clinical changes discussed. At this time the patient was taken off paralysis and sedation was weaned down to minimum ventilator and oxygen levels. By the end of the third week the patient had been successfully weaned down to CPAP and subsequently extubated to a nasal cannula. His clinical condition was no longer considered critical, but he continued to require close observation and evaluation.

Description of Pre-Service Work: Preparing to see the patient includes obtaining and reviewing the results of any lab work and/or radiologic studies, reviewing the care flow sheet and discussing the patient's status with the bedside nurse, and communicating with other health professionals, as appropriate.

Description of Intra-Service Work: A complete examination of the head, eyes, nose, mouth, chest, lungs, heart, abdomen, genitals, rectum, joints, spine, extremities, and a neurologic appraisal of movement, reflexes, cranial nerves, and degree of arousal and activity. All attached monitors and tubes are checked for secure placement and proper function.

Description of Post-Service Work: Post-service work includes all coordination of care, documentation, and telephone calls with the patient, family members, or other health professionals including writing the daily TPN

orders after recovery and/or writing new feeding orders, ordering daily laboratory and imaging studies, as necessary, documenting care changes in the patient's chart and verbally with the nursing staff, speaking with the family in person or by telephone, and updating the referring physician.

SURVEY DATA:

Presenter(s): Steve Krug, MD, FAAP, Rich Molteni, MD, FAAP, and David Jaimovich, MD, FAAP

Specialty(s): American Academy of Pediatrics

Sample Size: **68** Response Rate: (%): **72% (n=49)** Median RVW: **9.00**

Type of Sample (Circle One): random (panel) convenience

Explanation of sample size: We sent surveys out to those physician members most experienced with the service of pediatric critical care. This included pediatric intensivists as well as a group of neonatologists who frequently see their patients beyond 30 days of age. The results of those surveys were compiled and discussed by an expert panel until consensus was reached.

25th Percentile RVW: **8.00** 75th Percentile RVW: **10.83** Low: **5.00** High: **20.00**

Median Pre-Service Time: **20 minutes** Median Intra-Service Time: **90 minutes**

25th Percentile Intra-Service Time: **75 minutes** 75th Percentile Intra-Service Time: **120 minutes**

Low: **30 minutes** High: **200 minutes**

Median Post-Service Time:

	Total Time	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	**30 minutes**	
Critical Care:	N/A	
Other Hospital Visits:	N/A	
Discharge Day Mgmt.:	N/A	
Office Visits:	N/A	

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
99296	Subsequent neonatal intensive care, per day, for the evaluation and management of a critically ill and unstable neonate or infant	8.00

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: 99294X1	Key Reference CPT Code: 99296
Median Pre-Time	20	0
Median Intra-Time	90	180
Median Immediate Post-service Time	30	0
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	4.37	3.94
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.35	4.00
Urgency of medical decision making	4.41	4.31

Technical Skill/Physical Effort (Mean)

Technical skill required	4.37	4.14
Physical effort required	4.06	3.94

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.57	4.39
Outcome depends on the skill and judgement of physician	4.55	4.39
Estimated risk of malpractice suit with poor outcome	4.22	4.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.57	3.37
Intra-Service intensity/complexity	4.61	4.20

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Post-Service intensity/complexity	3.78	3.67

ADDITIONAL RATIONALE

Our expert panel reviewed the survey data and concluded that the survey median accurately reflected the physician work of providing subsequent pediatric critical care.

FREQUENCY INFORMATION

How was this service previously reported? **99291-99292**
(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** __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: **Pediatrics** Frequency: **Critically ill infants and young children (31 days to 2 years of age) comprise a third of the patients admitted to pediatric intensive care units. Infants and critically ill children make up a large proportion of inpatients in most major tertiary hospitals (37%). For example, at Hope Children's Hospital in Chicago, the average number of annual admits to the PICU is 1,700.**

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 250**

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

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
AAP SUPPLEMENTAL SURVEY
REVISED SUMMARY OF RECOMMENDATION

CPT Code: **99295** Tracking Number: **AK3** Global Period: **XXX** **Recommended RVW: 18.49**

CPT Descriptor: **Initial neonatal critical care, per day, for the evaluation and management of a critically ill neonate 30 days of age or less**

PRE-FACILITATION COMMITTEE RATIONALE

PART ONE: Evaluation and Management (Critical Care) Time

Question: Using the vignette provided, please indicate how much time you would typically spend providing evaluation and management services (ie, critical care). This should be the time you would spend providing critical care services EXCLUDING any time you would spend doing procedures.

Supplemental Survey Results:

Median Pre-Service Time: **60 minutes**

Median Intra-Service Time: **145 minutes** (205 minutes procedure time)

25th Percentile Intra-Service Time: **101.25 minutes**

75th Percentile Intra-Service Time: **180 minutes**

Low: **30 minutes** High: **300 minutes**

Median Post-Service Time: **60 minutes**

FEBRUARY 2002 SURVEY RESULTS:

TOTAL TIME = 273.75 minutes

Median Pre-Service Time: **45 minutes**

Median Intra-Service Time: **180 minutes**

25th Percentile Intra-Service Time: **120 minutes**

75th Percentile Intra-Service Time: **210 minutes**

Low: **60 minutes** High: **280 minutes**

Median Post-Service Time: **48.75 minutes**

PART TWO: Typical Procedures Performed and Their Typical Times

Question: Using the vignette provided, please indicate whether you would perform the following procedures and the number of times you would perform each in the first day of life. Please do NOT include those performed by a bedside nurse or those performed as part of the delivery room stabilization. You may include any procedures performed by a resident or nurse practitioner where you would typically be physically present for the critical portion of the procedure and supervising the procedure.

Supplemental Survey Results:

Procedure (CPT code/2002 RVWs)	Typical Frequency/Time	Number of Respondents Selecting Procedure (N=33)
Catheterization of umbilical vein for diagnosis or therapy; newborn (36510/1.09 RVW)	1 x 30 minutes each	n=32 (97%)
~~Introduction of needle or intracatheter, vein (36000/0.18 RVW)~~ **CONSIDERED INHERENT PART OF CRITICAL CARE**	~~1 x 15 minutes each~~	~~n=23 (70%)~~
Catheterization, umbilical artery, newborn, for diagnosis or therapy (36660/1.40 RVW)	1 x 30 minutes each	n=31 (94%)
~~Arterial puncture, withdrawal of blood for diagnosis~~	~~1 x 10 minutes each~~	~~n=25 (76%)~~

Procedure (CPT code/2002 RVWs)	Typical Frequency/Time	Number of Respondents Selecting Procedure (N=33)
~~(36600/0.32 RVW) CONSIDERED INHERENT PART OF CRITICAL CARE~~		
~~Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; first day (94656/1.22 RVW)~~ CONSIDERED INHERENT PART OF CRITICAL CARE	~~1 x 20 minutes each~~	~~n=33 (100%)~~
~~Continuous positive airway pressure (CPAP), initiation and management (94660/0.76 RVW)~~ CONSIDERED INHERENT PART OF CRITICAL CARE	~~1 x 15 minutes each~~	~~n=26 (79%)~~
~~Surfactant administration (no code)~~	~~2 x 15 minutes each = 30 minutes~~	~~n=33 (100%)~~
~~Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (94761/0.00 RVW)~~ CONSIDERED INHERENT PART OF CRITICAL CARE	~~1 x 10 minutes each~~	~~n=21 (64%)~~
~~Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring (94762/0.00 RVW)~~ CONSIDERED INHERENT PART OF CRITICAL CARE	~~1 x 10 minutes each~~	~~n=24 (73%)~~
~~Respiratory flow volume loop (94375/0.31 RVW)~~ CONSIDERED INHERENT PART OF VENTILATOR MANAGEMENT	~~5 x 5 minutes each = 25 minutes~~	~~n=20 (61%)~~
~~Intravenous infusion for therapy/diagnosis, administered by a physician or under direct supervision of physician; up to one hour (90780/0.00 RVW)~~ CONSIDERED INHERENT PART OF CRITICAL CARE	~~1 x 15 minutes each~~	~~n=28 (85%)~~
~~Intravenous infusion for therapy/diagnosis, administered by a physician or under direct supervision of physician; each additional hour, up to eight hours (90781/0.00 RVW)~~ CONSIDERED INHERENT PART OF CRITICAL CARE	~~2 x 15 minutes each = 30 minutes~~	~~n=23 (70%)~~
~~Write total parenteral nutrition orders (no code)~~	~~1 x 15 minutes each~~	~~n=26 (79%)~~
TOTAL: ~~7.61~~ 1.09 + 1.40 = 2.49 RVW	~~TOTAL: 270 minutes~~	

Rationale for RVW Recommendation:

Total evaluation and management service time:
60 minutes pre-service time
+ 145 minutes intra-service time
+ 60 minutes post-service time
265 minutes

First 75 minutes of the 265 minutes one unit of 99291 = 4 RVW
Next 30 minutes of the 265 minutes one unit of 99292 = 2 RVW
Next 30 minutes of the 265 minutes one unit of 99292 = 2 RVW

Next 30 minutes of the 265 minutes	**one unit of 99292**	**= 2 RVW**
Next 30 minutes of the 265 minutes	**one unit of 99292**	**= 2 RVW**
Next 30 minutes of the 265 minutes	**one unit of 99292**	**= 2 RVW**
Next 30 minutes of the 265 minutes	**one unit of 99292**	**= 2 RVW**
Final 10 minutes of the 265 minutes		**not counted**
Total:		**16.00 RVW**
		+
Plus total procedure RVW from above table		**2.49 RVW**
		18.49 RVW

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
AAP SUPPLEMENTAL SURVEY
REVISED SUMMARY OF RECOMMENDATION

CPT Code: **99296** Tracking Number: **AK4** Global Period: **XXX** **Recommended RVW: 8.00**

CPT Descriptor: **Subsequent neonatal critical care, per day, for the evaluation and management of a critically ill neonate 30 days of age or less**

PRE-FACILITATION COMMITTEE RATIONALE

PART ONE: Evaluation and Management (Critical Care) Time

Question: Using the vignette provided, please indicate how much time you would typically spend providing evaluation and management services (ie, critical care). This should be the time you would spend providing critical care services EXCLUDING any time you would spend doing procedures.

Supplemental Survey Results:

TOTAL TIME = 130 minutes

Median Pre-Service Time: **30 minutes**

Median Intra-Service Time: **70 minutes**

25th Percentile Intra-Service Time: **45 minutes**

75th Percentile Intra-Service Time: **98.75 minutes**

Low: **20 minutes** High: **250 minutes**

Median Post-Service Time: **30 minutes**

FEBRUARY 2002 SURVEY RESULTS:

TOTAL TIME = 145 minutes

Median Pre-Service Time: **25 minutes**

Median Intra-Service Time: **90 minutes**

25th Percentile Intra-Service Time: **53.75 minutes**

75th Percentile Intra-Service Time: **100 minutes**

Low: **20 minutes** High: **200 minutes**

Median Post-Service Time: **30 minutes**

PART TWO: Typical Procedures Performed and Their Typical Times

Question: Using the vignette provided, please indicate whether you would perform the following procedures and the number of times you would perform each on subsequent days beyond the first day {NOTE: Work and procedures performed on the first day should NOT be included.}. Please do NOT include those performed by a bedside nurse or those performed as part of the delivery room resuscitation. You may include any procedures performed by a resident or nurse practitioner where you would typically be physically present and supervising the procedure.

Supplemental Survey Results:

~~Procedure (CPT code/2002 RVWs)~~	~~Typical Frequency/Time~~	~~Number of Respondents Selecting Procedures (N=33)~~	~~Comments~~
~~Placement of central venous catheter; (subclavian, jugular, or other vein), percutaneous, age 2 years or under (36488/1.35 RVW)~~	~~1 x 35 minutes each~~	~~n=28 (85%)~~	~~Usually done once during stay*~~
~~Introduction of needle or intracatheter; extremity artery (36140/2.01 RVW)~~	~~1 x 30 minutes each~~	~~n=24 (73%)~~	~~Usually done once during stay*~~

Procedure (CPT code/2002 RVWs)	Typical Frequency/Time	Number of Respondents Selecting Procedures (N=33)	Comments
~~Continuous positive airway pressure (CPAP), initiation and management (94660/0.76 RVW)~~	~~1 x 15 minutes each~~	~~n=24 (73%)~~	~~Daily~~
~~Noninvasive ear or pulse oximetry for oxygen saturation, multiple determinations (94761/0.00 RVW)~~	~~1 x 10 minutes each~~	~~n=21 (64%)~~	~~Daily~~
~~Respiratory flow volume loop (94375/0.31 RVW)~~	~~5 x 5 minutes each = 25 minutes~~	~~n=25 (76%)~~	~~Multiple times per day~~
~~Transfusion, blood or blood components (36430/0.00 RVW)~~	~~1 x 10 minutes each~~	~~n=22 (67%)~~	~~Every 3 days*~~
~~Write total parenteral nutrition orders (no code)~~	~~1 x 15 minutes each~~	~~n=32 (97%)~~	~~Daily~~
~~*TOTAL: 7.50 RVW minus 1.35 RVW (36488) minus 2.01 RVW (36140) minus 1.17 RVW (half of the total RVW for 31500) minus 0.00 RVW (half of the total RVW for 36430) = 3.06~~	~~*TOTAL: 175 minus 35 minutes (36488) minus 30 minutes (36140) minus 7.5 minutes (half of the total for 31500) minus 5 minutes (half of the total for 36430) = 97.50~~		

Rationale for RVW Recommendation:

Total evaluation and management service time (February 2002):

25 minutes pre-service time
+ 90 minutes intra-service time
+ 30 minutes post-service time
145 minutes

First 75 minutes of the 145 minutes	**one unit of 99291**	**= 4 RVW**
Next 30 minutes of the 145 minutes	**one unit of 99292**	**= 2 RVW**
Next 30 minutes of the 145 minutes	**one unit of 99292**	**= 2 RVW**
Final 10 minutes of the 145 minutes		**not counted**
		8 RVW

Rather than trying to determine a fair way to account for the frequency with which procedures are typically performed during the subsequent neonatal critical care days as delineated in our supplemental survey, we opted to use the total time from our initial survey done in February 2002. This avoids any potential problem with perceived overlap of services and it also maintains a consistent value between the neonatal and pediatric critical care subsequent day codes.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: **99299** Tracking Number: **AK6** Global Period: **XXX** **Recommended RVW: 2.50**

CPT Descriptor: **Subsequent intensive care, per day, for the evaluation and management of the recovering low birthweight infant (present body weight of 1500-2500 grams)**

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A neonate, now weighing 2080 grams, is nine days of age. He was born at 35 weeks gestation and weighed 2000 grams. His mother presented to the hospital with a temperature of 103.5F. Membranes had been ruptured for six hours. The fetal monitoring strip was non-reassuring with a tachycardia and persistent variable declarations. Mother received one dose of Penicillin and delivery via cesarean section ws performed. Cervical culture was positive for Group B streptococcus. The infant was flaccid at birth. APGAR scores were 2,4,7 at 1,5 and 10 minutes respectively. The infant was intubated and needed five days of conventional ventilation. Chest X-Ray was consistent with pneumonia and the baby was started on a ten-day course of antibiotics. He was weaned to nasal CPAP on day six and nasal cannula oxygen on day seven. Hyperalimentation was begun on day three and gavage feedings on day seven. He currently is on nasal cannula oxygen (30%- ½ l) and 50% TPN through a PIC line. There is no apnea but there are 2-3 brief desaturation episodes/day which are self resolving. X-ray is improved but still not normal. He remains in an isolette on cardiorespiratory and oxygen saturation monitoring.

Description of Pre-Service Work: Preparing to see the patient includes obtaining and reviewing the results of any lab work and/or radiologic studies, reviewing the care flow sheet and discussing the patient's status with the bedside nurse, and communicating with other health professionals, as appropriate.

Description of Intra-Service Work: A complete examination of the head, eyes, nose, mouth, chest, lungs, heart, abdomen, genitals, rectum, joints, spine, extremities, and a neurologic appraisal of movement, reflexes, cranial nerves, and degree of arousal and activity. All attached monitors and tubes are checked for secure placement and proper function.

Description of Post-Service Work: Post-service work includes all coordination of care, documentation, and telephone calls with the patient, family members, or other health professionals including writing the daily TPN orders after recovery and/or writing new feeding orders, ordering daily laboratory and imaging studies, as necessary, documenting care changes in the patient's chart and verbally with the nursing staff, speaking with the family in person or by telephone, and updating the referring physician.

SURVEY DATA:

Presenter(s): Steve Krug, MD, FAAP, Rich Molteni, MD, FAAP, and David Jaimovich, MD, FAAP

Specialty(s): American Academy of Pediatrics

Sample Size: **106** Response Rate: (%): **52% (n=55)** Median RVW: **2.75**

Type of Sample (Circle One): random (panel) convenience

Explanation of sample size: We sent surveys out to those physician members most experienced with the service of low birth weight intensive care services. The results of those surveys were compiled and discussed by an expert panel until consensus was reached.

25th Percentile RVW: **2.50** 75th Percentile RVW: **3.13** Low: **1.97** High: **7.62**

Median Pre-Service Time: **10 minutes** Median Intra-Service Time: **30 minutes**

25th Percentile Intra-Service Time: **30 minutes**

75th Percentile Intra-Service Time: **45 minutes**

Low: **15 minutes**

High: **90 minutes**

Median Post-Service Time:

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

KEY REFERENCE SERVICE:

CPT Code	CPT Descriptor	RVW
99298	Subsequent neonatal intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (less than 1500 grams)	2.75

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 t service you are rating to the key reference services listed above. **Make certain that you are including existin time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

TIME ESTIMATES (Median)	New/Revis. CPT Code: 99299X1	Key Reference CPT Code: 99298
Median Pre-Time	10	10
Median Intra-Time	30	30
Median Immediate Post-service Time	15	20
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	3.22	3.29
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.27	3.36

Urgency of medical decision making	3.04	3.18

Technical Skill/Physical Effort (Mean)

Technical skill required	3.11	3.22
Physical effort required	2.98	3.04

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.22	3.45
Outcome depends on the skill and judgement of physician	3.42	3.56
Estimated risk of malpractice suit with poor outcome	3.65	3.69

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.87	3.02
Intra-Service intensity/complexity	3.36	3.49
Post-Service intensity/complexity	2.98	3.13

ADDITIONAL RATIONALE

Our expert panel reviewed the survey data and concluded that the 25th percentile accurately reflected the physician work of providing low birth weight intensive care. The panel believed that the physician work is less than the 2.75 survey median indicated since a large percentage of the patients will fall into the 2000-2500 gram range.

FREQUENCY INFORMATION

How was this service previously reported? **99297 and/or 99233**
(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** __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: **Pediatrics** Frequency: **The prematurity rate in the United States is ~6.8%. Most of these neonates will require admission to an NICU. Of this group, a proportion of those**

between 1500-2500 grams will require critical care services. Those <1500 grams represent ~ 1.2% of the total and almost all will require some period of critical care services. The incidence of significant congenital anomalies is ~2% of the newborn population. Approximately 0.5% will represent serious defects, cardiac, abdominal, neurologic, or orthopedic that will require some period of critical care in the preoperative and postoperative period.

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: 1999 Medicare frequency for 99298 was 16

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