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

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March 8, 2012

Marilyn Tavenner
Acting Administrator
Chief Operating Officer
Center for Medicare
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: RUC Recommendations

Dear Ms. Tavenner:

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

January 2012 RUC Recommendations

The enclosed recommendations result from the RUC's review of physicians' services from the January 26-28, 2012 meeting and address a number of screens, many specifically mentioned in the Affordable Care Act legislation including:

- New Technology/New Services
- High Intraservice Work Per Unit of Time (IWPUT)
- CMS Fastest Growing
- Multi-Specialty Points of Comparison (MPC) List
- CMS High Expenditure Procedural Codes
- High Volume Growth Screen.
- Harvard Valued, Utilization greater than 30,000 Screen
- CMS Requests – Final Rule for 2012 MFS

Update on Progress of the Relativity Assessment Workgroup

The RUC has reviewed nearly 1,000 physician services identified under one or more objective screens as potentially mis-valued. The implementation of these RUC recommendations to improve the relativity within the RBRVS began in 2009, with significant impact in 2011. The cumulative impact of the three years of effort is $1.5 billion in redistribution. The practice and professional liability redistribution occurs within the relative values, while the work value redistribution was implemented with minor increases to the Medicare conversion factor in 2009-2012.

The significance of the RUC's work should not be underestimated. This work would not be possible without the contributions of the volunteer physicians on the RUC and the medical specialty societies.

Many specialty societies have shepherded coding changes, surveys, and relative value recommendations that ultimately result in payment reductions for their members. The individuals in this process have done so as organized medicine understands that ensuring the relativity within the RBRVS is important. This volunteer effort should be recognized by CMS and other policymakers, not only in descriptions within rulemaking, but also in methods of implementation and expectations regarding ongoing review. This effort should also be considered when CMS supersedes the RUC process by implementing questionable broad based policies across the entire Medicare Physician Payment Schedule such as the recent application of the multiple procedure payment reduction to the professional component of imaging services.

In addition to the specific recommendations included in this submission, the RUC offers CMS the following additional information:

- *CMS High Expenditure Procedural Codes* - In rulemaking for the 2012 Medicare Physician Payment Schedule, CMS requested an additional screen to identify mis-valued services, a list of 70 high expenditure procedural codes representing services furnished by an array of specialties. CMS selected these codes based on the fact that they have not been reviewed for at least 6 years, and in many cases the last review occurred more than 10 years ago. In January 2012, the Relativity Assessment Workgroup reviewed action plans for all 70 High Expenditure Procedural Codes identified and prioritized review to complete by the April 2013 RUC meeting. **Several specific code recommendations identified through this screen are included in this submission and a timeline for review of the remaining services is attached.**

- *CMS Requests – Proposed and Final Rule for 2012 MFS* - In rulemaking for 2012, CMS requested that the RUC review specific codes in 2012 for consideration in rulemaking for the 2013 Medicare Physician Payment Schedule.

  Abdomen and Pelvis CT – 72192, 72193, 72194, 74150, 74160 & 74170
  CMS received comments that the resulting practice expense RVUs for the new bundled codes (74176, 74177 and 78178) create a rank order anomaly in comparison to the previous stand alone codes (72192, 72193, 72194, 74150, 74160 and 74170) and requested RUC review of practice expense inputs. Also, CMS requested that the RUC review the work for these codes (72192, 72193, 72194, 74150, 74160 and 74170), which were last reviewed for CPT 2007. The RUC indicated that it would review the CMS request at the September, 2011 RUC meeting however, it is apparent that any rank order anomaly is caused by CMS data entry errors (eg, Radiology Technician instead of a CT Technician for 74176, 74177 & 74178 and inconsistent room time for the new bundled codes).

  CMS requested that the RUC review both the direct practice expense inputs and work values for the abdomen and pelvis CT codes listed above. The Workgroup reviewed the specialty society comment letter to CMS, which agreed that there are some practice expense RVU anomalies. However, the specialty stated that once the base codes practice expenses are fully transitioned, the current anomalies will be corrected. The Workgroup indicated that it would address these codes again following publication of the 2012 Medicare Physician Payment Schedule, after the agency has considered the ACR comments explaining the rationale for the current rank order anomaly.

  CMS indicated in the November 28, 2011 Final Rule that the agency continues to believe that the direct practice expense inputs of the component codes should be reviewed and maintains their initial request that the RUC review the component codes for work and Practice Expense.

The RUC reviewed these services in January 2012 and agreed with the specialty society that the current practice expense RVUs are appropriate for the Abdomen and Pelvis CT codes and once the previous stand alone codes are fully transitioned for practice expense in 2013, the current practice expense RVU anomalies will cease to exist. Additionally, an error that added to the anomaly in the new bundled codes was corrected to indicate CT Technologists (L046A) as the allocated staff type.

In Situ Hybridization – 88365, 88367 & 88368
CMS received comments that unlike the new FISH codes for urinary tract specimens (88120 and 88121), the existing codes (88365-88368) still allow for multiple units of each code as these codes are reported per probe. CMS stated that they have reviewed the current work and practice costs associated with 88120 and 88121 and agree at this time that they are accurate. CMS requested that the RUC review both the direct practice expense inputs and the work values for codes 88365, 88367 and 88368. In September 2011, the Workgroup recommended that these services be tabled until January 2012 in order to review 2011 diagnosis data from CMS.

In January 2012, the RUC reviewed 2011 diagnosis claims data and the American College of Pathologists indicated that they will develop a CPT Assistant article to direct urologists to use the new FISH codes for urinary tract infections (CPT codes 88120 and 88120). The RUC indicated that the specialty should specify the number of probes utilized for these services in the CPT Assistant article. **The RUC recommended that codes 88365, 88367 and 88368 be reviewed one year after 2012 utilization data are available (January 2013).**

CMS Request to Re-Review Families of New/Revised CPT Codes
In the November 28, 2011 *Final Rule* for 2012 CMS requested that the RUC re-review specific codes in a family of services that were recently reviewed.

The RUC noted that in the recent review of these services, CMS had the opportunity to add CPT codes to each of these families of services prior to the survey and RUC review processes. AMA staff indicated that going forward, AMA staff will ask CMS to acknowledge the code families during the LOI process.

The RUC reviewed the CMS identified family of services and recommends:

Trim Skin Lesions	**Recommendation**
11055 11056* 11057	**Maintain the current work RVUs.** There are no apparent rank order anomalies. CMS had the opportunity to request review of other codes during the CPT LOI process.
Thoracoscopy	
32663*, 32480, 32669*, 32670*, 32482, 32671*, 32440, 32672*, 32491, 32673*, 60520, 60521, and 60522	**The RUC requests further information from CMS on why these services should be reviewed as part of a family.** CMS stated in the Final Rule that it will accept the RUC recommendation for some of these thoracoscopy services pending review of the open heart surgery analogs and that the RUC look at the incremental difference in RVUs and times between the open and laparoscopic surgeries. The specialty society noted that these are not open heart surgery codes and therefore are not relevant.
CT Angiography	
74174*, 74175 and 72191	**The RUC referred these services to the Practice Expense Subcommittee to review in April 2012 and determine if any**

	practice expense anomalies exist between these codes.
Evoked Potentials and Reflex Studies	
95938*, 95939*, 95925, 95926, 95928, and 95929	**The RUC referred these services to the Practice Expense Subcommittee to review in April 2012 and determine if any practice expense anomalies exist between these codes.**

** RUC recommendation submitted for 2012.*

Ultrasound Equipment

CMS requested that the RUC review 17 different ultrasound related equipment items (including ultrasound rooms) associated with 110 CPT codes ranging in price from $1,304.33 to $466,492.00. CMS requested that the RUC review the clinical necessity of the ultrasound equipment as well as the way the equipment is described for individual codes. A Workgroup was created to review this issue and offer recommendations to the Practice Expense Subcommittee and the RUC . The recommendations of the Workgroup were reviewed and accepted by the Practice Expense Subcommittee at the January 2012 RUC Meeting. The recommendations are included in this submission.

Berenson-Eggers Type of Service (BETOS)

In a letter dated, October 21, 2011 (attached), the American College of Surgeons (ACS) requested that the RUC collaborate with the CMS to: 1) Review the Berenson-Eggers Type of Service (BETOS) procedures categories and associated codes to make necessary changes. For example, the classification of "major" versus "minor" procedures should be reviewed and defined; and 2) Establish an ongoing process by which new or revised codes will be assigned to the correct BETOS category and class as the codes are reviewed by the RUC. Many of these classifications were established based on medical care as it was provided in 1980 and have not been updated in over 20 years. The RUC agreed with the ACS request to offer CMS the RUC's expertise and recommendations to review, revise and maintain BETOS as deemed necessary by the agency. We ask that your staff begin a dialogue with RUC staff regarding this potential project.

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

Sincerely,

Barbara S. Levy, MD

cc: John Cooper, MD
Edith Hambrick, MD
Ryan Howe
Christina Ritter
Sara Vitolo
RUC Participants

RUC Recommendations for Existing Codes - March 2012

CPT Code	Descriptor	RUC Recommendation	Harvard Valued - Util Over 30,000	CMS/Other Source - Util Over 500,000	CMS Request-NRPM for 2012	CMS High Expenditure Procedures	CMS Fastest Growing	High Volume Growth Screen	High IWPUT	Codes Reported Together	Low Value/ Billed in Multiple Units	Low Value/ High Volume	MPC List	New Technology
11055	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion	0.43 Reaffirmed work and PE			X									
11056	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions	0.50 Reaffirmed work and PE			X								X	
11057	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); more than 4 lesions	0.79 Reaffirmed			X									
11719	Trimming of nondystrophic nails, any number	0.17										X		
20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure)	2.50												X
29828	Arthroscopy, shoulder, surgical; biceps tenodesis	13.16												X
31231	Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)	1.10											X	
47562	Laparoscopy, surgical; cholecystectomy	11.76 Reaffirmed work and PE				X								
47563	Laparoscopy, surgical; cholecystectomy with cholangiography	12.11 Reaffirmed work and PE				X								
47600	Cholecystectomy	Postponed to April 2012			X									
47605	Cholecystectomy; with cholangiography	Postponed to April 2012			X									
49505	Repair initial inguinal hernia, age 5 years or older; reducible	7.96 Reaffirmed work and PE				X								
52214	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands	3.50						X						

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CPT Code	Descriptor	RUC Recommendation	Harvard Valued - Util Over 30,000	CMS/Other Source - Util Over 500,000	CMS Request-NRPM for 2012	CMS High Expenditure Procedures	CMS Fastest Growing	High Volume Growth Screen	High IWPUT	Codes Reported Together	Low Value/ Billed in Multiple Units	Low Value/ High Volume	MPC List	New Technology
52224	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy	4.05						X						
66982	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine	11.08				X	X		X					
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)	8.52							X				X	
67028	Intravitreal injection of a pharmacologic agent (separate procedure)	1.44 Reaffirmed work and PE				X								
73221	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)	1.35				X	X							
73721	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material	1.35											X	
77003	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)	0.60											X	
77080	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)	0.20			X									
77082	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment	0.17			X									
77280	Therapeutic radiology simulation-aided field setting; simple	Referred to CPT	X											
77285	Therapeutic radiology simulation-aided field setting; intermediate	Referred to CPT	X											
77290	Therapeutic radiology simulation-aided field setting; complex	Referred to CPT	X											
77295	Therapeutic radiology simulation-aided field setting; 3-dimensional	Referred to CPT	X											

RUC Recommendations for Existing Codes - March 2012

CPT Code	Descriptor	RUC Recommendation	Harvard Valued - Util Over 30,000	CMS/Other Source - Util Over 500,000	CMS Request-NRPM for 2012	CMS High Expenditure Procedures	CMS Fastest Growing	High Volume Growth Screen	High IWPUT	Codes Reported Together	Low Value/ Billed in Multiple Units	Low Value/ High Volume	MPC List	New Technology
88300	Level I - Surgical pathology, gross examination only	0.08 New PE Inputs	X		X						X			
88302	Level II - Surgical pathology, gross and microscopic examination Appendix, incidental, Fallopian tube, sterilization, Fingers/toes, amputation, traumatic, Foreskin, newborn, Hernia sac, any location, Hydrocele sac, Nerve, Skin, plastic repair, Sympathetic	0.13 New PE Inputs	X		X									
88304	Level III - Surgical pathology, gross and microscopic examination Abortion, induced, Abscess, Aneurysm - arterial/ventricular, Anus, tag, Appendix, other than incidental, Artery, atheromatous plaque, Bartholin's gland cyst, Bone fragment(s), other than pa	0.22 New PE Inputs	X		X							X		
88305	Level IV - Surgical pathology, gross and microscopic examination Abortion - spontaneous/missed, Artery, biopsy, Bone marrow, biopsy, Bone exostosis, Brain/meninges, other than for tumor resection, Breast, biopsy, not requiring microscopic evaluation of su	0.75 New PE Inputs	X		X									
88307	Level V - Surgical pathology, gross and microscopic examination Adrenal, resection, Bone - biopsy/curettings, Bone fragment(s), pathologic fracture, Brain, biopsy, Brain/meninges, tumor resection, Breast, excision of lesion, requiring microscopic evaluati	1.59 New PE Inputs	X		X									
88309	Level VI - Surgical pathology, gross and microscopic examination Bone resection, Breast, mastectomy - with regional lymph nodes, Colon, segmental resection for tumor, Colon, total resection, Esophagus, partial/total resection, Extremity, disarticulation,	2.80 New PE Inputs	X		X									
88312	Special stain including interpretation and report; Group I for microorganisms (eg, acid fast, methenamine silver)	0.54 Reaffirmed work and PE	X			X								
90801	Psychiatric diagnostic interview examination	Deleted from CPT				X								

RUC Recommendations for Existing Codes - March 2012

CPT Code	Descriptor	RUC Recommendation	Harvard Valued - Util Over 30,000	CMS/Other Source - Util Over 500,000	CMS Request-NRPM for 2012	CMS High Expenditure Procedures	CMS Fastest Growing	High Volume Growth Screen	High IWPUT	Codes Reported Together	Low Value/ Billed in Multiple Units	Low Value/ High Volume	MPC List	New Technology
90805	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services	Deleted from CPT				X								
90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;	Deleted from CPT				X								
90808	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;	Deleted from CPT				X								
90818	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;	Deleted from CPT				X								
90862	Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy	Deleted from CPT				X								
92235	Fluorescein angiography (includes multiframe imaging) with interpretation and report	0.81	X			X								
94240	Functional residual capacity or residual volume: helium method, nitrogen open circuit method, or other method	Deleted from CPT				X								
94720	Carbon monoxide diffusing capacity (eg, single breath, steady state)	Deleted from CPT				X								
95903	Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study	Deleted from CPT				X				X				
96920	Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm	1.15					X							
96921	Laser treatment for inflammatory skin disease (psoriasis); 250 sq cm to 500 sq cm	1.30					X	X						
96922	Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm	2.10					X	X						
97150	Therapeutic procedure(s), group (2 or more individuals)	0.29		X										

RUC Recommended Physician Time for CPT 2013 - March 2012 Submission

Code	Pre-Service Evaluation	Pre-Service Positioning	Pre-Service Scrub Dress & Wait	Intra-Service	Immediate Post Service	99204	99211	99212	99213	99214	99215	99231	99232	99233	99238	99239	99224	99225	99291	99292	Total Time	Source
20985	10.00	0.00	0.00	20	0																30	RUC
29828	33.00	12.00	15.00	75	20			2	2						0.5						252	RUC
31231	5.00	1.00	5.00	7	5																23	RUC
52214	19.00	5.00	5.00	30	20																79	RUC
52224	7.00	5.00	20.00	30	20																82	RUC
66982	19.00	1.00	5.00	33	10			2	2						0.5						165	RUC
66984	16.00	1.00	5.00	21	7			2	2						0.5						147	RUC
72040	1.00	0.00	0.00	3	2																6	RUC
72050	1.00	0.00	0.00	5	2																8	RUC
72052	1.00	0.00	0.00	5	2																8	RUC
73221	5.00	0.00	0.00	20	5																30	RUC
73721	5.00	0.00	0.00	20	5																30	RUC
77003	7.00	0.00	0.00	15	5																27	RUC
77080	2.00	0.00	0.00	5	2																9	RUC
77082	2.00	0.00	0.00	5	2																9	RUC
92235	3.00	0.00	0.00	15	5																23	RUC
96920	7.00	0.00	0.00	23	5																35	RUC
96921	7.00	0.00	0.00	30	5																42	RUC
96922	7.00	0.00	0.00	45	5																57	RUC

The RUC Relativity Assessment Workgroup Progress Report

In 2006, the RUC established the Five-Year Identification Workgroup (now referred to as the Relativity Assessment Workgroup) to identify potentially misvalued services using objective mechanisms for reevaluation prior to the next Five-Year Review. The RUC formed this Workgroup in response to criticisms that, despite reducing the work RVUs for nearly 400 services in the past, the process contains "bias in the 5-year review in favor of undervalued codes as compared to overvalued codes."[1] Since the inception of the Relativity Assessment Workgroup, the Workgroup and CMS have identified over 1,300 services through eleven different screening criteria for further review by the RUC. Additionally, the RUC charged the Workgroup with maintaining the "new technology" list of services that will be re-reviewed by the RUC as reporting and cost data become available.

New Technology

As the RUC identifies new technology services that should be re-reviewed, a list of these services is maintained and forwarded to CMS. Currently, codes are identified as new technology based on recommendations from the specialty society and consensus among RUC members at the time of the RUC review for these services. RUC members consider several factors to evaluate potential new technology services, including: recent FDA-approval, newness or novelty of the service, use of an existing service in a new or novel way, and migration of the service from a Category III to Category I CPT code. The Workgroup maintains and develops all standards and procedures associated with the list, which contains 384 services. In September 2010, the re-review cycle began and since then the RUC has recommended 4 services to be re-examined. The remaining services are rarely performed (ie, less than 500 times per year in the Medicare population) and will not be re-examined. The Workgroup will continue to review the remaining 321 services every September after three years of Medicare claims data is available for each service.

Site of Service Anomalies

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

The RUC identified 194 services through the site of service anomaly screen. The RUC required the specialties to resurvey 129 services to capture the appropriate physician work involved. These services were reviewed by the RUC between April 2008 and February 2011. CMS implemented 124 of these recommendations in the 2009, 2010 and 2011 Medicare Physician Payment Schedules. The RUC submitted another 5 recommendations as well as re-reviewed and submitted 44 recommendations to previously reviewed site-of-service identified codes to CMS for the 2012 Medicare Physician Payment Schedule.

Of the remaining 65 services that were not re-surveyed, the RUC modified the discharge day management for 46 services, maintained 3 codes and removed 2 codes from the screen as the

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

typical patient was not a Medicare beneficiary and would be an inpatient. The CPT Editorial Panel deleted 13 codes and will re-review 1 service in the CPT 2014 cycle.

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

High Volume Growth

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

The RUC recommended that 24 services be removed from the screen as the volume growth did not impact the resources required to provide the service. The CPT Editorial Panel deleted 16 codes and will review another 12 services in the CPT 2014 cycle. In September 2011, the RUC began review of services after two years of utilization data were collected. The RUC will provide recommendations to CMS for 3 services for the 2013 Medicare Physician Payment Schedule and will continue to review the remaining 6 services after additional utilization data is collected.

CMS Fastest Growing

In 2008, CMS developed the Fastest Growing Screen to identify all services with growth of at least 10% per year over the course of 3 years from 2005-2007. Through this screen, CMS identified 114 fastest growing services and the RUC expanded this screen by an additional 69 services to include the family of services, totaling 183. The RUC required the specialties to survey 72 services to capture the appropriate work effort and/or practice expense inputs. These services were reviewed by the RUC between February 2008 to April 2010 and submitted to CMS for the Medicare Physician Payment Schedule.

The RUC recommended that 51 services be removed from the screen as the volume growth did not impact the resources required to provide the service. The CPT Editorial Panel deleted 23 codes and will review another 15 services in the CPT 2014 cycle. The RUC will review 8 services in for the 2013 Medicare Physician Payment Schedule and 14 services after additional utilization data is available.

High IWPUT
The Workgroup assembled a list of all services with a total Medicare utilization of 1,000 or more that have an intra-service work per unit of time (IWPUT) calculation greater than 0.14, indicating an outlier intensity. The query resulted in identification of 32 services. Specialty societies submitted comments to the Workgroup in April 2008 for these services. As a result of this screen, the RUC has reviewed and submitted recommendations to CMS for 28 codes, removing 4 services from the screen as the IWPUT was considered appropriate. The RUC completed review of services under this screen.

Services Surveyed by One Specialty – Now Performed by A Different Specialty
Services that were originally surveyed by one specialty, but now performed predominantly by other specialties were identified and reviewed. The RUC identified 21 services by this screen, adding 19 services to address various families of codes. The majority of these services required clarification within CPT. To date, the CPT Editorial Panel has deleted 18 codes and will review 4 codes in the CPT 2014 cycle. The RUC submitted 18 recommendations for physician work and practice expense to CMS for the 2011 and 2012 Medicare Physician Payment Schedule.

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

Utilization over 100,000
The RUC continued to review Harvard-only valued codes with significant utilization. The Relativity Assessment Workgroup expanded the review of Harvard codes to those with utilization over 100,000 which totaled 38 services and the RUC expanded by the screen by 102 codes to include the family of services, totaling 140 services. The CPT Editorial Panel deleted 26 codes and will review 2 services in the CPT 2014 cycle. The RUC submitted 106 recommendations to CMS for the 2011-2013 Medicare Physician Payment Schedules. The RUC will review 4 codes in October 2012 after additional utilization data is available.

Utilization over 30,000
In April 2011, the RUC continued to identify Harvard-only valued codes with utilization over 30,000, based on 2009 Medicare claims data. The RUC determined that the specialty societies should survey the remaining 36 Harvard codes with utilization over 30,000 for September 2011. The RUC expanded the screen to include the family of services, totaling 60 services. The CPT Editorial Panel deleted 7 codes and will review 15 services in the 2014 cycle. The RUC will submit recommendations for 36 services for the 2013 Medicare Physician Payment Schedule and will review 2 services in September 2013.

Bundled CPT Services

Reported 95% or More Together

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

Reported 75% or More Together

In February 2010, the Workgroup continued review of services provided on the same day by the same provider at a lower threshold. The Workgroup analyzed code pairs provided on the same day by the same physician. The Relativity Assessment Workgroup reviewed the Medicare claims data for these services and found 151 relevant code pairs. These codes were divided into similar "groups" and the 20 code groups, totaling 80 codes with the highest allowed charges were sent to specialty societies to solicit action plans for consideration at the April 2010 RUC meeting. The RUC added 61 additional codes as part of the family of services, totaling 141 services. The CPT Editorial Panel deleted 22 codes and will consider 12 of codes in the CPT 2014 cycle. The RUC reviewed the work and practice expense and submitted recommendations to CMS for 62 services to account for efficiencies when performed together, for the 2012 Medicare Physician Payment Schedule. The RUC will submit recommendations for 39 services for the 2013 Medicare Physician Payment Schedule and 6 services for the 2014 Medicare Physician Payment Schedule.

Low Value/Billed in Multiple Units

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

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

Low Value/High Volume Codes

CMS has requested that services with low work RVUs and high utilization be reviewed. CMS has requested that the RUC review 24 services that have low work RVUs (less than or equal to 0.25) and high utilization. The RUC questioned the criteria CMS used to identify these services as it appeared some codes were missing from the screen criteria indicated. The RUC identified codes with a work RVU ranging from 0.01 - 0.50 and Medicare utilization greater than one million. In February 2011, the RUC reviewed the codes identified by this criteria added 5 codes to review under this screen, totaling 29. The RUC submitted 24 recommendations to CMS for the 2012 Medicare Physician Payment Schedule and 5 recommendations to CMS for the 2013 Medicare Physician Payment Schedule.

Multi-Specialty Points of Comparison List
CMS requested that services on the Multi-Specialty Points of Comparison (MPC) list should be reviewed. CMS prioritized the review of the MPC list to 33 codes, ranking the codes by allowed service units and charges based on CY 2009 claims data and as well as those services reviewed by the RUC more than six years ago. The RUC expanded the list to 155 services to include an additional codes as part of a family (105 codes of which are part of the revision to the GI endoscopy codes). The CPT Editorial Panel deleted 8 codes and will review 108 codes for revision. The RUC submitted recommendations for 22 codes for the 2012 Medicare Physician Payment Schedule and will submit recommendations for 17 services for the 2013 Medicare Physician Payment Schedule.

CMS High Expenditure Procedural Codes
In the July 19, 2011, Proposed Rule for 2012, CMS requests that the RUC review a list of 70 high PFS expenditure procedural codes representing services furnished by an array of specialties. CMS selected these codes based on the fact that they have not been reviewed for at least 6 years, and in many cases the last review occurred more than 10 years ago.

The RUC reviewed the 70 services identified and expanded the list to 103 services to include additional codes as part of the family. The CPT Editorial Panel deleted 7 codes and will review 12 codes for the 2014 cycle. The RUC will submit 40 recommendations to CMS for the 2013 Medicare Physician Payment Schedule and will submit the remaining recommendations for the 2014 Medicare Physician Payment Schedule.

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

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

CMS Requests and RUC Relativity Assessment Workgroup Code Status

Total Number of Codes Identified*	**1,311**
Codes Completed	**966**
Work and PE Maintained	311
Work Increased	62
Work Decreased*	313
Direct Practice Expense Revised (beyond work changes)*	118
Deleted from CPT	162
Codes Under Review	**345**
Referred to CPT	149
RUC to Review April 2012	109
Future Review or Re-review	87

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

Approximately $400 million was redistributed to the 2011 Medicare conversion factor (0.5% increase) to account for the efforts on the work relative values. This lead to $40 million redistribution within the PLI RVUs and combined with other recommendations, $570 million redistribution within the practice expense RVUs, for a total overall redistribution of **$1 billion** in 2011.

In 2009 and 2010 minor increases to the conversion factor and redistribution within the PLI and PE RVUs also occurred. The RUC's efforts for 2009-2012 have resulted in $1.5 billion in redistribution within the Medicare Physician Payment Schedule.

High Expenditure Procedural Codes - Status

CPT Code	Long Descriptor	RUC Surveyed	RAW Screen	Notes	SS Submitting Action Plan	RUC Recommendation	Code Family	Date of Review Rec
47562	Laparoscopy, surgical; cholecystectomy	Sep 2005		CMS identified this service as part of the 3rd Five-Year Review and accepted the RUC recommendation.	ACS, SAGES	No action/RUC recommendation reaffirmed. This service has been surveyed and RUC reviewed 3 times. Codes 47563 and 47564 were recently reviewed in Oct 2010 and 47562 was used as a stable reference service. The RAW determined that this service has not changed and resurveying would not produce a different result.		complete
47563	Laparoscopy, surgical; cholecystectomy with cholangiography	**Oct 2010**	4th Five-Year Review	CMS identified this service as part of the 4th Five-Year Review. The RUC recommendation is currently under review by CMS.	ACS, SAGES	RUC work RVU and PE recommendation reaffirmed.		complete
49505	Repair initial inguinal hernia, age 5 years or older; reducible	Sep 2005		CMS identified this service as part of the 3rd Five-Year Review and accepted the RUC recommendation.	ACS, SAGES	No action/RUC recommendation reaffirmed. This service has been surveyed and RUC reviewed 4 times. The RAW determined that this service has not changed and resurveying would not produce a different result.		complete
66982	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine	Feb 2000	High IWPUT / CMS Fastest Growing, Site of Service Anomaly (99238-Only)	Review September 2011. CPT Assistant article published; Apr 2008, reduced to 2x99213 & 3x99212	AAO	Surveyed January 2012 - issue complete.		complete
67028	Intravitreal injection of a pharmacologic agent (separate procedure)	**Oct 2009**	High Volume Growth / CMS Fastest Growing, Harvard Valued - Utilization over 100,000	Reviewed in Oct 2009 for CPT 2010. RUC recommended lower RVU than specialty, AAO appealed, RUC continued with recommendation to CMS. AAO requested refinement, CMS refinement panel recommended RUC rec, CMS rejected refinement panel recommendation.	AAO	No action/Feb 2009 RUC recommendation reaffirmed. This code was surveyed for work and PE for 2010. CMS rejected RUC recommendation.		complete
73221	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)	Apr 2001	CMS Fastest Growing	This code was scheduled for re-review Sept 2013, however will need to be addressed before then.	ACR	Surveyed January 2012 - issue complete.		complete
88312	Special stains; Group I for microorganisms (eg, Gridley, acid fast, methenamine silver), including interpretation and report, each	**Feb 2011**	Top 9 Harvard		CAP	No action/Feb 2011 RUC recommendation reaffirmed. This code was recently surveyed for work and PE for 2012 and accepted by CMS.		complete
92235	Fluorescein angiography (includes multiframe imaging) with interpretation and report	Sep 2005	Harvard Valued - Utilization over 30,000	CMS identified this service as part of the 3rd Five-Year Review and accepted the RUC recommendation. The RUC will be reviewing this service at the September 2011 meeting.	AAO	Surveyed January 2012 - issue complete.		complete

High Expenditure Procedural Codes - Status

CPT Code	Long Descriptor	RUC Surveyed	RAW Screen	Notes	SS Submitting Action Plan	RUC Recommendation	Code Family	Date of Review Rec
94240	Functional residual capacity or residual volume: helium method, nitrogen open circuit method, or other method	Aug 1995	Codes Reported Together 75% or More	**Deleted from CPT 2012**		Deleted from CPT 2012, no action required.		complete
94720	Carbon monoxide diffusing capacity (eg, single breath, steady state)	Aug 1995	Codes Reported Together 75% or More	**Deleted from CPT 2012**		Deleted from CPT 2012, no action required.		complete
43235	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	Sep 2005	MPC List	CMS identified this service as part of the 3rd Five-Year Review and accepted the RUC recommendation. In 2010, CMS indicated that one of the rationale for review of MPC services was that the code was not reviewed by the RUC in the last 6 years. This code was reviewed by the RUC in the last 6 years, therefore RUC reaffirmed its previous recommendation.	AGA, ASGE, SAGES	Refer to CPT, specialty intends on revising entire GI endoscopy family.		Refer to CPT
45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)	Sep 2005		CMS identified this service as part of the 3rd Five-Year Review and accepted the RUC recommendation.	AGA, ASGE, ASCRS, SAGES	Refer to CPT, specialty intends on revising entire GI endoscopy family.		Refer to CPT
69210	Removal impacted cerumen (separate procedure), 1 or both ears	Sep 2005		CMS identified this service as part of the 3rd Five-Year Review and accepted the RUC recommendation.	AAO-HNS	Survey work and PE for April 2013 RUC meeting.		Refer to CPT
77014	Computed tomography guidance for placement of radiation therapy fields	Aug 1995	CMS Request - Practice Expense Review / CMS-Other - Utilization over 500,000	Review September 2011 Action Plan	ACR, ASTRO	Refer to CPT		Refer to CPT
77421	Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy	Apr 2005	Codes Reported Together 75% or More	New PE Inputs	ACR, ASTRO	Refer to CPT		Refer to CPT
88112	Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal	Apr 2003			CAP	Refer to CPT.		Refer to CPT
88342	Immunohistochemistry (including tissue immunoperoxidase), each antibody	Apr 2003	CMS-Other - Utilization over 500,000	Review September 2011 Action Plan	CAP	Refer to CPT.		Refer to CPT
90801	Psychiatric diagnostic interview examination	Oct 2010	4th Five-Year Review	Referred to CPT	APA, APA(HCPAC), AACAP, NASW	Referred to CPT reviewing Feb 2012.		Refer to CPT
90805	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services	Oct 2010	4th Five-Year Review	Referred to CPT	APA, APA(HCPAC), AACAP	Referred to CPT reviewing Feb 2012.		Refer to CPT

High Expenditure Procedural Codes - Status

CPT Code	Long Descriptor	RUC Surveyed	RAW Screen	Notes	SS Submitting Action Plan	RUC Recommendation	Code Family	Date of Review Rec
90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;	Oct 2010	4th Five-Year Review	Referred to CPT	APA, APA(HCPAC), NASW	Referred to CPT reviewing Feb 2012.		Refer to CPT
90808	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;	Oct 2010	4th Five-Year Review	Referred to CPT	APA, APA(HCPAC), NASW	Referred to CPT reviewing Feb 2012.		Refer to CPT
90818	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;	Oct 2010	4th Five-Year Review	Referred to CPT	APA, APA(HCPAC), NASW	Referred to CPT reviewing Feb 2012.		Refer to CPT
90862	Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy	Oct 2010	4th Five-Year Review	Referred to CPT	APA, AACAP	Referred to CPT reviewing Feb 2012.		Refer to CPT
95861	Needle electromyography; 2 extremities with or without related paraspinal areas	Sep 2005	Codes Reported Together 75% or More	CMS identified this service as part of the 3rd Five-Year Review and accepted the RUC recommendation. In April 2011, the RUC recommended that this service be referred to CPT to develop a more comprehensive coding solution which bundles services commonly performed together.	AAN	Referred to CPT Feb 2012		Refer to CPT
95903	Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study	Apr 1995			AAN	Referred to CPT Feb 2012		Refer to CPT
97001	Physical therapy evaluation	Apr 1997			APTA	Refer to CPT.		Refer to CPT
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	May 1994			APTA	Refer to CPT.		Refer to CPT
97140	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes	May 1998			APTA	Refer to CPT.		Refer to CPT
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	May 1994			APTA	Refer to CPT.		Refer to CPT
20610	Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)	**Oct 2010**	Harvard Valued - Utilization over 100,000 / MPC List	This service was brought forward as part of the family of 20605. MPC List screen, RUC reaffirmed the RUC recommendation as this service was recently reviewed under another screen.	AAOS, ACRh	Review PE only at April 2012 meeting. Survey for work was completed recently (Oct 2010). RUC recommendation reaffirmed.		2012 Apr

High Expenditure Procedural Codes - Status

CPT Code	Long Descriptor	RUC Surveyed	RAW Screen	Notes	SS Submitting Action Plan	RUC Recommendation	Code Family	Date of Review Rec
33405	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	Sep 2005		The specialty societies identified this service in the 3rd Five-Year Review and CMS accepted the RUC recommendation.	STS	Review at April 2012 RUC meeting. STS to submit updated inputs.		2012 Apr
33430	Replacement, mitral valve, with cardiopulmonary bypass	Sep 2005	High IWPUT	The specialty societies identified this service in the 3rd Five-Year Review and CMS accepted the RUC recommendation. In Feb 2008 the RUC removed this service from the screen since it was recently reviewed at the 3rd Five-Year Review.	STS	Review at April 2012 RUC meeting. STS to submit updated inputs.		2012 Apr
33533	Coronary artery bypass, using arterial graft(s); single arterial graft	Sep 2005		The specialty societies identified this service in the 3rd Five-Year Review and CMS accepted the RUC recommendation.	STS	Review at April 2012 RUC meeting. STS to submit updated inputs.		2012 Apr
35475	Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel	Aug 1995			ACC, ACR, SIR, SVS	Survey for work and PE for April 2012.		2012 Apr
35476	Transluminal balloon angioplasty, percutaneous; venous	Aug 1995			ACR, SIR, SVS	Survey for work and PE for April 2012.		2012 Apr
50590	Lithotripsy, extracorporeal shock wave	Sep 2005		CMS identified this service as part of the 3rd Five-Year Review and accepted the RUC recommendation.	AUA	Survey for work and PE for April 2012.		2012 Apr
53850	Transurethral destruction of prostate tissue; by microwave thermotherapy	Feb 1997			AUA	Survey for work and PE for April 2012.		2012 Apr
76830	Ultrasound, transvaginal	Sep 2005		CMS identified this service as part of the 3rd Five-Year Review and accepted the RUC recommendation.	ACR, ACOG	Survey for work and PE for April 2012.		2012 Apr
76872	Ultrasound, transrectal	N/A			ACR, AUA	Survey for work and PE for April 2012.		2012 Apr
77301	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications	Apr 2001	CMS Fastest Growing / CMS Request - Practice Expense Review	This code was scheduled for re-review September 2012, however will need to be addressed before then.	ASTRO	Survey for work and PE for April 2012.		2012 Apr
92083	Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)	Sep 2005	MPC List	CMS indicated that one of the rationale for review of MPC services was that the code was not reviewed by the RUC in the last 6 years. This code was reviewed by the RUC in the last 6 years, therefore RUC reaffirmed its previous recommendation.	AAO, AOA(HCPAC)	Survey for work and PE for April 2012.		2012 Apr
93015	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report	Sep 2005	Codes Reported Together 75% or More	CMS identified this service as part of the 3rd Five-Year Review and accepted the RUC recommendation. In April 2010 the RUC recommended that a CPT Assistant article be developed to educate correct coding practices.	ACC	Survey for work and PE for April 2012.	93016, 93017, 93018	2012 Apr

High Expenditure Procedural Codes - Status

CPT Code	Long Descriptor	RUC Surveyed	RAW Screen	Notes	SS Submitting Action Plan	RUC Recommendation	Code Family	Date of Review Rec
95117	Professional services for allergen immunotherapy not including provision of allergenic extracts; 2 or more injections	N/A, 0.00 work RVUs			AAAAI, ACAAI	Review PE for 95115 and 95117 in April 2012.	95115	2012 Apr
95819	Electroencephalogram (EEG); including recording awake and asleep	Aug 2005		CMS identified this service as part of the 3rd Five-Year Review and accepted the RUC recommendation.	AAN, ACNS	Survey for April 2012 or October 2012.	95822	2012 Apr
22851	Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), methylmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure)	Apr 1995	CMS Fastest Growing	This code was scheduled for re-review Oct 2012.	NASS	Review utilization data at the RAW in Oct 2012 as part of the re-review of this service under the CMS Fastest Growing screen.		2012 Oct RAW
27236	Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement	Sep 2005		CMS identified this service as part of the 3rd Five-Year Review and accepted the RUC recommendation.	AAOS	Survey for work and PE for Oct 2012 RUC meeting.		2012 Oct
62311	Injection, single (not via indwelling catheter), 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)	May 1999			AAPMR, ASA, ISIS, NASS	Survey for work and PE for Oct 2012 RUC meeting.	62310, 62318, 62319	2012 Oct
63047	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar	Sep 2005		CMS identified this service as part of the 3rd Five-Year Review and accepted the RUC recommendation.	AAOS, NASS, AANS/CNS	Survey work for Jan 2013 RUC meeting. (Facility Only)	63048	2012 Oct
93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report	Aug 1995			ACC	Survey for work and PE for Oct 2012 RUC meeting.	93005, 93010	2012 Oct
93880	Duplex scan of extracranial arteries; complete bilateral study	Aug 1995	Codes Reported Together 75% or More / CMS-Other - Utilization over 500,000	Review September 2011 Action Plan	ACC, ACR, SIR, SVS	Survey for work and PE for Oct 2012 RUC meeting.	93882	2012 Oct
98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions	Apr 1996			ACA	Survey 98940-98943 for October 2012.	98940-98943	2012 Oct
98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions	Apr 1996			ACA	Survey 98940-98943 for October 2012.	98940-98943	2012 Oct
98942	Chiropractic manipulative treatment (CMT); spinal, 5 regions	Apr 1996			ACA	Survey 98940-98943 for October 2012.	98940-98943	2012 Oct
17004	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions	Feb 2006		This service was identified by the RUC as a rank order anomaly as part of the 3rd Five-Year Review. CMS did not accept the RUC recommendation, but established a lower work RVU.	AAD	Survey work and PE for January 2013 RUC meeting.	17000, 17003	2013 Jan

High Expenditure Procedural Codes - Status

CPT Code	Long Descriptor	RUC Surveyed	RAW Screen	Notes	SS Submitting Action Plan	RUC Recommendation	Code Family	Date of Review Rec
22612	Arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique)	Sep 2005	Codes Reported Together 75% or More	This service was identified by CMS in the 3rd Five-Year Review. CMS did not accept the RUC recommendation at that time, but assigned a lower work RVU of 21.79. Additionally, in Feb 2011 - Referred to CPT and a new code was created to describe the physician work when the services are performed together on the same date of service by the same physician. Additionally, a parenthetical was created to indicate that the separate services (22630 and 22612) are not to be reported together. The change to code 22612 was Editorial, no change in work RVU.	AAOS, NASS, AANS/CNS	Review 3/4 2012 utilization data at the RAW in Jan 2013. The specialty socities ability to survey will change as surgeons are able to understand correct coding.		2013 Jan RAW
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft	Sep 2005		CMS identified this service as part of the 3rd Five-Year Review and accepted the RUC recommendation.	AAOS	Survey work and PE for Jan 2013 RUC meeting.		2013 Jan
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)	Sep 2005		CMS identified this service as part of the 3rd Five-Year Review and accepted the RUC recommendation.	AAOS	Survey work and PE for Jan 2013 RUC meeting.		2013 Jan
35301	Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision	Aug 1995			SVS	Survey for work and PE for Jan 2013.		2013 Jan
36870	Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)	Apr 2000	Site of Service Anomaly (99238-Only)	Sep 2007, reduced 99238 to 0.5	ACR, SIR, SVS	Survey for work and PE for Jan 2013.		2013 Jan
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Oct 2004			ACRh, AGA, ASGE, ASCO	Survey work and PE for January 2013 RUC meeting.	96366	2013 Jan
96367	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion, up to 1 hour (List separately in addition to code for primary procedure)	Oct 2004			ACRh, AGA, ASGE, ASCO	Survey work and PE for January 2013 RUC meeting.	96368	2013 Jan
96413	Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug	Oct 2004	Codes Reported Together 75% or More	Oct 2010 New PE Inputs	ACRh, AGA, ASGE, ASCO	Survey work and PE for January 2013 RUC meeting.	96415, 96417	2013 Jan

High Expenditure Procedural Codes - Status

CPT Code	Long Descriptor	RUC Surveyed	RAW Screen	Notes	SS Submitting Action Plan	RUC Recommendation	Code Family	Date of Review Rec
17311 * **See foot note**	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 histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks	Apr 2006			AAD	Survey work and PE for April 2013 RUC meeting.	17313, 17314, 17315	2013 Apr
17312 * **See foot note**	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 histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)	Apr 2006			AAD	Survey work and PE for April 2013 RUC meeting.	17313, 17314, 17315	2013 Apr
31237	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)	Jun 1993			AAO-HNS	Survey work and PE for April 2013 RUC meeting.	31238, 31239, 31240	2013 Apr
70450	Computed tomography, head or brain; without contrast material	Aug 1995	CMS-Other - Utilization over 500,000	Review September 2011 Action Plan	ACR, ASNR	Survey work and PE for April 2013 RUC meeting.	70460	2013 Apr
70551	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material	Aug 1995			ACR, ASNR	Survey work and PE for April 2013 RUC meeting.		2013 Apr
70553	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences	Aug 1995	CMS-Other - Utilization over 500,000	Review September 2011 Action Plan	ACR, ASNR	Survey work and PE for April 2013 RUC meeting.		2013 Apr
72141	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material	Apr 2001			ACR, ASNR	Survey work and PE for April 2013 RUC meeting.		2013 Apr
72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material	Aug 1995	CMS-Other - Utilization over 500,000	Review September 2011 Action Plan	ACR, ASNR	Survey work and PE for April 2013 RUC meeting.		2013 Apr

*** Shaving of Epidermal or Dermal Lesions codes 11300-11313 should be validated for physician work at the April 2012 meeting.**

Summary

2	deleted
3	reviewing at this Jan 2012 meeting
16	already referred or rec to refer to CPT
1	0.00 work RVU (will need to review PE only)
4	recently reviewed (some may need PE review)
13	rec to review April 2012
3	rec to review Oct 2012
4	rec to review Jan 2013
7	rec to review April 2013
17	remaining that need to be assigned to a meeting
70	

American College of Surgeons

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October 21, 2011

Barbara Levy, M.D.
Chair, Relative Value Scale Update Committee
American Medical Association
515 North State Street
Chicago, IL 60654

Re: Concerns Regarding the Berenson-Eggers Type of Service Procedures Category

Dear Dr. Levy:

On behalf of the more than 75,000 members of the American College of Surgeons (ACS), we write to bring to light some issues and inconsistencies regarding the Berenson-Eggers Type of Service (BETOS) procedures category. Given increased national attention to the development of new approaches to Medicare payment for physician services, it is possible that the BETOS coding system could play a larger role in physician reimbursement in the future; however, some aspects of the BETOS procedures category, as discussed below, are outdated. For example, there is currently no process for delineating whether BETOS procedures are classified as major or minor procedures.

Consequently, the ACS requests that the American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee (RUC) collaborate with the Centers for Medicare & Medicaid Services (CMS) to: (1) review the current BETOS categories and associated codes and make necessary changes; and (2) establish an ongoing process by which new or revised codes will be assigned to the correct BETOS category and class as the codes are reviewed by the RUC. This letter describes some of our concerns with the BETOS procedures category and offers initial suggestions for improvement for the RUC's consideration.

Background

The BETOS coding system is used by CMS and other researchers primarily for the purposes of tracking utilization of Medicare services and analyzing growth in Medicare expenditures. The BETOS coding system collapses the Health Care Financing Administration Common Procedure Coding System (HCPCS) procedure codes into generally agreed upon clinically meaningful groupings of procedures and

services. There are seven BETOS categories: 1) Evaluation and Management; 2) Procedures; 3) Imaging; 4) Tests; 5) Durable Medical Equipment; 6) Other; and 7) Exceptions/Unclassified.

The focus of this letter is the "procedures" category. Under the BETOS category of procedures, there are currently 45 BETOS classes organized into seven broad types: 1) anesthesia; 2) major procedures; 3) eye procedures; 4) ambulatory procedures; 5) minor procedures; 6) endoscopy; and 7) dialysis services.

Issue

Numerous inconsistencies exist in the current allocation of HCPCS codes into BETOS classes in the procedures category. Many of these classifications have their origins in medical care as it was provided in the 1980s. As a result, many of these classes are no longer current and have not been updated in over 20 years. These inconsistencies can open the validity of the BETOS coding system to criticism, and can even lead to inaccurate conclusions about the impact of new volume trends and payment policies. Review and revision of the procedures category of the BETOS coding system would greatly improve many of the weaknesses of the BETOS coding system overall and could make the coding system a more reliable and useful research and payment policy tool.

As such, we make two recommendations below on ways to begin to bring the procedures category of the BETOS coding system up to date.

Recommendations

1. **Classification of major vs. minor procedures**: The classification of procedures as either major or minor should be examined and revised. Below are two options for the separation of procedures into major or minor classes for the purposes of BETOS.

   Option 1: Global periods – This option would classify codes as either major or minor procedures for the purposes of BETOS based on their global periods. As such, all 90-day global services would be considered BETOS major procedures and all 10- and 0-day global services would be considered minor BETOS procedures. From the start of the fee schedule in 1992, Medicare has defined "major procedures" as procedures with a 90-day global period. However, BETOS currently classifies some codes without 90-day global periods as major procedures, and classifies some 90-day global services in classes other than major procedures. We believe that Option 1 allows for a clear and straightforward delineation between major and minor procedures.

Option 2: RVU cutoff – Alternatively, a Relative Value Unit (RVU) cutoff could be established to separate services into BETOS major or minor procedures. If an RVU cutoff approach is utilized, we recommend that a panel be convened to determine the appropriate cutoff. Under this option, any code (regardless of the global period) that is not low volume (i.e. the code has at least 1,000 claims per year), that is not an office-based procedure, and that meets the defined RVU cutoff, would be considered a BETOS major procedure. All other procedures would be considered minor for the purposes of BETOS. The classification of low volume services (less than 1000 claims per year) would be determined on a case-by-case basis.

Under this approach, most of the procedures that would be considered major would be those with 90-day globals. The RVU cutoff option would also apply to services with 10- and 0-day global periods; however, because more of these codes are performed in an office-based setting they would be less likely to meet the definition of BETOS major procedures. Office-based procedures would be excluded from being considered BETOS major procedures, even if they meet the RVU cutoff.

2. **Removal of mismatched procedures**: Some procedures located in the BETOS procedures category would be more suitable for other categories/classes. Two examples of such mismatched procedures are described below.

Anesthesia – One of the classes in the procedures category is class P0 "Anesthesia." This classification of anesthesia is somewhat incongruous, relative to the other classes included in the BETOS category of procedures. It would be more appropriate to remove the anesthesia class and create an entirely new BETOS category for anesthesia. Because anesthesia has its own conversion factor, which is distinct from the Medicare Conversion Factor, and is paid using a different formula, it is logical to create a new BETOS category for anesthesia, separate from the BETOS procedures category.

Interventional cardiovascular and interventional radiology procedures – These two types of procedures are scattered throughout several of the major procedures classes. Many of these interventional cardiovascular and interventional radiology codes have high RVUs and 0-day global periods and are performed by non-surgeons, while the other codes in the major procedures classes are performed by surgeons the vast majority of the time. A more coherent grouping would be to create separate BETOS procedures classes for interventional cardiovascular procedures and interventional radiology procedures.

As noted above, we request that the RUC collaborate with CMS to: (1) review the current BETOS categories and associated codes and make necessary changes; and (2) establish an ongoing process by which new or revised codes will be assigned to the correct BETOS category and class at the time of RUC review. The RUC has the required expertise and therefore is the ideal entity to conduct a comprehensive review of the BETOS coding system and to establish a process for codes to be classified appropriately going forward.

We welcome the opportunity to further discuss the benefits and limitations of each of the suggested approaches for revising the BETOS procedures category, and to share additional information and recommendations. Updating the BETOS procedures category will help maintain the validity of the BETOS coding system, will work to avoid inaccurate conclusions about the impact of new payment policies and volume trends, and could result in a more reliable and useful research and payment policy tool for the future.

We appreciate your attention to this important matter. If you have any questions about our recommendations, please contact Bob Jasak, Assistant Director for Regulatory and Quality Affairs, in the ACS Division of Advocacy and Health Policy. He may be reached at bjasak@facs.org or at (202) 672-1508.

Sincerely,

David B. Hoyt

David B. Hoyt, MD, FACS
Executive Director

cc: Sherry L. Smith, Director, Physician Payment Policy and Systems, AMA

AMA/Specialty Society RVS Update Committee Summary of Recommendations
New Technology/New Services Screen

January 2012

Computer Navigation

In April 2007, CPT code 20985 *Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less* (work RVU=2.50) was added to the new technology list to be re-reviewed after three years of utilization data were available. In September 2011, the RAW noted that the Medicare utilization was higher than the original estimate and recommended that this service be surveyed for work and practice expense for January 2012.

The RUC reviewed the survey results from 41 orthopaedic surgeons and recommends to maintain the current work RVU of 2.50. Although the data supported the 25th percentile (work RVU=3.00), it was determined that there is no compelling evidence that the physician work has changed since the last review. The RUC noted that the current survey indicates pre-service time of 10 minutes and intra-service time of 20 minutes, which appropriately accounts for the required physician time and is identical to the current time for this service. The RUC agreed that while add-on codes typically do not have pre-service time, 20985 is unique because of the significant time and effort required to initiate and calibrate the computer equipment and review the preoperative report with the patient. The RUC compared 20985 to key reference service 61783 *Stereotactic computer-assisted (navigational) procedure; spinal* (work RVU=3.75) and determined that the surveyed code requires less physician time, 20 and 30 minutes intra-service time, respectively, and requires less technical skill and psychological stress than the reference code. The RUC also noted that like 20985, code 61783 is an add-on service with separately identifiable pre-service time. Finally the RUC reviewed the rest of the family of computer-assisted navigational procedures, CPT codes 61781 *Stereotactic computer-assisted (navigational) procedure; cranial, intradural (*work RVU= 3.75) and 61782 *Stereotactic computer-assisted (navigational) procedure; cranial, extradural* (work RVU= 3.18) and agreed that the with similar physician work, but less total time, the current work value for 20985 maintains appropriate relativity within this family of similar services. **The RUC recommends a work RVU of 2.50 for CPT code 20985.**

Practice Expense:
The RUC approved the direct practice expense inputs as modified and submitted by the Practice Expense Subcommittee.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure)	ZZZ	2.50 (No Change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:20985 Tracking Number Original Specialty Recommended RVU: **2.50**
Presented Recommended RVU: **2.50**
Global Period: ZZZ RUC Recommended RVU: **2.50**

CPT Descriptor: Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old woman presents with increasing pain when walking and stair climbing. Examination shows an antalgic gait, bilateral varus knee deformities, painful crepitus of both medial joint lines, and limited knee range of motion. Standing planar radiographs demonstrate complete loss of medial joint space, marginal osteophytes, and wear of the medial subchondral bone. A unilateral knee replacement and deformity correction is planned with image-less computer assisted navigation. [Note: When completing this survey, consider ONLY the additional physician work for this add-on service. The primary procedure(s) would be reported separately.]

Percentage of Survey Respondents who found Vignette to be Typical: 88%

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

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

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: At the time of the initial visit, in addition to the standard discussion of total knee replacement, the surgeon spends additional time discussing the use of computer navigation as an adjunct to the total knee procedure. This involves explaining the rationale for the use of the system, how it helps align the knee and that the surgery may be somewhat longer and more complicated. The explanation describes the use of additional small incisions for placement of the pins through the bone along with the additional risks of wound healing issues at the pin sight and the risk of a fracture through one of the pinholes. Prior to the surgical procedure and positioning, the computer navigation unit is brought into the room and following booting up of the computer, the surgeon activates the navigation software and enters patient specific information such as identifiers, surgeon, and side of surgery. Setup options for the program are checked and adjusted as necessary. Once the patient has been positioned on the operating table, the navigation unit is moved into place so the intra-operative trackers will be in the field of view of the cameras and the surgeon will be able to see the computer monitor screen.

Description of Intra-Service Work: Pins are placed through the tibia and femur to which clamps are attached to hold the trackers that will be used during the surgical procedure. If these are placed outside the intended surgical wound, they are inserted percutaneously through separate stab wounds and engage to one or both cortices. One or two pins may be used on the tibia and femur. If the pins are placed inside the operative wound, the pins are placed after the surgical exposure. Other systems employ small electromagnetic trackers that are also attached to the femur and tibia.

Once the pins are placed, the navigation trackers are secured to them. The trackers may be passive devices with reflective balls whose position is determined by infrared light signals sent from the camera system which senses their position. They may also be active devices that emit infrared light signals that are sensed by a camera system. The initial part of the procedure is to register these trackers with the computer navigation system.

Following activation and identification of the trackers, the registration process begins with moving the hip in a circular fashion that allows the computer software to identify the center of the sphere created in space which is also the center of the femoral head. Following surgical exposure, the bony landmarks of the femur and tibia are identified individually by directed digitization with a "pointer" device that also has tracker components on it. The landmarks identified are generally the medial epicondyle, the lateral epicondyle, distal femoral center, axis of the femoral trochlear groove, the surfaces of the medial and lateral distal and posterior condyles and the topography of the medial and lateral anterior distal femur. The tibia is then registered by digitizing the center of the tibial plateau, the anterior-posterior axis of the tibia and the surfaces of the medial and lateral tibial condyles. The ankle center is found by digitizing the tips of the medial and lateral malleoli and the point between them.

After the anatomy has been registered, an initial assessment is made of the range of motion of the knee with the values displayed on the computer screen. The amount of angular deformity and degree of ligament imbalance are also determined. With this information, some systems then also determine an optimal implant size and position with the bone cuts needed to place it.

In all total knee systems, the instruments are designed to place metal cutting blocks that are used to guide the power saws for the bone cuts. With navigation, these are positioned and pinned into place using navigated guidance while following the position of the block relative to the bone on the computer screen. Once the blocks are placed, the bone cuts are made with a saw in the same manner as it would be for a conventional total knee. However, once the cut is completed, with navigation there is an opportunity to check the accuracy of the cut which may be off due to cutting errors made by the surgeon or deflection of the blade by sclerotic bone. With navigation, each cut can be verified with the opportunity to re-do or adjust the cut. The navigation verification and subsequent correction of the bony cuts involve extra time and work. Either the tibia or femur may be cut first in these systems. Implant sizing and positioning of additional cutting blocks to finish the shaping of the femur is done with navigated guidance followed by the saw cuts as would be done in a standard total knee.

After the bony cuts are made, a trial reduction is performed and the navigation system is used to check the overall mechanical alignment (the general goal is to achieve 0 degrees of varus/valgus). The navigation system can also be used to quantify whether the collateral ligaments are balanced (equal tension on both sides) to determine if soft tissue releases are needed. The navigation system also shows if the procedure has resulted in full range of motion, especially extension to a least 0 degrees, or a straight knee. If these goals are not achieved, the appropriate surgical technique or modification of the implant choices is made using the navigation screen as a guide.

Following the trial reduction and preparation of the bone, the implants are inserted, usually with bone cement for fixation. As the bone cement is curing, navigation can be used to make minor adjustments in alignment and extension to ensure that the alignment and range of motion goals are maintained as the bone cement hardens. Once the implants are fixed, the final alignment, ligament stability and range of motion are recorded with the software system.

At the conclusion of the surgical procedure, the trackers are removed and the pins backed out of the femur and tibia. Pin wounds are closed.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012				
Presenter(s):	William Creevy, MD; John Heiner, MD				
Specialty(s):	orthopaedic surgery (AAOS, AAHKS)				
CPT Code:	20985				
Sample Size:	500	**Resp N:**	41	**Response:** 8.2 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	10.00	**50.00**	125.00	500.00
Survey RVW:	1.20	3.00	**3.70**	4.00	6.70
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	15.00	**20.00**	30.00	70.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

CPT Code:	20985	**Recommended Physician Work RVU: 2.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**0.00**	**10.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
61783	ZZZ	3.75	**RUC Time**

CPT Descriptor Stereotactic computer-assisted (navigational) procedure; spinal (List separately in addition to code for primary procedure)

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
22525	ZZZ	4.47	**RUC Time**	12,038

CPT Descriptor 1 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
63048	ZZZ	3.47	**RUC Time**	122,621

CPT Descriptor 2 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
61782	ZZZ	3.18	**RUC Time**

CPT Descriptor Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 17 **% of respondents:** 41.4 **%**

TIME ESTIMATES (Median)	**CPT Code: 20985**	**Key Reference CPT Code:** 61783	**Source of Time** **RUC Time**
Median Pre-Service Time	10.00	15.00	
Median Intra-Service Time	20.00	30.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**30.00**	**45.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.82	2.76
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.24	3.18
Urgency of medical decision making	2.71	2.76
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.35	4.47
Physical effort required	3.29	3.29
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.06	3.35
Outcome depends on the skill and judgment of physician	4.35	4.47
Estimated risk of malpractice suit with poor outcome	3.76	4.06

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.40	2.27
Intra-Service intensity/complexity	4.24	4.24
Post-Service intensity/complexity	1.50	1.40

Additional Rationale and Comments

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

Code 20985 was approved by the CPT Editorial Panel in February 2007 to replace a Category III CPT code. The RUC reviewed code 20985 in April 2007 and added it to the new technology list to be re-reviewed after three years of utilization data were available. In September 2011, the RAW noted that the Medicare utilization was higher than what was originally estimated and requested that this service be surveyed for work and practice expense for January 2012. (Please note that the estimate for utilization provided in 2007 was based on the utilization of the Category III code that was to be deleted.)

The AAOS conducted a RUC survey and received 41 responses from surgeons without a financial conflict. The median pre-, intra-, and post-service survey times are identical to the current database times. Two other codes for computer-assisted surgical navigation (61783 and 61782) were chosen as references by 39 of the 41 respondents.

We continue to support additional pre-time that is required to initiate and calibrate computer navigation equipment as well as additional patient positioning time for the computer navigation to be used. This additional work and time was accepted previously by the RUC for 20985.

We are recommending the current work RVU of 2.50 for 20985, pre-time of 10 minutes, and intra-time of 20 minutes. The physician work and technology for this service has not changed. A work RVU of 2.50 ranks 20985 correct relative to similar services 61783 and 61782.

CPT	DESC	RVW	TOT MIN	PRE MIN	INTRA MIN	POST MIN
20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure)	2.50	**30**	10	**20**	0
61782	Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure)	3.18	**40**	15	**25**	0
61783	Stereotactic computer-assisted (navigational) procedure; spinal (List separately in addition to code for primary procedure)	3.75	**45**	15	**30**	0

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

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

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

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. 20985 may be reported as an add-on code to total joint replacement surgery

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 20985

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

Specialty orthopaedic surgery How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national frequency unknown

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
12,757 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. CMS Website: 2010 Medicare final utilization for CY 2012 PFS

Specialty orthopaedic surgery Frequency 12649 Percentage 99.15 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

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

---

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 20985

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

SS Rec Summary

ISSUE: Computer Navigation

TAB: 14

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
REF	61783	Stereotactic computer-assisted (navigational) proc	17	0.114			3.75			45	15					30			0
REF	61782	Computer-assisted surgical navigational procedur	12	0.114			3.18			40	15					25			0
CURRENT	20985	Computer-assisted surgical navigational procedur		0.114			2.50			30	10					20			0
SVY	20985	Computer-assisted surgical navigational procedur	41	0.174	1.20	3.00	3.70	4.00	6.70	30	10			10	15	20	30	70	0
REC	20985	Computer-assisted surgical navigational procedur		0.114			2.50			30	10					20			0

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

CPT Long Descriptor:
Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure)

Global Period: ZZZ Meeting Date: 01/2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: Consensus committee reviewed current PE details and determined no change.

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale: Consensus committee reviewed current PE details and determined no change.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

n/a

Intra-Service Clinical Labor Activities:

n/a

Post-Service Clinical Labor Activities:

n/a

	A	B	C	D	E	F	G
1	**Computer Navigation**		**CPT Code**	**Current 20985 approved 2007**		**20985 (no change)**	
2	**Meeting Date: 01/2012 Specialty: AAOS, AAHKS**	**CMS**	**Staff**	**Computer-assisted surgical navigational procedure for musculoskeletal**		**Computer-assisted surgical navigational procedure for musculoskeletal**	
3	**GLOBAL PERIOD**			**ZZZ**		**ZZZ**	
4	**LOCATION**	**Code**	**Type**	**OFF**	**FAC**	**OFF**	**FAC**
5	**TOTAL CLINICAL LABOR TIME**			**0**	**0**	**0**	**0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0**	**0**	**0**	**0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**0**	**0**	**0**	**0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0**	**0**	**0**	**0**
9	**PRE-SERVICE**						
10	**Start: Following visit when decision for surgery**						
17	**End: When patient enters office/facility for surge**						
18	**SERVICE PERIOD**						
19	**Start: When patient enters office/facility for surgery/pr**						
39	**End: Patient leaves office**						
40	**POST-SERVICE Period**						
41	**Start: Patient leaves office/facility**						
53	**MEDICAL SUPPLIES**						
54							
55	**Equipment**						
56							

AMA/Specialty Society RVS Update Committee Summary of Recommendations
New Technology/New Services Screen

January 2012

Arthroscopic Biceps Tenodesis

In April 2007, CPT code 29828 *Arthroscopy, shoulder, surgical; biceps tenodesis* (work RVU=13.16) was identified through the New Technology/New Services List. In September 2011, the Relativity Assessment Workgroup noted that the Medicare utilization was higher than what was originally estimated and recommended that this service be surveyed for work and practice expense for January 2012.

The RUC reviewed the survey results from 38 orthopaedic surgeons and recommends to maintain the current work RVU of 13.16. The RUC reviewed the physician time components and determined that 60 minutes pre-service time,75 minutes intra service time and 20 minutes post-service time appropriately accounts for the physician time required to perform this service. It was determined that the additional pre-service positioning time of 9 minutes appropriately accounts for the physician time required to position the patient, pad areas of the body, including the head and neck, strap the patient to equipment to ensure he/she remains in the lateral decubitis position and place the patient's hand in traction. The Committee noted that the physician time is the same as the current time, expect for pre-service time which is slightly less due to the selection of the pre-service time package. The RUC compared code 29828 to key reference service 29807 *Arthroscopy, shoulder, surgical; repair of SLAP lesion* (work RVU=14.67) and two hip arthroscopic codes, 29915 *Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)* (work RVU=15.00) and 29916 *Arthroscopy, hip, surgical; with labral repair* (work RVU=15.00) and determined that these reference services require slightly more physician time (90 minutes intra-service) and physician work to perform than the surveyed code. The RUC also reviewed the specialty society's request for 4 office visits (2-99212 and 2-99213) and agreed that these are necessary to exam and evaluate post-operative progress, assess pain and prescribe narcotics and physical therapy. **The RUC recommends a work RVU of 13.16 for CPT code 29828.**

Practice Expense:
The RUC reviewed and approved the direct practice expense inputs as modified by the Practice Expense Subcommittee.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
29828	Arthroscopy, shoulder, surgical; biceps tenodesis	090	13.16 (No Change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:29828 Tracking Number Original Specialty Recommended RVU: **13.16**
Presented Recommended RVU: **13.16**
Global Period: 090 RUC Recommended RVU: **13.16**

CPT Descriptor: Arthroscopy, shoulder, surgical; biceps tenodesis

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 57-year-old male presents with a 5-month history of anterior shoulder pain. He has been treated with physical therapy, anti-inflammatory medications, and an injection without improvement. There is a normal contour to his biceps muscle. He has pain over of the bicipital groove and with resisted elbow flexion and supination. A diagnosis of biceps tendon degeneration and tendonitis is made. An arthroscopic biceps tenodesis is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 87%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 42% , In the ASC 58%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Write preadmission orders for preoperative medications. Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs. Reexamine patient to make sure that physical findings have not changed, and update H&P. Meet with patient and family to review planned procedure and post-operative management. Review informed consent with patient. Verify that all required instruments and supplies are available, including positioning of monitors and arthroscopic/video equipment. Monitor/assist with patient positioning - position the patient supinely and apply a shoulder boom to support the arm and allow the appropriate amount and angle of traction. Roll the patient into the lateral decubitus position and place pads to protect areas from pressure. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Under anesthesia, a posterior portal is made to gain access to the glenohumeral joint. A diagnostic arthroscopy is performed. The biceps tendon exhibits a partial tear involving 25% of its width. An anterior portal is introduced and the cuff and biceps tears are debrided. An 18-gauge spinal needle is percutaneously passed through the biceps tendon and a monofilament stitch is placed in the needle and retrieved through the anterior portal to capture the tendon. The biceps tendon is then tenotomized at superior glenoid labrum and the tendon is delivered throughout the anterior portal. A nonabsorbable suture is then used to create a whipstitch in the terminal 20 mm of the biceps tendon stump. While viewing the subacromial space through the lateral portal, an anterolateral portal is then created and a guide wire is driven into the humerus at the bicipital groove. A bone tunnel is then created with a cannulated reamer. The end of the biceps tendon is then brought into the subacromial space and placed in the bone tunnel. An interference screw then fixes the tendon in the tunnel. The arthroscope is removed and the portals are closed with sutures. The portals are injected with Marcaine and a sterile dressing is applied.

Description of Post-Service Work:
Facility: Apply bulky dressing and a sling. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Monitor patient stabilization in the recovery room. Discuss postoperative recovery care with anesthesia and nursing staff. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Prior to discharge, check patient's vital signs. Assess circulation, sensation, and motor function of the operated extremity. Discuss home restrictions (ie, activity, bathing) with the patient and family. Write prescriptions for medications needed post-discharge. Complete all appropriate medical records, including discharge summary, discharge instructions, and insurance forms.

Post-op Office Visits: Examine and talk with patient. Answer patient/family questions. Remove sling/dressings. Assess surgical wound. Remove sutures. Assess ROM, strength, and neurovascular status of the operated extremity. Assess opposite extremity for comparison. Redress wound. Reapply sling. Order physical therapy. Order radiographs, as necessary. Supervise rehabilitation. Discuss progress with PCP (verbal and written). Write prescriptions for medications, as necessary. Dictate progress notes for medical chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012					
Presenter(s):	William Creevy, MD; John Heiner, MD; Louis McIntyre, MD					
Specialty(s):	orthopaedic surgery (AAOS, AANA, ASES)					
CPT Code:	29828					
Sample Size:	250	**Resp N:**	38	**Response:** 15.2 %		
Sample Type:	Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	6.00	**15.00**	30.00	100.00
Survey RVW:	10.00	12.50	**14.67**	15.00	18.00
Pre-Service Evaluation Time:			**48.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	45.00	60.00	**75.00**	90.00	120.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**78.00**	99211x **0.00** 12x **2.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	29828	**Recommended Physician Work RVU: 13.16**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**12.00**	**3.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**75.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**78.00**	99211x **0.00** 12x **2.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
29807	090	14.67	**RUC Time**

CPT Descriptor Arthroscopy, shoulder, surgical; repair of SLAP lesion

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
58660	090	11.59	**RUC Time**	1,829

CPT Descriptor 1 Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
63047	090	15.37	**RUC Time**	81,430

CPT Descriptor 2 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 16 **% of respondents:** 42.1 **%**

TIME ESTIMATES (Median)	**CPT Code: 29828**	**Key Reference CPT Code:** 29807	**Source of Time RUC Time**
Median Pre-Service Time	60.00	55.00	
Median Intra-Service Time	75.00	90.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	78.0	94.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**252.00**	**288.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.94	3.88
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.63	3.63
Urgency of medical decision making	2.69	2.69
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.13	4.13
Physical effort required	3.81	3.75
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.38	3.38
Outcome depends on the skill and judgment of physician	4.25	4.31
Estimated risk of malpractice suit with poor outcome	3.25	3.19

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.44	3.44
Intra-Service intensity/complexity	3.81	3.69
Post-Service intensity/complexity	3.06	3.19

Additional Rationale and Comments

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

In February 2010, code 29828 was identified in the 75% or More Reported Together Screen with 29826. In September 2011, the RUC reviewed survey data for code 29826 (revised to be an add-on code) and agreed that the revision in the global period as well as the elimination of pre-and post-service time eliminates all overlapping work with other

procedures in the pre-operative and post-operative periods. The RUC affirmed a work RVU of 13.16 for CPT code 29828 as correct and not overlapping with the work RVUs for 29826, is an add-on code as of January 1, 2012.

Code 29828 was also identified through the New Technology/New Services List in April 2007. In September 2011, the Relativity Assessment Workgroup noted that the Medicare utilization is higher than what was originally estimated and therefore requests that this service be surveyed for work and practice expense for January 2012.

The AAOS and AANA conducted a RUC survey and received 38 responses from surgeons without a financial conflict. The survey median time and visit data have not changed and support the current work RVU.

Pre-time package 3 (Straightforward Patient/Difficult Procedure) with the addition of 9 minutes for beach chair or lateral decubitus positioning and positioning arthroscopic equipment and imaging equipment relative to the patient and anesthesia lines. Positioning requires padding areas of the body, including the head and neck, strapping the patient to equipment to ensure he/she remains in the lateral decubitis position and place the patient's hand in traction.

We are recommending the current work RVU of 13.16 for 29828. When originally valued, the procedure was mature. The physician work and technology for this service has not changed.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

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

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

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. 29826 is an add-on code for the 2012 Medicare Physician Fee Schedule and 29828 is often a base code with which 29826 is reported, however because 29826 is a ZZZ code there is not overlapping time as the intra-service time for 29826 is strictly the time for the additional intra-service work and does not include pre, immediate post, or any post-service hospital or office visits.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 29828

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

Specialty orthopaedic surgery How often? Commonly

Specialty How often?

Specialty How often?

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

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 6,927
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. CMS Website: 2010 Medicare final utilization for CY 2012 PFS

Specialty orthopaedic surgery Frequency 6727 Percentage 97.11 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 29828

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

SS Rec Summary

ISSUE: Arthoscopic Biceps Tenodesis

TAB: 15

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-in 38	FAC-in 39	Office 15	Office 14	Office 13	Office 12	Office 11
REF	29807	Arthroscopy, shoulder, surgical; repair of SLAP lesi	16	0.097			14.67			288	55					90			30	0.5				2	3	
CURRENT	29828	Arthroscopy, shoulder, surgical; biceps tenodesis		0.104			13.16			262	40	15	15			75			20	0.5				2	2	
SVY	29828	Arthroscopy, shoulder, surgical; biceps tenodesis	38	0.122	10.00	12.50	14.67	15.00	18.00	270	48	15	15	45	60	75	90	120	20	0.5				2	2	
REC	29828	Arthroscopy, shoulder, surgical; biceps tenodesis		0.106			13.16			255	33	15	15			75			20	0.5				2	2	

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

CPT Long Descriptor:
Arthroscopy, shoulder, surgical; biceps tenodesis

Global Period: 090 Meeting Date: 01/2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: Consensus committee reviewed current PE details and determined no change.

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale: Consensus committee reviewed current PE details and determined no change.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Standard 90-day global times to: Complete pre-service diagnostic & referral forms; Coordinate pre-surgery services; Schedule space and equipment in facility; Provide pre-service education/obtain consent, and follow-up phone calls & prescriptions

Intra-Service Clinical Labor Activities:

Standard 6 minutes for discharge day management coordination.

Post-Service Clinical Labor Activities:

Standard times for 4 post-operative office visits.

	A	B	C	D	E	F	G
1	**Arthroscopic Biceps Tenodesis**		**CPT Code**	**CURRENT 29828 Std 90-day**		**29828 (no change)**	
2	**Meeting Date: 01/2012 Specialty: AAOS, AANA**	**CMS**	**Staff**	**Arthroscopy, shoulder, surgical; biceps tenodesis**		**Arthroscopy, shoulder, surgical; biceps tenodesis**	
3	**GLOBAL PERIOD**			**090**		**090**	
4	**LOCATION**	**Code**	**Type**	**OFF**	**FAC**	**OFF**	**FAC**
5	**TOTAL CLINICAL LABOR TIME**	L037D	RN/LPN/MA	**0**	**192**	**0**	**192**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MA	**0**	**60**	**0**	**60**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L037D	RN/LPN/MA	**0**	**6**	**0**	**6**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MA	**0**	**126**	**0**	**126**
9	**PRE-SERVICE**						
10	**Start: Following visit when decision for surgery or procedure made**						
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MA		**5**		**5**
12	Coordinate pre-surgery services	L037D	RN/LPN/MA		**20**		**20**
13	Schedule space and equipment in facility	L037D	RN/LPN/MA		**8**		**8**
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MA		**20**		**20**
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MA		**7**		**7**
17	**End: When patient enters office/facility for surgery/procedure**						
18	**SERVICE PERIOD**						
19	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**						
37	Discharge day management	L037D	RN/LPN/MA		**6**		**6**
39	**End: Patient leaves office**						
40	**POST-SERVICE Period**						
41	**Start: Patient leaves office/facility**						
43	*Office visits:*						
44	*List Number and Level of Office Visits*						
45	99211 16 minutes	L037D	16				
46	99212 27 minutes	L037D	27		**2**		**2**
47	99213 36 minutes	L037D	36		**2**		**2**
48	99214 53 minutes	L037D	53				
49	99215 63 minutes	L037D	63				
50	99238 12 minutes	L037D	12				
51	*Total Office Visit Time*				**126**		**126**
52	Other Activity (please specify)						
53	**MEDICAL SUPPLIES**		Unit				
54	pack, minimum multi-specialty visit	SA048	pack		**4**		**4**
55	pack, post-op incision care (suture)	SA054	pack		**1**		**1**
56	**Equipment**						
57	table, power	EF031			**126**		**126**
58	light, exam	EQ168			**126**		**126**

AMA/Specialty Society RVS Update Committee Summary of Recommendations
MPC List Screen

January 2012

Diagnostic Nasal Endoscopy

In October 2012, CMS identified CPT code 31231 *Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)* through the MPC List screen. In September 2011, the RUC recommended that the specialty society should re-survey this service for the January 2012 RUC meeting with an improved vignette to describe the typical unilateral vs. bilateral nasal endoscopy and better define the work of the involved topical and pledgets anesthetic in the survey instrument.

In January 2012, the RUC reviewed the survey results from 135 otolaryngologists for CPT code 31231 and determined that the survey 25th percentile and current work RVU of 1.10 should be maintained. The RUC noted that this service is typically performed with an Evaluation and Management service on the same day and the specialty society confirmed that 12 minutes was specifically removed from pre-time package-6, to account for any duplication of work with the Evaluation and Management service. Therefore, 5 minutes of pre-evaluation time accounts for the time to obtain consent, move the patient, check equipment and review the CT scan, 1 minute for positioning the patient and 5 minutes of scrub/dress/wait time to administer local anesthetic and have it take effect. The RUC compared 31231 to key reference service 31575 *Laryngoscopy, flexible fiberoptic; diagnostic* (work RVU = 1.10) and noted that 31231 requires slightly less intra-service time to perform, 7 minutes and 8 minutes, respectively. The specialty society indicated and the RUC agreed that this difference in time and intensity may be because 31231 is typically performed using a rigid endoscope, whereas 31575 is performed using a flexible endoscope. The specialty society indicated that use of a flexible endoscope is easier and requires less skill. The RUC compared 31231 to similar service 30901 *Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method* (work RVU = 1.10) and noted that 31231 requires 3 minutes less intra-service time, however is more intense as the surveyed service requires the use of an endoscope. Additionally, the RUC compared 31231 to 99213 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 0.97 and 23 minutes total time) and determined that these services require the same total physician time to perform, however 31231 is more intense and complex because it is an invasive procedure and therefore should be valued higher.

Lastly, the RUC noted that the survey respondents indicated that the intra-time is 3 minutes less than current time but requires the same physician work, thus increasing the intensity. The RUC reviewed the comparative intrusive diagnostic services referenced by the specialty society [CPT codes 52000 *Cystourethroscopy* (work RVU = 2.23), 43250 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery* (work RVU = 3.20) and 31629 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration*

biopsy(s), trachea, main stem and/or lobar bronchus(i) (work RVU = 4.09)] and determined that a slight decrease in physician time for the surveyed code is appropriate compared to these services that combine technical skill for insertion of a scope for the purpose of cognitive/diagnostic evaluation. The RUC agreed that services such as 31231, that have low work RVUs and do not require a significant amount of time to perform will be more effected by small valuations in time, however, the survey data and reference services support to maintain the current value. **The RUC recommends a work RVU of 1.10 for CPT code 31231.**

Practice Expense:
The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
31231	Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)	000	1.10 (No change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:31231 Tracking Number Original Specialty Recommended RVU: **1.10**
Presented Recommended RVU: **1.10**
Global Period: 000 RUC Recommended RVU: **1.10**

CPT Descriptor: Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 47 year-old male is evaluated for nasal obstruction, chronic rhinorrhea, and recurrent rhino sinusitis, unresponsive to prior medical therapy. Physical examination, including anterior rhinoscopy, is normal except for nasal mucosal edema. The patient undergoes a diagnostic nasal endoscopy of both nasal passages.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

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

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

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 17%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 3%

Description of Pre-Service Work: After decision is made to perform nasal endoscopy, the patient is moved to room equipped with video tower and protective gown/drape is provided. The physician ensures that proper nasal endoscope, suction and video recording equipment are available and working. The procedure is explained to the patient, consent obtained. Time out is performed. Physician washes hands and dons sterile gloves. Topical decongestant and anesthetic sprays are applied with 5 minute wait time for these to take effect.

Description of Intra-Service Work: The nasal cavity is examined to ensure that there is adequate patency and further anesthetic on pledgets applied with endoscopic direction to specific areas requiring more profound anesthesia (ex, middle meatus, sphenoid cleft) in order to allow full visualization of key areas. After additional wait to allow topical anesthetic to take effect; systematic nasal endoscopy is performed (one side or both evaluating inferior, middle and superior meati with attention to all major sinus ostia, septal contour, and nasopharyngeal entrance). Images are captured on digital system. Culture swabs are taken from areas of mucopurulence as indicated. Temporary re-positioning of pledgets in any region of minor hemorrhage applied as needed.

Description of Post-Service Work: Aftercare treatment and findings are explained to the patient (often by the use of the procedure video recording, archiving of images file), including subsequent therapeutic plan. Images are saved on digital video system. The procedure note is dictated and findings communicated to relevant care providers.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012					
Presenter(s):	Wayne Koch, MD					
Specialty(s):	American Academy of Otolaryngology - Head and Neck Surgery					
CPT Code:	31231					
Sample Size: 283	**Resp N:** 135	**Response:** 47.7 %				
Sample Type: Random	**Additional Sample Information:**					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	10.00	200.00	**360.00**	800.00	5000.00	
Survey RVW:	0.35	1.10	**1.30**	2.25	5.75	
Pre-Service Evaluation Time:			**5.00**			
Pre-Service Positioning Time:			**2.00**			
Pre-Service Scrub, Dress, Wait Time:			**10.00**			
Intra-Service Time:	0.00	5.00	**7.00**	10.00	30.00	
Immediate Post Service-Time:	**5.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

CPT Code:	31231	**Recommended Physician Work RVU: 1.10**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**17.00**	**-12.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**7.00**		
Immediate Post Service-Time:	**5.00**			
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**		
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**		
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**		
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**		
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**		
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**		
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**		

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
31575	000	1.10	**RUC Time**

CPT Descriptor Laryngoscopy, flexible fiberoptic; diagnostic

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
78315	XXX	1.02	**RUC Time**	105,814

CPT Descriptor 1 Bone and/or joint imaging; 3 phase study

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
78494	XXX	1.19	**RUC Time**	5,973

CPT Descriptor 2 Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing.

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 81 **% of respondents:** 60.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 31231**	**Key Reference CPT Code:** 31575	**Source of Time RUC Time**
Median Pre-Service Time	11.00	15.00	
Median Intra-Service Time	7.00	8.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**23.00**	**28.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.98	3.88
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.52	3.34
Urgency of medical decision making	3.16	3.27
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.98	3.67
Physical effort required	3.08	2.93
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.32	2.31
Outcome depends on the skill and judgment of physician	3.71	3.60
Estimated risk of malpractice suit with poor outcome	2.48	2.53

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.61	2.56
Intra-Service intensity/complexity	3.53	3.29
Post-Service intensity/complexity	2.59	2.51

Additional Rationale and Comments

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

Why is this Code Being Reviewed?

Code 31231 was identified by the MPC List screen. This code has not been reviewed by the RUC in the past 6 years and the RUC recommended that this service be surveyed. The code was initially surveyed by American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) for the September 2011 RUC meeting. However, based on difficulty interpreting the survey data received by our expert panel, the AAO-HNS requested the opportunity to re-

survey the code for the January 2012 RUC meeting in pre-facilitation. The Research Subcommittee accepted the AAO-HNS proposed revised vignette and survey instrument to provide clarification to survey respondents and a repeat survey was performed.

Work RVU Recommendation

The American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) conducted a RUC survey in fall of 2011, receiving 135 responses and a very robust survey response rate of 47%. The survey median RVW was 1.30, however the expert panel reviewing did not find compelling evidence that the work has changed to support an increased valuation. Therefore, the Academy recommends maintaining the current value of 1.10 which is the survey 25th percentile.

The panel's recommendations are in line with comparator codes: the key reference service code 31575 *Laryngoscopy, flexible fiberoptic; diagnostic*, and 30901 *Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method*, both with RVWs of 1.10. Key reference code 31575 has similar time and is a similar service. The time for 31575 includes more pre-service time, but the survey indicates a modestly higher level of intensity for 31231.

Pre-time

Pre-time package 6 (office procedure with anesthesia) is selected.
Evaluation: Subtract 12 minutes overall (total = 5) Typically, an E/M is performed the same day so 9 minutes is subtracted for history and exam.
Position: No change (total = 1).
Scrub, dress, wait: No change (total = 5) for initial spray application of topical anesthetic and decongestant agents

Comparison to key reference code

	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	IM-post
31231	1.10	0.116	23	5	1	5	7	5
31575	1.10	0.090	28	5	5	5	8	5

Comparison to MPC codes

CPT	DESCRIPTOR	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	IM-post
78315	Bone and/or joint imaging; 3 phase study	1.02	.0995	18	5			8	5
31231	Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)	1.10	.116	23	5	1	5	7	5
78494	nuclear med gated blood pool study	1.19	.0488	26	3			23	0

The table below compares the survey code to other RUC reviewed codes of similar time and work, providing further support that the recommended value for 31231 is appropriate.

RUC Year	CPT	2011 RVW	2011 IWPUT	Total Time	Pre eval	Pre posit	Pre s,d,w	INTRA	Post sd-im
2002	78306	0.86	0.0794	18	5			8	5
2006	99202	0.93	0.0516	22	2			15	5
2002	20526	0.94	0.1387	16	6			5	5
2000	99213	0.97	0.0527	23	3			15	5
2001	12011	1.07	0.068	24	5	1	1	12	5
2000	30901	1.1	0.0813	26	6		5	10	5
2007	36620	1.15	0.0924	22	2	2	3	10	5
2003	74160	1.27	0.0727	23	3			15	5
2009	67028	1.44	0.2261	22	6	1	5	5	5
2005	67500	1.44	0.2127	25	5	5	5	5	5
2003	65430	1.47	0.1067	28	10			10	8
2007	58100	1.53	0.097	35	20			10	5

2000	53620	1.62	0.1284	25	15			10	0

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 31231

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

Specialty Otolaryngology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 390,494 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Otolaryngology Frequency 365500 Percentage 93.59 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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

---

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 31231

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

Tab 19 Rec Summary

ISSUE: Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure) CPT 31231. Originated from MPC List screen.

TAB: 19

Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD
					MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
REF	31575	Laryngoscopy, flexible fiberoptic; diagnostic	81	0.0904			1.10			28	5	5	5			8			5
CURRENT	31231	Nasal endoscopy, diagnostic, unilateral or bilateral	37	0.0652			1.10			30	10					10			10
SVY	31231	Nasal endoscopy, diagnostic, unilateral or bilateral	135	0.1357	0.35	1.10	1.30	2.25	5.75	29	5	2	10	0	5	7	10	30	5
REC	31231	Nasal endoscopy, diagnostic, unilateral or bilateral	135	0.1162			1.10			23	5	1	5			7			5

August 4, 2011

CPT Code:___31231_____
Specialty Society('s)_____AAO-HNS_____

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

CPT Long Descriptor: Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)

Global Period:__0___ Meeting Date:___January 2012_____

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
An expert panel of AAOHNS members composed of multiple practicing physicians both academic and non-academic with broad geographic distribution who are familiar with performing 31231 reviewed the PE details and added, deleted, and revised times, supplies and equipment as appropriate.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
Since 31231 is billed with an E/M approximately 60% of the time, the standard times for pre-service are recommended.

Intra AND Post-Service Clinical Labor Activities:

	facility 31231
SERVICE PERIOD	
Discharge day management	**6**
POST-SERVICE PERIOD	
Conduct phone calls/call in prescriptions	**3**

No Supplies or Equipment

CPT Code: 31231
Specialty Society('s) AAO-HNS

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

CPT Long Descriptor: Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)

Global Period: 0 Meeting Date: January 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
An expert panel of AAOHNS members composed of multiple practicing physicians both academic and non-academic with broad geographic distribution who are familiar with performing 31231 reviewed the PE details and added, deleted, and revised times, supplies and equipment as appropriate.

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

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
Since 31231 is billed with an E/M approximately 60% of the time, the standard times for pre-service are recommended with 2 minutes for completing pre-service diagnostic & referral forms after the decision has been made to undergo procedure.

Intra-Service Clinical Labor Activities:

As indicated in PE spreadsheet.

Post-Service Clinical Labor Activities:

As indicated in PE spreadsheet.

Supplies and Equipment

As indicated in PE spreadsheet.

	A	B	C	D	E	F	G	H	I	J	K
1	**TAB 19: REVISED 1.26.12**			**31231 Recommendation**						**31231 current**	
2	**Meeting Date: January 2012 Specialty: AAOHNS**	**CMS**	**Staff**	**Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)**			**Meeting Date: September 2002 Specialty: AAO-HNS**	**CMS**	**Staff**	**Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**		**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD 000**						**GLOBAL PERIOD 000**				
5	**TOTAL CLINICAL LABOR TIME**	130	RN/LPN/ MA	66.0	9.0		**Total Clinical Labor Time**	130	RN/LPN /MA	**82**	**36**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**	130	RN/LPN/ MA	0.0	0.0		**PRE-service time**	130	RN/LPN /MA	**18**	**30**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	130	RN/LPN/ MA	63.0	6.0		**SERVICE time**	130	RN/LPN /MA	**64**	**6**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**	130	RN/LPN/ MA	3.0	3.0		**POST-service time**	130	RN/LPN /MA	**0**	**0**
9	**PRE-SERVICE**						**PRE-SERVICE - BEFORE ADMISSION**	**Code**	**Desc**		
10	**Start: Following visit when decision for surgery or procedure made**		RN/LPN/ MA				**Start: Following visit when decision for surgery or procedure made**		RN/LPN /MA		
11	Complete pre-service diagnostic & referral forms	130	RN/LPN/ MA	0	0		Complete pre-service diagnostic & referral forms (5/5)	130	RN/LPN /MA	**5**	**5**
12	Coordinate pre-surgery services	130	RN/LPN/ MA	0	0		Coordinate pre-surgery services review exam/test results (10/20)	130	RN/LPN /MA	**3**	**10**
13	Schedule space and equipment in facility	130	RN/LPN/ MA	0	0		Schedule space and equipment in facility (0/8)	130	RN/LPN /MA	**0**	**5**
14	Provide pre-service education/obtain consent	130	RN/LPN/ MA	0	0		Provide pre-service education/obtain consent (10/20)	130	RN/LPN /MA	**7**	**7**
15	Follow-up phone calls & prescriptions	130	RN/LPN/ MA	0	0		Follow-up phone calls & prescriptions (10/7)	130	RN/LPN /MA	**3**	**3**
16	Other Clinical Activity (please specify)	130	RN/LPN/ MA				**Other Clinical Activity (please specify)**				
17	**End: When patient enters office/facility for surgery/procedure**	130					**End: When patient enters office/facility for surgery/procedure**	130			
18	**SERVICE PERIOD**						**SERVICE PERIOD - ADMISSION TO DISCHARGE**	**Code**	**Desc**		
19	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**						**Pre-service services**				
20	Greet patient, provide gowning, ensure appropriate medical records are available	130	RN/LPN/ MA	0			Assemble/review X-ray, lab, path reports (99213=2)	130	RN/LPN /MA	**5**	**--**
21	Obtain vital signs	130	RN/LPN/ MA	0			Greet patient and provide gowning (peac std=3)	130	RN/LPN /MA	**3**	**--**
22	Provide pre-service education/obtain consent	130	RN/LPN/ MA	**3**			Obtain vital signs (Vitals 0=0; 1-3=3; 4-6=5)	130	RN/LPN /MA	**5**	**--**
23	Prepare room, equipment, supplies	130	RN/LPN/ MA	**2**			Review pre-service education/obtain consent	130	RN/LPN /MA	**3**	**--**
24	Setup scope (non facility setting only)	130	RN/LPN/ MA	**5**			Prepare room, equipment,supplies (99213=2)	130	RN/LPN /MA	**8**	**--**
25	Prepare and position patient/ monitor patient/ set up IV	130	RN/LPN/ MA	**2**			Prepare and position patient	130	RN/LPN /MA	**2**	**--**
26	Sedate/apply anesthesia	130	RN/LPN/ MA	**2**			Sedate/apply anesthesia	130	RN/LPN /MA	**7**	**--**
27	**Intra-service**						**Intra-service**				
28	Assist physician in performing procedure	130	RN/LPN/ MA	**7**			1st assist physician in performing procedure	130	RN/LPN /MA	**10**	**--**
29	**Post-Service**						**Post-Service**				
30	Monitor pt. following service/check tubes, monitors, drains	130	RN/LPN/ MA	**5**			Monitor pt. following service/check tubes, monitors, drains	130	RN/LPN /MA	**5**	**--**
31	Clean room/equipment by physician staff	130	RN/LPN/ MA	**3**			Clean room/equipment (99213=3)	130	RN/LPN /MA	**10**	**--**
32	Clean Scope	130	RN/LPN/ MA	10							
33	Clean Surgical Instrument Package	130	RN/LPN/ MA	15							
34	Complete diagnostic forms, lab & X-ray requisitions	130	RN/LPN/ MA	**3**			Complete diagnostic forms, lab & X-ray requisitions	130	RN/LPN /MA	**3**	**--**
35	Review/read X-ray, lab, and pathology reports	130	RN/LPN/ MA	**0**			Review/read X-ray, lab, and pathology reports	130	RN/LPN /MA	**5**	
36	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	130	RN/LPN/ MA	**3**			Home care instructions /coord office vis /Rxs	130	RN/LPN /MA	**3**	**--**
37	Discharge day management	130	RN/LPN/ MA	**0**	**6**						
38	**Other Clinical Activity (please specify)**										
39	**End: Patient leaves office**										

	A	B	C	D	E	F	G	H	I	J	K
1	**TAB 19: REVISED 1.26.12**			**31231 Recommendation**						**31231 current**	
40	**POST-SERVICE Period**										
41	**Start: Patient leaves office/facility**						**Other Clinical Activity (please specify)**				
42	Conduct phone calls/call in prescriptions			**3**	**3**						
43	*Office visits:*										
44	*List Number and Level of Office Visits*			**pre**							
45	99211 16 minutes		16								
46	99212 27 minutes		27								
47	99213 36 minutes		36								
48	99214 53 minutes		53								
49	99215 63 minutes		63								
50	99238 12 minutes		12		**0**		99238 discharge visit			**--**	**0.5**
51	*Total Office Visit Time*			**0**	**0**		***99238 discharge time***	130	RN/LPN /MA	**--**	**6**
52	Other Activity (please specify)										
53	**End: with last office visit before end of global period**										
54	**MEDICAL SUPPLIES**						**MEDICAL SUPPLIES**	**Code**	**Desc**		
55	**Minimum supply package for visits**	PEAC	pack	**1**			**Minimum supply package for visits**	PEAC	pack	**1**	**--**
56	***Procedure supplies - day of service:***						***Procedure supplies - day of service:***				
57	**dress,scrub,prep:**						**dress,scrub,prep:**				
58	gown, staff, impervious, disposable	11304	item	**2**			gown, staff, impervious, disposable	11304	item	**2**	
59	mask, surgical (with eye shield)	11306	item	**2**			mask, surgical (with eye shield)	11306	item	**2**	
60	gloves, sterile	14005	pair	**4**			gloves, sterile	14005	pair	**4**	
61	drape, sheet	11106	item	**1**			drape, sheet	11106	item	**1**	
62	drape, sterile mayo	14003	item	**1**			drape, sterile mayo	14003	item	**1**	
63	**suction:**						**suction:**				
64	Suction Canister, Disposable	93604	item	**1**			Suction Canister, Disposable	93604	item	**1**	
65	tubing, non-latex	3D132	foot	**12**			tubing, non-latex	new	foot	**12**	
66	**procedure:**						**procedure:**				
67	emesis basin	11506	item	**1**			emesis basin	11506	item	**1**	**--**
68	chux	11102	item	**1**			chux	11102	item	**1**	**--**
69	Gauze,Sterile 4 x 4	31505	item	**5**			Gauze,Sterile 4 x 4	31505	item	**5**	**--**
70	disposable atmoizer tips	93809	item	**1**			disposable atmoizer tips	93809	item	**1**	**--**
71	oxymetazoline (Afrin)	SJ037	ml	**10**			oxymetazoline (Afrin)	new	ml	**10**	**--**
72	xylocaine, topical 4%	SH050	ml	**5**			xylocaine, topical 4%	new	ml	**5**	**--**
73	cottonoides	SG031	item	**2**			cottonoides	new	item	**2**	**--**
74	defog	SM014	ml	**1**			Polaroid film, type 667	75010	exposur e	**3**	**--**
75	**equipment cleaning:**						defog	new	ml	**1**	**--**
76	pack, cleaning and disinfecting, endoscope ****	SA042	pack	**1**			gluteraldehyde (disinfectant/sanitizing agent)	52306	oz	**2**	**--**
77											
78											
79	**Equipment**	**Code**	**Desc**	**Time in use**			**Equipment**	**Code**	**Desc**	**Time in use**	
80	fiberoptic exam light	EQ170		**43**			fiberoptic exam light	E11006		**64**	**--**
81	reclining exam chair with headrest	EF008		**43**			reclining exam chair with headrest	E11011		**64**	**--**
82	SMR suction cabinet	EQ234		**43**			SMR suction cabinet	new		**64**	**--**
83	DIGITAL video system with photo documentation (for scope) (camera, monitor, ETC)	ES031		**43**			sinus endoscope, 30 or 70 deg, 4 in	E13126		**64**	**--**
84	Endoscope, rigid sinoscopy (1)	ES013		**63**			sinus endoscope, 0 deg	new		**64**	**--**
85	Endoscope, rigid sinoscopy (2)	ES013		**63**			DIGITAL video system with photo documentation (for scope) (camera, monitor, ETC)	new		**64**	**--**
86	printer	ED032		**43**			***New***				
87	light source, xenon	EQ167		**43**	**--**		***New***				
88	**Nasal Endoscopy Instrument Package:**	***new***		**63**			***New***				
89	Blakesley forceps, 0 degrees	1					xenon light source - cable for endoscope	new		**64**	**--**
90	Blakesley forceps, 45 degrees	1					**Nasal Endoscopy Instrument Package:**	new		**--**	**--**
91	Blakesley forceps, 90 degrees	1					Blakesley forceps, 0 degrees	1			
92	Frazier tip, 3mm	1					Blakesley forceps, 45 degrees	1			
93	Frazier tip, 5mm	1					Blakesley forceps, 90 degrees	1			
94	Frazier tip, 7m	1					Frazier tip, 3mm	1			
95	Nasal speculum set (4 mm to 9 mm)	1					Frazier tip, 5mm	1			
96	Thru-cut forceps-straight	1					Frazier tip, 7m	1			
97	Thru-cut forceps-upbite	1					Nasal speculum set (4 mm to 9 mm)	1			
98	Bayonet forceps	1					Thru-cut forceps-straight	1			
99							Thru-cut forceps-upbite	1			
100							Bayonet forceps	1			
101	*** Note: The SA042, pack, cleaning and disinfecting, endoscope; line 78, will be revised to include an appropriate basin and gluteraldehyde (disinfectant/sanitizing agent) at the April 2012 RUC meeting.										

	A	B	C	D	E	F	G	H	I	J	K
1	**TAB 19: REVISED 1.26.12**			**31231 Recommendation**						**31231 current**	
2	**Meeting Date: January 2012 Specialty: AAOHNS**	**CMS**	**Staff**	**Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)**			**Meeting Date: September 2002 Specialty: AAO-HNS**	**CMS**	**Staff**	**Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**		**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD 000**						**GLOBAL PERIOD 000**				
5	**TOTAL CLINICAL LABOR TIME**	130	RN/LPN/ MA	66.0	9.0		**Total Clinical Labor Time**	130	RN/LPN /MA	**82**	**36**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**	130	RN/LPN/ MA	0.0	0.0		**PRE-service time**	130	RN/LPN /MA	**18**	**30**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	130	RN/LPN/ MA	63.0	6.0		**SERVICE time**	130	RN/LPN /MA	**64**	**6**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**	130	RN/LPN/ MA	3.0	3.0		**POST-service time**	130	RN/LPN /MA	**0**	**0**
9	**PRE-SERVICE**						**PRE-SERVICE - BEFORE ADMISSION**	**Code**	**Desc**		
10	**Start: Following visit when decision for surgery or procedure made**		RN/LPN/ MA				**Start: Following visit when decision for surgery or procedure made**		RN/LPN /MA		
11	Complete pre-service diagnostic & referral forms	130	RN/LPN/ MA	0	0		Complete pre-service diagnostic & referral forms (5/5)	130	RN/LPN /MA	**5**	**5**
12	Coordinate pre-surgery services	130	RN/LPN/ MA	0	0		Coordinate pre-surgery services review exam/test results (10/20)	130	RN/LPN /MA	**3**	**10**
13	Schedule space and equipment in facility	130	RN/LPN/ MA	0	0		Schedule space and equipment in facility (0/8)	130	RN/LPN /MA	**0**	**5**
14	Provide pre-service education/obtain consent	130	RN/LPN/ MA	0	0		Provide pre-service education/obtain consent (10/20)	130	RN/LPN /MA	**7**	**7**
15	Follow-up phone calls & prescriptions	130	RN/LPN/ MA	0	0		Follow-up phone calls & prescriptions (10/7)	130	RN/LPN /MA	**3**	**3**
16	Other Clinical Activity (please specify)	130	RN/LPN/ MA				**Other Clinical Activity (please specify)**				
17	**End: When patient enters office/facility for surgery/procedure**	130					**End: When patient enters office/facility for surgery/procedure**	130			
18	**SERVICE PERIOD**						**SERVICE PERIOD - ADMISSION TO DISCHARGE**	**Code**	**Desc**		
19	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**						**Pre-service services**				
20	Greet patient, provide gowning, ensure appropriate medical records are available	130	RN/LPN/ MA	2			Assemble/review X-ray, lab, path reports (99213=2)	130	RN/LPN /MA	**5**	**--**
21	Obtain vital signs	130	RN/LPN/ MA	1			Greet patient and provide gowning (peac std=3)	130	RN/LPN /MA	**3**	**--**
22	Provide pre-service education/obtain consent	130	RN/LPN/ MA	**3**			Obtain vital signs (Vitals 0=0; 1-3=3; 4-6=5)	130	RN/LPN /MA	**5**	**--**
23	Prepare room, equipment, supplies	130	RN/LPN/ MA	**2**			Review pre-service education/obtain consent	130	RN/LPN /MA	**3**	**--**
24	Setup scope (non facility setting only)	130	RN/LPN/ MA	**5**			Prepare room, equipment,supplies (99213=2)	130	RN/LPN /MA	**8**	**--**
25	Prepare and position patient/ monitor patient/ set up IV	130	RN/LPN/ MA	**2**			Prepare and position patient	130	RN/LPN /MA	**2**	**--**
26	Sedate/apply anesthesia	130	RN/LPN/ MA	**2**			Sedate/apply anesthesia	130	RN/LPN /MA	**7**	**--**
27	**Intra-service**						**Intra-service**				
28	Assist physician in performing procedure	130	RN/LPN/ MA	**7**			1st assist physician in performing procedure	130	RN/LPN /MA	**10**	**--**
29	**Post-Service**						**Post-Service**				
30	Monitor pt. following service/check tubes, monitors, drains	130	RN/LPN/ MA	**5**			Monitor pt. following service/check tubes, monitors, drains	130	RN/LPN /MA	**5**	**--**
31	Clean room/equipment by physician staff	130	RN/LPN/ MA	**3**			Clean room/equipment (99213=3)	130	RN/LPN /MA	**10**	**--**
32	Clean Scope	130	RN/LPN/ MA	10							
33	Clean Surgical Instrument Package	130	RN/LPN/ MA	10							
34	Complete diagnostic forms, lab & X-ray requisitions	130	RN/LPN/ MA	**3**			Complete diagnostic forms, lab & X-ray requisitions	130	RN/LPN /MA	**3**	**--**
35	Review/read X-ray, lab, and pathology reports	130	RN/LPN/ MA	**5**			Review/read X-ray, lab, and pathology reports	130	RN/LPN /MA	**5**	
36	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	130	RN/LPN/ MA	**3**			Home care instructions /coord office vis /Rxs	130	RN/LPN /MA	**3**	**--**
37	Discharge day management	130	RN/LPN/ MA	**0**	**6**						
38	**Other Clinical Activity (please specify)**										
39	**End: Patient leaves office**										

	A	B	C	D	E	F	G	H	I	J	K
1	**TAB 19: REVISED 1.26.12**			**31231 Recommendation**						**31231 current**	
40	**POST-SERVICE Period**										
41	**Start: Patient leaves office/facility**						**Other Clinical Activity (please specify)**				
42	Conduct phone calls/call in prescriptions			**3**	**3**						
43	*Office visits:*										
44	*List Number and Level of Office Visits*			**pre**							
45	99211 16 minutes		16								
46	99212 27 minutes		27								
47	99213 36 minutes		36								
48	99214 53 minutes		53								
49	99215 63 minutes		63								
50	99238 12 minutes		12		**0**		99238 discharge visit			**--**	**0.5**
51	*Total Office Visit Time*			**0**	**0**		***99238 discharge time***	130	RN/LPN /MA	**--**	**6**
52	Other Activity (please specify)										
53	**End: with last office visit before end of global period**										
54	**MEDICAL SUPPLIES**						**MEDICAL SUPPLIES**	**Code**	**Desc**		
55	**Minimum supply package for visits**	PEAC	pack	**1**			**Minimum supply package for visits**	PEAC	pack	**1**	**--**
56	***Procedure supplies - day of service:***						***Procedure supplies - day of service:***				
57	**dress,scrub,prep:**						**dress,scrub,prep:**				
58	gown, staff, impervious, disposable	11304	item	**2**			gown, staff, impervious, disposable	11304	item	**2**	
59	mask, surgical (with eye shield)	11306	item	**2**			mask, surgical (with eye shield)	11306	item	**2**	
60	gloves, sterile	14005	pair	**4**			gloves, sterile	14005	pair	**4**	
61	drape, sheet	11106	item	**1**			drape, sheet	11106	item	**1**	
62	drape, sterile mayo	14003	item	**1**			drape, sterile mayo	14003	item	**1**	
63	**suction:**						**suction:**				
64	Suction Canister, Disposable	93604	item	**1**			Suction Canister, Disposable	93604	item	**1**	
65	tubing, non-latex	3D132	foot	**12**			tubing, non-latex	new	foot	**12**	
66	**procedure:**						**procedure:**				
67	emesis basin	11506	item	**1**			emesis basin	11506	item	**1**	**--**
68	chux	11102	item	**1**			chux	11102	item	**1**	**--**
69	Gauze,Sterile 4 x 4	31505	item	**5**			Gauze,Sterile 4 x 4	31505	item	**5**	**--**
70	disposable atmoizer tips	93809	item	**1**			disposable atmoizer tips	93809	item	**1**	**--**
71	oxymetazoline (Afrin)	SJ037	ml	**10**			oxymetazoline (Afrin)	new	ml	**10**	**--**
72	xylocaine, topical 4%	SH050	ml	**5**			xylocaine, topical 4%	new	ml	**5**	**--**
73	cottonoides	SG031	item	**2**			cottonoides	new	item	**2**	**--**
74	defog	SM014	ml	**1**			Polaroid film, type 667	75010	exposur e	**3**	**--**
75	**equipment cleaning:**						defog	new	ml	**1**	**--**
76	pack, cleaning and disinfecting, endoscope ****	SA042	pack	**1**			gluteraldehyde (disinfectant/sanitizing agent)	52306	oz	**2**	**--**
77											
78											
79	**Equipment**	**Code**	**Desc**	**Time in use**			**Equipment**	**Code**	**Desc**	**Time in use**	
80	fiberoptic exam light	EQ170		**43**			fiberoptic exam light	E11006		**64**	**--**
81	reclining exam chair with headrest	EF008		**43**			reclining exam chair with headrest	E11011		**64**	**--**
82	SMR suction cabinet	EQ234		**43**			SMR suction cabinet	new		**64**	**--**
83	DIGITAL video system with photo documentation (for scope) (camera, monitor, ETC)	ES031		**43**			sinus endoscope, 30 or 70 deg, 4 in	E13126		**64**	**--**
84	Endoscope, rigid sinoscopy (1)	ES013		**63**			sinus endoscope, 0 deg	new		**64**	**--**
85	Endoscope, rigid sinoscopy (2)	ES013		**63**			DIGITAL video system with photo documentation (for scope) (camera, monitor, ETC)	new		**64**	**--**
86	printer	ED032		**43**			***New***				
87	light source, xenon	EQ167		**43**	**--**		***New***				
88	**Nasal Endoscopy Instrument Package:**	***new***		**63**			***New***				
89	Blakesley forceps, 0 degrees	1					xenon light source - cable for endoscope	new		**64**	**--**
90	Blakesley forceps, 45 degrees	1					**Nasal Endoscopy Instrument Package:**	new		**--**	**--**
91	Blakesley forceps, 90 degrees	1					Blakesley forceps, 0 degrees	1			
92	Frazier tip, 3mm	1					Blakesley forceps, 45 degrees	1			
93	Frazier tip, 5mm	1					Blakesley forceps, 90 degrees	1			
94	Frazier tip, 7m	1					Frazier tip, 3mm	1			
95	Nasal speculum set (4 mm to 9 mm)	1					Frazier tip, 5mm	1			
96	Thru-cut forceps-straight	1					Frazier tip, 7m	1			
97	Thru-cut forceps-upbite	1					Nasal speculum set (4 mm to 9 mm)	1			
98	Bayonet forceps	1					Thru-cut forceps-straight	1			
99							Thru-cut forceps-upbite	1			
100							Bayonet forceps	1			
101	*** Note: The SA042, pack, cleaning and disinfecting, endoscope; line 78, will be revised to include an appropriate basin and gluteraldehyde (disinfectant/sanitizing agent) at the April 2012 RUC meeting.										

AMA/Specialty Society RVS Update Committee Summary of Recommendations
July 19, 2011 NPRM Screen

January 2012

Cholecystectomy

CMS identified CPT codes 47600 and 47605 in the Proposed Rule for 2012, stating the agency received comments regarding a potential relativity problem between these cholecystectomy codes. It appears that the visits for these services do not appropriately reflect the relativity of these two services and that 47600 should not have more time and visits association with the service than 47605. The specialty society recognized that the value for code 47605 may be incorrect and the RUC recommended that codes 47600 and 47605 be resurveyed for physician work and practice expense for January 2012. At the January 2012 RUC meeting the specialty society requested to postpone review of these services, due to a low survey response, until April 2012 after a valid response rate could be obtained. **The RUC agreed to postpone review of 47600 and 47605 until April 2012.**

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
47600	Cholecystectomy;	090	Postpone to April 2012
47605	with cholangiography	090	Postpone to April 2012

December 11, 2011

Sherry L. Smith, MS, CPA
Director, AMA/Specialty Society RVS Update Committee
American Medical Association
515 North State Street
Chicago, Illinois 60654

Dear Sherry,

On behalf of the American College of Surgeons (ACS) and Society of American Gastrointestinal and Endoscopic Surgeons (SAGES), we would like to inform the RUC in a timely manner that we will not be able to present recommendations at the January 2012 RUC meeting for codes 47600 and 47605 due to a low survey response. We will continue to collect more responses for presentation of a recommendation at the April 2012 RUC meeting. The following information summarizes our survey efforts under a shortened timeline.

The ACS and SAGES agreed to survey these codes per our September 2011 RUC Action Plan. We submitted a request for review of vignettes to the Research Subcommittee on September 29 immediately after the RUC meeting. The revised vignettes were vetted and approved by the Research Subcommittee on November 14.

As of December 9 (our survey deadline), we have received 26 completed surveys for code 47600 and 24 completed surveys for code 47605. Although the summary data for these limited responses is consistent with what we believe to be accurate time and visit data, we do not believe that this low number of surveys is sufficient by RUC standards to summarize and report a recommendation to the RUC.

We plan to extract another large random sample from the ACS and SAGES databases and send out another request to complete the survey, but will do this after the holidays. Our survey experience over many years confirms that surveying over a holiday is not productive. Case in point is the low response rate for the survey request sent before the Thanksgiving holiday. In addition, it will be difficult over the holidays for the ACS and SAGES expert panel to convene to discuss survey data and develop a recommendation to submit by January 3, 2012.

We apologize for this scheduling inconvenience.

Regards,

Christopher Senkowski, MD, FACS
ACS RUC Advisor

Don Selzer, MD, FACS
SAGES RUC Advisor

AMA/Specialty Society RVS Update Committee Summary of Recommendations
High Volume Growth Screen

January 2012

Cystoscopy and Treatment

In February 2008, CPT code 52214 was identified by the High Volume Growth screen. CPT code 52224 was added as part of the family. The RUC recommended that a CPT Assistant article be published stating that CPT codes 52204, 52214 and 52224 should only be billed once regardless of the number of areas biopsied or fulgurated. In September 2011, the Relativity Assessment Workgroup re-reviewed these services and recommended that the specialty develop physician work and practice expense recommendations for review by RUC in January 2012.

52214 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands*
The RUC reviewed the survey results from 85 urologists and recommends the following physician time components: 29 minutes pre-service time (with the standard 4 additional minutes of time to place the patient in the dorsal lithotomy position), 30 minutes intra service time and 20 minutes post-service time. The RUC also agreed with the specialty that the median survey work RVU of 3.50 is an accurate measure of the physician work and intensity involved in this service. This value represents a lower valuation than the current work RVU of 3.70. To further justify this value, the RUC compared the surveyed code to the key reference service CPT code 52204 *Cystourethroscopy, with biopsy(s)* (work RVU= 2.59) and given that 52214 has greater total time compared to 52204, 79 minutes and 54 minutes, respectively, the RUC agreed that the surveyed code should be valued higher. Additionally, the survey respondents ranked 52214 higher in every intensity/complexity measure compared to the reference code. Finally, the RUC compared the surveyed code to MPC code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (work RVU= 2.78) and noted that with greater total time, 79 minutes compared to 65 minutes, 52214 should be valued higher than 31622. **The RUC recommends a work RVU of 3.50 for CPT code 52214.**

52224 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy*
The RUC first discussed the compelling evidence as presented by the specialty society. There are two primary compelling evidence standards involved in this service. First, new technology has changed the physician work. Subsequent to Harvard valuation of this service in 1988, the 120 degree deflection bi-directional third generation digital, high-definition flexible cystoscope with large working channels are now available. This has also caused a rise in physician work intensity because the patient is under local anesthesia, whereas during the previous valuation the patient was not. Second, an anomalous relationship exists between CPT codes 52224 and 52214. Currently, 52224 (work RVU= 3.14), a more difficult and intense procedure to perform, is ranked lower than 52214 (RUC recommended work RVU= 3.50). To substantiate this claim, the surveyed intensity/complexity measures for these two services were compared and 52224 ranked higher than 52214 in all but one category. The RUC agreed with the specialty society that there was overwhelming compelling evidence to change the work value of this service.

The RUC reviewed the survey results from 80 urologists and recommends the following physician time components: 32 minutes pre-service time (with additional time to position the patient in the dorsal lithotomy position and wait for the local anesthesia to take effect), 30 minutes intra service time and 20 minutes post-service time. The RUC also agreed with the specialty that the median survey work RVU of 4.05 is an accurate measure of the physician work and intensity involved in this service. To further justify this value, the RUC compared the surveyed code to the key reference service CPT code 52204 *Cystourethroscopy, with biopsy(s)* (work RVU= 2.59) and agreed that the surveyed code should be valued substantially higher than the reference code due to greater total time, 82 minutes compared to 54 minutes. The RUC also reviewed CPT code 31629 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)* (work RVU= 4.09) and agreed that since these two services have identical intra service time, 30 minutes, and analogous total time, 82 minutes and 80 minutes, respectively, these services should have similar work values.

Finally, the RUC noted that the recommended work RVU of 4.05 results in a rise in physician work intensity for this procedure. However, there are two arguments that substantiate this work value. First, the intensity of this procedure has increased significantly since the prior valuation. The intensity of working with a flexible cystoscope increases the likelihood of multiple damages to the bladder. In addition, the inflow and outflow through the scope is small, resulting in potential obstruction of field when small amounts of bleeding occur. Second, and most importantly, the specialty presented strong survey data with a median survey work RVU of 4.05. The RUC concurred that the 25th percentile was too low and it was inappropriate to crosswalk the service to another code, given the robust survey data. **The RUC recommends a work RVU of 4.05 for CPT code 52224.**

Practice Expense:
The RUC approved the practice expense inputs as modified and submitted by the Practice Expense Subcommittee.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
52214	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands	000	3.50
52224	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy	000	4.05

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:52214 Tracking Number Original Specialty Recommended RVU: **3.50**
Presented Recommended RVU: **3.50**
Global Period: 000 RUC Recommended RVU: **3.50**

CPT Descriptor: Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 82 year old man with a long history of histologically proven non-invasive transitional cell carcinoma of the bladder had undergone routine surveillance cystourethroscopy last week; he also has micro-hematuria. Red "velvety" appearing mucosa was noted in several areas of the bladder. A CT scan is negative. The patient is brought to the OR and the areas of abnormal mucosa are fulgurated.

Percentage of Survey Respondents who found Vignette to be Typical: 85%

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

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

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 29%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 14%

Description of Pre-Service Work:

- Place patient on cystoscopy table in supine position
- Elevate right and left knee in knee holders and feet into stirrups into dorsal lithotomy position
- Pad ankles, feet, knees and shoulders
- Change table to cystoscopy configuration
- Don gown, protective glasses and sterile gloves
- Prep and drape the perineum
- Connect irrigation tubing and light source to rigid cystoscope
- Connect laser fiber and insert through working channel of cystoscope.
- Attach camera and "white balance"
- Check video equipment

Description of Intra-Service Work:

- Insert cystoscope into the urethra and bladder
- Repeat cystoscopic exam of the bladder
- Insert laser fiber through cystoscope
- Document procedure with still photographs from video unit and transfer images to medical record
- Fulgurate lesions with laser
- Remove cystoscope

- Drain bladder with straight catheter
- Place Foley catheter if appropriate

Description of Post-Service Work:

- Irrigate catheter with 300 cc of sterile water and observe for drainage and patency
- Attach leg bag to catheter
- Remove drapes
- Alter table to supine position
- Bring patient's legs out of dorsal-lithotomy position
- Remove one or both stirrups
- Lower the table to safe height off the floor
- Move patient off of table and take to post anesthesia recovery area
- Monitor vital signs as appropriate
- Remove surgical clothing and dress
- Discuss findings with patient and family as appropriate
- Give post operative instruction sheet
- Write prescriptions
- Schedule follow-up appointment
- Irrigate catheter before discharge
- Dictate operative report with diagram of abnormal areas
- Contact referring physician or primary care physician as appropriate

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012				
Presenter(s):	Thomas Cooper, MD; Norman Smith, MD; James Ulchaker, MD ; Martin Dineen, MD				
Specialty(s):	Urology				
CPT Code:	52214				
Sample Size: 158	**Resp N:** 85	**Response:** 53.7 %			
Sample Type: Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	6.00	**10.00**	20.00	250.00
Survey RVW:	2.40	2.75	**3.50**	5.25	9.00
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	10.00	20.00	**30.00**	30.00	60.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 1b-FAC Straightforw Pat Procedure(w sedate/anes)

CPT Code: 52214	**Recommended Physician Work RVU: 3.50**		
	Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:	**19.00**	**19.00**	**0.00**
Pre-Service Positioning Time:	**5.00**	**1.00**	**4.00**
Pre-Service Scrub, Dress, Wait Time:	**5.00**	**5.00**	**0.00**
Intra-Service Time:	**30.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
52204	000	2.59	**RUC Time**

CPT Descriptor Cystourethroscopy, with biopsy(s)

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31622	000	2.78	**RUC Time**	85,410

CPT Descriptor 1 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
19103	000	3.69	**RUC Time**	109,655

CPT Descriptor 2 Biopsy of breast, percutaneous, automated vacuum assisted or rotating biopsy device, using image guidance

Other Reference CPT Code	Global	Work RVU	Time Source
31625	000	3.36	**RUC Time**

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 50 **% of respondents:** 58.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 52214**	**Key Reference CPT Code:** 52204	**Source of Time RUC Time**
Median Pre-Service Time	29.00	17.00	
Median Intra-Service Time	30.00	25.00	
Median Immediate Post-service Time	20.00	12.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**79.00**	**54.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.18	2.90
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.16	2.88
Urgency of medical decision making	3.06	2.84
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.10	2.90
Physical effort required	2.78	2.64
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.84	2.70
Outcome depends on the skill and judgment of physician	3.00	2.96
Estimated risk of malpractice suit with poor outcome	2.90	2.86

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.76	2.66
Intra-Service intensity/complexity	3.10	2.88
Post-Service intensity/complexity	2.68	2.58

Additional Rationale and Comments

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

There are six CPT codes in the family of Endoscopic Bladder Lesion Codes (All 000 Global Procedures). CPT Codes 52214 and 52224 (in bold) are being considered at this RUC meeting.

52204 Cysto with bladder biopsy - RUC 2005
52214 Cysto with fulguration - RUC January, 2012
52224 Cysto with fulguration of MINOR lesions up to 0.5 cm with or without biopsy - RUC January, 2012
52234 Cysto with TUR SMALL bladder tumors (0.5 to 2.0 cm) – RUC September 2011
52235 Cysto with TUR MEDIUM bladder tumors (2.0 to 5.0 cm) – RUC September 2011
52240 Cysto with TUR LARGE bladder tumors – RUC September 2011

Additional Rationale

In the current Medicare fee schedule, 52214 (a less difficult and less intense procedure, as confirmed by the intensity measures) is valued higher than 52224 (a more difficult and more intense procedure as confirmed by the intensity measures). The current survey recognizes this rank order anomaly, and reduces the RVW for 52214 from 3.70 to the median value of 3.50. Likewise, the survey recognizes that 52224 is currently undervalued at 3.14 and increases it to a median value of 4.05 which fits in the hierarchy of the six codes in the endoscopic family. See table below.

Endoscopic Bladder Lesion Codes								
CPT	2012 RVW	RVW source	Sept 2011 RUC action (CMS 2013)	Median Intra-Service time	Total Time	January 2012 RUC Survey RVW	New RVW Rank Order	IWPUT
52204	2.59	RUC 2005		25	54		2.59	0.0805
52214	3.70	Harvard		30	79	3.50 (median)	3.50	0.0825*
52224	3.14	Harvard		30	82	4.05 (median)	4.05	0.1057*
52234	4.62	Harvard	4.62 value maintained	30	79		4.62	0.1198**
52235	5.44	Harvard	5.44 value maintained	45	94		5.44	0.0981**
52240	9.71	Harvard	8.75 value reduced	60	133		8.75	0.1222**

*IWPUT from January 2012 Specialty Society Recommendations

**IWPUT if CMS accepts September 2011 RUC Action

Site of Service (SOS)	Hospital Inpatient	Hospital Outpatient	ASC	Office
52214	20.28%	30.00%	9.61%	39.96%
52224	5.36%	23.56%	7.71%	63.34%

Rationale for additional minutes of positioning time

Five minutes positioning time for the dorsal lithotomy position was established by the RUC during its October 2010 meeting.

Comparisons for Intensity/Complexity Survey Results	**52214 Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands**		**52224 Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy**	
Intensity/Complexity Measures(Mean)	**CPT Code**	**Key Reference Code: Cystourethroscopy, with biopsy(s)**	**CPT Code**	**Key Reference Code: Cystourethroscopy, with biopsy(s)**
Mental Effort and Judgment (Mean)	52214	52204	52224	52204
The number of possible diagnosis and/or the number of management options that must be considered	3.18	2.90	3.21	2.79

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.16	2.88	3.33	2.90
Urgency of medical decision making	3.06	2.84	3.05	2.67
Technical Skill/Physical Effort (Mean)				
Technical skill required	3.10	2.90	3.43	2.95
Physical effort required	2.78	2.64	3.05	2.67
Psychological Stress (Mean)				
The risk of significant complications, morbidity and/or mortality	2.84	2.70	3.19	2.69
Outcome depends on the skill and judgment of physician	3.00	2.96	3.31	2.83
Estimated risk of malpractice suit with poor outcome	2.90	2.86	3.07	2.60
INTENSITY/COMPLEXITY MEASURES				
Time Segments (Mean)				
Pre-Service intensity/complexity	2.76	2.66	3.05	2.74
Intra-Service intensity/complexity	3.10	2.88	3.45	2.88
Post-Service intensity/complexity	2.68	2.58	3.05	2.69

Comparison Codes
All RUC Valued and MPC 2012 where indicated

CPT Code 31622 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)
MPC Yes

Global	**Work RVU**	RUC Review	Intra Time	Total Time	IWPUT
000	**2.78**	August 2009	30	65	0.0688

CPT Code 43239 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple
MPC No

Global	**Work RVU**	RUC Review	Intra Time	Total Time	IWPUT
000	**2.87**	August 2000	34	84.5	0.0511

CPT Code 31625 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites
MPC No

Global	**Work RVU**	RUC Review	Intra Time	Total Time	IWPUT
000	**3.36**	April 2003	30	70	0.0869

CPT Code 19103 Biopsy of breast, percutaneous, automated vacuum assisted or rotating biopsy device, using image guidance
MPC Yes

Global	**Work RVU**	RUC Review	Intra Time	Total Time	IWPUT
000	**3.69**	April 2000	30	65	0.0969

CPT Code 45378 Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)
MPC No

Global	**Work RVU**	RUC Review	Intra Time	Total Time	IWPUT
000	**3.69**	Aug 2005	30	75	0.0917

CPT Code 31629 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem

and/or lobar bronchus(i) **MPC No**					
Global	**Work RVU**	RUC Review	Intra Time	Total Time	IWPUT
000	**4.09**	April 2003	30	80	0.1038

CPT Code 52276 Cystourethroscopy with direct vision internal urethrotomy **MPC Yes**					
Global	**Work RVU**	RUC Review	Intra Time	Total Time	IWPUT
000	**4.99**	August 1995	35	95	0.1042

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 52214

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Urology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 26000
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. The estimate includes 2010 Medicare utilization data with an additional 25% increase to represent the national utilization.

Specialty Urology Frequency 25500 Percentage 98.07 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 21,169 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2010 Medicare data from RUC database

Specialty Urology Frequency 21169 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 52214

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:52224 Tracking Number Original Specialty Recommended RVU: **4.05**
Presented Recommended RVU: **4.05**
Global Period: 000 RUC Recommended RVU: **4.05**

CPT Descriptor: Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year old man with a history of cigarette smoking and histologically proven non-invasive transitional cell carcinoma of the bladder had undergone routine surveillance cystourethroscopy last week and was noted to have a number of discrete papillary appearing lesions measuring 2 to 3 mm in size. He also has micro-hematuria. A CT scan is negative. The lesions are fulgurated. Random bladder biopsies may be taken.

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

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

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

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 32%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 12%

Description of Pre-Service Work:

- Place patient on cystoscopy table in supine position
- Elevate right and left knee in knee holders and feet into stirrups into dorsal lithotomy position
- Pad ankles, feet, knees and shoulders
- Change table to cystoscopy configuration
- Don gown, protective glasses and sterile gloves
- Prep and drape the perineum
- Connect irrigation tubing and light source to flexible cystoscope
- Instill 10 ml of 2% Xylocaine jelly into urethra and apply penis clamp
- Wait 10 minutes for Xylocaine to take effect and numb urethra
- Drain bladder with straight catheter until empty
- Instill 50 ml of 2% Xylocaine into bladder
- Wait 10 minutes for Xylocaine to take effect and numb bladder
- Connect laser and insert through working channel of flexible cystoscope
- Attach camera and “white balance”
- Check video equipment

Description of Intra-Service Work:

- Insert flexible cystoscope into the urethra and bladder

- Repeat cystoscopic exam of the bladder
- Insert laser fiber through flexible cystoscope
- Document procedure with still photographs from video unit and transfer images to medical record
- Fulgurate lesions
- Remove laser fiber
- Insert flexible cup biopsy forceps through flexible cystoscope and take random biopsies, if necessary; place each biopsy in separate container
- Remove cup biopsy forceps
- Reinsert laser fiber and fulgurate the biopsy sites
- Inspect bladder for bleeding
- Remove flexible cystoscope
- Drain bladder with straight catheter
- Place Foley catheter if appropriate

Description of Post-Service Work:

- Irrigate catheter with 300 cc of sterile water and observe for drainage and patency
- Attach leg bag to catheter
- Remove drapes, disconnect grounding pad
- Alter table to supine position
- Bring patient's legs out of dorsal-lithotomy position
- Remove one or both stirrups
- Lower the table to safe height off the floor
- Move patient off of table and take to post anesthesia recovery area
- Monitor vital signs as appropriate
- Remove surgical clothing and dress
- Discuss findings with patient and family as appropriate
- Give post operative instruction sheet
- Write prescriptions
- Schedule follow-up appointment
- Irrigate catheter before discharge
- Dictate operative report with diagram of abnormal areas
- Contact referring physician or primary care physician as appropriate

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012					
Presenter(s):	Thomas Cooper, MD; Norman Smith, MD; James Ulchaker, MD; Martin Dineen, MD					
Specialty(s):	Urology					
CPT Code:	52224					
Sample Size:	157	**Resp N:**	80	**Response:** 50.9 %		
Sample Type:	Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	10.00	**15.00**	25.00	250.00
Survey RVW:	2.50	3.05	**4.05**	5.50	10.00
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	15.00	20.00	**30.00**	45.00	70.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	52224	**Recommended Physician Work RVU: 4.05**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**7.00**	**0.00**
Pre-Service Positioning Time:		**5.00**	**0.00**	**5.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**0.00**	**20.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
52204	000	2.59	**RUC Time**

CPT Descriptor Cystourethroscopy, with biopsy(s)

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
19103	000	3.69	**RUC Time**	109,655

CPT Descriptor 1 Biopsy of breast, percutaneous, automated vacuum assisted or rotating biopsy device, using image guidance

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52276	000	4.99	**RUC Time**	11,514

CPT Descriptor 2 Cystourethroscopy with direct vision internal urethrotomy

Other Reference CPT Code	Global	Work RVU	Time Source
31629	000	4.09	**RUC Time**

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 42 **% of respondents:** 52.5 **%**

TIME ESTIMATES (Median)	**CPT Code: 52224**	**Key Reference CPT Code:** 52204	**Source of Time RUC Time**
Median Pre-Service Time	32.00	17.00	
Median Intra-Service Time	30.00	25.00	
Median Immediate Post-service Time	20.00	12.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**82.00**	**54.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.21	2.79
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.33	2.90
Urgency of medical decision making	3.05	2.67
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.43	2.95
Physical effort required	3.05	2.67
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.19	2.69
Outcome depends on the skill and judgment of physician	3.31	2.83
Estimated risk of malpractice suit with poor outcome	3.07	2.60

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.05	2.74
Intra-Service intensity/complexity	3.45	2.88
Post-Service intensity/complexity	3.05	2.69

Additional Rationale and Comments

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

There are six CPT codes in the family of Endoscopic Bladder Lesion Codes (All 000 Global Procedures). CPT Codes 52214 and 52224 (in bold) are being considered at this RUC meeting.

52204 Cysto with bladder biopsy - RUC 2005
52214 Cysto with fulguration - RUC January, 2012

52224 Cysto with fulguration of MINOR lesions up to 0.5 cm with or without biopsy - RUC January, 2012
52234 Cysto with TUR SMALL bladder tumors (0.5 to 2.0 cm) – RUC September 2011
52235 Cysto with TUR MEDIUM bladder tumors (2.0 to 5.0 cm) – RUC September 2011
52240 Cysto with TUR LARGE bladder tumors – RUC September 2011

Compelling Evidence Comments

The AUA expert panel believes that this code meets the compelling evidence argument based on the following:

1. Change in technology – When the Harvard work value was assigned to this code in 1988, the 120 degree deflection bi-directional third generation digital, high-definition flexible cystoscopes with large working channels were not available. In addition, in 1988, there was really no good effective laser to treat bladder lesions; now with advances, particularly the Holmium laser in-office, treatment is feasible. See attached article.

2. Current procedure is more intense because patient is under local anesthesia.

3. At present a rank order anomaly exists: CPT code 52214 has work RVU's greater than CPT code 52224 which is a more difficult procedure and, therefore, more intense.

Additional Rationale

In the current Medicare fee schedule, 52214 (a less difficult and less intense procedure, as confirmed by the intensity measures) is valued higher than 52224 (a more difficult and more intense procedure as confirmed by the intensity measures.). The current survey recognizes this rank order anomaly and reduces the RVW for 52214 from 3.70 to the median value of 3.50. Likewise, the survey recognizes that 52224 is currently undervalued at 3.14 and increases it to a median value of 4.05, which fits in the hierarchy of the six codes in the endoscopic family. See table below.

		Endoscopic Bladder Lesion Codes						
CPT	2012 RVW	RVW source	Sept 2011 RUC action (CMS 2013)	Median Intra-Service time	Total Time	January 2012 RUC Survey RVW	New RVW Rank Order	IWPUT
52204	2.59	RUC 2005		25	54		2.59	0.0805
52214	3.70	Harvard		30	79	3.50 (median)	3.50	0.0825*
52224	3.14	Harvard		30	82	4.05 (median)	4.05	0.1057*
52234	4.62	Harvard	4.62 value maintained	30	79		4.62	0.1198**
52235	5.44	Harvard	5.44 value maintained	45	94		5.44	0.0981**
52240	9.71	Harvard	8.75 value reduced	60	133		8.75	0.1222**

*IWPUT from January 2012 Specialty Society Recommendations

**IWPUT if CMS accepts September 2011 RUC Action

Site of Service (SOS)	Hospital Inpatient	Hospital Outpatient	ASC	Office
52214	20.28%	30.00%	9.61%	39.96%
52224	5.36%	23.56%	7.71%	63.34%

Rationale for additional minutes of positioning time

Five minutes positioning time for the dorsal lithotomy position was established by the RUC during its October 2010 meeting.

Comparisons for Intensity/Complexity Survey Results	52214 Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands		52224 Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy	
Intensity/Complexity Measures(Mean)	**CPT Code**	**Key Reference Code: Cystourethroscopy, with biopsy(s)**	**CPT Code**	**Key Reference Code: Cystourethroscopy, with biopsy(s)**
Mental Effort and Judgment (Mean)	52214	52204	52224	52204
The number of possible diagnosis and/or the number of management options that must be considered	3.18	2.90	3.21	2.79
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.16	2.88	3.33	2.90
Urgency of medical decision making	3.06	2.84	3.05	2.67
Technical Skill/Physical Effort (Mean)				
Technical skill required	3.10	2.90	3.43	2.95
Physical effort required	2.78	2.64	3.05	2.67
Psychological Stress (Mean)				
The risk of significant complications, morbidity and/or mortality	2.84	2.70	3.19	2.69
Outcome depends on the skill and judgment of physician	3.00	2.96	3.31	2.83
Estimated risk of malpractice suit with poor outcome	2.90	2.86	3.07	2.60
INTENSITY/COMPLEXITY MEASURES				
Time Segments (Mean)				
Pre-Service intensity/complexity	2.76	2.66	3.05	2.74
Intra-Service intensity/complexity	3.10	2.88	3.45	2.88
Post-Service intensity/complexity	2.68	2.58	3.05	2.69

Comparison Codes
All RUC Valued and MPC 2012 where indicated

CPT Code 31622 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure) **MPC Yes**					
Global	**Work RVU**	RUC Review	Intra Time	Total Time	IWPUT
000	**2.78**	August 2009	30	65	0.0688

CPT Code 43239 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple **MPC No**					
Global	**Work RVU**	RUC Review	Intra Time	Total Time	IWPUT
000	**2.87**	August 2000	34	84.5	0.0511

CPT Code 31625 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites **MPC No**					
Global	**Work RVU**	RUC Review	Intra Time	Total Time	IWPUT
000	**3.36**	April 2003	30	70	0.0869

CPT Code 19103 Biopsy of breast, percutaneous, automated vacuum assisted or rotating biopsy device, using image guidance **MPC Yes**					
Global	**Work RVU**	RUC Review	Intra Time	Total Time	IWPUT
000	**3.69**	April 2000	30	65	0.0969

CPT Code 45378 Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure) **MPC No**					
Global	**Work RVU**	RUC Review	Intra Time	Total Time	IWPUT
000	**3.69**	Aug 2005	30	75	0.0917

CPT Code 31629 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i) **MPC No**					
Global	**Work RVU**	RUC Review	Intra Time	Total Time	IWPUT
000	**4.09**	April 2003	30	80	0.1038

CPT Code 52276 Cystourethroscopy with direct vision internal urethrotomy **MPC Yes**					
Global	**Work RVU**	RUC Review	Intra Time	Total Time	IWPUT
000	**4.99**	August 1995	35	95	0.1042

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 52224

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

Specialty Urology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 70000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The estimate includes 2010 Medicare utilization data with an additional 25% increase to represent the national utilization.

Specialty Urology Frequency 69500 Percentage 99.28 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 54,400 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2010 Medicare data from RUC database

Specialty Urology Frequency 54400 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 52224

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

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
12	**ISSUE:**	**Cystoscopy and Treatment**																		
13	**TAB:**	**16**																		
14						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
15	**Source**	**CPT**	**DESC**	**Resp**	**IWPUT**	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
16	REF	52204	Cystourethroscopy, with biopsy(s)	50	0.080			2.59			54	10	2	5			25			12
17	CURRENT	52214	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands		0.078			3.70			88	22		15			35			16
18	SVY	52214	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands		0.080	2.40	2.75	3.50	5.25	9.00	85	15	10	10	10	20	30	30	60	20
19	REC	52214	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands		0.082			3.50			79	19	5	5			30			20
20																				
21						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
22	**Source**	**CPT**	**DESC**	**Resp**	**IWPUT**	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
23	REF	52204	Cystourethroscopy, with biopsy(s)	42	0.080			2.59			54	10	2	5			25			12
24	CURRENT	52224	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy		0.072			3.14			81	19		15			31			16
25	SVY	52224	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy		0.099	2.50	3.05	4.05	5.50	10.00	85	15	10	10	15	20	30	45	70	20
26	REC	52224	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy		0.106			4.05			82	7	5	20			30			20

TAB 16: CYSTOSCOPY AND TREATMENT
JANUARY 2012 RUC MEETING

SOURCE (RUC MTG)	CPT	DESCRIPTOR	RESP	IWPUT	RVW					TOTAL TIME	PRE-TIME			INTRA-TIME					IMM. POST
					MIN	25th	MED	75TH	MAX		Eval	Posit	SDW	MIN	25th	MED	75TH	MAX	
Reference	**52204**	Cystourethroscopy, with biopsy(s)	50	0.0805			**2.59**			54	10	2	5			25			12
Current	**52214**	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands		0.0779			**3.70**			88	22	0	15			35			16
Survey	**52214**			0.0804	2.40	2.75	**3.50**	5.25	9.00	85	15	10	10	10	20	30	30	**60**	20
AUA Recom	**52214**			0.0825			**3.50**			79	19	5	5			30			20
Reference	**52204**	Cystourethroscopy, with biopsy(s)	42	0.0805			**2.59**			54	10	2	5			25			12
Current	**52224**	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy		0.0721			**3.14**			81	19	0	15			31			16
Survey	**52224**			0.0987	2.50	3.05	**4.05**	5.50	10.00	85	15	10	10	15	20	30	45	70	20
AUA Recom	**52224**			0.1057			**4.05**			82	7	5	20			30			20
COMPARISON CODES																			
RUC (4/09) MPC List	**31622**	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)		0.0688			**2.78**			65	10	5	5			30			15
RUC (8/00)	**43239**	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple		0.0511			**2.87**			84.5	27	0	0			34			23.5
RUC (4/03)	**31625**	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites		0.0869			**3.36**			70	10	5	10			30			15
RUC (4/00) MPC List	**19103**	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance		0.0969			**3.69**			65	20	0	0			30			15
RUC (8/05)	**45378**	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)		0.0917			**3.69**			75	20	5	5			30			15
RUC (4/03)	**31629**	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)		0.1038			**4.09**			80	10	10	10			30			20
RUC (8/95) MPC List	**52276**	Cystourethroscopy with direct vision internal urethrotomy		0.1042			**4.99**			95	30	0	0			35			30

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
000 Day Global Period
Non Facility Direct Inputs

CPT Long Descriptor:

52214 Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands

52224 Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy

Global Period: 000

Recommendation Process: Panel

Geographic Practice Setting %: Rural____ Suburban___50%__ Urban__50%___

Type of Practice %: _25 _Solo Practice
_50__Single Specialty Group
_____Multispecialty Group
_25__Medical School Faculty Practice Plan

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

Our Panel consists of ten urologists who represent urological practices, both academic and private settings, from across the United States. They represent the states of Washington, Illinois, New York, Connecticut, Kentucky, and Tennessee. The panel reviews current RUC practice expense information, requests input from several urology practices, makes recommendations and submits them to the AMA.

Reason for request:

The AUA is submitting these recommendations at the request of the CMS to research appropriate supplies and equipment to perform CPT codes 52214 and 52224. The AUA is requesting the removal of the rigid cystoscope when this procedure is performed in the office setting and add a flexible cystoscope and video unit as well as other supplies and equipment. We also note that there are additional supply deletions as well as changes in pricing information which will be supported through current manufacturer invoices. Since we are changing to a flexible cystoscope to represent current urological practice, the scope cleaning time has been changed from 10 to 30 minutes.

Pre-Service Clinical Labor Activities:

- Charts are reviewed by clinical staff to verify that correct procedure is ordered for the patient.
- Room is prepared and exam table is covered with paper.
- Patients are greeted and a gown is provided.
- Patient education and consent is obtained.
- The nursing staff reviews with patient each step of the treatment and enables patient to ask questions.
- Sets up the equipment (cystoscope, video, laser, etc.) and sets up the supplies needed for the procedure.
- Assist the physician with positioning and padding of patient in the dorsal lithotomy position.
- Assist the physician with the preparation and draping of the patient.
- Assist the physician with the general anesthesia prior to the procedure.

Intra-Service Clinical Labor Activities:

- Performs a time-out with physician to make sure proper procedure and proper patient is being treated.

- Clinical staff person hands supplies and equipment to the physician during procedure.
- Assist the physician to make sure proper settings are available for laser equipment.
- Assist the physician with removing padding and repositioning patient after procedure.

Post-Service Clinical Labor Activities:

- Clean the room and disinfect cystoscope in proper sterilizing equipment and according to sterilization protocols.
- Check catheter once more before patient leaves the office.
- Provide follow up information to patient.
- Discuss any adverse reaction at insertion site.
- Confers with the MD verbally for any last minute instructions for patient.
- Next appt is set up for patient while checking out.

	A	B	C	D	E
2				**52214**	**52224**
3	**Meeting Date: January, 2012** **Specialty: American Urological Association**	**CMS**	**Staff**	**Cystourethroscopy, with fulguration (including cryosurgery or laswer surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands**	**Cystourethroscopy, with fulguration (including cryosurgery or laswer surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy**
4	**LOCATION: Tuscon, Arizona**	**Code**	**Type**	**Non Facility**	**Non Facility**
5	**GLOBAL PERIOD**				
6	**TOTAL CLINICAL LABOR TIME**		**L037D**	**98.0**	**100.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**		**L037D**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**		**L037D**	**95.0**	**97.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**		**L037D**	**3.0**	**3.0**
10	**PRE-SERVICE**				
11	**Start: Following visit when decision for surgery or procedure made**				
12	Complete pre-service diagnostic & referral forms			**0**	**0**
13	Coordinate pre-surgery services			**0**	**0**
14	Provide pre-service education/obtain consent			**0**	**0**
15	Follow-up phone calls & prescriptions			**0**	**0**
16	Other Clinical Activity (please specify)				
17	**End: When patient enters office/facility for surgery/procedure**				
18	**SERVICE PERIOD**				
19	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**				
20	Review chart		**L037D**	**0**	**0**
21	Greet patient, provide gowning		**L037D**	**3**	**3**
22	Provide pre-service education/obtain consent		**L037D**	**3**	**3**
23	Obtain vital signs		**L037D**	**3**	**3**
24	Prepare room, equipment, supplies		**L037D**	**2**	**2**
25	Setup and calibrate laser		**L037D**	**5**	**5**
26	Setup scope (non facility setting only)		**L037D**	**5**	**5**
27	Prepare and position patient/monitor patient		**L037D**	**3**	**3**
28	**Intra-service**				
29	Assist physician in performing procedure	100%	**L037D**	**30**	**30**
30	**Post-Service**				
31	Monitor pt. following service		**L037D**	**2**	**2**
32	Clean room/equipment by physician staff		**L037D**	**3**	**3**
33	Clean Scope		**L037D**	**30**	**30**
34	Complete diagnostic forms, lab & X-ray requisitions		**L037D**	**3**	**3**
35	Prepare biopsy specimen		**L037D**		**2**
36	Check catheters/coordinate office visits /prescriptions		**L037D**	**3**	**3**
37	**End: Patient leaves office**				
38	**POST-SERVICE Period**				
39	**Start: Patient leaves office/facility**				
40	Conduct phone calls/call in prescriptions			**3**	**3**
41	*Office visits:*				
42	*List Number and Level of Office Visits*			**pre**	**post**
43	99211 16 minutes		16		
44	99212 27 minutes		27		
45	99213 36 minutes		36		
46	99214 53 minutes		53		
47	99215 63 minutes		63		
48	99238 12 minutes		12		
49	*Total Office Visit Time*			**0**	**0**
50	Other Activity (please specify)				
51	**End: with last office visit before end of global period**				
52	**MEDICAL SUPPLIES**	**CMS Code**	**Unit**		
53	Pack, minimum multi-specialty visit	SA048	pack	**1**	**1**
54	Pack, cleaning and disenfecting	SA042	pack	**1**	**1**
55	Pack, urology cystoscopy visit	SA058	pack	**1**	**1**
56	Scissors	SA027	item	**1**	**1**
57	Dressing, 3inx4in (Telfa, Release)	SG035	item		**1**
58	Drainage bag	SJ031	item	**1**	**1**
59	Foley catheter	SD024	item	**1**	**1**
60	*Tray, catheter insertion (w-o catheter)*	*SA063*	*tray*	**1**	**1**
61	Underpad - chux (2ft x 3ft)	SB044	item	**1**	**1**
62	Laser fiber, disposable	SF028	item	**1**	**1**
63	Drape-towel, sterile (18in x 26in)	SB019	item	**1**	**1**
64	*Penis clamp (see invoice)*		*item*	**1**	**1**
65	*Lidocaine 1-2% inj (Xylocaine)*	*SH047*	*ml*	**50**	**50**
66	*Gloves, sterile*	*SB024*	*pair*	**2**	**3**
67	*Catheter, urethral straight*	*SD030*	*item*	**1**	**1**
68	*Catheter, tip adapter*	*SD015*	*item*	**1**	**1**
69	*Syringe, Toomey*	*SC062*	*item*	**1**	**1**
70	*Cup, biopsy specimen cup, sterile (4 oz)*	*SL036*	*item*		**6**
71	*Sanitizing cloth-wipe (surface, instruments, equipment)*	*SM022*	*oz*	**4**	**4**
72	*Water, sterile for irrigation (250-1000ml uou)*	*SH074*	*item*	**2**	**2**
73	*Syringe, 30 ml*	*SC054*	*item*	**1**	**1**

	A	B	C	D	E
2				**52214**	**52224**
3	**Meeting Date: January, 2012** **Specialty: American Urological Association**	**CMS**	**Staff**	**Cystourethroscopy, with fulguration (including cryosurgery or laswer surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands**	**Cystourethroscopy, with fulguration (including cryosurgery or laswer surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy**
4	**LOCATION: Tuscon, Arizona**	**Code**	**Type**	**Non Facility**	**Non Facility**
74	**Equipment**			**Minutes**	**Minutes**
75	Light source	EQ167		**100**	**105**
76	Power table	EF031		**100**	**105**
77	Forceps, grasping	ES007		**100**	**105**
78	Mobile back table with wheels	EF027		**100**	**105**
79	*Cystoscope, flexible, Fiberscope (see invoice)*	*ES018*		**100**	**105**
80	*Video system, endoscopy (processor, digital capture, monitor, printer, cart)(see invoice)*	*ES031*		**100**	**105**
81	Laser (gs, uro, obg, ge) ***Indigo laser no longer manufactured	EQ153		**100**	**105**
82	Biopsy forceps	ES006		**100**	**105**
83	*Instrument pack, basic ($500-$1500) Van Buren Sounds (see invoice)*	*EQ137*		**100**	**105**

	A	B	C	D	E
2				**52214**	**52224**
3	**Meeting Date: January, 2012** **Specialty: American Urological Association**	**CMS**	**Staff**	**Cystourethroscopy, with fulguration (including cryosurgery or laswer surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands**	**Cystourethroscopy, with fulguration (including cryosurgery or laswer surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy**
4	**LOCATION: Tuscon, Arizona**	**Code**	**Type**	**Non Facility**	**Non Facility**
5	**GLOBAL PERIOD**				
6	**TOTAL CLINICAL LABOR TIME**		**L037D**	**101.0**	**106.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**		**L037D**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**		**L037D**	**98.0**	**103.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**		**L037D**	**3.0**	**3.0**
10	**PRE-SERVICE**				
11	**Start: Following visit when decision for surgery or procedure made**				
12	Complete pre-service diagnostic & referral forms			**0**	**0**
13	Coordinate pre-surgery services			**0**	**0**
14	Provide pre-service education/obtain consent			**0**	**0**
15	Follow-up phone calls & prescriptions			**0**	**0**
16	Other Clinical Activity (please specify)				
17	**End: When patient enters office/facility for surgery/procedure**				
18	**SERVICE PERIOD**				
19	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**				
20	Review chart		**L037D**	**3**	**3**
21	Greet patient, provide gowning		**L037D**	**3**	**3**
22	Provide pre-service education/obtain consent		**L037D**	**3**	**3**
23	Obtain vital signs		**L037D**	**3**	**3**
24	Prepare room, equipment, supplies		**L037D**	**2**	**2**
25	Setup and calibrate laser		**L037D**	**5**	**5**
26	Setup scope (non facility setting only)		**L037D**	**5**	**5**
27	Prepare and position patient/monitor patient		**L037D**	**3**	**3**
28	**Intra-service**				
29	Assist physician in performing procedure	100%	**L037D**	**30**	**30**
30	**Post-Service**				
31	Monitor pt. following service		**L037D**	**2**	**2**
32	Clean room/equipment by physician staff		**L037D**	**3**	**3**
33	Clean Scope		**L037D**	**30**	**30**
34	Complete diagnostic forms, lab & X-ray requisitions		**L037D**	**3**	**3**
35	Prepare biopsy specimen		**L037D**		**5**
36	Check catheters/coordinate office visits /prescriptions		**L037D**	**3**	**3**
37	**End: Patient leaves office**				
38	**POST-SERVICE Period**				
39	**Start: Patient leaves office/facility**				
40	Conduct phone calls/call in prescriptions			**3**	**3**
41	*Office visits:*				
42	*List Number and Level of Office Visits*			**pre**	**post**
43	99211 16 minutes		16		
44	99212 27 minutes		27		
45	99213 36 minutes		36		
46	99214 53 minutes		53		
47	99215 63 minutes		63		
48	99238 12 minutes		12		
49	*Total Office Visit Time*			**0**	**0**
50	Other Activity (please specify)				
51	**End: with last office visit before end of global period**				
52	**MEDICAL SUPPLIES**	**CMS Code**	**Unit**		
53	Pack, minimum multi-specialty visit	SA048	pack	**1**	**1**
54	Pack, cleaning and disenfecting	SA042	pack	**1**	**1**
55	Pack, urology cystoscopy visit	SA058	pack	**1**	**1**
56	Scissors	SA027	item	**1**	**1**
57	Dressing, 3inx4in (Telfa, Release)	SG035	item		**1**
58	Drainage bag	SJ031	item	**1**	**1**
59	Foley catheter	SD024	item	**1**	**1**
60	*Tray, catheter insertion (w-o catheter)*	*SA063*	*tray*	**1**	**1**
61	Underpad - chux (2ft x 3ft)	SB044	item	**1**	**1**
62	Laser fiber, disposable	SF028	item	**1**	**1**
63	Drape-towel, sterile (18in x 26in)	SB019	item	**1**	**1**
64	*Penis clamp (see invoice)*		*item*	**1**	**1**
65	*Lidocaine 1-2% inj (Xylocaine)*	*SH047*	*ml*	**50**	**50**
66	*Gloves, sterile*	*SB024*	*pair*	**2**	**3**
67	*Catheter, urethral straight*	*SD030*	*item*	**1**	**1**
68	*Catheter, tip adapter*	*SD015*	*item*	**1**	**1**
69	*Syringe, Toomey*	*SC062*	*item*	**1**	**1**
70	*Cup, biopsy specimen cup, sterile (4 oz)*	*SL036*	*item*		**6**
71	*Sanitizing cloth-wipe (surface, instruments, equipment)*	*SM022*	*oz*	**4**	**4**
72	*Water, sterile for irrigation (250-1000ml uou)*	*SH074*	*item*	**2**	**2**
73	*Syringe, 30 ml*	*SC054*	*item*	**1**	**1**

	A	B	C	D	E
2				**52214**	**52224**
3	**Meeting Date: January, 2012** **Specialty: American Urological Association**	**CMS**	**Staff**	**Cystourethroscopy, with fulguration (including cryosurgery or laswer surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands**	**Cystourethroscopy, with fulguration (including cryosurgery or laswer surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy**
4	**LOCATION: Tuscon, Arizona**	**Code**	**Type**	**Non Facility**	**Non Facility**
74	**Equipment**			**Minutes**	**Minutes**
75	Light source	EQ167		**100**	**105**
76	Power table	EF031		**100**	**105**
77	Forceps, grasping	ES007		**100**	**105**
78	Mobile back table with wheels	EF027		**100**	**105**
79	*Cystoscope, flexible, Fiberscope (see invoice)*	*ES018*		**100**	**105**
80	*Video system, endoscopy (processor, digital capture, monitor, printer, cart)(see invoice)*	*ES031*		**100**	**105**
81	Laser (gs, uro, obg, ge) ***Indigo laser no longer manufactured	EQ153		**100**	**105**
82	Biopsy forceps	ES006		**100**	**105**
83	*Instrument pack, basic ($500-$1500) Van Buren Sounds (see invoice)*	*EQ137*		**100**	**105**

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Laser Treatment for Invasive and Noninvasive Carcinoma of the Bladder

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ABSTRACT

Lasers are widely used in urologic surgery and have many well-developed applications. The use of lasers for the treatment of bladder cancer has been proven to be safe and minimally invasive. The neodymium:YAG laser is the most widely used instrument, although the holmium:YAG laser has also gained recent popularity. Noninvasive, small lesions are especially amenable to management with laser energy and have been treated with success rates that are at least as good as those of standard electrocautery resection. Complication rates are low. Laser therapy of invasive bladder cancer has significant limitations and should probably be restricted to stage T_2 lesions.

INTRODUCTION

THE BASIC PREMISE for the use of surgical lasers is that thermal energy can be applied safely and effectively to specific tissues and lesions with great precision and, probably, decreased morbidity. Within the field of urologic surgery, the laser has become an increasingly important tool. These instruments have been applied successfully to a variety of benign conditions, including stones, strictures, benign prostastic hyperplasia, genital warts, and angiomatous lesions. Additionally, laser energy has been used for malignancies such as urothelial tumors or squamous-cell carcinoma. The purpose of this article is to review the basic principles of laser therapy and assess its success in the treatment of invasive and noninvasive transitional-cell carcinoma (TCC) of the bladder.

LASER PRINCIPLES AND TISSUE EFFECTS

Surgical lasers are powered by electricity to energize and excite atoms of the active medium within the laser resonator.[1] This influx of energy causes these atoms to reach higher energy states and release photons of light energy as they return to their steady state. The photons are collected, amplified, focused, and channeled out through a series of mirrors or a flexible fiber. The wavelength of a particular laser is determined by the active medium that is used to generate the photons. The tissue response to a particular wavelength, in turn, is determined by chromophores within the cells that selectively absorb different wavelengths of light. In addition, the amount of energy delivered to a specific site (the energy density) depends on the duration of energy exposure as well as the ability of the machinery to deliver the energy within a narrow focus (angle of divergence). Most lasers used today are able to focus the energy within a 5° to 15° angle of divergence. Although this focusing permits more efficient energy delivery, it also increases the risk of thermal injury to nearby structures, because such high-density energy exposure can extend for several centimeters.

Tissue injury is brought about by the delivery of thermal energy to the exposed cells.[2] Temperatures within the tissues need to reach 60°C to 100°C and create irreversible damage through protein denaturation and tissue coagulation. Tissue vaporization is achieved when temperatures exceed 100−C. Whereas this temperature is easy to produce on the body surface, the effects of circulating irrigation fluid makes it more difficult to achieve vaporization within the bladder.

CHOICE OF LASERS

The wavelength of the light emitted from surgical lasers differs according to the active medium used to generate the photon energy. Several lasers have been developed and used for urologic applications (Table 1).[1]

The Nd:YAG laser has historically been the most widely used instrument in the field of urology. Neodymium is the active medium and is contained within a lattice of yttrium, aluminum, and garnet. The 1064-nm wavelength of the light from this instrument is poorly absorbed by water and tissue pigments, and the energy therefore is able to attain deep tissue penetration. As a result, this laser tends to produce excellent thermal coagulation of the treated lesion, both at the surface and below. The treated tissue usually takes on a white, fluffy appearance and is sloughed over the next several days. Hemostasis is typ-

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Table 1. Lasers Used in Urologic Surgery

Type	*Wavelength (nm)*	*Endoscopic delivery?*	*Depth of penetration (mm)*
Nd:YAG	1064	Yes	3–5
KTP:YAG	532	Yes	1–2
CO_2	10600	No	0.1
Argon	488–514	Yes	0.5–1.5
Ho:YAG	2100	Yes	0.5–1.0

ically complete. Adjacent tissue is at risk for thermal injury, especially at the bladder dome and over previously thinned bladder tissue, such as after a transurethral resection.

The KTP laser directs Nd:YAG-produced energy through a crystal of potassium, titanyl, and phosphate to produce a visible green light with a 532-nm wavelength. However, this interaction decreases the power of the effective energy that can be delivered through a single burst. The 532-nm wavelength has less tissue penetration than that of the Nd:YAG laser. Although this feature makes treatment of larger lesions more difficult and tedious, there may be a greater margin of safety for the treatment of smaller, superficial lesions.

Argon lasers produce energy with a wavelength between 488 and 514 nm. Its energy is strongly absorbed by pigments such as hemoglobin and melanin. This feature has made the argon laser useful for the management of cutaneous hemangiomata or during partial nephrectomy. Its application in the treatment of bladder cancer has been limited by the low power outputs and has not found wide acceptance.

The CO_2 laser can deliver a powerful amount of energy to specific lesions and cause marked tissue vaporization. The 10,600-nm wavelength is absorbed by glass and water. Practical concerns have limited the endoscopic use of a CO_2 laser in the bladder.

The argon laser can also be used in conjunction with a dye laser to produce photon energy at specific wavelengths. This specificity allows the surgeon to target selective tissue chromophores and is the basis for hematoporphyrin therapy of superficial tumors and carcinoma *in situ* of the bladder. The use of this laser alone is severely limited by the greatly reduced power output, which results from the use of one laser to drive another.

The most recent laser wavelength to become available for surgical use is the Ho:YAG. This instrument uses the rare earth element, holmium, in conjunction with a YAG crystal. The resulting 2100-nm wavelength is invisible to the human eye and requires the addition of an aiming light that is also directed down the delivery fiber. Through the manipulation of power and pulse settings, this laser is capable of both efficient tissue coagulation and vaporization. In addition, the hemostatic effects of this instrument are excellent, allowing the surgeon to work in a nearly bloodless field. Finally, the high absorption of holmium laser energy by water (as with the CO_2 laser) means that the superficial tissues suffer the majority of the thermal injury and limit the depth of tissue penetration to around 0.5 to 1.0 mm. The holmium laser has gained wide acceptance for intracorporeal lithotripsy since the first reports of its use in 1995.3 The holmium laser has not been as widely applied to the management of urothelial cancer, although several authors have reported on its efficacy in both the bladder and the upper urinary tracts.[4–6]

TECHNIQUES AND RESULTS OF LASER THERAPY FOR NONINVASIVE BLADDER CANCER

Small, papillary bladder lesions are the most amenable to management with laser energy. Many authors feel that this technique is best reserved for those patients who have had previous biopsy-proven, noninvasive (T_a/T_1), low-grade papillary TCC. Alternatively, cold-cup biopsies can be taken of the bladder wall and of an indicative lesion, using the laser to achieve hemostasis and to eradicate all other lesions. Laser therapy for superficial bladder cancer was first reported in Germany in the mid 1970s and was approved for use in the USA in 1984.

Laser therapy of noninvasive tumors is usually performed on an outpatient basis and may require less anesthesia than standard electrocautery resection. This finding likely is attributable to the fact that laser energy results in rapid heating and destruction of tissue and neural fibers, whereas the electrical current of a standard cautery instrument can propagate back along the nerve fibers. In addition, the ability to deliver laser energy through a flexible fiber means that flexible cystoscopy may be employed, avoiding the discomfort of a rigid instrument. For those patients under spinal or general anesthesia, a rigid cystoscope with a laser bridge provides excellent fiber control and accuracy.

The Nd:YAG laser generally requires 30 to 40 W of energy to coagulate the targeted bladder lesions. Using a standard 400- or 600-μm fiber, the tip is placed 3 to 4 mm from the papillary lesion, and the energy is used in a continuous fashion to "paint" the tumor until the tissue demonstrates a whitish discoloration. At times, the tumor exhibits subsurface boiling or "popping" as the tissues undergo complete coagulation. The coagulated fronds may then be dislodged with the fiber tip or the cystoscope to expose the base of the tumor for further treatment. Two to three seconds usually is required in any one spot to achieve complete coagulation of the treated tissue. Any type of irrigant will transmit the laser energy. Continuous-flow systems are not routinely needed, because there should be nearly complete hemostasis.

The biggest drawback of the Nd:YAG laser is that it can be difficult to predict the precise depth of tissue penetration accurately.[7] Reports of adjacent bowel injury in the face of an intact (albeit coagulated) bladder wall do exist. In general, the Nd:YAG energy can be expected to produce consistent penetration of at least 3 to 5 mm. Limiting the duration of laser application, employing reasonable power settings, and careful monitoring of the visible tissue changes can all reduce the risk of thermal injury, especially at the bladder dome. Nonetheless, a Nd:YAG laser can be used to treat tumors within bladder diverticula. Special care is taken to avoid excessive energy delivery. It should be noted that the obturator nerve will not be stimulated by laser energy, and, therefore, obturator spasm and

its accompanying leg jerk are avoided. Tumors that overlie ureteral orifices can be treated with apparently little risk of ureteral stricture, although the laser energy can melt ureteral stents or can even cut through guidewires.

The holmium laser is applied in a fashion similar to the Nd:YAG with the exception that it has shallower tissue penetration. For this reason, it may have a greater safety margin for smaller tumors and those lesions located on the dome of the bladder. At the same time, however, treatment of larger tumors may become tedious, and the energy may not adequately penetrate the tumor base. The holmium laser usually requires lower wattage (5–15) and most often is used with energy settings of 0.5 to 1.5 J/pulse at a pulse rate of 8 to 15 Hz.

A Foley catheter usually is not required after the use of either laser. Many patients will not notice any difference in their urine, although a few will see increased urine sedimentation as the coagulated tissue sloughs. Delayed bleeding is rare.

Several authors have reported that laser therapy of larger, superficial lesions may lead to a lower local recurrence rate than electrocautery resection.[8–10] Although this therapy probably does not affect the incidence of recurrence in untreated portions of the urothelium, the transmural transmission of the laser thermal energy may deliver a more even and effective dose of radiant energy to the bladder wall than electrocautery can achieve. For this same reason, it is important to keep the bladder partially empty during laser therapy to avoid thinning the wall and permitting the transmission of energy to adjacent structures. In a randomized study, Beisland and Seland[9] reported a local recurrence rate of 7% for Nd:YAG-treated stage T_1 tumors *v* 43% for similar tumors treated with standard electrocautery. Beer and associates[8] reported a similar local recurrence rate in their series of 252 consecutive patients treated with the laser for superficial lesions.

TECHNIQUES AND RESULTS OF LASER THERAPY OF INVASIVE BLADDER CANCER

The Nd:YAG laser has been used as an adjunct to electrocautery resection for the treatment of higher-stage bladder cancers (T_2, $T_{3a–b}$, and T_4). The basic premise in this setting is that the application of laser energy to the tumor crater may induce full, transmural tissue coagulation and therefore eliminate any residual tumor that might remain in the region. In addition, investigations by Hofstetter and colleagues[11] suggested that circumferential application of Nd:YAG energy at the base of a tumor may induce lymphatic sealing around the lesion. The clinical significance of this theoretical effect is unclear, however.

An aggressive transurethral resection with electrocautery is first performed, and the crater usually is allowed to heal for several days. This waiting period permits the lysis and clearance of any residual clot that may remain on the crater surface; the presence of such debris can interfere with the transmission of the laser photon energy into the deeper tissues. A rigid cystoscope with a laser bridge is typically employed, although a flexible cystoscope may be used for less accessible areas such as the anterior bladder neck. Power settings of 35 to 50 W generally are used, with the energy delivered in a continuous fashion. Any single area of the bladder tumor or the surrounding wall should be treated until the whitish discoloration typical of coagulation occurs, usually after 3 to 4 seconds. It is important to treat the entire tumor bed as well as a 1-cm margin around the tumor. Caution must be used when treating particularly thin areas of the bladder, because this tissue will be more prone to through-transmission of the laser energy to neighboring structures. This is especially true on the dome and posterior walls of the bladder.

A combined cystoscopic and laparoscopic technique has been described in which an intraperitoneal laparoscope is used to help retract the intestines off the bladder wall as well as to observe the effects of the cystoscopically applied laser energy.[12] In addition, the laser fiber can be passed through the laparoscope to treat the intraperitoneal side of the bladder and thereby ensure a full transmural effect. This technique does not increase the risk of bladder perforation because of the typical preservation of the cytoskeleton, providing bladder structural integrity. Additionally, rapid fibroblast infiltration and collagen deposition help prevent bladder wall disintegration. This technique can be limited by difficult visibility when the lesions are located over the trigone or deep on the posterior wall.

Not unexpectedly, the results of reported series of laser therapy for invasive bladder tumors have illustrated the limitations of this technique.[13–15] On average, patients with stage T_2 lesions suffered local recurrences in 16% of the cases. All T_4 lesions recurred, and the T_3 tumors recurred in 25% to 100% of patients (Table 2). Tarantino and coworkers[16] performed laser therapy on 18 patients prior to radical cystectomy and were therefore able to attain accurate pathologic staging of all lesions. The results were poor for all stages in this study, including T_2 lesions. A serious limitation of this study, however, was the lengthy interval that some of the patients had between laser treatment and cystectomy (39 weeks maximum).

It is apparent from the data that laser therapy for invasive lesions is best suited for patients with minimal T_2 lesions and no evidence of disease elsewhere in the bladder. These patients should undergo aggressive electrocautery resection, and the laser should be used to attempt to extend the surgical margins. As with other bladder salvage techniques, those patients too ill to undergo radical cystectomy may also benefit from this minimally invasive technique.

PHOTODYNAMIC LASER THERAPY

Photodynamic therapy uses laser photon energy to injure or destroy target cells that have previously been sensitized to the specific wavelength that is being employed.[17] The most widely used sensitizing agent is hematoporphyrin derivative, which is delivered intravenously 48 to 72 hours prior to laser therapy. This agent is preferentially taken up by malignant cells, particularly carcinoma *in situ* of the bladder. When these cells are then exposed to laser energy (such as from an argon pulsed-dye laser), the hematoporphyrin derivative is raised to an ex-

TABLE 2. RECURRENCE RATES (%) BY STAGE AFTER ND:YAG LASER THERAPY FOR INVASIVE TCC

Series	T_2	T_3	T_4
McPhee et al (1988)[13]	0	43	100
Smith (1989)[14]	18	50	100
Beisland & Sander (1990)[15]	27	–	–
Average	16	47	100

cited state and creates oxygen free radicals within the mitochondria of the target cells. This leads to cell death.

Results reported in several small series have shown response rates from 60% to 90%.[18,19] The durability of these responses remains to be determined. Most patients develop some degree of light supersensitivity after this therapy and should avoid direct sunlight for 4 to 6 weeks. Additionally, the reported incidence of irritative voiding symptoms and loss of bladder capacity varies widely.

There are numerous reports of alternative sensitizing agents that can be used for therapeutic as well as diagnostic purposes. The utility of these agents is as yet undetermined.

COMPLICATIONS

The complication rate from laser therapy of bladder carcinoma is generally low. Most patients experience little discomfort, and many are able to avoid routine postoperative Foley catheterization. Postoperative hemorrhage is uncommon, because the coagulation caused by the laser photon energy averts immediate or delayed bleeding.

The most serious complication of laser therapy is perforation of an adjacent organ, such as the colon or small bowel. As discussed previously, this risk is greatest when treating lesions on the posterior wall or dome of the bladder. Several large series, including one with 2000 consecutive patients, have bowel injury rates of 0.15% to 0.30%.[8,20] Most patients with a bowel perforation present within 8 to 48 hours with signs and symptoms of an acute abdomen. It is important to remember that bowel injury can occur in the absence of a complete bladder perforation. In fact, a cystogram may be normal despite obvious free air from the perforated viscus. Immediate laparotomy is indicated if enteric perforation is suspected.

CONCLUSION

The use of lasers for the treatment of bladder cancer has been demonstrated to be safe and minimally invasive. Available data show that small, noninvasive lesions are easily treated with this modality and that local recurrence rates are as good as, if not superior to, those of standard electrocautery resection. The use of laser therapy for the management of invasive lesions should be limited to small T_2 lesions with a bladder otherwise free of pathology or for those patients with excessive comorbidities.

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Urologists At Work

LIDOCAINE AS A TOPICAL ANESTHETIC FOR BLADDER BIOPSIES

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ABSTRACT

The use of lidocaine as a topical anesthetic in bladder biopsies is described. Lidocaine was used in 7 patients undergoing random bladder biopsies and serum lidocaine levels were measured 7 to 10 minutes after instillation. Adequate pain control was noted in each patient with negligible serum lidocaine levels even in the face of denuded bladder mucosa.

KEY WORDS: lidocaine, anesthesia, bladder, biopsy

Random biopsies of the bladder mucosa (bladder mappings) are frequently performed after intravesical chemotherapy for superficial bladder carcinoma to determine efficacy of therapy or to evaluate a suspicious region of bladder mucosa discovered during cystoscopy. It has been suggested that no anesthetic is required during this procedure due to the brevity of discomfort.[1] However, we have found that, with few exceptions, most patients require an anesthetic to complete the procedure. We describe a safe, effective and simple method of topically anesthetizing the bladder mucosa for subsequent random bladder biopsies.

MATERIALS AND METHODS

A total of 7 patients 54 to 75 years old underwent bladder biopsies using topical lidocaine anesthesia. Four women and 3 men were evaluated. Bladder biopsies were performed subsequent to intravesical chemotherapy or in conjunction with a suspicious region of bladder mucosa found at cystoscopy. When bladder lesions appeared large enough to require resection rather than cold-cup biopsy the procedure was not attempted.

The patient is placed in the lithotomy position and 5 to 10 ml. 2% lidocaine hydrochloride are instilled into the urethra. A 16F Foley catheter is placed into the bladder and the bladder is drained of all urine. Then, 50 ml. 2% lidocaine hydrochloride are instilled into the bladder and the catheter is removed. The anesthetic is allowed to stay in contact with the bladder mucosa for 7 to 10 minutes. The cystoscope then is introduced into the bladder to drain the anesthetic and perform the cold-cup biopsies. The patients were questioned during the procedure regarding any pain experienced. One patient required 1 mg. midazolam hydrochloride intravenously to supplement the anesthetic.

Serum lidocaine levels were obtained at introduction of the cystoscope, since further absorption of the anesthetic would not be expected after bladder drainage. Serum lidocaine levels were measured using fluorescent polarization immunoassay. Biopsy sites were cauterized as needed using a Bugbee electrode. All patients were kept in the hospital overnight for observation with Foley catheter drainage.

RESULTS

All patients noted adequate anesthesia during the procedure with 1 exception. This patient required a supplemental intravenous amnestic agent to allow completion of the procedure. The patient had been extremely anxious about the investigative nature of the procedure but had decided to proceed. The patient subsequently remembered no pain or discomfort postoperatively.

In each of the 7 cases serum lidocaine levels returned as negligible, despite cystoscopic evidence of diffusely denuded mucosa in 2 patients. These 2 patients had undergone 6 weekly treatments of intravesical chemotherapy with followup cystoscopy 6 weeks later.

There were no postoperative complications and in each patient the urethral catheter was removed the next morning before he or she was discharged from the hospital. Each patient stated that they experienced minimal or no discomfort during the procedure.

DISCUSSION

Although performance of random bladder biopsies without anesthesia has been advocated,[1] any pain encountered by the patient may be detrimental to the physician-patient relationship. Topical lidocaine instillation offers a safe and effective method of painless bladder biopsy especially applicable to the outpatient setting. Due to the experimental nature of the procedure all of our patients were observed overnight. However, in each case minimal bleeding was observed and these patients could have been discharged from an outpatient surgery setting.

Of the 7 patients 6 reported excellent anesthesia, with the need for a small dose of an amnestic agent in 1 anxious patient. Such a need in an outpatient setting would simply require blood pressure and respiratory monitoring during the procedure and for a short interval postoperatively.

If the urologist finds a suspicious region during routine cystoscopy the lidocaine can be instilled through a cystoscope bridge, circumventing the need to place a Foley catheter for instillation. Even with the addition of the Foley catheter the procedure is much more cost-effective than regional or general anesthesia.

Previous investigators were concerned about the possible absorption of lidocaine from the bladder mucosa and questioned the amount of absorption from traumatized mucosa.[2] We found that even with denuded mucosa lidocaine absorption was negligible. Therefore, we conclude that topical lidocaine is a safe, inexpensive and effective mode of anesthesia for bladder biopsies even in cases of traumatized bladder mucosa.

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The views of the authors do not purport to reflect the position of the Army or the Department of Defense.

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EDITORIAL COMMENTS

The method detailed by the authors is appealing and, based on the limited experience presented, seems simple, safe and effective. In fact, I found it so appealing that after reviewing the paper I tried it in 2 of my patients with bladder cancer. These patients generally have required general or spinal anesthesia for periodic random bladder biopsies. Both patients and I were happy with the resultant pain control and I will continue to use this approach.

I suspect other urologists will share my curiosity and impulsive enthusiasm and give it a try. If a broader and more extensive experience resembles that reported we will save health care dollars. In our practice setting it converts an outpatient hospital or surgical center experience involving an anesthesiologist into a convenient, simple office procedure. A single caveat is that the number of patients treated and monitored with denuded mucosa (2) is especially small upon which to base firm conclusions. Further observations on serum lidocaine levels in this subset are desirable.

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We have also found that few patients can tolerate multiple bladder biopsies without some form of anesthesia and it is fair to say that most commonly these procedures are performed with the patient under general anesthesia at most institutions simply because of their brevity. This report should be welcome because it demonstrates the safety and efficacy of intravesical lidocaine use as a topical anesthetic agent. The cost savings with widespread use of this technique should be considerable and it is an example of how innovative ideas can decrease the cost of medical care without compromising the quality. The technique may not be applicable to larger tumors or for long-lasting procedures. Even so, this is an eminently practical adjunct to the urological armamentarium.

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RANDOMIZED, PROSPECTIVE, DOUBLE-BLIND STUDY OF THE EFFECTS ON PAIN PERCEPTION OF LIDOCAINE JELLY VERSUS PLAIN LUBRICANT DURING OUTPATIENT RIGID CYSTOSCOPY

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ABSTRACT

Purpose: There is no clear evidence that intraurethral lidocaine jelly decreases pain and/or makes rigid cystoscopy more tolerable for patients. Since lidocaine jelly is significantly more expensive than plain lubricant, we attempted to assess the true benefit of this agent.

Materials and Methods: We performed a randomized, prospective, double-blind study to compare the anesthetic effects of intraurethral 2% lidocaine jelly versus plain lubricant in patients undergoing rigid cystoscopy. Unlike previous studies, we ensured adequate urethral filling by using 30 cc of each agent and we waited 20 minutes after instillation of the agent before performing cystoscopy to allow adequate absorption. Cystoscopy was performed using a 17 to 21F rigid instrument. A total of 189 patients was entered into the study but 10 were excluded from analysis due to incomplete questionnaires. A 10-point scale (1—least to 10—most painful) was used to measure pain perception.

Results: In men pain perception was significantly decreased when lidocaine jelly was used (mean plus or minus standard error 3.00 ± 0.21 versus 4.36 ± 0.37 points, $p = 0.002$). In women there was no observed difference in pain perception when lidocaine jelly or plain lubricant was used (3.21 ± 0.38 versus 3.11 ± 0.30 points, $p = 0.823$). Patient race, performance of a related procedure, cystoscope size or history of cystoscopy did not significantly affect reported pain scores. There was a slight decrease in pain perception with increasing age (−0.23 ± 0.10 points per decade, $p = 0.021$). The level of patient anxiety before cystoscopy was also significantly associated with pain perception ($p < 0.001$).

Conclusions: Lidocaine jelly offers no advantage over plain lubricant in regard to pain control during rigid cystoscopy in women. However, when used in adequate amounts and allowed to dwell in the urethra for 20 minutes before cystoscopy, lidocaine jelly can significantly decrease pain in men.

KEY WORDS: urethra, lidocaine, cystoscopy, anesthesia, pain

Various anesthetic approaches have been used in an attempt to make rigid cystoscopy more tolerable for patients, including general and spinal anesthesia as well as topical agents, such as dibucaine, intracaine, cocaine, dyclonine hydrochloride and silicone fluid.[1-4] However, these agents have been largely replaced by lidocaine, which has been shown to be safe and well tolerated during rigid cystoscopy.[5-7] Discovered in 1946, lidocaine stabilizes the neuronal membrane by inhibiting ionic fluxes required for depolarization, blocking initiation and conduction of the action potential.[8]

Others have studied the efficacy of lidocaine during rigid cystoscopy. In 1949 Haines and Grabstald reported the successful use of 10 cc 2% lidocaine jelly in 250 patients.[9] This study was uncontrolled with the end point measured by a subjective physician report, not by an objective and reproducible scale of pain assessment. In 1953 Persky and Davis also reported good success with lidocaine jelly during rigid cystoscopy.[10] This study was also uncontrolled with success measured by a subjective physician report but the results were further invalidated because all patients received premedication with 75 to 100 mg. intramuscular meperidine before cystoscopy. Recently Stein et al compared 2% lidocaine jelly to plain lubricant.[11] They did not report the amount of lubricant used and allowed a 5 or 10-minute intraurethral dwell time before cystoscopy. Using a visual analogue scale there was no difference in pain perception between patients who received lidocaine jelly or plain lubricant. Based on the hypothesis that the effectiveness of lidocaine jelly during rigid cystoscopy depends on an adequate volume that is allowed to dwell in the urethra for a sufficient period, we performed a randomized, prospective, double-blind study to compare the efficacy of 2% lidocaine jelly versus plain lubricant.

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MATERIALS AND METHODS

All patients referred to our hospital outpatient urology clinic who were to undergo rigid cystoscopy were asked to participate in this institutional review board approved study and were enrolled after informed consent was obtained. Before and after rigid cystoscopy all patients completed a questionnaire regarding pretreatment anxiety and level of pain associated with the procedure. Pain was assessed by a 10-point scale (1—least to 10—most painful).[12] Patient reported pain score was the primary outcome variable. Physician subjective assessment of the level of discomfort perceived by the patient and patient anxiety level before cystoscopy were also recorded on a 10-point scale. Patients were assigned to 1 of 2 treatment groups. Group 1 received 30 cc lidocaine gel injected transurethrally for 30 seconds. In men a penile clamp was placed for 20 minutes. The patient lay supine during the 20-minute interval. In women no clamp was placed but they lay supine for 20 minutes. Group 2 underwent the same

procedure but 30 cc plain lubricant were used instead of lidocaine gel. Since Brekkan et al noted that average urethral volume in men and women is 19.5 and 1.3 ml., respectively,[13] these doses ensured adequate urethral filling. Instillation was performed by the clinical nurse and cystoscopy was done by 1 of 13 urologists using a rigid 17 (diagnostic) or 21F (stent removal) cystoscope.

A total of 106 patients was initially assigned to 1 of the 2 treatment groups in an alternating fashion. Syringes containing lidocaine or plain lubricant were prepared in advance by one of us who was not otherwise involved in performing the procedures or evaluating patient responses. These syringes were then arrayed on a shelf in the examination room with lidocaine and plain lubricant in an alternating sequence, which were administered successively to patients. Neither the patient, nurse nor treating physician was aware of the agent instilled. After these 106 patients were entered into the study a formal randomization method was adopted in which the order of treatment was determined using a table of random numbers and permuted blocks of size 8.[14] A total of 83 additional patients was entered into the study and, therefore, 189 were evaluated.

The 2 treatment groups were compared with respect to demographic and other baseline variables (covariates) by chi-square or Fisher's exact test for categorical variables and 2-sample t tests for interval data. Pain scores were compared in the 2 treatment groups using 2-sample t tests and nonparametric Wilcoxon rank-sum tests. Analysis of variance and covariance was used to examine and adjust for the effects of baseline variables on pain scores and to assess the significance of treatment by covariate interaction terms. Analyses were performed for the entire group of patients as well as the subset that was formally randomized. Results were similar and, therefore, we present as our primary results the findings based on all enrolled patients, because they provide more precise estimates of treatment effects. However, we also summarize main outcomes in the subset of patients that was formally randomized.

RESULTS

A total of 189 patients was initially entered into the study but 10 were excluded from analysis (6 from the lidocaine and 4 from the plain lubricant group) due to incomplete questionnaires. Indications for cystoscopy included hematuria in 63 patients (35%), bladder cancer surveillance in 38 (21%), stent removal in 47 (26%) and other in 31 (17%). In addition, 13 patients were inadvertently included during repeat cystoscopy and only data from the first procedure were used.

Baseline distributions for the 2 treatment groups are shown in table 1. The 2 groups are comparable with respect to patient age, race, gender, history of cystoscopy, the performance of additional procedures during cystoscopy and anxiety level before cystoscopy as assessed by the patient. Mean anxiety level before cystoscopy as assessed by the physician was slightly greater in the plain lubricant group ($p = 0.047$). A 21F cystoscope was used in all patients undergoing an additional procedure, whereas the 17F (diagnostic) cystoscope was used in all others. Thus, the 2 treatment groups are also comparable with respect to cystoscope size but the effects of an additional procedure and cystoscope size on outcome cannot be differentiated.

Mean pain scores according to treatment group are shown in table 2. The overall mean pain score was significantly lower in the lidocaine than plain lubricant group (3.07 versus 3.86, $p = 0.014$). Likewise, physician pain scores favored the lidocaine group but the difference was not statistically significant. However, analysis of variance of patient pain scores revealed a significant ($p = 0.028$) treatment by sex interaction. In men the average patient pain score was approximately 1.4 points lower in the lidocaine than plain lubricant group (95% confidence interval -2.2 to -0.5, table 2). Similar but slightly smaller differences were obtained for men using physician reported pain scores. However, in women there was no evidence of decreased pain from lidocaine use. Based on 95% confidence intervals data are consistent with a true benefit of no more than 0.9 points for the patient or physician reported assessments. The figure shows the percent distribution of patient pain scores for men and women. Three of the 63 men (4.8%) in the lidocaine group had scores of 6 or higher versus 11 of the 52 (21.1%) receiving plain lubricant ($p = 0.016$). No man in the lidocaine group but 8 (15.4%) in the plain lubricant group reported a pain score of 9 or 10. Three of the 28 women (10.7%) receiving lidocaine jelly and 4 of the 34 (11.8%) receiving plain lubricant reported pain scores of 6 or greater. No woman in either group reported a pain score of 9 or 10.

Table 2 also shows results in the subset of cases that were formally randomized. For patient reported pain scores the overall difference significantly favors lidocaine ($p = 0.014$) but again there was a statistically significant treatment by sex interaction ($p = 0.011$). For men the average pain score was approximately 2.5 points lower in those treated with lidocaine compared to those receiving plain lubricant, whereas for women there was little difference between the 2 treatment groups. The differences in physician reported pain scores were similar in magnitude to those for all enrolled patients. However, due to smaller sample size the difference for men did not reach statistical significance.

TABLE 1. *Baseline characteristics of the treatment groups*

	Lidocaine	Plain Lubricant	p Value
No. pts.	92	87	
Mean pt. age ± SE (range)	59.5 ± 1.6 (24–88)	60.6 ± 1.6 (23–86)	0.631
No. race (%):			
White	50 (54)	46 (53)	0.960*
Black	39 (42)	40 (46)	
Hispanic	3 (3)	1 (1)	
No. sex (%):			
M	64 (70)	52 (60)	0.224
F	28 (30)	35 (40)	
No. with previous cystoscopy (%):			
Yes	45 (49)	34 (39)	0.241
No	47 (51)	53 (61)	
No. with additional procedure (%):			
Yes	59 (64)	61 (70)	0.489
No	33 (36)	26 (30)	
Mean anxiety level before cystoscopy ± SE (range):†			
Pt.	5.37 ± 0.24 (1–10)	5.77 ± 0.24 (1–10)	0.245
Physician	4.99 ± 0.21 (1–10)	5.61 ± 0.23 (2–10)	0.047

* Chi-square test with 1 degree of freedom pooling black and Hispanic patients.
† As assessed by a 10-point scale (1—least to 10—most painful) completed before cystoscopy.

TABLE 2. *Mean pain scores plus or minus standard error according to treatment group using a 10-point scale, as reported by patients and physicians*

	Lidocaine	Plain Lubricant	Difference	95% Confidence Interval	p Value*
		All enrolled pts.			
No. men and women:	92	87			
Pts.	3.07 ± 0.18†	3.86 ± 0.26†	−0.79	(−1.43−−0.16)	0.014
Physicians	3.95 ± 0.22	4.42 ± 0.25†	−0.47	(−1.13− 0.19)	0.162
No. men:	64	52			
Pts.	3.00 ± 0.21†	4.36 ± 0.37	−1.36	(−2.21−−0.50)	0.002
Physicians	3.99 ± 0.26	4.93 ± 0.35†	−0.94	(−1.81−−0.07)	0.034
No. women:	28	35			
Pts.	3.21 ± 0.38	3.11 ± 0.30†	0.10	(−0.86− 1.08)	0.823
Physicians	3.86 ± 0.43	3.67 ± 0.29	0.19	(−0.86− 1.23)	0.722
		Formally randomized pts.			
No. men and women:	40	39			
Pts.	3.23 ± 0.29†	4.54 ± 0.43†	−1.31	(−2.35−−0.27)	0.014
Physicians	4.74 ± 0.35	5.04 ± 0.38†	−0.30	(−1.33− 0.72)	0.560
No. men:	27	19			
Pts.	3.04 ± 0.31†	5.58 ± 0.64	−2.54	(−4.00−−1.08)	0.001
Physicians	4.83 ± 0.41	5.89 ± 0.60†	−1.06	(−2.54− 0.43)	0.158
No. women:	13	20			
Pts.	3.62 ± 0.63	3.51 ± 0.47†	0.11	(−1.51− 1.73)	0.890
Physicians	4.54 ± 0.67	4.28 ± 0.42	0.26	(−1.38− 1.90)	0.742

* Two-sample t tests with similar results using nonparametric tests.
† Data were unavailable for 1 patient.

Analysis of covariance of the entire group of 179 evaluable patients detected a small but statistically significant age effect. Average pain score decreased by −0.23 ± 0.10 points per each increasing decade of age ($p = 0.021$). Thus, older men and women in both treatment groups tended to have less pain than younger individuals, although there was considerable variability in the responses in each age group. However, lidocaine jelly reduced pain in older as well as younger men. Physician assessment of the patient anxiety level before cystoscopy was also a significant predictor of the subsequent patient pain score. Each 1-point increase in anxiety level was associated with a mean pain score increase of 0.38 ± 0.07 points ($p < 0.001$). Analysis of covariance did not detect any statistically significant effects of race ($p = 0.57$), history of cystoscopy ($p = 0.70$), performance of an additional procedure ($p = 0.69$) or patient reported anxiety level ($p = 0.42$) on patient reported pain scores.

As noted, cystoscope size is entirely confounded with the performance of an additional procedure. However, analysis of covariance indicated no detectable effect of an additional procedure/cystoscope size on patient reported pain scores. In addition, while there was a slight difference in the rate of use of the 21F cystoscope in men (40 of 64 [62%] in the lidocaine versus 39 of 52 [75%] in the plain lubricant group), this difference was not statistically significant and it did not account for the observed difference in pain scores. For men in whom the 17F cystoscope was used mean pain score was 3.12 ± 0.41 in the lidocaine versus 5.31 ± 0.97 in the plain lubricant group ($p = 0.054$). For patients in whom the 21F cystoscope was used mean scores were 2.92 ± 0.23 and 4.04 ± 0.38, respectively ($p = 0.014$). A total of 19 of the 28 women (68%) in the lidocaine and 22 of the 35 (63%) in the plain lubricant group were treated with the 17F cystoscope and there was no significant difference in outcome after stratification by cystoscope size.

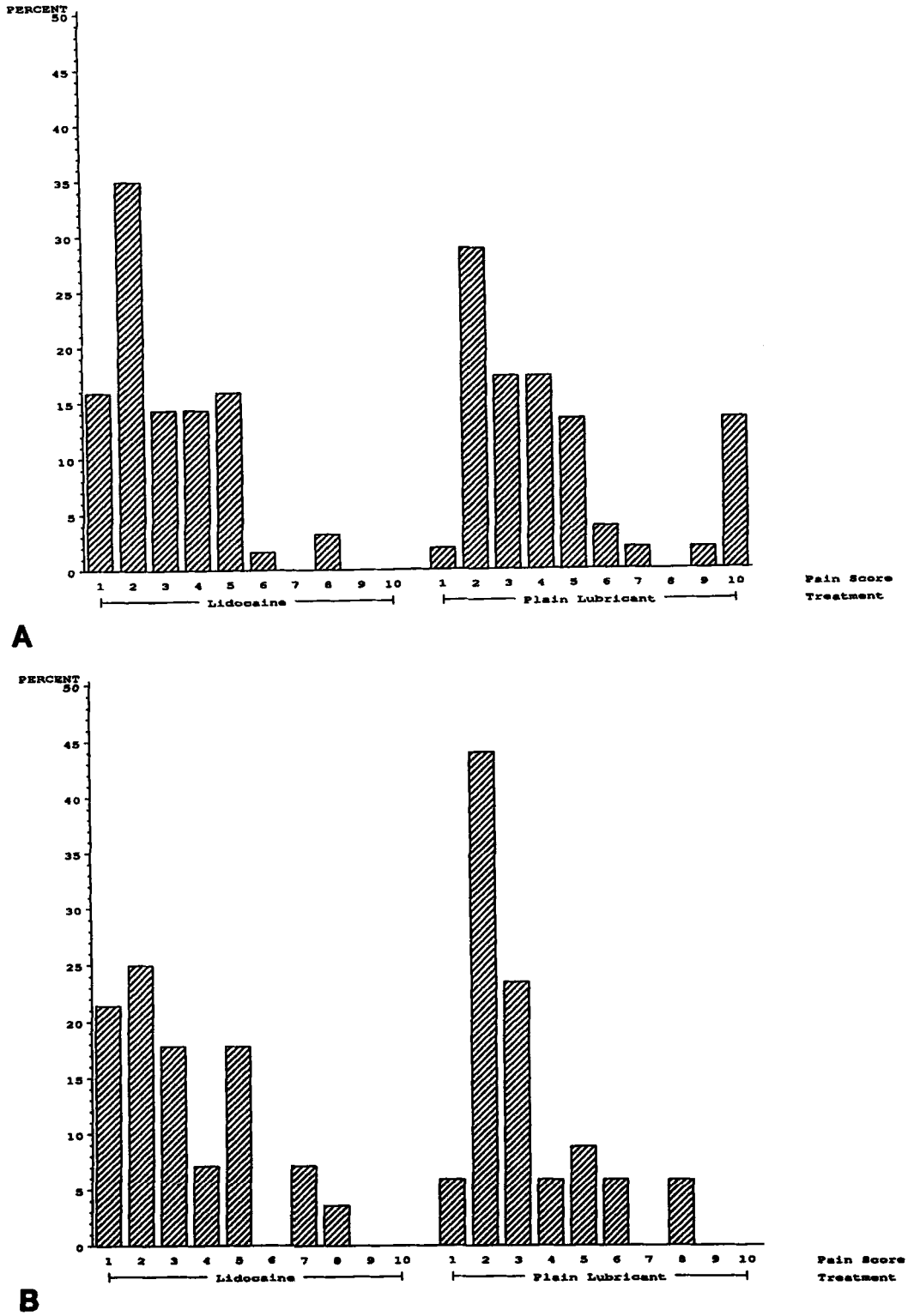
DISCUSSION

Cystoscopy remains one of the most common office procedures performed by urologists. Since it is often associated with significant anxiety and discomfort, it is important that cystoscopy be made as tolerable as possible for patients. In this study we observed that men undergoing rigid cystoscopy had significantly less pain when 30 cc lidocaine jelly were instilled and allowed to dwell in the urethra for 20 minutes compared to plain lubricant administered in an identical fashion. Conversely there was no observed difference in pain perception in women. While it could be argued that the mean difference in pain score of 1.4 points in men may not be clinically significant, there was an important observed difference in the incidence of severe pain. Specifically, no man who received lidocaine had an extreme pain score of 9 or 10 compared to 8 men (15%) who received plain lubricant. The overall incidence of severe pain scores of 6 or greater was also significantly lower in the lidocaine group. Therefore, we believe that the decreased average pain scores in men as well as the marked decreased incidence in severe pain justify the routine use of lidocaine jelly in men undergoing rigid cystoscopy.

Stein[11] and Brekkan[13] et al did not observe that lidocaine jelly led to decreased pain perception in patients undergoing rigid cystoscopy. The disparity between their results and those of our study may be related to the volume of lubricant and/or time the lidocaine was allowed to dwell in the urethra before cystoscopy. The package insert of Astra Xylocaine* 2% jelly states that 15 to 30 cc of this agent should be used in men with an intraurethral dwell time of 5 to 10 minutes and 3 to 5 cc should be instilled in women several minutes before cystoscopy. Stein et al noted no difference in pain perception in 236 patients randomized to receive lidocaine jelly or plain lubricant for 5 or 10 minutes before rigid cystoscopy.[11] However, it is unclear whether an adequate amount of lidocaine jelly was used, since the quantity was not stated. In addition, the improved results that we observed may also be related to a longer intraurethral dwell time of 20 minutes, which may improve local absorption and anesthetic effect. The benefits of larger volumes of lidocaine jelly are supported by the findings of Brekkan et al, who noted decreased pain perception in men younger than 55 years who received 20 cc lidocaine jelly compared to those who received only 11 cc.[13] Their results and those of Pliskin et al[7] support the finding that older men tolerate rigid cystoscopy better than younger men.

While we observed an improvement in pain perception in men using 30 cc lidocaine jelly and an intraurethral dwell time of 20 minutes, it is not clear whether similar results could be achieved with lower volumes and/or less time. Further investigation is necessary to define how these variables affect patient pain scores. In addition, our results demonstrate that physicians can accurately assess the level of patient anxiety, which correlates with increased pain percep-

* Astra USA, Westborough, Massachusetts.



Distribution of pain scores after cystoscopy according to treatment group. *A*, men. *B*, women

tion. Therefore, preoperative counseling to reduce anxiety may be helpful, although this hypothesis also requires further study. In addition, the lack of efficacy of lidocaine jelly in reducing pain perception in women may be related to the ease of passage of the cystoscope through the shorter female urethra or overall better tolerance of pain by women.

An alternative means of performing diagnostic evaluation of the bladder includes flexible cystoscopy. However, many urologists continue to perform rigid cystoscopy by choice or because the technology of flexible cystoscopy is unavailable. Since flexible cystoscopy is becoming more widely used, the role of lidocaine in reducing pain during this procedure must also be addressed. In a recent randomized study of 138 men using 10 ml. 2% lidocaine jelly and an intraurethral dwell time of 10 to 15 minutes Birch et al noted no difference in pain perception between men who received lidocaine versus

those who received plain lubricant.[15] However, it is possible that a larger volume of lidocaine allowed to dwell in the urethra for a longer period would lead to different results. Our hospital cost of 30 cc plain lubricant is $0.76, while the cost of 30 cc lidocaine is $14.25. Therefore, a busy urology clinic with a large number of cystoscopic procedures can realize significant cost savings by only using lidocaine jelly in men and plain lubricant in women.

CONCLUSIONS

Lidocaine jelly (2%) is more effective than plain lubricant in reducing pain during outpatient rigid cystoscopy in men, particularly younger men. In addition, a marked decrease in the incidence of severe pain in men receiving lidocaine jelly was also noted. However, 2% lidocaine jelly is no more effective than plain lubricant in reducing pain in women undergoing outpatient rigid cystoscopy. Patient race, a history of cystoscopy, performance of an additional procedure during cystoscopy and/or cystoscope size did not affect patient pain perception during cystoscopy. Physicians are accurate in assessing patient anxiety before cystoscopy and increased anxiety correlates with increased pain.

Drs. Charles B. Brendler, Edward L. Lyon, Gary D. Steinberg and Daniel B. Rukstalis provided cases for study inclusion.

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EDITORIAL COMMENT

The interpretation of a randomized clinical trial depends not only on the question that the investigators are evaluating, but also on specific features regarding design and conduct of the trial. Several issues relating to the design and conduct of this trial are worth expanding.

An important consideration in this trial is the amount of difference in the pain scale that is judged to be clinically significant. Does the difference between 3.0 and 4.36 in the group of men studied represent a clinically significant difference on this 10-point scale? The answer to this question does not rely simply on statistics. Rather, it relates to the difference between pain scores that would make the clinician or patient alter their own approach to treatment. The degree of normal variance expected in a scale contributes to this determination.

The authors describe that the technique of treatment assignment changed from alternating lidocaine with plain lubricant to a formal randomization method during the trial. Their finding that pain scores were not significantly different between the 2 forms of randomization is important. Simply alternating 1 treatment with another even when blinded may result in the difference between the 2 groups becoming obvious. Block randomization was performed later in this trial, in which patients are divided into blocks of equal size corresponding to the time that they are entered into the trial. Within each block treatments are assigned, such that equal numbers receive each treatment. Although generally superior to simple randomization, block randomization may also lead to undesirable patterns of randomization. In this study there is a difference in the number of men undergoing procedures with the larger 21F cystoscope in the control arm. The authors correctly recognized this potential source of bias in the statistical analysis.

The difference between efficacy and effectiveness of a treatment is worth considering. In general, when we set out to determine the efficacy of a treatment, we perform a tightly controlled experiment and we ask, "Can the treatment work?" The intervention is applied under strictly controlled circumstances to ensure that treatment is received as intended. The goal is for 100% compliance and co-interventions that may affect outcome are minimized. In the case of effectiveness, we ask a broader question, "Will the treatment work?" In this situation the goal is to simulate the real world where treatment is given under customary circumstances by a wide variety of physicians in a wide variety of settings. Co-interventions, such as environmental factors that may affect patient perception of pain, are not controlled. In this study the authors wished to determine the efficacy of lidocaine jelly and they concluded that the treatment was efficacious in men but not in women. Whether these conclusions apply to a broad variety of clinic settings relates to the effectiveness of the treatment. It is possible for a minimally efficacious treatment to be found ineffective when it is adopted in general practice.

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REPLY BY AUTHORS

Although the mean difference of 1.4 points in men is not large, we believe that the use of lidocaine jelly leads to clinically important decreased pain perception in men undergoing cystoscopy. Specifically only 5% of the men in the lidocaine group had pain scores of 6 or more compared to 20% in the plain lubricant group, and no man in the lidocaine group had an extreme score of 9 or 10 compared to 8 men (15%) in the plain lubricant group.

When used in a double-blind study, block randomization is unlikely to lead to undesirable patterns of randomization. We also used a large block size of 8 specifically to avoid that possibility. In addition, in the alternating and block phases of the trial the urologists performing cystoscopy were unaware of the method of randomization. While there was a slight difference in the rate of use of the 21F cystoscope in men, this difference was not statistically significant and it did not account for the observed difference in pain scores when adjusted for the imbalance in the analysis of covariance. Therefore, we do not believe that this is a source of bias in the statistical analysis.

Important issues are raised in the comment regarding efficacy and effectiveness of treatment. We believe that this study not only demonstrates the efficacy of lidocaine jelly in reducing pain in men undergoing rigid cystoscopy, but it also demonstrates its effectiveness. We accepted all patients into the study who presented to our clinic for cystoscopy and were willing to sign an informed consent form, ensuring a diverse study population. Therefore, we think that our conclusions will remain valid when adopted in general practice.

AMA/Specialty Society RVS Update Committee Summary of Recommendations
High IWPUT, CMS Fastest Growing, MPC List and CMS High Expenditure Procedural Codes Screen

January 2012

Cataract Surgery

In September 2007, CPT code 66982 was first identified by the High IWPUT and CMS Fastest Growing screens. The RUC recommended that the specialty society develop a CPT Assistant article, published in September 2009, to describe the accurate reporting of the service. Additionally, in February 2008 the RUC identified CPT code 66984 by the High IWPUT screen. In 2012, CMS identified both services via the CMS High Expenditure Procedural codes screen and the Relativity Assessment Workgroup recommended in September 2011 to have both services surveyed for the January 2012 RUC meeting.

66984 ***Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)***
The RUC reviewed the survey results from 76 ophthalmologists and recommends the following physician time components: 22 minutes pre-service time, 21 minutes intra-service time and 7 minutes post-service time. The Committee also recommends a half-day discharge (99238), two 99212s and two 99213s, the current post-operative visits for this service. While the RUC agreed that the survey respondents accurately estimated the physician time at the median level, there was consensus that the estimated work RVU was overestimated at the 25th percentile, 11.00 work RVUs. To determine a more appropriate work value, the RUC first discussed the high intensity of this procedure. The Committee noted that in the Third Five-Year review, the high intensity of this procedure was thoroughly discussed and the RUC was comfortable that the high IWPUT (.211) was reasonable given the high intensity of this procedure from the initiation of the surgery until the conclusion. The Committee again affirmed that while technology has allowed physicians to perform the service faster, the intensity, and threat of complication, throughout this service has not changed. With this understanding of intensity, the RUC noted that the survey results showed minor reductions in pre and post service times and a 9 minute reduction in intra-service time, 30 minutes to 21 minutes. To account for this change in time, magnitude estimation was used to deduct 2.00 work RVUs from the current work RVU of 10.52 to arrive at a work value of 8.52.

To ensure the recommended value is appropriate, the RUC reviewed CPT code 66711 *Ciliary body destruction; cyclophotocoagulation, endoscopic* (work RVU= 7.93). While this reference code has greater intra-service compared to 66984, 30 minutes compared to 21 minutes, the surveyed code is a more intense procedure because the immediate threat of blindness is greater compared to the reference code. Additionally, 66984 is performed on an eye that is normal which increases the intensity as any error would have greater consequences. Therefore, 66984 should be valued higher than 66711. In addition, the RUC looked at 000 global period service CPT code 37191 *Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed* (work RVU= 4.71). Taking out the post-operative visits from

66984 derives a work RVU of 4.98, which given the increased intensity, accurately places the surveyed code in appropriate relativity. Finally, the RUC compared the surveyed code to MPC code 67904 *Repair of blepharoptosis; (tarso) levator resection or advancement, external approach* (work RVU= 7.97) and noted that while the MPC code has greater total time compared to 66984, 185 minutes compared to 147 minutes, the intensity is much greater for 66984. Therefore, the recommended work RVU of 8.52 appropriately aligns itself relative to this service. **The RUC recommends a work RVU of 8.52 for CPT code 66984.**

66982 ***Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage***

The RUC reviewed the survey results from 76 ophthalmologists and recommends the following physician time components: 25 minutes pre-service time, 33 intra-service time and 10 minutes post-service time. The Committee also recommends a half-day discharge (99238), two 99212s and two 99213s. While the RUC agreed that the survey respondents accurately estimated the physician time at the median level, there was consensus that the estimated work RVU was overestimated at the 25th percentile, 13.00 work RVUs. To determine a more appropriate work value, the RUC noted that this procedure is a longer procedure compared to the base cataract surgery code, 66984, to account for the more complex nature of the patient, due to future deterioration of the eye. With roughly identical intensity for both procedure, the RUC noted that 66982 has 30% more intra-service time than 66984, 33 minutes compared to 21 minutes. Therefore, the Committee added 30% more work RVUs to the recommended work RVU of 8.52 to arrive at a work RVU of 11.08 for code 66982.

To justify this value, the RUC first reviewed CPT code 52647 *Laser coagulation of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included if performed)* (work RVU= 11.30) and noted that while the reference code has more intra-service time, 45 minutes compared to 33 minutes, the surveyed code is a more intense procedure and should be valued slightly less. Additionally, the RUC reviewed CPT code 52400 *Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds* (work RVU= 8.69) and noted that if one 99212 and two 99213s are added to the value of this code, to match the recommended post-operative visits for 66982, the resulting work RVU is 11.11. The Committee noted again, that while 52400 has greater intra-service time, 40 minutes compared to 33 minutes, 66982 is one of the most intense procedures in the RBRVS and thus the two services should be valued similarly. **The RUC recommends a work RVU of 11.08 for CPT code 66982.**

Practice Expense:

The RUC accepted the direct practice inputs as modified by the Practice Expense Subcommittee.

Work Neutrality

The RUC's recommendation for this code will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

CPT Code (●New)	CPT Descriptor	Global Period	Work RVU Recommenda-tion
66982	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage	090	11.08
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)	090	8.52

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:66982 Tracking Number Original Specialty Recommended RVU: **13.00**
Presented Recommended RVU: **11.08**
Global Period: 090 RUC Recommended RVU: **11.08**

CPT Descriptor: Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 71-year-old patient presents with chronic angle closure glaucoma, who 8 years ago had laser iridotomies with subsequent posterior synechiae. She is currently taking a topical beta blocker twice a day and pilocarpine 2% 4 times a day with an IOP of 19. Over the past 2 years, the patient has experienced a gradual and painless loss of vision to a level of 20/100 which interferes with their ability to read and drive. The pupil is fixed at 2.5 mm and will not dilate. The lens has 3+ nuclear sclerosis. A cataract is performed using mechanical means, iris hooks, to open the small pupil.

Or

A 5-year-old child is noted to have developed traumatic cataract with 20/100 vision following blunt trauma 3 months prior to surgery. An extracapsular cataract extraction with IOL implantation is performed under general anesthesia. Post-op vigorous amblyopia therapy is begun.

Percentage of Survey Respondents who found Vignette to be Typical: 85%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 21% , In the ASC 79%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 37%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The eye for surgery is identified and marked by the surgeon. The eye is briefly examined to rule out any changes since the last examination. The adequacy of pupillary dilation is checked. Preoperative topical antibiotics may be administered to the operative eye. The patient's and family's questions or concerns are addressed. The surgeon checks pertinent aspects of the patient's chart and notes vital signs, laboratory, radiologic and electrocardiographic data.

Description of Intra-Service Work: The patient is positioned for intraocular microsurgery. A "time-out" is performed. The ophthalmic surgeon places the anesthesia. This may be topical, peribulbar or retrobulbar anesthetic block. This may be performed while short-acting intravenous neuroleptic anesthesia is given by an anesthetist. The patient's vital signs are monitored to guard against respiratory arrest or other such potential emergency. The operative site is prepped and draped.

A lid speculum is placed. The adequacy of the anesthetic block is checked. If a peribulbar or retrobulbar anesthetic block is not used, the topical or sub-Tenon's anesthetic is applied. Cataract extraction devices are checked to assure that the proper irrigation, aspiration and phacoemulsification parameters are entered and that the machine operates properly. The microscope is positioned.

A side-port incision is made remote from the anticipated surgical incision. The anterior chamber is filled with a viscoelastic. The anterior chamber is then entered with a sharp blade of a precise size according to the surgeon's preference. Four additional 1mm incisions are made at the limbus in order to place iris hooks in a diamond pattern around the eye. One by one, the iris hooks are inserted into the incisions and manipulated to retract the iris. A sharp bent needle and forceps are used to fashion an opening in the anterior capsule of the cataract. The iris hooks are repositioned in the areas of loose zonules to better support the iris and the capsule during cataract removal. The cataractous lens is loosened by injecting fluid between the lens and its capsule, a process known as hydrodissection. The surgeon may choose to inject fluid between the lamella of the lens material itself. Additional viscoelastic material may is injected into the anterior chamber prior to phacoemulsification. The function of the phacoemulsification handpiece is checked again. When satisfactory, the tip is inserted into the eye. Phacoemulsification with simultaneous aspiration of the lens material is carried out. The lens nucleus must be rotated and "disassembled" to avoid inadvertent trauma to intraocular structures. The side-port incision is used to allow access for a second instrument to aid in the disassembly process. The phacoemulsification tip is removed from the eye.

An irrigation-aspiration tip is introduced into the eye in order to aspirate the remainder of the cortical lens material. The thin, transparent posterior lens capsule is then carefully vacuumed and polished in an attempt to avoid future secondary membrane formation. At this point, the surgeon will decide whether the capsular bag requires more support for the lens implant. This may be in the form of a capsular tension ring or other device, either sutured to the sclera under scleral flaps or not, or, if there is insufficient capsular support, then suturing the lens haptics to the sclera may be required. After this, the anterior segment is ready for the intraocular lens. Depending on the lens style deemed appropriate by the surgeon, the incision may need to be enlarged slightly. The lens is placed in the eye using an injection device. Once in the eye, the lens is properly positioned and centered using a lens hook. One by one, the iris hooks are removed. A peripheral iridectomy may be performed.

The surgeon then evacuates the viscoelastic substance from the eye using the irrigation and aspiration hand piece. The anterior chamber is reformed and the wound is inspected for leaks. If necessary, the wound is sutured with 10-0 suture material. A miotic drug is injected into the anterior chamber to produce pupillary miosis. The lid speculum is removed. It is common to inject antibiotic and steroid into the sub-Tenon's space. An antibiotic ointment is placed on the eye. A soft patch and a rigid shield is positioned on the operative eye by the surgeon.

Description of Post-Service Work: The surgeon will speak with the patient and the patient's family. Instructions are given and explained, questions are addressed and a prognosis is given. All post-operative examinations include a history of the postoperative course, an examination of the operative eye including vision, intraocular pressure, and evaluation of the anterior and posterior segments, and further instructions are given for medication use, patient activity and future follow-up. The patient is seen the next day in the ophthalmic office. Corneal keratometry and topography are commonly performed post- operatively to ascertain surgical astigmatism. Typically at least two dilated exams of the retina are performed during the 4 or more post-op visits as well as an examination with a refraction during the global period. Between weeks three and six a spectacle prescription is dispensed if the refraction is stable.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012		
Presenter(s):	Stephen A. Kamentzky, M.D. and Priscilla Arnold, M.D.		
Specialty(s):	ophthalmology/cataract		
CPT Code:	66982		
Sample Size:	400	**Resp N:** 76	**Response:** 19.0 %
Sample Type:	Random **Additional Sample Information:** A random sample of comprehensive and anterior segment members was drawn from AAO database along with a random sample of ASCRS members.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**21.00**	40.00	90.00
Survey RVW:	10.55	13.00	**15.45**	16.81	20.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	16.00	28.75	**33.00**	45.00	90.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**94.00**	99211x **0.00** 12x **3.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 1b-FAC Straightforw Pat Procedure(w sedate/anes)

CPT Code:	66982	**Recommended Physician Work RVU: 11.08**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**19.00**	**19.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**33.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**78.00**	99211x **0.00** 12x **2.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
66850	090	10.55	**Harvard Time**

CPT Descriptor Removal of lens material; phacofragmentation technique (mechanical or ultrasonic) (eg, phacoemulsification), with aspiration

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 31 **% of respondents:** 40.7 **%**

TIME ESTIMATES (Median)	**CPT Code: 66982**	**Key Reference CPT Code:** 66850	**Source of Time Harvard Time**
Median Pre-Service Time	25.00	40.00	
Median Intra-Service Time	33.00	44.00	
Median Immediate Post-service Time	10.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	0.00	
Median Office Visit Time	78.0	103.50	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**165.00**	**207.50**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.27	3.13
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.17	3.53
Urgency of medical decision making	3.83	2.83
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.83	3.83
Physical effort required	4.53	3.53
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.67	3.87
Outcome depends on the skill and judgment of physician	4.80	3.43
Estimated risk of malpractice suit with poor outcome	4.23	3.43

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.87	3.03
Intra-Service intensity/complexity	4.77	3.56
Post-Service intensity/complexity	3.50	2.87

Additional Rationale and Comments

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

CPT *66982 Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic*

developmental stage is being reviewed as a Table 7 code from the 2012 NPRM for services with high volume that have not been reviewed within 5 years. It was also on the RUC high IWPUT screen for another review in 2 years. At the time of re-review at the last RUC meeting, a new survey was requested.

There were 76 respondents in the survey, over 85% of whom felt that the vignette was typical. The 25th percentile WRVU in the survey was 13.00 RVU and the median 15.45. The preservice time was a total of 25 minutes; the median IST was 33.0 min (25^{th} = 29, 75^{th} = 45) and the postservice time was 10 minutes. The reference code chosen was 66850 *Removal of lens material; phacofragmentation technique (mechanical or ultrasonic) (eg, phacoemulsification), with aspiration*. This code has a WRVU of 10.55. This is the basic cataract removal without placing a lens implant. The survey respondents felt that the overall mental effort and judgment, technical skill and physical effort and psychological stress were greater for 66982 than the reference code which is to be expected because of the additional intensity and complexity of placing an implant in an eye using techniques not generally required in the typical patient for whom CPT 66982 would be the correct code to use. The survey supported 4 postoperative visits during the global period. All patients were examined on postoperative day one and again at 7-10 days. A third visit took place at 30 days and another visit took place between 30-60 days. A 5^{th} visit took place between 60-90 days in a significant number of patients (but fewer than half the patients) and was not counted in the total. The survey indicated that the majority of the respondents felt that these visits were at the 99213 level. Time package 1B was used corresponding to 25 minutes of preservice time in the survey.

The expert consensus panel of the Health Policy Committee of the AAO reviewed the survey results. All menbers were familiar with the procedure and the RUC review process. Prior to making a recommendation on the value the consensus panel reviewed the issues discussed below.

It was the feeling of the panel, that there had been a change in the physician work for this code since it was reviewed in 2000. The early devices used to assist removal of the complex cataract were cumbersome and sometimes difficult to insert and remove. Newer devices are easier to use. Also, physicians have become more familiar with this type of cataract surgery as the volume grew due to increased use of tamsulosin (Flomax) and similar drugs which adversely impact iris motility and stability.

The panel felt that the time needed to perform the procedure was less than in 2000. Some of the decrease was due to the device changes noted above. Additionally the time needed for this procedure decreased as times for small-incision cataract surgery became shorter due to improvements in techniques and technology between 2000 and 2011. This is reflected in the reduction in the time for 66984 noted in 2005 when that code was reviewed during the Third Five Year review. Review of 66984 this year showed times since 2005 were essentially the same.

The panel also reviewed the primary reference code chosen, 66850. This code, rarely performed today, is the base code for the family, but could not be surveyed because of its extremely low volume. All time values for this code are high relative to the current times for 66982. This is due to the fact that the reference code was not reviewed in 2005 when the RUC adjusted the times for 66984 (as noted above) to account for changes in technique. The panel felt however that the surveyed work values could be used to determine a new work value for 66982 and the panel used these values to determine our recommended work value for 66982. The society hopes that the RUC will agree to allow an expert panel process to consider the work value for 66850 once values for 66984 and 66982 have been determined.

The Panel reviewed the definition of physician work provided to those who participated in the survey process. The RUC has consistently reaffirmed that its primary method for evaluating physican work is magnitude estimation of total work (the Hsiao method). The survey instrument emphasizes that work is not just time spent in performing the service and that simply considering time spent is not an adequate proxy measurement for physician work. Additional components are “Physician mental effort and judgment; physician technical skill and physical effort; and physician psychological stress that occurs when an adverse outcome has serious consequences”. The contibution to work from these additional components can only be measured by magnitude estimation using standards the RUC has established as valid.

For complex cataract surgery, the additional work components of technical skill and psychologic stress in the event of an adverse outcome are particularly relevant. Loss of vision is one of the most devastating complications in medicine. The survey indicated that the successful outcome of the procedure is heavily dependent on the technical skill of the physician. This is true for cararact surgery in general and this more complesx procedure in particular. Complications related to cataract surgery are the leading cause of malpractice suits against ophthalmolgists.

The IWPUT for the code is high as the procedure has no period of low intensity work. The IWPUT measures the average intensity of the intraservice work and periods of high intensity work in most codes with long intraservice times are balanced by lower intensity aspects of the procedures. Additionally, the indirect (reverse building block) method of calculating IWPUT guarantees low IWPUTs for demanding surgical procedures which have high total times and extended hospital and postoperative care requirements . The society continues to have concern over the use of IWPUT for comparing codes that are not closely related and even more so for comparisons of codes with wildly disparate intraservice and total times. CMS has voiced similar concerns in the Federal Register.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

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

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty How often?

Specialty How often?

Specialty How often?

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

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 149,455 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 66982

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:66984 Tracking Number Original Specialty Recommended RVU: **10.39**
Presented Recommended RVU: **8.52**
Global Period: 090 RUC Recommended RVU: **8.52**

CPT Descriptor: Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old female complains of vision problems. Examination reveals that a cataract in her right eye has progressed to the point of visual impairment. She has difficulty reading and recently failed a driving test.

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

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

Percent of survey respondents who stated they perform the procedure; In the hospital 22% , In the ASC 78%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The eye for surgery is identified and marked by the surgeon. The eye is briefly examined to rule out any changes since the last examination. The adequacy of pupillary dilation is checked. Preoperative topical antibiotics may be administered to the operative eye. The patient's final questions or concerns are addressed. The surgeon checks pertinent aspects of the patient's chart and notes vital signs, laboratory, radiologic and electrocardiographic data. A "time-out" is performed. The ophthalmic surgeon or anesthesia professional may then place the anesthetic, which may be topical, peribulbar or retrobulbar anesthetic block. This may be performed while short-acting intravenous neuroleptic anesthesia is given. The patient's vital signs are monitored to guard against respiratory arrest or other such potential emergency.

Description of Intra-Service Work: The patient is positioned for intraocular microsurgery. The surgeon or assistant preps and drapes the operative site. A lid speculum is placed. The adequacy of the anesthetic block is checked. If a peribulbar or retrobulbar anesthetic block is not used, topical or sub Tenon's anesthetic is placed.

Cataract extraction devices such as phacoemulsification units must be checked to assure that the proper irrigation, aspiration and phacoemulsification parameters are entered and that the machine operates properly. The microscope then is positioned. A precise side-port incision is made away from the surgical incision. The anterior chamber is filled with a viscoelastic. The anterior chamber is then entered with a sharp blade to a precise incision size according to the surgeon's preference. A sharp bent needle and forceps are used to fashion an opening in the anterior capsule of the cataract. The

cataractous lens is loosened by injecting fluid between the lens and its capsule, a process known as hydrodissection. The surgeon may choose to inject fluid between the lamella of the lens material itself. Additional viscoelastic material may is injected into the anterior chamber prior to phacoemulsification. The function of the phacoemulsification hand-piece is

checked again. If satisfactory, the tip is inserted into the eye. Phacoemulsification with simultaneous aspiration of the lens material is carried out. The lens must be rotated and "disassembled" to avoid inadvertent trauma to intraocular structures. The side-port incision is used to allow access for a second instrument to aid in the disassembly process. The phacoemulsification tip is removed from the eye. An irrigation-aspiration tip is introduced into the eye in order to aspirate the remainder of the cortical lens material. The thin, transparent lens capsule is then carefully vacuumed and polished in an attempt to avoid future secondary membrane formation.

At this point, the anterior segment is ready for the intraocular lens. Depending on the lens style deemed appropriate by the surgeon, the incision may need to be enlarged slightly. The lens is placed in the eye using an injection device. Once in the eye, the lens is properly positioned and centered using a lens hook. A peripheral iridectomy may be performed. The surgeon now evacuates the viscoelastic substance from the eye using the irrigation and aspiration hand piece. The anterior chamber is reformed and the wound is inspected for leaks. If necessary the wound is sutured. A miotic drug may be injected into the eye to produce pupillary miosis. The lid speculum is removed. It is common to inject an antibiotic and steroid in the subtenons space. An antibiotic ointment may be placed on the eye. A soft patch and a rigid shield are then positioned on the operative eye by the surgeon.

Description of Post-Service Work: The surgeon discusses the procedure with the patient and the patient's family. Instructions on activity limitations and follow-up are given and explained and patient is advised of being seen the next day in the office, questions are addressed and a prognosis and the possibility of post-operative testing/eyewear changes are explained. A note is placed in the medical record and an operative report is dictated/completed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012				
Presenter(s):	Stephen A. Kamenestkzy, M.D. and Priscilla Arnold, M.D.				
Specialty(s):	ophthalmology/cataract				
CPT Code:	66984				
Sample Size: 400	**Resp N:** 76	**Response:** 19.0 %			
Sample Type:	**Additional Sample Information:** Random sample of comprehensive/anterior segment members were pulled from the AAO and ASCRS database.				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	150.00	**300.00**	412.00	1200.00
Survey RVW:	9.80	11.00	**12.00**	14.00	16.80
Pre-Service Evaluation Time:			**7.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	14.00	19.50	**21.00**	30.00	45.00

Immediate Post Service-Time:	**7.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**78.00**	99211x **0.00** 12x **2.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 1b-FAC Straightforw Pat Procedure(w sedate/anes)

CPT Code:	66984	**Recommended Physician Work RVU: 8.52**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**16.00**	**19.00**	**-3.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**21.00**		

Immediate Post Service-Time:	**7.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**78.00**	99211x **0.00** 12x **2.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
66850	090	10.55	**Harvard Time**

CPT Descriptor Removal of lens material; phacofragmentation technique (mechanical or ultrasonic) (eg, phacoemulsification), with aspiration

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 48 **% of respondents:** 63.1 **%**

TIME ESTIMATES (Median)	**CPT Code: 66984**	**Key Reference CPT Code:** 66850	**Source of Time** Harvard Time
Median Pre-Service Time	22.00	40.00	
Median Intra-Service Time	21.00	44.00	
Median Immediate Post-service Time	7.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	0.00	
Median Office Visit Time	78.0	103.50	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**147.00**	**207.50**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.48	3.13
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.73	3.17
Urgency of medical decision making	3.04	2.92
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.44	3.92
Physical effort required	3.92	3.52
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.06	3.81
Outcome depends on the skill and judgment of physician	4.50	4.23
Estimated risk of malpractice suit with poor outcome	4.10	3.79

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.25	2.92
Intra-Service intensity/complexity	4.15	3.58
Post-Service intensity/complexity	3.08	2.92

Additional Rationale and Comments

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

CPT 66984 *Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)* is being reviewed as a Table 7 code from the 2012 NPRM for services with high volume that have not been reviewed within 5 years. There were 76 respondents in the survey, 95% of whom felt that the vignette was typical. The 25th percentile RVU in the survey was 11.00 RVU and the median 12.00. The preservice time was 22 minutes, the median

IST was 21 minutes and the postservice time was 7 minutes. The reference code chosen was 66850 *Removal of lens material; phacofragmentation technique (mechanical or ultrasonic) (eg, phacoemulsification), with aspiration*. This code has a WRVU of 10.55. This is the basic cataract removal without placing a lens implant. The survey respondents felt that the overall mental effort and judgment, technical skill and physical effort and psychological stress were greater for 66984 than the reference code which is to be expected because of the additional intensity and complexity of placing an implant. The survey supported 4 postoperative visits during the global period. All patients were examined on postoperative day one and again at 7-10 days. The third visit took place at 30 days and the 4th visit was at 2-3 months. The survey indicated that the majority of the respondents felt that these visits were at the 99213 level.

The expert consensus panel of the Health Policy Committee of the AAO reviewed the survey results. All menbers were familiar with the procedure and the RUC review process. Prior to making a recommendation on the value the panel reviewed the issues discussed below.

It was the feeling of the consensus committee that there had been very little change in the procedure since 2005. Small incision surgery has been the standard for the last decade. While techniques have been refined and implant technology improved, no major changes in instrumentation and surgical techniques have evolved since the code was last reviewed. This conclusion was bolstered by the remarkable similarity of the results of the survey in 2011when compared with that completed in September 2005. For both surveys the 25th percentile for IST was 20 minutes. For the 75th percentile of IST, both surveys were 30 minutes. The median IST was 25 minutes in 2005 and 21 minutes in 2011. The distribution of the times in 2011 was skewed as indicated by how much closer the 25th percentile was to the median than to the 75th percentile. The panel also recommended preservice package 1B after removal of 3 minutes from the history and exam section to account for the survey preservice time of 22 minutes. The panel accepted the postservice time from the survey of 7 minutes. The society recommends times of 22/30/7 minutes.

The panel also considered the Instructions for Specialty Societies Developing Work Value Recommendations posted by the RUC on the participant's Web Site. These instructions indicate that there is a presumption by the RUC that "the current values assigned to the codes are correct". A great deal of discussion went into determining the value for 66984 in 2005. Issues such as intraservice time reductions and intensity of service were debated at great length and the recommendations contained in the database were ratified by the full RUC and acceptd as valid by CMS. The consensus panel reviewed those areas relevant to an outpatient procedure to see if the work has changed including technique, knowledge and technology, patient population, site-of-service and physician time.The panel considered each element and found that there had been no significant changes in any of them.

The AAO panel reviewed as well the definition of physician work provided to those who participated in the survey process. The RUC has consistently reaffirmed that its primary method for evaluating physican work is magnitude estimation of total work (the Hsiao method). The survey instrument emphasizes that work is not just time spent in performing the service and that simply considering time spent is not an adequate proxy measurement for physician work. Additional components are "Physician mental effort and judgment; physician technical skill and physical effort; and physician psychological stress that occurs when an adverse outcome has serious consequences". The contibution to work from additional components can only be measured by magnitude estimation against standards the RUC has established as valid.

For cataract surgery, the additional work components of technical skill and psychologic stress in the event of an adverse outcome are particularly relevant. Loss of vision is one of the most devastating complications in medicine. The survey indicated that the successful outcome of the procedure is heavily dependent on the technical skill of the physician. Complications related to cataract surgery are the leading cause of malpractice suits against ophthalmolgists.

The panel also reviewed the primary reference code chosen, 66850. This suggested reference code is rarely performed today, but is the base code for the family. Unfortunately, if could not be surveyed because of its extremely low volume. All time values for this reference code are high relative to the time for 66984. This is due to the fact that the reference code was not reviewed in 2005 when the RUC adjusted the times for 66984 to account for changes in technique. The panel felt however that the increment between the WRVU for the reference code and the surveyed code median (10.55 v 12.00) was a reasonable estimate of the differences in

work intensity and complexity of the two services. The society hopes that the RUC will agree to allow an expert panel process to consider the work vale for 66850 once values for 66984 and 66982 have been determined.

The IWPUT for the code is high. The reasons for this are outlined in detail in the RUC rationale contained in the current database. The IWPUT measures the average intensity of the intraservice work and periods of high intensity work in most codes with long intraservice times are balanced by lower intensity aspects of the procedures. Low intensity intraservice work is largely absent in 66984 because there is little time spent on opening and closing entrance wounds which are now constructed to be self-sealing.. Additionally, the indirect (reverse building block) method of calculating IWPUT guarantees unreasonably low IWPUTs for demanding surgical procedures. The society continues to have concern over the use of IWPUT for comparing codes that are not closely related and even more so for comparisons of codes with wildly disparate intraservice and total times. CMS has voiced similar concerns in the Federal Register.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

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

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

Specialty How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,636,936 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC db

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 66984

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

SS Rec Summary

ISSUE: 66982
TAB: 17

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	FAC-obs 26	25	24	17	Office 15	14	13	12	11	Prolonged 54	55	56	57
REF	66850	Removal of lens material; phacofragmentation technique (mechanical or ultrasonic) (eg, phacoemulsification), with aspiration		0.115			10.55			208	25		15			44			20													4.5						
CURRENT	66982	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex	324	0.163			15.02			228	40					60			15						0.5							2	3				
SVY			76	0.325	10.55	13.00	15.45	16.81	20.00	181	19	1	5			33			10						0.5							2	3				
REC				0.152			11.08			177	19	1	5			45			10						0.5							2	2				

ISSUE: 66984
TAB: 17

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	FAC-obs 26	25	24	17	Office 15	14	13	12	11	Prolonged 54	55	56	57
REF	66850	Removal of lens material; phacofragmentation technique (mechanical or ultrasonic) (eg, phacoemulsification), with aspiration		0.115			10.55			208	25		15			44			20													4.5						
CURRENT	66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)	66	0.211			10.52			162	10	5	10			30			10						0.5							2	2				
SVY			76	0.379	9.80	11.00	12.00	14.00	16.80	147	7	5	10	14	20	21	30	45	7						0.5							2	2				
REC				0.147			8.52			156	16	1	5			30			7						0.5							2	2				

	A	B	C	D	E	F	G
1				66984		66982	
2	**Meeting Date:January 2012 Specialty:Ophthalmology**	**CMS**	**Staff**	**Extracapsular cataract extraction w/ insertion of**		**Extracapsular cataract removal w/ insertion of**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**			**N/A**	**90**	N/A	90
5	**TOTAL CLINICAL LABOR TIME**	**L038A**	**COMT/COT/RN CST**	**0.0**	**192.0**	**0.0**	**192.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L038A**	**COMT/COT/RN CST**	**0.0**	**60.0**	**0.0**	**60.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L038A**	**COMT/COT/RN CST**	**0.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L038A**	**COMT/COT/RN CST**	**0.0**	**132.0**	**0.0**	**132.0**
9	**PRE-SERVICE**						
10	**Start: Following visit when decision for surgery or procedure made**						
11	Complete pre-service diagnostic & referral forms	**L038A**	**COMT/COT/RN CST**		**5**		5
12	Coordinate pre-surgery services	**L038A**	**COMT/COT/RN CST**		**20**		20
13	Schedule space and equipment in facility	**L038A**	**COMT/COT/RN CST**		**8**		8
14	Provide pre-service education/obtain consent	**L038A**	**COMT/COT/RN CST**		**20**		20
15	Follow-up phone calls & prescriptions	**L038A**	**COMT/COT/RN CST**		**7**		7
16	Other Clinical Activity (please specify)						
17	**End: When patient enters office/facility for surgery/procedure**						
18	**SERVICE PERIOD**						
19	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**						
20	Greet patient, provide gowning, ensure appropriate medical records are available						
21	Obtain vital signs						
22	Provide pre-service education/obtain consent						
23	Prepare room, equipment, supplies						
24	Setup scope (non facility setting only)						
25	Prepare and position patient/ monitor patient/ set up IV						
26	Sedate/apply anesthesia						
27	**Intra-service**						
28	Assist physician in performing procedure						
29	**Post-Service**						
30	Monitor pt. following service/check tubes, monitors, drains						
31	Clean room/equipment by physician staff						
32	Clean Scope						
33	Clean Surgical Instrument Package						
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	Discharge day management						
38	Other Clinical Activity (please specify)						
39	**End: Patient leaves office**						
40	**POST-SERVICE Period**						
41	**Start: Patient leaves office/facility**						
42	Conduct phone calls/call in prescriptions						
43	*Office visits:*						
44	*List Number and Level of Office Visits*						
45	99211 16 minutes		16				
46	99212 27 minutes	**L038A**	27		**2**		2
47	99213 36 minutes	**L038A**	36		**2**		2
48	99214 53 minutes		53				
49	99215 63 minutes		63				
50	99238 12 minutes	**L038A**	12		**0.5**		0.5
51	*Total Office Visit Time*	**L038A**		**0**	**132**	**0**	**132**
52	Other Activity (please specify)						
53	**End: with last office visit before end of global period**				**0**		0
54	**MEDICAL SUPPLIES**		**Unit**				
55	Pack, ophthalmology visit (w/ dilation)	SA082	pack		**2**		2
56	Pack, ophthalmology visit (w/o dilation)	SA050	pack		**2**		2
57							
58							
59	**Equipment**						
60	Lane, Exam (oph)	EL005			**132**		**132**
61							
62							

AMA/Specialty Society RVS Update Committee Summary of Recommendations
MPC List Screen

January 2012

MRI of Lower Extremity Joint

In October 2010, CPT code 73721 *Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material* was identified through the MPC List screen. This service had not been reviewed by the RUC in the last 6 years, therefore, in September 2011, the RUC recommended that the specialty societies resurvey this service for work and practice expense. CPT code 73221 *Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)* was identified initially through the CMS Fastest Growing screen and most recently through the CMS High Expenditure Procedural Codes. CPT code 73221 was scheduled for re-review in September 2013 and had not been reviewed for work in the last 6 years, therefore the specialty society indicated it would survey for January 2012 along with 73721.

73221
The RUC reviewed the survey results of 50 radiologists for CPT code 73221 and recommends to maintain the current work RVU of 1.35, lower than the survey's 25th percentile. The specialty society recommended an increase to 1.54 work RVUs for this service, stating that the technological advancements have resulted in an increase in the number of sequences performed and slices obtained, improved capability to see smaller abnormalities and thus increased level of interpretation required. The RUC agreed that these technological advancements have occurred but have not resulted in more physician work. The RUC noted that the survey respondents indicated a median intra-service time of 20 minutes, which is the same as the current intra-service time. The RUC compared 73221 to key reference service 74177 *Computed tomography, abdomen and pelvis; with contrast material(s)* (work RVU = 1.82) and determined that the reference service requires more physician work, including contrast material, and time to perform (20 versus 25 minutes intra-service time). The RUC also compared 73221 to 99203 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 1.42) and noted that these services have almost identical time 30 and 29 minutes, respectively. Therefore, maintaining the current value of 1.35 for CPT code 73221 appropriately accounts for the physician work required to perform this service relative to the key reference service. **The RUC recommends a work RVU of 1.35 for CPT 73221.**

73721
The RUC reviewed the survey results of 51 radiologists for CPT code 73721 and recommends to maintain the current work RVU of 1.35, lower than the survey's 25th percentile. The specialty society recommended an increase to 1.54 work RVUs for this service, stating that the technological advancements have resulted in an increase in the number of sequences performed and slices obtained, improved capability to see smaller abnormalities and thus increased level of interpretation required. The RUC agreed that these technological advancements have occurred but have not resulted in more physician work. The RUC noted that the survey respondents indicated a median intra-service time of 20 minutes, which is the same as the current intra-service time. The RUC compared 73721 to key reference service 74177 *Computed tomography, abdomen and pelvis;*

with contrast material(s) (work RVU = 1.82) and determined that the reference service requires more physician work, including contrast material, and time to perform (20 versus 25 minutes intra-service time). The RUC also compared 73721 to 99203 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 1.42) and noted that these services have almost identical time 30 and 29 minutes, respectively. Therefore, maintaining the current value of 1.35 for CPT code 73721 appropriately accounts for the physician work required to perform this service relative to similar services. **The RUC recommends a work RVU of 1.35 for CPT 73721.**

Practice Expense:
The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
73221	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)	XXX	1.35 (No Change)
73721	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material	XXX	1.35 (No Change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:73221 Tracking Number Original Specialty Recommended RVU: **1.54**
Presented Recommended RVU: **1.54**
Global Period: XXX RUC Recommended RVU: **1.35**

CPT Descriptor: Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65 year old woman complains of chronic shoulder pain and decreased range of motion which has failed to respond to conservative therapy. X-rays show mild degenerative changes. An MRI is ordered for further evaluation.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

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

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

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work:
-Review request and history.
-Review any prior applicable imaging studies.
-Set protocol for exam including selection of pulse sequences.
-Review exam to assure that all needed pulse sequences and imaging planes have been acquired and determine whether repositioning (e.g.ABER position for capsule/labrum/cuff assessment) or contrast-enhanced imaging is required.

Description of Intra-Service Work:
-Interpret the examination
Standard interpretation includes evaluation of all of the following structures:

- All four rotator cuff tendons and their attachments
- The glenoid labrum and glenohumeral joint including cartilage surfaces and joint fluid
- The joint capsule and intraarticular ligaments
- The acromioclavicular joint, acromial morphology and proliferative changes for impingement
- The biceps tendon, the bicipital groove, pulley and anchor
- The deltoid attachment
- Osseous structures for marrow signal abnormalities and focal lesions
- The axillary soft tissues for aneurysm and lymph nodes
- Periarticular soft tissues
- Postoperative changes / complications, if applicable

-Compare to applicable prior studies.

-Dicate report for the medical record.

Description of Post-Service Work:
-Review, edit and sign written report.
-Communicate result to referring physician and patient as appropriate.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012					
Presenter(s):	Geraldine McGinty, M.D. and Zeke Silva, M.D.					
Specialty(s):	American College of Radiology					
CPT Code:	73221					
Sample Size:	823	**Resp N:**	50	**Response:** 6.0 %		
Sample Type:	Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	10.00	200.00	**368.00**	875.00	2000.00
Survey RVW:	1.00	1.72	**1.92**	2.17	2.50
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	14.00	**20.00**	20.00	40.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	73221	**Recommended Physician Work RVU: 1.35**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
74177	XXX	1.82	**RUC Time**

CPT Descriptor Computed tomography, abdomen and pelvis; with contrast material(s)

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
74160	XXX	1.27	**RUC Time**	2,254,722

CPT Descriptor 1 Computed tomography, abdomen; with contrast material(s))

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
70496	XXX	1.75	**RUC Time**	128,793

CPT Descriptor 2 Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing

Other Reference CPT Code	Global	Work RVU	Time Source
74176	XXX	1.74	**RUC Time**

CPT Descriptor Computed tomography, abdomen and pelvis; without contrast material

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 22.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 73221**	**Key Reference CPT Code:** 74177	**Source of Time RUC Time**
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	20.00	25.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**30.00**	**35.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.91	3.91
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	2.45	3.64
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.27	3.45
Physical effort required	2.91	2.64
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.55	3.73
Outcome depends on the skill and judgment of physician	4.27	3.64
Estimated risk of malpractice suit with poor outcome	2.91	3.91

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.00	2.18
Intra-Service intensity/complexity	3.73	3.27
Post-Service intensity/complexity	2.00	2.00

Additional Rationale and Comments

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

Background

Code 73721 (*Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material*) was identified through the MPC list screen. As a result, the RUC requested the code be resurveyed and reviewed by the January 2012 RUC meeting. The American College of Radiology (ACR) surveyed this code, and another procedure in the same family of non-enhanced MRI extremity codes, code 73221(*Magnetic resonance (eg, proton) imaging, any joint of upper*

extremity; without contrast material(s)), which was recently identified by CMS for RUC review. The ACR convened an expert panel that included a number of physicians familiar with the services to review the survey data and provide a recommendation to the RUC.

Work RVU Recommendation
For both codes 73721 and 73221, the American College of Radiology recommends 1.54 RVW. The current values in the RUC database are 1.35 RVU for both procedures, which were established in 2001. The original RUC recommended values of 1.48 RVU for both procedures were adjusted down by CMS. Since the recommendations for these codes are higher than the existing values, the ACR requests the RUC consider the following compelling evidence argument demonstrating significant change in technology since prior valuation.

Compelling Evidence
Since these codes were previously valued, there have been substantial and continual advancements in the technological abilities of MR imaging to assess the structure and function of the musculoskeletal system. These advancements include the progressive improvement of coil technology, with multichannel coils of 8 channels or more in standard use, compared to single-channel technology 10 years ago; improvement in magnet design and computer processing capabilities, including increased market saturation of 3 Tesla magnets; development of new sequence technologies, including cartilage-specific and 3D sequences; and improved efficacy of previously established sequences, such as fat-saturation techniques.

These advancements have resulted in an increase in the number of sequences routinely performed, and a decrease in slice thickness profiles and interslice gaps creating more slices per sequence for interpretation. Sequences performed 10 years ago with 5mm sections are now routinely performed at 2 or 3 mm, and sequences with 1 mm slice thickness are routinely performed. This has led to a concomitant increase in the number of slices routinely obtained for interpretation.

For these reasons there have been substantial gains in the capability of the interpreting physician to see smaller abnormalities; to see cartilage lesions that were previously undetectable; and to allow greater sensitivity, specificity, and improved predictive value in the assessment of abnormalities in and around joints.

There is therefore greater expectation by referring clinicians that entities not routinely observed 10 years ago will be evaluated and discussed by the radiologist in the report. In addition to a detailed classification of articular cartilage injury, other conditions that routinely went undetected in the upper extremity include pulley injuries in the rotator interval, adhesive capsulitis, synovial disease in rheumatologic conditions, and an increasing specificity and refinement of labral tears and microinstability. In the knee, there is now the ability to appreciate chondral injury, chondrocalcinosis, arcuate complex and other posterolateral injuries, popliteomeniscal fascicle injuries, and recognition of an ever-increasing number of postoperative appearances.

Finally, these procedure codes are also used for *any* joint of the upper or lower extremity. Although a single vignette could not encompass all the uses of these procedure codes, there has been a similar increase in the technological complexity of the exams of the other appendicular joints (elbow, wrist, finger; hip, ankle, and toe); an increase in their utilization; evolutionary changes in - and an increased number of - pathologic entities that have been described in these joints; and increased expectations from clinical colleagues regarding the sensitivity and specificity of the MR exams of these other joints as well. Furthermore, imaging these more complex joints has become much more common in clinical practice than ten years ago.

Pre, Intra, and Post Service Times
The ACR recommends the median survey pre, intra and post times of 5, 20 and 5 minutes, respectively for both codes. Pre- and post-service time compare favorably to other recently reviewed cross-sectional imaging codes such as the reference service, 74177 (*Computed tomography, abdomen and pelvis; with contrast material(s))* and also 73200 (*Computed tomography, upper extremity; without contrast material*) and 73700 (*Computed tomography, lower extremity; without contrast material*).

Total survey time is higher than the existing total service time of 20 minutes for each code; however, while these codes were reviewed by the RUC in 2001, it is not clear that they were re-surveyed at that time. However, 73222 (*Magnetic resonance (eg, proton) imaging, any joint of upper extremity; with contrast material(s)*) and 73722 (*Magnetic resonance (eg, proton) imaging, any joint of lower extremity; with contrast material(s)*) were both surveyed in 2001 with 1.62 RVU and 10 minutes pre-service, 20 minutes intra-service and 10 minutes post service for a total of 40 minutes for each code. These times are higher than the current survey times for 73221 and 73721. So based on the current survey, the new times

of 30 total minutes are between the old times for 73221/73721 and 73222/73722 suggesting the value for 73221/73721 should be higher than the existing but less than 73222/73722.

Summary

We believe 73221 and 73722 compare favorably with the key reference services in many respects. Overall, survey times are quite similar with the reference services having slightly higher intra-service times. Overall intensity and complexity measures are similar but suggest that the reference service requires more urgent medical decision making with higher risk of poor outcomes; whereas, 73221 and 73222 had higher scores for the technical skill and physical effort required. Most notable was that the respondents believe that as compared to the reference CT codes, the MRI codes require a higher level of physician skill to assure a good outcome. We believe this reflects clinical practice and supports a valuation of MRI services at a higher level than the corresponding CT services. CT interpretation is based solely on the differences in radiographic density between adjacent objects; whereas, MRI interpretation requires knowledge of a number of specific MR experiments and the response of normal and pathologic tissue to these experiments. While both CT and MRI interpretation require knowledge of both normal and pathological anatomy, MRI interpretation requires the assessment of a number of physiological properties of normal and abnormal tissues. This likely explains why 73700 was not chosen as reference services by the survey respondents.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 73221

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

Specialty Diagnostic Radiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1254102

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services for 73221 in one year period is estimated to be 1,254,102.

Specialty Diagnostic Radiology Frequency 702799 Percentage 56.04 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 411,261 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2010 Medicare data.

Specialty Diagnostic Radiology Frequency 234267 Percentage 56.96 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 73221

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:73721 Tracking Number Original Specialty Recommended RVU: **1.54**
Presented Recommended RVU: **1.54**
Global Period: XXX RUC Recommended RVU: **1.35**

CPT Descriptor: Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 46 year old male presents after injury with swelling, pain on motion of the knee joint and occasional locking of joint.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

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

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

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work:
-Review request and history.
-Set protocol for exam including selection of pulse sequences.

Description of Intra-Service Work:
-Review exam to assure that all needed pulse sequences and imaging planes have been acquired and determine whether contrast-enhanced imaging is required.
-Compare to applicable prior studies.
-Interpretation:
Standard interpretation includes evaluation of all of the following structures:

- Medial compartment:
  - Evaluate medial collateral ligaments
  - Evaluate medial meniscus
  - Evaluate articular cartilage for osteochondral lesions
- Lateral compartment:
  - Evaluate lateral collateral ligaments
  - Evaluate lateral meniscus
  - Evaluate popliteus tendon an dposterior lateral corner structures
  - Evaluate articular cartilage for osteochondral lesions
- Patellofemoral compartment:
  - Evaluate articular cartilage surfaces
  - Evaluate the synovial capsule and joint fluid;
  - Evaluate the patellofemoral complex, including quadriceps and patellar tendons, medial and lateral retinacula;

- Evaluate cruciate ligaments
- Popliteal fossa soft tissues:
  - Evaluate for Baker cyst, aneurysm
  - Evaluate periarticular musculature for injury, myositis, atrophy;
- Osseous structures
  - Evaluate osseous structures for marrow signal, focal lesions, or proliferative degenerative changes;
  - Evaluate pes anserinus and tibial tubercle
- Characterize any post-operative changes, if applicable

-Dictate report for the medical record.

Description of Post-Service Work:
-Review, edit and sign report.
-Communicate result to referring physician and patient as appropriate.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012		
Presenter(s):	Geraldine McGinty, M.D. and Zeke Silva, M.D.		
Specialty(s):	American College of Radiology		
CPT Code:	73721		
Sample Size:	823	**Resp N:** 51	**Response:** 6.1 %
Sample Type:	Random	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	8.00	188.00	**475.00**	825.00	3000.00
Survey RVW:	1.00	1.71	**1.85**	2.10	2.50
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	12.00	**20.00**	20.00	40.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	73721	**Recommended Physician Work RVU: 1.35**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
74177	XXX	1.82	**RUC Time**

CPT Descriptor Computed tomography, abdomen and pelvis; with contrast material(s)

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
74160	XXX	1.27	**RUC Time**	2,254,722

CPT Descriptor 1 Computed tomography, abdomen; with contrast material(s)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
70496	XXX	1.75	**RUC Time**	128,793

CPT Descriptor 2 Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing

Other Reference CPT Code	Global	Work RVU	Time Source
74176	XXX	1.74	**RUC Time**

CPT Descriptor Computed tomography, abdomen and pelvis; without contrast material

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 19.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 73721**	**Key Reference CPT Code:** 74177	**Source of Time RUC Time**
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	20.00	25.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**30.00**	**35.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.80	3.90
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.10	3.30
Urgency of medical decision making	2.50	3.70
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.20	3.30
Physical effort required	3.10	2.80
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.70	3.80
Outcome depends on the skill and judgment of physician	4.30	3.70
Estimated risk of malpractice suit with poor outcome	2.90	3.90

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.00	2.20
Intra-Service intensity/complexity	3.70	3.10
Post-Service intensity/complexity	2.10	2.10

Additional Rationale and Comments

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

Background

Code 73721 (*Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material*) was identified through the MPC list screen. As a result, the RUC requested the code be resurveyed and reviewed by the January

2012 RUC meeting. The American College of Radiology (ACR) surveyed this code, and another procedure in the same family of non-enhanced MRI extremity codes, code 73221(*Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)*), which was recently identified by CMS for RUC review. The ACR convened an expert panel that included a number of physicians familiar with the services to review the survey data and provide a recommendation to the RUC.

Work RVU Recommendation

For both codes 73721 and 73221, the American College of Radiology recommends 1.54 RVW. The current values in the RUC database are 1.35 RVU for both procedures, which were established in 2001. The original RUC recommended values of 1.48 RVU for both procedures were adjusted down by CMS. Since the recommendations for these codes are higher than the existing values, the ACR requests the RUC consider the following compelling evidence argument demonstrating significant change in technology since prior valuation.

Compelling Evidence

Since these codes were previously valued, there have been substantial and continual advancements in the technological abilities of MR imaging to assess the structure and function of the musculoskeletal system. These advancements include the progressive improvement of coil technology, with multichannel coils of 8 channels or more in standard use, compared to single-channel technology 10 years ago; improvement in magnet design and computer processing capabilities, including increased market saturation of 3 Tesla magnets; development of new sequence technologies, including cartilage-specific and 3D sequences; and improved efficacy of previously established sequences, such as fat-saturation techniques.

These advancements have resulted in an increase in the number of sequences routinely performed, and a decrease in slice thickness profiles and interslice gaps creating more slices per sequence for interpretation. Sequences performed 10 years ago with 5mm sections are now routinely performed at 2 or 3 mm, and sequences with 1 mm slice thickness are routinely performed. This has led to a concomitant increase in the number of slices routinely obtained for interpretation.

For these reasons there have been substantial gains in the capability of the interpreting physician to see smaller abnormalities; to see cartilage lesions that were previously undetectable; and to allow greater sensitivity, specificity, and improved predictive value in the assessment of abnormalities in and around joints.

There is therefore greater expectation by referring clinicians that entities not routinely observed 10 years ago will be evaluated and discussed by the radiologist in the report. In addition to a detailed classification of articular cartilage injury, other conditions that routinely went undetected in the upper extremity include pulley injuries in the rotator interval, adhesive capsulitis, synovial disease in rheumatologic conditions, and an increasing specificity and refinement of labral tears and microinstability. In the knee, there is now the ability to appreciate chondral injury, chondrocalcinosis, arcuate complex and other posterolateral injuries, popliteomeniscal fascicle injuries, and recognition of an ever-increasing number of postoperative appearances.

Finally, these procedure codes are also used for *any* joint of the upper or lower extremity. Although a single vignette could not encompass all the uses of these procedure codes, there has been a similar increase in the technological complexity of the exams of the other appendicular joints (elbow, wrist, finger; hip, ankle, and toe); an increase in their utilization; evolutionary changes in - and an increased number of - pathologic entities that have been described in these joints; and increased expectations from clinical colleagues regarding the sensitivity and specificity of the MR exams of these other joints as well. Furthermore, imaging these more complex joints has become much more common in clinical practice than ten years ago.

Pre, Intra, and Post Service Times

The ACR recommends the median survey pre, intra and post times of 5, 20 and 5 minutes, respectively for both codes. Pre- and post-service time compare favorably to other recently reviewed cross-sectional imaging codes such as the reference service, 74177 (*Computed tomography, abdomen and pelvis; with contrast material(s))* and also 73200 (*Computed tomography, upper extremity; without contrast material*) and 73700 (*Computed tomography, lower extremity; without contrast material*).

Total survey time is higher than the existing total service time of 20 minutes for each code; however, while these codes were reviewed by the RUC in 2001, it is not clear that they were re-surveyed at that time. However, 73222 (*Magnetic resonance (eg, proton) imaging, any joint of upper extremity; with contrast material(s)*) and 73722 (*Magnetic resonance (eg, proton) imaging, any joint of lower extremity; with contrast material(s)*) were both surveyed in 2001 with 1.62 RVU and 10 minutes pre-service, 20 minutes intra-service and 10 minutes post service for a total of 40 minutes for each code.

These times are higher than the current survey times for 73221 and 73721. So based on the current survey, the new times of 30 total minutes are between the old times for 73221/73721 and 73222/73722 suggesting the value for 73221/73721 should be higher than the existing but less than 73222/73722.

Summary

We believe 73221 and 73722 compare favorably with the key reference services in many respects. Overall, survey times are quite similar with the reference services having slightly higher intra-service times. Overall intensity and complexity measures are similar but suggest that the reference service requires more urgent medical decision making with higher risk of poor outcomes; whereas, 73221 and 73222 had higher scores for the technical skill and physical effort required. Most notable was that the respondents believe that as compared to the reference CT codes, the MRI codes require a higher level of physician skill to assure a good outcome. We believe this reflects clinical practice and supports a valuation of MRI services at a higher level than the corresponding CT services. CT interpretation is based solely on the differences in radiographic density between adjacent objects; whereas, MRI interpretation requires knowledge of a number of specific MR experiments and the response of normal and pathologic tissue to these experiments. While both CT and MRI interpretation require knowledge of both normal and pathological anatomy, MRI interpretation requires the assessment of a number of physiological properties of normal and abnormal tissues. This likely explains why 73700 was not chosen as reference services by the survey respondents.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 73721

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1827561

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services for 73721 in one year period is estimated to be 1,827,561.

Specialty Diagnostic Radiology Frequency 1078809 Percentage 59.02 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 599,170 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2010 Medicare data estimates that code 73721 was billed approximately 599,170

Specialty Diagnostic Radiology Frequency 359603 Percentage 60.01 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

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

---

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 73721

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

INSTRUCTIONS

Insert information and data into all applicable cells except IWPUT and TOTAL TIME. These cells will automatically calculate.

Hide columns and rows that do not contain data.

REF = Key Reference code data

CURRENT = Current data (Harvard or RUC) for code being surveyed. If this is a new code, this row will be blank.

SVY = Survey data - as it appears on the Summary of Recommendation form.

REC = Specialty Society recommended data as it appears on the Summary of Recommendation form.

ISSUE: MRI of Upper and Lower Extremities joints

TAB: 20

Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD
					MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
REF	74177	Computed tomography, abdomen and pe	10	0.064			1.82			35	5					25			5
CURRENT	73721	Magnetic resonance (eg, proton) imaging, any j		0.068			1.35			20						20			
SVY	73721	Magnetic resonance (eg, proton) imaging	51	0.081	1.00	1.71	1.85	2.10	2.50	30	5			5	12	20	20	40	5
REC	73721			0.056			1.35			30	5					20			5

Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD
					MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
REF	74177	Computed tomography, abdomen and pe	11	0.064			1.82			35	5					25			5
CURRENT	73221	Magnetic resonance (eg, proton) imaging, any j		0.068			1.35			20						20			
SVY	73221	Magnetic resonance (eg, proton) imaging	50	0.085	1.00	1.72	1.92	2.17	2.50	30	5			5	14	20	20	40	5
REC	73221			0.056			1.35			30	5					20			5

CPT Code: 73221 and 73721
Specialty Society('s) American College of Radiology

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

CPT Long Descriptor:
73221- Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)
73721- Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material

Global Period: XXX Meeting Date: 01/2012

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 Radiology convened a consensus panel to finalize the practice expense data for codes 73221 and 73721.

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

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Retrieve prior appropriate imaging exams and hang for MD review; Verify orders, review chart; verify physician order including clinical information

Intra-Service Clinical Labor Activities:

- Greet patient and provide gowning, ensure appropriate medical records are available
- Provide pre-service education/obtain consent/interview patient for contraindications
- Prepare room, equipment, supplies/Enter patient data and choose coil
- Prepare and position patient/monitor patient/set up IV
- Assist physician in performing procedure/acquire images
- Clean room/equipment by physician staff
- Photography/image processing/film hanging with comparisons
- Escort patient from exam room due to magnetic sensitivity

Post-Service Clinical Labor Activities:

	A	B	C	D	E	F
1				**73221**	**73221**	**73721**
2	**Meeting Date: Jan 2012** **Specialty:ACR**	**CMS**	**Staff**	**Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)** **PEAC Reviewed- Jan 2002**	**Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)** **Jan 2012**	**Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material(s)** **PEAC Reviewed- Jan 2002**
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Non Facility**	**Non Facility**
4	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**71.0**	**66.0**	**71.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**8.0**	**8.0**	**8.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**63.0**	**58.0**	**63.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**
9	**PRE-SERVICE**					
10	Other Clinical Activity (please specify) *Retrieve prior appropriate imaging exams and hang for MD review. Verify orders, review the chart, verify physician order including clinical information.*	**L047A**	MR Tech	8	8	8
11	**SERVICE PERIOD**					
12	**Start: When patient enters office/facility for surgery/procedure:** **Services Prior to Procedure**					
13	Greet patient, provide gowning, ensure appropriate medical records are available	**L047A**	MR Tech	3	3	3
14	Obtain vital signs					
15	Provide pre-service education/obtain consent/ *interview patient for contraindications*	**L047A**	MR Tech	7	7	7
16	Prepare room, equipment, supplies/ *Enter patient data and choose coil*	**L047A**	MR Tech	5	3	5
17	Setup scope (non facility setting only)					
18	Prepare and position patient/ monitor patient/ set up IV	**L047A**	MR Tech	3	2	3
19	Sedate/apply anesthesia					
20	**Intra-service**					
21	Assist physician in performing procedure/ *Acquire images*	**L047A**	MR Tech	25	25	25
22	**Post-Service**					
23	Monitor pt. following service/check tubes, monitors, drains					
24	Clean room/equipment by physician staff	**L047A**	MR Tech	3	3	3
25	Clean Scope					
26	Clean Surgical Instrument Package					
27	Complete diagnostic forms, lab & X-ray requisitions					
28	Review/read X-ray, lab, and pathology reports					
29	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions					
30	Discharge day management					
31	Other Clinical Activity (please specify):					
32	*Photography/image processing/film hanging with comparisons*	**L047A**	MR Tech	15	15	15
33	*Escort patient from exam room due to magnetic sensitivity*	**L047A**	MR Tech	2	0	2
34	*Process image reconstructions*					
35	**End: Patient leaves office**					
36	**POST-SERVICE Period**					
37						
38	**MEDICAL SUPPLIES**		**Unit**			
39	Ear plug	SJ018		1 item	1 item	1 item
40	film, x-ray 14 x 17	SK034		10 item	10 item	10 item
41	Insert folder			1 item	0	1 item
42	Receive coil					
43	Fiberoptic EKG lead					
44	Cardiac package					
45	Patient gown	SB026			1 item	
46	Pillow case	SB037			1 item	
47	Developer	SK089			8 oz	
48	Film fixer	SK092			8 oz	
49						
50	**Equipment**					
51	MRI room with maintenance contract	EL008			33 min	
52	Film alternator	ER029			33 min	
53	Film processor	ED024			33 min	

	A	B	C	G
1				**73721**
2	**Meeting Date: Jan 2012** **Specialty:ACR**	**CMS**	**Staff**	**Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material(s)** **Jan 2012**
3	**LOCATION**	**Code**	**Type**	**Non Facility**
4	**GLOBAL PERIOD**			**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**66.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**8.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**58.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**
9	**PRE-SERVICE**			
10	Other Clinical Activity (please specify) *Retrieve prior appropriate imaging exams and hang for MD review. Verify orders, review the chart, verify physician order including clinical information.*	**L047A**	MR Tech	8
11	**SERVICE PERIOD**			
12	**Start: When patient enters office/facility for surgery/procedure:** **Services Prior to Procedure**			
13	Greet patient, provide gowning, ensure appropriate medical records are available	**L047A**	MR Tech	3
14	Obtain vital signs			
15	Provide pre-service education/obtain consent/ *interview patient for contraindications*	**L047A**	MR Tech	7
16	Prepare room, equipment, supplies/ *Enter patient data and choose coil*	**L047A**	MR Tech	3
17	Setup scope (non facility setting only)			
18	Prepare and position patient/ monitor patient/ set up IV	**L047A**	MR Tech	2
19	Sedate/apply anesthesia			
20	**Intra-service**			
21	Assist physician in performing procedure/ *Acquire images*	**L047A**	MR Tech	25
22	**Post-Service**			
23	Monitor pt. following service/check tubes, monitors, drains			
24	Clean room/equipment by physician staff	**L047A**	MR Tech	3
25	Clean Scope			
26	Clean Surgical Instrument Package			
27	Complete diagnostic forms, lab & X-ray requisitions			
28	Review/read X-ray, lab, and pathology reports			
29	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions			
30	Discharge day management			
31	Other Clinical Activity (please specify):			
32	*Photography/image processing/film hanging with comparisons*	**L047A**	MR Tech	15
33	*Escort patient from exam room due to magnetic sensitivity*	**L047A**	MR Tech	0
34	*Process image reconstructions*			
35	**End: Patient leaves office**			
36	**POST-SERVICE Period**			
37				
38	**MEDICAL SUPPLIES**		**Unit**	
39	Ear plug	SJ018		1 item
40	film, x-ray 14 x 17	SK034		10 item
41	Insert folder			0
42	Receive coil			
43	Fiberoptic EKG lead			
44	Cardiac package			
45	Patient gown	SB026		1 item
46	Pillow case	SB037		1 item
47	Developer	SK089		8 oz
48	Film fixer	SK092		8 oz
49				
50	**Equipment**			
51	MRI room with maintenance contract	EL008		33 min
52	Film alternator	ER029		33 min
53	Film processor	ED024		33 min

	A	B	C	D	E	F
1				73221	73221	73721
2	**Meeting Date: Jan 2012** **Specialty:ACR**	**CMS**	**Staff**	**Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)** **PEAC Reviewed- Jan 2002**	**Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)** **Jan 2012**	**Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material(s)** **PEAC Reviewed- Jan 2002**
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Non Facility**	**Non Facility**
4	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**71.0**	**71.0**	**71.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**8.0**	**8.0**	**8.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**63.0**	**63.0**	**63.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**
9	**PRE-SERVICE**					
10	Other Clinical Activity (please specify) *Retrieve prior appropriate imaging exams and hang for MD review. Verify orders, review the chart, verify physician order including clinical information.*	**L047A**	MR Tech	8	8	8
11	**SERVICE PERIOD**					
12	**Start: When patient enters office/facility for surgery/procedure:** **Services Prior to Procedure**					
13	Greet patient, provide gowning, ensure appropriate medical records are available	**L047A**	MR Tech	3	3	3
14	Obtain vital signs					
15	Provide pre-service education/obtain consent/ *interview patient for contraindications*	**L047A**	MR Tech	7	7	7
16	Prepare room, equipment, supplies/ *Enter patient data and choose coil*	**L047A**	MR Tech	5	5	5
17	Setup scope (non facility setting only)					
18	Prepare and position patient/ monitor patient/ set up IV	**L047A**	MR Tech	3	3	3
19	Sedate/apply anesthesia					
20	**Intra-service**					
21	Assist physician in performing procedure/ *Acquire images*	**L047A**	MR Tech	25	25	25
22	**Post-Service**					
23	Monitor pt. following service/check tubes, monitors, drains					
24	Clean room/equipment by physician staff	**L047A**	MR Tech	3	3	3
25	Clean Scope					
26	Clean Surgical Instrument Package					
27	Complete diagnostic forms, lab & X-ray requisitions					
28	Review/read X-ray, lab, and pathology reports					
29	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions					
30	Discharge day management					
31	Other Clinical Activity (please specify):					
32	*Photography/image processing/film hanging with comparisons*	**L047A**	MR Tech	15	15	15
33	*Escort patient from exam room due to magnetic sensitivity*	**L047A**	MR Tech	2	2	2
34	*Process image reconstructions*					
35	**End: Patient leaves office**					
36	**POST-SERVICE Period**					
37						
38	**MEDICAL SUPPLIES**		**Unit**			
39	Ear plug	SJ018		1 item	1 item	1 item
40	film, x-ray 14 x 17	SK034		10 item	10 item	10 item
41	Insert folder			1 item	1 item	1 item
42	Receive coil					
43	Fiberoptic EKG lead					
44	Cardiac package					
45	Patient gown	SB026			1 item	
46	Pillow case	SB037			1 item	
47	Developer	SK089			8 oz	
48	Film fixer	SK092			8 oz	
49						
50	**Equipment**					
51	MRI room with maintenance contract	EL008			63 min	
52	Film alternator	ER029			63 min	
53	Film processor	ED024			63 min	

	A	B	C	G
1				**73721**
2	**Meeting Date: Jan 2012** **Specialty:ACR**	**CMS**	**Staff**	**Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material(s)** **Jan 2012**
3	**LOCATION**	**Code**	**Type**	**Non Facility**
4	**GLOBAL PERIOD**			**XXX**
5	**TOTAL CLINICAL LABOR TIME**			**71.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**8.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**63.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**
9	**PRE-SERVICE**			
10	Other Clinical Activity (please specify) *Retrieve prior appropriate imaging exams and hang for MD review. Verify orders, review the chart, verify physician order including clinical information.*	**L047A**	MR Tech	8
11	**SERVICE PERIOD**			
12	**Start: When patient enters office/facility for surgery/procedure:** **Services Prior to Procedure**			
13	Greet patient, provide gowning, ensure appropriate medical records are available	**L047A**	MR Tech	3
14	Obtain vital signs			
15	Provide pre-service education/obtain consent/ *interview patient for contraindications*	**L047A**	MR Tech	7
16	Prepare room, equipment, supplies/ *Enter patient data and choose coil*	**L047A**	MR Tech	5
17	Setup scope (non facility setting only)			
18	Prepare and position patient/ monitor patient/ set up IV	**L047A**	MR Tech	3
19	Sedate/apply anesthesia			
20	**Intra-service**			
21	Assist physician in performing procedure/ *Acquire images*	**L047A**	MR Tech	25
22	**Post-Service**			
23	Monitor pt. following service/check tubes, monitors, drains			
24	Clean room/equipment by physician staff	**L047A**	MR Tech	3
25	Clean Scope			
26	Clean Surgical Instrument Package			
27	Complete diagnostic forms, lab & X-ray requisitions			
28	Review/read X-ray, lab, and pathology reports			
29	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions			
30	Discharge day management			
31	Other Clinical Activity (please specify):			
32	*Photography/image processing/film hanging with comparisons*	**L047A**	MR Tech	15
33	*Escort patient from exam room due to magnetic sensitivity*	**L047A**	MR Tech	2
34	*Process image reconstructions*			
35	**End: Patient leaves office**			
36	**POST-SERVICE Period**			
37				
38	**MEDICAL SUPPLIES**		**Unit**	
39	Ear plug	SJ018		1 item
40	film, x-ray 14 x 17	SK034		10 item
41	Insert folder			1 item
42	Receive coil			
43	Fiberoptic EKG lead			
44	Cardiac package			
45	Patient gown	SB026		1 item
46	Pillow case	SB037		1 item
47	Developer	SK089		8 oz
48	Film fixer	SK092		8 oz
49				
50	**Equipment**			
51	MRI room with maintenance contract	EL008		63 min
52	Film alternator	ER029		63 min
53	Film processor	ED024		63 min

AMA/Specialty Society RVS Update Committee Summary of Recommendations
MPC List Screen

January 2012

Fluoroscopic Guidance for Spine Injection

In October 2012, CMS identified CPT code 77003 *Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, subarachnoid, or sacroiliac joint), including neurolytic agent destruction* on the MPC List screen. The RUC noted that this service had not been reviewed in the past six years and requested that it be surveyed. Recently, fluoroscopic guidance was bundled into facet joint injections (codes 64490-64495) in 2010, transforminal epidural injections (codes 64479-64484) in 2011, SI joint injection (code 27096) in 2012 and paravertebral facet joint destruction (new codes 64633-64636) in 2012. The specialty societies surveyed 77003 for the September 2011 RUC meeting, however, the RUC noted many issues with the survey conducted for this service that is performed concurrently with an injection procedure. The specialties did not include the new 2012 CPT descriptor in the survey and there were issues related to the clinical vignette. The RUC urged the specialty to develop a new vignette and instructions to inform the respondent that the injection is reported separately. The Research Subcommittee reviewed the revised vignette and instructions prior to the survey for the January 2012 RUC meeting.

The specialty societies noted that the current injection codes (62310, 62311, 62318 and 62319) to be reported with 77003 do not include any pre- or post-service work duplication and will be re-surveyed and presented to the RUC in October 2012. No other injection codes are to be reported with 77003 and therefore there is no duplicative work. The specialty societies noted that the parenthetical for 77003 of the CPT book advises that injection of contrast during fluoroscopic guidance and localization is an inclusive component of these services 62310-62319 and not included in the reporting of 77003.

In January 2012, the RUC reviewed the survey responses from 122 anesthesiologists, interventional radiologists, radiologists, spine surgeons and pain medicine physicians and determined that the physician work for CPT code 77003 should be maintained at 0.60 work RVUs, lower than the survey's 25th percentile. The specialty society indicated and the RUC agreed that there is extra positioning time in the intra-service work, which accounts for the physician repositioning the patient depending on the type of injection to be performed. The RUC noted that the survey respondents indicate a slightly decreased intra-service time, while the physician work remains the same. However, the RUC discussed that the current time for 77003 was derived from a survey in 1999 from only radiologists. In contrast, this service has a robust survey with over 120 survey respondents, completed by a diverse set of practicing physician specialties, and should be valued based upon this strong data.
The RUC compared 77003 to 77001 *Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site*

or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (work RVU = 0.38 and 9 minutes intra-service time) and determined that 77003 requires more physician work, time, intensity and complexity to perform than 77001. For further support the RUC compared 77003 to similar service 76881 *Ultrasound, extremity, nonvascular, real-time with image documentation; complete* (work RVU=0.63 and intra-service time = 15 minutes) and code 99241 *Office consultation for a new or established patient* (work RVU= 0.64 and intra-service time= 15 minutes) and determined that these services require similar physician work and time to perform compared to 77003 Therefore, the current work RVU of 0.60 and intra-service time of 15 minutes appropriately places this service relative to similar services. **The RUC recommends a work RVU of 0.60 for CPT code 77003.**

Practice Expense
The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Relativity Assessment
The RUC recommends that the Relativity Assessment Workgroup review codes *77001Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)* (ZZZ global period) and 77002 *Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)* (renumbered from 76003 in CPT 2007, XXX global period), to determine if this family of services needs to be re-surveyed as well.

CPT Code (●New)	CPT Descriptor	Global Period	Work RVU Recommendation
77003	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, subarachnoid, or sacroiliac joint), including neurolytic agent destruction	XXX	0.60 (No Change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:77003 Tracking Number Original Specialty Recommended RVU: **0.60**
Presented Recommended RVU: **0.60**
Global Period: XXX RUC Recommended RVU: **0.60**

CPT Descriptor: Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is a 52 year-old male with neck pain and radicular pain from cervical disc disease that has not responded to conservative therapy. He is scheduled for a cervical epidural steroid injection (the injection is reported separately), and fluoroscopic guidance is used during needle placement to assure proper position of the needle and maximize safety.

NOTE: Placement of the needle/catheter is not included in code 77003, but rather is included in the injection code(s). When completing this survey, consider only the fluoroscopic guidance as described by code 77003. Do not include the injection procedure.

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

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

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

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 44%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 30%

Description of Pre-Service Work: The physician reviews the patients prior imaging studies (radiographs, CT scans, MRI exams) to be familiar with the patients spine anatomy (numbering of levels, anatomic variants, prior surgey, pathology, etc.). The physician dresses in radiation attire and instructs radiologic technologists in imaging equipment required and the proper settings for the imaging equipment.

Description of Intra-Service Work: The patient is placed on an x-ray table in the prone, decubitus or prone oblique position, depending on the type of injection to be performed. Preliminary fluoroscopy is performed to identify the appropriate level and approach for initial needle placement, and the skin entry site marked. During the needle/catheter placement, intermittent fluoroscopy is used to confirm the correct approach and need for needle repositioning or realignment. When the needle position appears correct, radiographic contrast may be injected to confirm proper position. If position is not correct, additional fluoroscopy is provided during repositioning until proper position is achieved. If a catheter is to be placed, additional fluoroscopic guidance is provided during and after the catheter positioning to confirm proper positioning, and additional contrast injection may be performed.

Description of Post-Service Work: A report describing the guidance procedure, including the final position of the needle/catheter is dictated, proofread and submitted for the patient record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012		
Presenter(s):	Marc Lieb, MD; Christopher Merifield, MD; Joe Zuhosky, MD; William Sullivan, MD; Eddy Fraifeld, MD; Sean Tutton, MD; Zeke Silva, MD; David Caraway, MD		
Specialty(s):	ASA, ISIS, NASS, ACR, SIR, AAPMR, AAPM, ASIPP		
CPT Code:	77003		
Sample Size: 1203	**Resp N:** 122	**Response:** 10.1 %	
Sample Type: Panel	**Additional Sample Information:**		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	20.00	**100.00**	500.00	4500.00
Survey RVW:	0.18	0.64	**1.00**	1.31	2.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	10.00	**15.00**	20.00	60.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	77003	**Recommended Physician Work RVU: 0.60**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**0.00**	**7.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
72291	XXX	1.31	**RUC Time**

CPT Descriptor Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under fluoroscopic guidance

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92083	XXX	0.50	**RUC Time**	2,651,934

CPT Descriptor 1 Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
76700	XXX	0.81	**RUC Time**	1,053,471

CPT Descriptor 2 Ultrasound, abdominal, real time with image documentation; complete

Other Reference CPT Code	Global	Work RVU	Time Source
77001	ZZZ	0.38	**RUC Time**

CPT Descriptor Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 38 **% of respondents:** 31.1 **%**

TIME ESTIMATES (Median)	**CPT Code: 77003**	**Key Reference CPT Code:** 72291	**Source of Time** **RUC Time**
Median Pre-Service Time	7.00	45.00	
Median Intra-Service Time	15.00	60.00	
Median Immediate Post-service Time	5.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**27.00**	**120.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.42	3.37
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.63
Urgency of medical decision making	3.29	3.24
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.18	4.16
Physical effort required	2.89	3.05
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.18	4.11
Outcome depends on the skill and judgment of physician	4.39	4.39
Estimated risk of malpractice suit with poor outcome	4.55	4.45

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.76	2.76
Intra-Service intensity/complexity	4.11	4.16
Post-Service intensity/complexity	2.31	2.39

Additional Rationale and Comments

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

This code was flagged for review as part of the CMS request for review of services included on the MPC list. In their Action Plan, the specialties suggested that this code be revisited after we had two years of data that reflect all the recent coding changes that will impact use of this code. {Fluoroscopic guidance was bundled into 1. facet joint injections (codes 64490-64495) in 2010; 2. transforaminal epidural injections (codes 64479-64484) in 2011; 3. SI joint injections (code 27096) and 4. paravertebral facet joint destruction (new codes 64633– 64636, which replaced 64622-64627) in 2012} The specialties believed that it would be necessary to have 2012 data in order to establish dominant specialty, site of service, associated diagnoses and identification of procedures for which fluoroscopic guidance would remain separately reportable. The RAW and the RUC requested that the code be surveyed for this September 2011 meeting.

For the September 2011 meeting eight specialty societies participated in the survey and collected 100 responses. The key reference service selected by the survey respondents was 77002 – Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device). With median survey value of 1.00 RVUs and 25th percentile of 0.61 RVUs. The specialty societies recommended maintaining the current value of 0.60.

Due to RUC Members' concerns that the surveyees were not clear that code 77003 includes only guidance and might have included the work of the injection in their responses, the specialty societies were asked to re-survey with clear instructions in the vignette as well as an updated CPT descriptor. The vignette and RSL were reviewed by the Research Committee, which made a suggestion that 77002 should not be used on the RSL.

Eight specialty societies surveyed the code 77003 with revised vignette, descriptor and RSL, and collected 122 responses. The results came back with identical median value, nearly identical 25th percentile value and identical intra-service time as the survey for Sepbember 2011 meeting.

The specialty societies recommend maintaining of the current value of 0.60 RVUs for 77003.

Comparison Codes:

Code	Descriptor	Pre-Service	Intra-Service	Post-Service	Global	RVUw
76886	Ultrasound, infant hips, real time with imaging documentation; limited, static (not requiring physician manipulation)	0	15	0	XXX	0.62
77300	Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician	0	15	0	XXX	0.62
51797	Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)	0	15	0	ZZZ	0.80

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

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

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.

☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
☐ Multiple codes are used to maintain consistency with similar codes.
☐ Historical precedents.
☒ Other reason (please explain) This is not a stand-alone service. It would only be reported along with another procedure when that procedure was done with flurosocpic guidance and that guidance was not already bundled into the procedure

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. This code would only be reported in conjunction with a procedure when imaging guidance is not already bundled into the code that describes the underlying procedure. The incidence of this will decrease markedly, as CPT code changes to bundle fluoroscopic guidance into a large number of codes will be accounted for.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 77003

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

Specialty Interventional Pain Management How often? Commonly

Specialty Anesthesiology How often? Commonly

Specialty Physical Medicine and Rehabilitation How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 896228
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate that this would be 1.5 times the Medicare frequency

Specialty Interventional Pain Management Frequency 289302 Percentage 32.27 %

Specialty Anesthesiology Frequency 223071 Percentage 24.88 %

Specialty Physical Medicine and Rehabilitation Frequency 161321 Percentage 17.99 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 574,054 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2010 Medicare frequency for 77003 minus the 2010 Medicare frequency of the services which were since revised to bundle 77003: (transforaminal injections (64479, 64483), neurolytic agent nerve destruction 64622, 64626) and SI joint injection (27096))

2010 Frequency for 77003:	1,890,663
less 2010 Frequency for 64479:	43,666
less 2010 Frequency for 64483:	803663
less 2010 Frequency for 64622:	137,505
less 2010 Frequency for 64626:	30,537
less 2010 Frequency for 27096:	301,238

Estimated Medicare Frequency for revised code 77003: 574,054

Specialty Interventional Pain Management Frequency 192868 Percentage 33.59 %

Specialty Anesthesiology Frequency 148714 Percentage 25.90 %

Specialty Physical Medicine and Rehabilitation Frequency 107547 Percentage 18.73 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 77003

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

SS Rec Summary

ISSUE: Fluoroscopic guidance for spinal injection

TAB: 21

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME OS/DV	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
REFERENCE	72291	Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under fluoroscopic guidance		-0.001			1.31			120	45				60			15
CURRENT	77003	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, subarachnoid)		0.013			0.60			35	10				20			5
SURVEY	77003		122	0.044	0.18	0.64	1.00	1.31	2.00	30	10		2	10	15	20	60	5
RECOMMEND	77003			0.022			0.60			27	7				15			5

DATA FROM SURVEY PRESENTED AT SEPTEMBER 2011 MEETING

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME OS/DV	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
REFERENCE	77002	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)	100	0.045			0.54			12	0							0
CURRENT	77003			0.013			0.60			35	10				20			5
SURVEY	77003	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, subarachnoid, or sacroiliac joint), including neurolytic agent destruction		0.041	0.38	0.61	1.00	1.25	2.50	32	10				15			7
RECOMMEND	77003			0.022			0.60			27	7				15			5

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

CPT Long Descriptor: Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, subarachnoid)

Global Period: XXX Meeting Date: January 2012

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 comprised of representatives from the specialty societies convened to review the PE inputs for code 77003. The panel included physicians from a variety of practice locales and settings.

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

We have included several additional CPT codes on our spreadsheet. CPT code 75901 is included as a supervision and interpretation (S&I) reference code and although the code is not in this spine family it is recently RUC'ed and follows the same process of care. CPT code 77002 has been included an another S&I. This code is in the spine family. However, the direct line items for clinical time are not available, so just the summed times, supplies and equipment items are in included in the spreadsheet. The current inputs for CPT code 77003 are included as a reference. CPT code 62310 has been included on the spreadsheet as well. That is a typical surgical companion code that is billed with 77003 (source is the 5% file). We have included that code to demonstrate there is no double counting of clinical times. Finally, CPT code 64493 has been included as an example of what the inputs of a bundled code look like.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
A Radiology Tech will prepare prior imaging studies for review by the physician.

Intra-Service Clinical Labor Activities:
The Radiology Tech will prepare the imaging equipment and input patient and procedure information. S/he positions the imaging equipment and assists with patient positioning. S/he will perform the required imaging and at the end of the procedure will clean the equipment and process and store the films.

Post-Service Clinical Labor Activities:
N/A

	A	B	C	D	E	F	G	H	I	J	K	N	O	P	Q	R
1				75901		77002		77003		77003		62310		64493		
2	**Meeting Date:** February 2012 **Specialty:** ASA, ISIS, AAPM, AAOS, ACRO, NASS, ASIPP, AAPMR, ACR and SIR	CMS	Staff	*Mechanical removal of pericatheter obstructive material (eg. Fibrin sheath) from central venous device via separate venous access, radiologic supervision and interpretation* *Reference Code*		*Flouroscopic guidance for needle placement (eg, biopsy, aspiration, injectio, localizaiton device)* *Reference Code*		*Flouroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)* ***RECOMMENDATIONS***		*Flouroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)* *CURRENT* *(CMS made changes to PEAC approved)*		*Injection, single (not via indwelling catheter), not including neurolytic substance, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opiod, steroid, other solution), epidural or subarachnoid, crvical or thoracic* *Example of Code Billed w/77003*		*Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level* *Example of a bundled code*		
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**			XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	000	000	000	000	000
5	**TOTAL CLINICAL LABOR TIME**	L041B	RadTech	**68.0**	**0.0**	**35.0**	**0.0**	**25.0**	**0.0**	**10.0**	**0.0**			**20.0**		
6	**TOTAL CLINICAL LABOR TIME**	L037D	RN/LPN/MTA									**77.0**	**21.0**		**67.0**	**24.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**3.0**	**0.0**	**3.0**	**0.0**	**3.0**	**0.0**	**11.0**	**21.0**	**3.0**	**11.0**	**21.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**68.0**	**0.0**	**32.0**	**0.0**	**22.0**	**0.0**	**7.0**	**0.0**	**63.0**	**0.0**	**17.0**	**53.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**3.0**	**0.0**	**0.0**	**3.0**	**3.0**
10	**PRE-SERVICE**															
11	**Start: Following visit when decision for surgery or procedure made**													**RT**	**RN/LPN/MTA**	
12	Complete pre-service diagnostic & referral forms											3	3		3	3
13	Coordinate pre-surgery services												5		0	5
14	Schedule space and equipment in facility												5		0	5
15	Provide pre-service education/obtain consent											5	5		5	5
16	Follow-up phone calls & prescriptions											3	3		3	3
17	Other Clinical Activity (please specify)	L041B	RadTech			3		3		3				3		
18																
19	**End: When patient enters office/facility for surgery/procedure**															
20	**SERVICE PERIOD**															
21	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**													**RT**	**RN/LPN/MTA**	
22	Greet patient, provide gowning, ensure appropriate medical records are available											3			3	
23	Obtain vital signs											3			5	
24	Provide pre-service education/obtain consent														3	
25	Prepare room, equipment, supplies	L041B	RadTech	3				1		1		3			3	
26	Setup scope (non facility setting only)															
27	Prepare and position patient/ monitor patient/ set up IV	L041B	RadTech	12				1		1		3			3	
28	Sedate/apply anesthesia															
29	**Intra-service**															
30	Assist physician in performing procedure	L037D	RN/LPN/MTA									30			15	
31	Assist physician with flouro and image acquisition	L041B	RadTech	45				15						15		
32	**Post-Service**															
33	Monitor pt. following service/check tubes, monitors, drains											15			15	
34	Clean room/equipment by physician staff	L041B	RadTech	3				2		2		3			3	
35	Clean Scope															
36	Clean Surgical Instrument Package															
37	Complete diagnostic forms, lab & X-ray requisitions															
38	Review/read X-ray, lab, and pathology reports															
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions											3			3	
40	Discharge day management															
41	Other Clinical Activity (please specify)													2		
42	*Process films, hang films and review study with interpreting MD prior to patient discharge*	L041B	RadTech	5				3		3						
43	**End: Patient leaves office**															
44	**POST-SERVICE Period**															
45	**Start: Patient leaves office/facility**													**RT**	**RN/LPN/MTA**	
46	Conduct phone calls/call in prescriptions											3			3	3
47	*Office visits:*															
48	*List Number and Level of Office Visits*			**pre**		**pre**		**post**		**post**		**post**		**post**	**post**	
49	99211 16 minutes		16													
50	99212 27 minutes		27													
51	99213 36 minutes		36													
52	99214 53 minutes		53													
53	99215 63 minutes		63													
54	99238 12 minutes		12													
55	*Total Office Visit Time*			**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
56	Other Activity (please specify)															
57	**End: with last office visit before end of global period**				**0**		**0**		0		0		0			0

	A	B	C	D	E	F	G	H	I	J	K	N	O	P	Q	R
1				75901		77002		77003		77003		62310		64493		
2	**Meeting Date:** February 2012 **Specialty:** ASA, ISIS, AAPM, AAOS, ACRO, NASS, ASIPP, AAPMR, ACR and SIR	CMS	Staff	*Mechanical removal of pericatheter obstructive material (eg. Fibrin sheath) from central venous device via separate venous access, radiologic supervision and interpretation* *Reference Code*		*Flouroscopic guidance for needle placement (eg, biopsy, aspiration, injectio, localizaiton device)* *Reference Code*		*Flouroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)* ***RECOMMENDATIONS***		*Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)* *CURRENT* *(CMS made changes to PEAC approved)*		*Injection, single (not via indwelling catheter), not including neurolytic substance, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opiod, steroid, other solution), epidural or subarachnoid, crvical or thoracic* *Example of Code Billed w/77003*		*Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level* *Example of a bundled code*		
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Non Facility**	**Facility**
58	**MEDICAL SUPPLIES**		**Unit**													
59	drape, sterile, c-arm, flouro	SB008						1		1				1		
60	film, flouroscopic 14x17	SK028		3		1		1		1						
61	x-ray developer solution	SK089						1		1						
62	x-ray fixer solution	SK092						1		1						
63	x-ray ID card	SK093				1										
64	cap, surgical	SB001										1				
65	gloves, sterile	SB024										2				
66	gloves, non-sterile	SB022				1		1								
67	disinfectant	SM013				1		1								
68	gown, staff	SB027										1				
69	mask, surgical	SB033										1				
70	underpad 2ft x 3ft (chux)	SB044										1				
71	computer media, dvd	SK013				1										
72	pack, minimum multi-specialty visit	SA048										1		1		
73	tray, epidural	SA064										1				
74	drape, sterile barrier 16in x 29in	SB007		3												
75	x-ray envelope	SK091		1		1		1								
76	needle, 18-25	SC028												1		
77	Marcaine	SH021												5		
78	syringe	SC051												1		
79	film, dry, radiographic, 8x10	SK025												2		
80	pack, basic injection	SA041												1		
81	**Equipment**															
82	film alternator	ER029				3		3		3						
83	film processor	ED025				3		3		3						
84	room, radiographic-flouro	EL014		68		9		9		7		37				
85	stretcher	EF018										26		40		
86	room, mobile C-ARM	EL018												19		
87	printer, laser, paper	ED032												19		
88	x-ray view box, 4 panel	ER067												19		

	A	B	C	D	E	F	G	H	I	J	K	N	O	P	Q	R
1				75901		77002		77003		77003		62310		64493		
2	**Meeting Date:** February 2012 **Specialty:** ASA, ISIS, AAPM, AAOS, ACRO, NASS, ASIPP, AAPMR, ACR and SIR	CMS	Staff	*Mechanical removal of pericatheter obstructive material (eg. Fibrin sheath) from central venous device via separate venous access, radiologic supervision and interpretation* *Reference Code*		*Flouroscopic guidance for needle placement (eg, biopsy, aspiration, injectio, localizaiton device)* *Reference Code*		*Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)* ***RECOMMENDATIONS***		*Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)* *CURRENT* *(CMS made changes to PEAC approved)*		*Injection, single (not via indwelling catheter), not including neurolytic substance, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opiod, steroid, other solution), epidural or subarachnoid, crvical or thoracic* *Example of Code Billed w/77003*		*Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level* *Example of a bundled code*		
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**			XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	000	000	000	000	000
5	**TOTAL CLINICAL LABOR TIME**	L041B	RadTech	**68.0**	**0.0**	**35.0**	**0.0**	**23.0**	**0.0**	**10.0**	**0.0**			**20.0**		
6	**TOTAL CLINICAL LABOR TIME**	L037D	RN/LPN/MTA									**77.0**	**21.0**		**67.0**	**24.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**3.0**	**0.0**	**3.0**	**0.0**	**3.0**	**0.0**	**11.0**	**21.0**	**3.0**	**11.0**	**21.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**68.0**	**0.0**	**32.0**	**0.0**	**20.0**	**0.0**	**7.0**	**0.0**	**63.0**	**0.0**	**17.0**	**53.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**3.0**	**0.0**	**0.0**	**3.0**	**3.0**
10	**PRE-SERVICE**															
11	**Start: Following visit when decision for surgery or procedure made**													**RT**	**RN/LPN/MTA**	
12	Complete pre-service diagnostic & referral forms											3	3		3	3
13	Coordinate pre-surgery services												5		0	5
14	Schedule space and equipment in facility												5		0	5
15	Provide pre-service education/obtain consent											5	5		5	5
16	Follow-up phone calls & prescriptions											3	3		3	3
17	Other Clinical Activity (please specify)	L041B	RadTech			3		3		3				3		
18																
19	**End: When patient enters office/facility for surgery/procedure**															
20	**SERVICE PERIOD**															
21	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**													**RT**	**RN/LPN/MTA**	
22	Greet patient, provide gowning, ensure appropriate medical records are available											3			3	
23	Obtain vital signs											3			5	
24	Provide pre-service education/obtain consent														3	
25	Prepare room, equipment, supplies	L041B	RadTech	3				1		1		3			3	
26	Setup scope (non facility setting only)															
27	Prepare and position patient/ monitor patient/ set up IV	L041B	RadTech	12				1		1		3			3	
28	Sedate/apply anesthesia															
29	**Intra-service**															
30	Assist physician in performing procedure	L037D	RN/LPN/MTA									30			15	
31	Assist physician with flouro and image acquisition	L041B	RadTech	45				15						15		
32	**Post-Service**															
33	Monitor pt. following service/check tubes, monitors, drains											15			15	
34	Clean room/equipment by physician staff	L041B	RadTech	3				1		2		3			3	
35	Clean Scope															
36	Clean Surgical Instrument Package															
37	Complete diagnostic forms, lab & X-ray requisitions															
38	Review/read X-ray, lab, and pathology reports															
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions											3			3	
40	Discharge day management															
41	Other Clinical Activity (please specify)													2		
42	*Process films, hang films and review study with interpreting MD prior to patient discharge*	L041B	RadTech	5				2		3						
43	**End: Patient leaves office**															
44	**POST-SERVICE Period**															
45	**Start: Patient leaves office/facility**													**RT**	**RN/LPN/MTA**	
46	Conduct phone calls/call in prescriptions											3			3	3
47	*Office visits:*															
48	*List Number and Level of Office Visits*			**pre**		**pre**		**post**		**post**		**post**		**post**	**post**	
49	99211 16 minutes		16													
50	99212 27 minutes		27													
51	99213 36 minutes		36													
52	99214 53 minutes		53													
53	99215 63 minutes		63													
54	99238 12 minutes		12													
55	*Total Office Visit Time*			**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
56	Other Activity (please specify)															
57	**End: with last office visit before end of global period**				**0**		**0**		0		0		0			0

	A	B	C	D	E	F	G	H	I	J	K	N	O	P	Q	R
1				75901		77002		77003		77003		62310		64493		
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3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Non Facility**	**Facility**
58	**MEDICAL SUPPLIES**		**Unit**													
59	drape, sterile, c-arm, flouro	SB008						1		1				1		
60	film, flouroscopic 14x17	SK028		3		1		1		1						
61	x-ray developer solution	SK089						1		1						
62	x-ray fixer solution	SK092						1		1						
63	x-ray ID card	SK093				1										
64	cap, surgical	SB001										1				
65	gloves, sterile	SB024										2				
66	gloves, non-sterile	SB022				1		1								
67	disinfectant	SM013				1		1								
68	gown, staff	SB027										1				
69	mask, surgical	SB033										1				
70	underpad 2ft x 3ft (chux)	SB044										1				
71	computer media, dvd	SK013				1										
72	pack, minimum multi-specialty visit	SA048										1		1		
73	tray, epidural	SA064										1				
74	drape, sterile barrier 16in x 29in	SB007		3												
75	x-ray envelope	SK091		1		1		1								
76	needle, 18-25	SC028												1		
77	Marcaine	SH021												5		
78	syringe	SC051												1		
79	film, dry, radiographic, 8x10	SK025												2		
80	pack, basic injection	SA041												1		
81	**Equipment**															
82	film alternator	ER029				3		2		3						
83	film processor	ED025				3		2		3						
84	room, radiographic-flouro	EL014		68		9		18		7		37				
85	stretcher	EF018										26		40		
86	room, mobile C-ARM	EL018												19		
87	printer, laser, paper	ED032												19		
88	x-ray view box, 4 panel	ER067												19		

AMA/Specialty Society RVS Update Committee Summary of Recommendations
July 19, 2011 NPRM CMS Request

January 2012

Dual-energy X-ray Absoptiometry

In the July 19, 2011, Proposed Rule, CMS indicated that for 2010 and 2011, the Affordable Care Act (ACA) modified the payment for dual x-ray absorptiometry (DXA) services described by 77080 and 77082 to an imputed value, 70 percent of the product of the CY 2006 RVUs for these services, the CY 2006 conversion factor and the geographic adjustment for the relevant payment year. The ACA also allowed for a study to be conducted by the Institute of Medicine on the ramifications of Medicare payment reductions for DXA on beneficiary access to bone mass density tests. To date, this study has not been initiated. Therefore, CMS requested that the AMA RUC review CPT codes 77080 and 77082.

The RUC understood that there was a duplicate practice expense item that CMS corrected several years ago, which led to a significant reduction in payment. However, Congress reversed this payment reduction. The Congressional correction expired on December 31, 2011. The RUC recommended that the physician work and practice expense be reviewed for January 2012.

77080 ***Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)***
In January 2012, the RUC reviewed the survey results from 104 radiologists, endocrinologists and rheumatologists and agreed with the presenters that the previous RUC recommended work RVU of 0.20 appropriately accounts for the physician work to perform this service. The RUC agreed with the specialty societies that the typical patient has numerous previous exams and studies, therefore 2 minutes of pre-service time is appropriate to account for the physician review of the patient's history. Likewise, the post-service time of 2 minutes appropriately accounts for the physician correlating the previous studies with the current findings as well as determining use of medications and treatment for osteoporosis. The RUC compared 77080 to key reference code 77081 *Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel*) (work RVU = 0.22) and determined that these services require the exact same intra-service time of 5 minutes. The RUC also compared 77080 to MPC code 93010 *Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only* (work RVU = 0.17 and 4 minutes intra-service time) and determined that these services require similar physician work and time to perform. Therefore, a work RVU of 0.20 appropriately accounts for the physician work and time required to perform 77080 relative to other services. The RUC noted that 77080 is slightly more intense and complex than 77082 due to the body sites examined and therefore should be valued slightly higher. **The RUC recommends a work RVU of 0.20 for CPT code 77080.**

77082 ***Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment***
The RUC reviewed the survey results from 44 radiologists, endocrinologists and rheumatologists and agreed with the presenters that the previous RUC recommended work RVU of 0.17 appropriately accounts for the physician work to perform this service. The RUC agreed with the specialty societies that the typical patient has numerous previous exams and studies, therefore 2 minutes of pre-service time is appropriate to account for the physician review of this history. Likewise, the post-service time of 2 minutes appropriately accounts for the physician correlating the previous studies with the current findings as well as determining use of medications and treatment for osteoporosis and following up with the referring physician regarding the fracture. The RUC compared 77082 to key reference code 77081 *Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel*) (work RVU = 0.22) and determined that these services require the exact same intra-service time of 5 minutes. The RUC also compared 77082 to MPC codes 93010 *Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only* (work RVU = 0.17 and 4 minutes intra-service time) and 73560 *Radiologic examination, knee; 1 or 2 views* (work RVU = 0.17 and 3 minutes intra-service time) and determined that these services require similar physician work and time to perform. Therefore, a work RVU of 0.17 appropriately accounts for the physician work and time required to perform 77082 relative to other services. The RUC noted that 77082 is slightly less intense and complex than 77082 due to the body sites examined and therefore should be valued slightly lower **The RUC recommends a work RVU of 0.17 for CPT code 77082.**

Practice Expense
The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

CPT Code (●New)	CPT Descriptor	Global Period	Work RVU Recommendation
77080	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)	XXX	0.20
77082	vertebral fracture assessment	XXX	0.17

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:77080 Tracking Number Original Specialty Recommended RVU: **0.20**
Presented Recommended RVU: **0.20**
Global Period: XXX RUC Recommended RVU: **0.20**

CPT Descriptor: Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66 year old woman had previous bone density demonstrating severe osteoporosis. The patient has been on hormone replacement therapy for one year and a follow-up DXA scan is ordered.

Percentage of Survey Respondents who found Vignette to be Typical: 64%

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

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

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work:
- Review the reason for the exam and any pertinent clinical history
- Review any prior DXA studies

Description of Intra-Service Work:
- Review scout images to assure scanning technique was satisfactory
- Supervise the radiologic technologist in acquiring images
- Interpret the DXA scan data and compare to established norms
- Compare the results of the DXA scan to previous studies
- Dictate report for the medical record

Description of Post-Service Work:
- Review and sign final report
- Discuss findings with referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012		
Presenter(s):	Geraldine McGinty. M.D., Zeke Silva, M.D., Allan Glass, M.D., Afonso Bello, M.D., John Seibel, M.D. and Howard Lando, M.D.		
Specialty(s):	ACR, AACE, ACRh, TES		
CPT Code:	77080		
Sample Size: 1814	**Resp N:** 104	**Response:** 5.7 %	
Sample Type: Random	**Additional Sample Information:**		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	150.00	**350.00**	900.00	6000.00
Survey RVW:	0.20	0.25	**0.33**	0.58	3.50
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	1.00	5.00	**8.00**	10.00	35.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code: 77080	**Recommended Physician Work RVU: 0.20**		
	Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:	**2.00**	**0.00**	**2.00**
Pre-Service Positioning Time:	**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:	**0.00**	**0.00**	**0.00**
Intra-Service Time:	**5.00**		

Immediate Post Service-Time:	**2.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
77081	XXX	0.22	**RUC Time**

CPT Descriptor Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95900	XXX	0.42	**RUC Time**	1,374,620

CPT Descriptor 1 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93010	XXX	0.17	**RUC Time**	19,219,718

CPT Descriptor 2 Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only

Other Reference CPT Code	Global	Work RVU	Time Source
99212	XXX	0.48	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 46 **% of respondents:** 45 **%**

TIME ESTIMATES (Median)	**CPT Code: 77080**	**Key Reference CPT Code:** 77081	**Source of Time** **RUC Time**
Median Pre-Service Time	2.00	5.00	
Median Intra-Service Time	5.00	5.00	
Median Immediate Post-service Time	2.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**9.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.18	3.05
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.57	3.61
Urgency of medical decision making	2.67	2.61
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.45	3.37
Physical effort required	2.21	2.20
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.82	2.68
Outcome depends on the skill and judgment of physician	3.24	3.21
Estimated risk of malpractice suit with poor outcome	2.41	2.36

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.41	2.44
Intra-Service intensity/complexity	3.02	2.93
Post-Service intensity/complexity	2.68	2.56

Additional Rationale and Comments

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

Background

CPT codes 77080 (*Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton*) and 77082 (*Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment*) were identified through a CMS request in the NPRM for 2012. As a result, the RUC requested that the codes be resurveyed and reviewed by the January 2012 RUC meeting. The American College of Radiology (ACR), American College of Rheumatology (ACRh), The Endocrine Society (TES), the International Society for Clinical Densitometry (ISCD), and American Association of Clinical Endocrinology (AACE) surveyed these two codes. An expert panel that included a number of physicians familiar with the services was then convened to review the survey data.

It should be noted that the work RVU numbers in the "General Information" section of the RUC database for these codes, 0.23 for 77080 and 0.13 for 77082, are imputed values calculated in order to meet the current legislatively-mandated payment rates for these services. The resource-based RUC-approved values, as confirmed by AMA staff and as contained in the "RUC Rationale" section of the RUC database, are 0.20 for 77080 and 0.17 for 77082.

Work RVU recommendation
For both codes 77080 and 77082, the societies recommend maintenance of the current RUC-approved work RVU values: 0.20 for 77080 and 0.17 for 77082.

Pre, Intra, and Post Service Times
The societies recommend the median survey times from the dominant specialty (ACR). These are pre, intra and post times of 2, 5 and 2 minutes, respectively for both codes. Although there were significantly longer times given by survey respondents from other specialties, the expert panel felt that there may have been some confusion among those survey respondents between work performed during a concurrent E&M service. It should be noted that an E&M service is not typically performed with either of these codes (15% with 77080 and 23% with 77082).

The recommended values for these codes place them in appropriate rank order with the most commonly selected reference service, 77081 (*Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel*)) which has 0.22 RVU.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 77080

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

Specialty Diagnostic Radiology How often? Commonly

Specialty Rheumatology How often? Commonly

Specialty Endocrinology How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 7,555,023
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services for 77080 in one year period is estimated to be 7,555,023.

Specialty Diagnostic Radiology Frequency 2140338 Percentage 28.32 %

Specialty Rheumatology Frequency 813675 Percentage 10.76 %

Specialty Endocrinology Frequency 441213 Percentage 5.83 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,479,421 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2010 Medicare data estimates that code 77080 was billed approximately 2,479,421.

Specialty Diagnostic Radiology Frequency 713446 Percentage 28.77 %

Specialty Rheumatology Frequency 271225 Percentage 10.93 %

Specialty Endocrinology Frequency 147071 Percentage 5.93 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 77080

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:77082 Tracking Number Original Specialty Recommended RVU: **0.17**
Presented Recommended RVU: **0.17**
Global Period: XXX RUC Recommended RVU: **0.17**

CPT Descriptor: Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 71 year old woman with a diagnosis of osteopenia by DXA scan using WHO criteria is referred for a vertebral fracture assessment to evaluate for undiagnosed thoracolumbar spinal fracture to determine whether pharmacologic intervention may be necessary

Percentage of Survey Respondents who found Vignette to be Typical: 93%

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

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

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work:

- The physician reviews the patient's history and clinical findings to confirm the appropriateness of scanning for vertebral fracture assessment (VFA).

Description of Intra-Service Work:

- Supervise the radiologic technologist in acquiring images.
- The physician reviews the VFA images obtained and the post-processed measurements to assure that the measurements were accurately done and that scanning technique was satisfactory.
- The physician interprets the VFA thoracic and lumbar images (lateral views) using accepted fracture assessment methodology, the Semiquantitative Analysis of Genant and Quantitative Morphometry, to determine the number and severity of fractures present.
- The physician compares the results of the VFA interpretation to previous radiographic or VFA images to determine if a significant change in vertebral anatomy has occurred in the interim.
- The physician dictates the report for the medical record.

Description of Post-Service Work:

- The physician reviews and signs the report of the examination.
- The physician discusses the results with the patient and referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012				
Presenter(s):	Geraldine McGint, M.D., Zeke Silva, M.D., Allan Glass, M.D., Afonso Bello, M.D., John Seibel, M.D. and Howard Lando, M.D.				
Specialty(s):	ACR, AACE, ACRh, and TES				
CPT Code:	77082				
Sample Size:	1814	**Resp N:**	44	**Response:** 2.4 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	16.00	**63.00**	180.00	1000.00
Survey RVW:	0.03	0.22	**0.27**	0.48	2.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	3.00	**6.00**	15.00	20.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	77082	**Recommended Physician Work RVU: 0.17**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**2.00**	**0.00**	**2.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**5.00**		

Immediate Post Service-Time:	**2.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
77081	XXX	0.22	**RUC Time**

CPT Descriptor Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
73560	XXX	0.17	**RUC Time**	2,147,582

CPT Descriptor 1 Radiologic examination, knee; 1 or 2 views

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93010	XXX	0.17	**RUC Time**	19,219,718

CPT Descriptor 2 Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only

Other Reference CPT Code	Global	Work RVU	Time Source
72100	XXX	0.22	**CMS Time File**

CPT Descriptor Radiologic examination, spine, lumbosacral; 2 or 3 views

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 14 **% of respondents:** 73 **%**

TIME ESTIMATES (Median)	**CPT Code: 77082**	**Key Reference CPT Code:** 77081	**Source of Time RUC Time**
Median Pre-Service Time	2.00	5.00	
Median Intra-Service Time	5.00	5.00	
Median Immediate Post-service Time	2.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**9.00**	**20.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.86	3.07
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.93	3.07
Urgency of medical decision making	2.29	2.21
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.50	3.50
Physical effort required	2.00	2.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.29	2.21
Outcome depends on the skill and judgment of physician	3.07	3.07
Estimated risk of malpractice suit with poor outcome	2.07	1.93

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.14	2.21
Intra-Service intensity/complexity	3.07	3.00
Post-Service intensity/complexity	2.29	4.43

Additional Rationale and Comments

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

Background

CPT codes 77080 (*Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton*) and 77082 (*Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment*) were identified through a CMS request in the NPRM for 2012. As a result, the RUC requested that the codes be resurveyed and

reviewed by the January 2012 RUC meeting. The American College of Radiology (ACR), American College of Rheumatology (ACRh), the Endocrine Society (TES), the International Society for Clinical Densitometry (ISCD), and American Association of Clinical Endocrinology (AACE) surveyed these two codes. An expert panel that included a number of physicians familiar with the services was then convened to review the survey data.

It should be noted that the work RVU numbers in the "General Information" section of the RUC database for these codes, 0.23 for 77080 and 0.13 for 77082, are imputed values calculated in order to meet the current legislatively-mandated payment rates for these services. The resource-based RUC-approved values, as confirmed by AMA staff and as contained in the "RUC Rationale" section of the RUC database, are 0.20 for 77080 and 0.17 for 77082.

Work RVU recommendation
For both codes 77080 and 77082, the societies recommend maintenance of the current RUC-approved work RVU values: 0.20 for 77080 and 0.17 for 77082.

Pre, Intra, and Post Service Times
The societies recommend the median survey times from the dominant specialty (ACR). These are pre, intra and post times of 2, 5 and 2 minutes, respectively for both codes. Although there were significantly longer times given by survey respondents form other specialties, the expert panel felt that there may have been some confusion among those survey respondents between work performed during a concurrent E&M service. It should be noted that an E&M service is not typically performed with either of these codes (15% with 77080 and 23% with 77082).

The recommended values for these codes place them in appropriate rank order with the most commonly selected reference service, 77081 (Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)) which has 0.22 RVU.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

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

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☒ Other reason (please explain) 77082 is typically reported with code 77080.

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

CPT	Long Descriptors	Global Period	Work RVU	Pre	Intra	Post	Total Time
77080	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)	XXX	0.20	2	5	2	9

77082 Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment	XXX	0.17	2	5	2	9

* The current existing total times for codes 77080 and 77082 are 6 (1, 4, 1) and 7 (1, 5, 1) minutes respectively.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 77082

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

Specialty Diagnostic Radiology How often? Commonly

Specialty Rheumatology How often? Commonly

Specialty Endocrinology How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 485880
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services for 77082 in one year period is estimated to be 485,880.

Specialty Rheumatology Frequency 96301 Percentage 19.81 %

Specialty Diagnostic Radiology Frequency 68849 Percentage 14.16 %

Specialty Endocrinology Frequency 38870 Percentage 7.99 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 156,183 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2010 Medicare data estimates that code 77082 was billed approximately 156,183.

Specialty Rheumatology Frequency 32133 Percentage 20.57 %

Specialty Diagnostic Radiology Frequency 22949 Percentage 14.69 %

Specialty Endocrinology Frequency 12598 Percentage 8.06 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 77082

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

INSTRUCTIONS

Insert information and data into all applicable cells except IWPUT and TOTAL TIME. These cells will automatically calculate.

Hide columns and rows that do not contain data.

REF = Key Reference code data

CURRENT = Current data (Harvard or RUC) for code being surveyed. If this is a new code, this row will be blank.

SVY = Survey data - as it appears on the Summary of Recommendation form.

REC = Specialty Society recommended data as it appears on the Summary of Recommendation form.

ISSUE: 77080

TAB: 23

Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD
					MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
REF	77081	Dual-energy X-ray absorptiometry (DX	46	-0.023			0.22			20	5					5			10
CURRENT	77080	Dual-energy X-ray absorptiometry (DXA), bon		0.046			0.23			6	1					4			1
SVY	77080	Dual-energy X-ray absorptiometry (DX	104	0.013	0.20	0.25	0.33	0.58	3.50	18	5			1	5	8	10	35	5
REC	77080			0.022			0.20			9	2					5			2

ISSUE: 77082

Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD
					MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
REF	77081	Dual-energy X-ray absorptiometry (DX	14	-0.023			0.22			20	5					5			10
CURRENT	77082	Dual-energy X-ray absorptiometry (DXA), bon		0.017			0.13			7	1					5			1
SVY	77082	Dual-energy X-ray absorptiometry (DX	44	0.008	0.03	0.22	0.27	0.48	2.00	15.5	5			2	3	6	15	20	5
REC	77082			0.016			0.17			9	2					5			2

CPT Code: 77080 and 77082
Specialty Society('s) ACR, ACRh, AACE, TES

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

CPT Long Descriptor:
77080- Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)
77082- Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment

Global Period: XXX Meeting Date: 01/2012

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 utilized to finalize the practice expense data for codes 77080 and 77082. Specialty societies that were involved include American College of Rheumatology, American College of Radiology, The Endocrine Society, and American Association of Clinical Endocrinologists.

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

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information

Intra-Service Clinical Labor Activities:

- Greet patient and provide gowning, ensure appropriate medical record are available
- Obtain vital signs
- Provide pre service education/obtain consent
- Prepare room, equipment, supplies
- Assist physician in performing procedure/Acquire Images
- Clean room /equipment by physician staff
- Post processing
- Perform Quality control

Post-Service Clinical Labor Activities:

	A	B	C	D	E	F
1				**77080 (76075)**	**77080**	**77082 (76077)**
2	**Meeting Date:** Jan 2012 **Speciality:** American College of Rheumatology The Endocrine Society The International Society for Clinical Densitometry American Association of Clinical Endocrinologists American College of Radiology	**CMS**	**Staff**	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine) **PEAC approved Feb 2007**	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine) **Jan 2012**	Dual-energy X-ray absorptiomerty (DXA), bone density study 1 or more sites; vertebral fracture assessment **PEAC approved Feb 2007**
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Non Facility**	**Non Facility**
4	**GLOBAL PERIOD**			**xxx**	**xxx**	**xxx**
5	**TOTAL CLINICAL LABOR TIME**			**43.0**	**43.0**	**20.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**5.0**	**0.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**43.0**	**38.0**	**20.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**
9	**PRE-SERVICE**					
10	Other Clinical Activity (please specify):					
11	- Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information				5	
12	**SERVICE PERIOD**					
13	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**					
14	**Pre-service services**					
15	Review charts	LO41B	RT	5		
16	Greet patient, provide gowning, ensure appropriate medical records are available	LO41B	RT	3	3	
17	Obtain vital signs	LO41B	RT	3	3	
18	Provide pre-service education/obtain consent	LO41B	RT	5	5	
19	Prepare room, equipment, supplies	LO41B	RT	2	2	
20	Setup scope (non facility setting only)					
21	Prepare and position patient/ monitor patient/ set up IV					
22	Sedate/apply anesthesia					
23	**Intra-service**					
24	Assist physician in performing procedure	LO41B	RT	15	15	10
25	**Post-Service**					
26	Monitor pt. following service/check tubes, monitors, drains					
27	Clean room/equipment by physician staff	LO41B	RT	3	3	
28	Clean Scope					
29	Clean Surgical Instrument Package					
30	Complete diagnostic forms, lab & X-ray requisitions					
31	Review/read X-ray, lab, and pathology reports					
32	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions					
33	Discharge day management					
34	Other Clinical Activity (please specify): quality control and post-processing					
35	*-post processing*	LO41B	RT	5	5	10
36	*-perform Quality Control*	LO41B	RT	2	2	
37	**End: Patient leaves office**					
38	**POST-SERVICE Period**					
39	**MEDICAL SUPPLIES**	**CMS Code**	**Unit**			
40	Pillow case, disposable	SB026		1	1	1
41	Gown, disposable	SB037		1	1	1
42	Table Paper, 7 feet	SB036		1	1	1
43						
44	**Equipment**	**CMS Code**				
45	Densitometry unit, whole body	ER024		1		
46	Densitometry unit, fan beam, DXA (with computer hardware & software)	ER019			38 min	1
47	Phantom	ER078		1	1	

	A	B	C	G
1				**77082**
2	**Meeting Date:** Jan 2012 **Speciality:** American College of Rheumatology The Endocrine Society The International Society for Clinical Densitometry American Association of Clinical Endocrinologists American College of Radiology	**CMS**	**Staff**	Dual-energy X-ray absorptiomerty (DXA), bone density study 1 or more sites; vertebral fracture assessment **Jan 2012**
3	**LOCATION**	**Code**	**Type**	**Non Facility**
4	**GLOBAL PERIOD**			**xxx**
5	**TOTAL CLINICAL LABOR TIME**			**20.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**20.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**
9	**PRE-SERVICE**			
10	Other Clinical Activity (please specify):			
11	- Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information			
12	**SERVICE PERIOD**			
13	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Pr**			
14	**Pre-service services**			
15	Review charts	LO41B	RT	
16	Greet patient, provide gowning, ensure appropriate medical records are available	LO41B	RT	
17	Obtain vital signs	LO41B	RT	
18	Provide pre-service education/obtain consent	LO41B	RT	
19	Prepare room, equipment, supplies	LO41B	RT	
20	Setup scope (non facility setting only)			
21	Prepare and position patient/ monitor patient/ set up IV			
22	Sedate/apply anesthesia			
23	**Intra-service**			
24	Assist physician in performing procedure	LO41B	RT	10
25	**Post-Service**			
26	Monitor pt. following service/check tubes, monitors, drains			
27	Clean room/equipment by physician staff	LO41B	RT	
28	Clean Scope			
29	Clean Surgical Instrument Package			
30	Complete diagnostic forms, lab & X-ray requisitions			
31	Review/read X-ray, lab, and pathology reports			
32	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions			
33	Discharge day management			
34	Other Clinical Activity (please specify): quality control and post-processing			
35	*-post processing*	LO41B	RT	10
36	*-perform Quality Control*	LO41B	RT	
37	**End: Patient leaves office**			
38	**POST-SERVICE Period**			
39	**MEDICAL SUPPLIES**	**CMS Code**	**Unit**	
40	Pillow case, disposable	SB026		
41	Gown, disposable	SB037		
42	Table Paper, 7 feet	SB036		
43				
44	**Equipment**	**CMS Code**		
45	Densitometry unit, whole body	ER024		
46	Densitometry unit, fan beam, DXA (with computer hardware & software)	ER019		20 min
47	Phantom	ER078		

	A	B	C	D	E
1				**77080 (76075)**	**77080**
2	**Meeting Date:** Jan 2012 **Speciality:** American College of Rheumatology The Endocrine Society The International Society for Clinical Densitometry American Association of Clinical Endocrinologists American College of Radiology	**CMS**	**Staff**	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine) **PEAC approved Feb 2007**	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine) **Jan 2012**
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Non Facility**
4	**GLOBAL PERIOD**			**xxx**	**xxx**
5	**TOTAL CLINICAL LABOR TIME**			**43.0**	**43.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**5.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**43.0**	**38.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**
9	**PRE-SERVICE**				
10	Other Clinical Activity (please specify):				
11	**-** Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information				5
12	**SERVICE PERIOD**				
13	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**				
14	**Pre-service services**				
15	Review charts	LO41B	RT	5	
16	Greet patient, provide gowning, ensure appropriate medical records are available	LO41B	RT	3	3
17	Obtain vital signs	LO41B	RT	3	3
18	Provide pre-service education/obtain consent	LO41B	RT	5	5
19	Prepare room, equipment, supplies	LO41B	RT	2	2
20	Setup scope (non facility setting only)				
21	Prepare and position patient/ monitor patient/ set up IV				
22	Sedate/apply anesthesia				
23	**Intra-service**				
24	Assist physician in performing procedure	LO41B	RT	15	15
25	**Post-Service**				
26	Monitor pt. following service/check tubes, monitors, drains				
27	Clean room/equipment by physician staff	LO41B	RT	3	3
28	Clean Scope				
29	Clean Surgical Instrument Package				
30	Complete diagnostic forms, lab & X-ray requisitions				
31	Review/read X-ray, lab, and pathology reports				
32	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions				
33	Discharge day management				
34	Other Clinical Activity (please specify): quality control and post-processing				
35	*-post processing*	LO41B	RT	5	5
36	*-perform Quality Control*	LO41B	RT	2	2
37	**End: Patient leaves office**				
38	**POST-SERVICE Period**				
39	**MEDICAL SUPPLIES**	**CMS Code**	**Unit**		
40	Pillow case, disposable	SB026		1	1
41	Gown, disposable	SB037		1	1
42	Table Paper, 7 feet	SB036		1	1
43					
44	**Equipment**	**CMS Code**			
45	Densitometry unit, whole body	ER024		1	
46	Densitometry unit, fan beam, DXA (with computer hardware & software)	ER019			38 min
47	Phantom	ER078		1	2

	A	B	C	F	G
1				**77082 (76077)**	**77082**
2	**Meeting Date:** Jan 2012 **Speciality:** American College of Rheumatology The Endocrine Society The International Society for Clinical Densitometry American Association of Clinical Endocrinologists American College of Radiology	**CMS**	**Staff**	Dual-energy X-ray absorptiomerty (DXA), bone density study 1 or more sites; vertebral fracture assessment **PEAC approved Feb 2007**	Dual-energy X-ray absorptiomerty (DXA), bone density study 1 or more sites; vertebral fracture assessment **Jan 2012**
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Non Facility**
4	**GLOBAL PERIOD**			**xxx**	**xxx**
5	**TOTAL CLINICAL LABOR TIME**			**20.0**	**20.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**20.0**	**20.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**
9	**PRE-SERVICE**				
10	Other Clinical Activity (please specify):				
11	**-** Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information				
12	**SERVICE PERIOD**				
13	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Proce**				
14	**Pre-service services**				
15	Review charts	LO41B	RT		
16	Greet patient, provide gowning, ensure appropriate medical records are available	LO41B	RT		
17	Obtain vital signs	LO41B	RT		
18	Provide pre-service education/obtain consent	LO41B	RT		
19	Prepare room, equipment, supplies	LO41B	RT		
20	Setup scope (non facility setting only)				
21	Prepare and position patient/ monitor patient/ set up IV				
22	Sedate/apply anesthesia				
23	**Intra-service**				
24	Assist physician in performing procedure	LO41B	RT	10	10
25	**Post-Service**				
26	Monitor pt. following service/check tubes, monitors, drains				
27	Clean room/equipment by physician staff	LO41B	RT		
28	Clean Scope				
29	Clean Surgical Instrument Package				
30	Complete diagnostic forms, lab & X-ray requisitions				
31	Review/read X-ray, lab, and pathology reports				
32	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions				
33	Discharge day management				
34	Other Clinical Activity (please specify): quality control and post-processing				
35	*-post processing*	LO41B	RT	10	10
36	*-perform Quality Control*	LO41B	RT		
37	**End: Patient leaves office**				
38	**POST-SERVICE Period**				
39	**MEDICAL SUPPLIES**	**CMS Code**	**Unit**		
40	Pillow case, disposable	SB026		1	
41	Gown, disposable	SB037		1	
42	Table Paper, 7 feet	SB036		1	
43					
44	**Equipment**	**CMS Code**			
45	Densitometry unit, whole body	ER024			
46	Densitometry unit, fan beam, DXA (with computer hardware & software)	ER019		1	20 min
47	Phantom	ER078			

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Harvard Valued- Utilization over 30,000 Screen

January 2012

Set Radiation Therapy Field

In April 2011, the RUC identified CPT code 77280 *Therapeutic radiology simulation-aided field setting; simple* as part of the Harvard Valued – Utilization over 30,000 screen and requested that this service be surveyed. At the September 2011 RUC Meeting, the specialty societies indicated that it was their understanding that 77280 had been reviewed by the RUC during the Third Five-Year Review in 2005 and should have RUC time. The RUC reviewed its past actions regarding this code and determined that although this code was reviewed during the third Five-Year Review and the value was maintained, the rationale specifically states, "the RUC believed that the current Harvard total and intra-service time of 23 minutes of physician time was more typical and maintained the current time." The RUC interpreted this rationale to indicate that the time associated with this code should remain the Harvard valued time. Therefore, the RUC did not approve the specialty society's request and recommends that the specialty society survey this code and the other codes in the family, 77285, 77290 and 77295 for the January 2012 RUC Meeting.

The specialty society reviewed the process of care associated with all the codes in this simulation family and determined that there is ambiguity on how to bill for the auto simulations performed right before the treatment. The specialty also noted that there appears that the volume for the complex procedure, 77290, is too high in relation to the intermediate code, 77285. CPT language will be added to this family to address both of these issues. Finally, a 4-dimensional code is needed to describe current physician practices in this field. Altogether there will be five therapeutic radiology simulation codes for RUC review in the CPT 2014 cycle. **The RUC recommends that CPT codes 77280, 77285, 77290 and 77295 be referred to the CPT Editorial Panel for revision and RUC review in the CPT 2014 cycle.**

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
77280	Therapeutic radiology simulation-aided field setting; simple	XXX	Refer to the CPT Editorial Panel
77285	intermediate	XXX	Refer to the CPT Editorial Panel
77290	complex	XXX	Refer to the CPT Editorial Panel
77295	3-dimensional	XXX	Refer to the CPT Editorial Panel

AMA/Specialty Society RVS Update Committee Summary of Recommendations
July 19th NPRM Screen

January 2012

Pathology Consultations-PE Only

In the CY 2012 proposed rule CMS requested a review of both the direct PE inputs and work values of CPT code 88305 in accordance with the consolidated approach to reviewing potentially misvalued codes. It was determined that a review of the work was not necessary because the most recent extensive review of the professional component was conducted by the RUC in April of 2010, and that a review of the direct PE inputs alone is appropriate.

The RUC reviewed the direct PE inputs for CPT code 88300 *Level I - Surgical pathology, gross examination only* (work RVU=0.08); CPT code 88302 *Level II - Surgical pathology, gross and microscopic examination* (work RVU=0.13); CPT code 88304 *Level III - Surgical pathology, gross and microscopic examination* (work RVU=0.22); CPT code 88305 *Level IV* - Surgical *pathology, gross and microscopic examination* (work RVU=0.75); CPT code 88307 *Level V - Surgical pathology, gross and microscopic examination* (work RVU=1.59) and CPT code 88309 *Level VI - Surgical pathology, gross and microscopic examination* (work RVU=2.80). **The PE Subcommittee carefully reviewed the supply inputs to ensure there is no overlap with the indirect expenses and made necessary adjustments. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
88300		**Level I** - Surgical pathology, gross examination only	XXX	0.08 (No Change)

88302		**Level II** - Surgical pathology, gross and microscopic examination	XXX	0.13 (No Change)
88304		**Level III** - Surgical pathology, gross and microscopic examination	XXX	0.22 (No Change)
88305		**Level IV** - Surgical pathology, gross and microscopic examination	XXX	0.75 (No Change)
88307		**Level V** - Surgical pathology, gross and microscopic examination	XXX	1.59 (No Change)
88309		**Level VI** - Surgical pathology, gross and microscopic examination	XXX	2.80 (No Change)

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

Global Period:_XXX Meeting Date: _ February 2012

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

The College of American Pathologists contacted interested specialties (American Academy of Dermatology, American Society for Gastrointestinal Endoscopy, American Gastroenterological Association, and the American Urological Association) for their recommendations and comments regarding the direct practice inputs for codes 88300 – 88309. A conference call was convened and the practice expense recommendations were reviewed and agreed upon by all specialties.

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

No good comparison code is available; the entire family of services is under review.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities - where applicable.
Order, fill, label, restock and distribute specimen containers.

Intra-Service Clinical Labor Activities:
Accession specimen in lab computer system including the following: Unwrap and/or remove specimen bottle and requisition slip from plastic bag. Check demographics to ensure they are correct and to ensure proper billing. Check requisition slip against bottle to see if the patient's name and/or specimen location (s) match each other.
Distribute requisition form and specimen to grossing station.
Prepare tissue cassettes. When appropriate, photograph gross specimen, download file into lab computer system (88307-9 only)
Obtain and display applicable specimen radiographs.
Assist pathologist with gross specimen examination, cleaning grossing area between specimens.
Load solutions into tissue processor. Load and sort cassettes into tissue processor includes drain cassette basket, place basket in processor, put lid on basket, close lid, set processor. Confirm settings. Take requisitions to administrative staff.
Confirm specimen ID. Embed tissue in paraffin includes: Review applicable gross information (number of fragments, orientation, size) Take cassette out of embedding chamber, open cassette, put paraffin in bottom of embedding mold, embed tissue, put cassette on top of mold and fill mold with paraffin. Put mold on cold plate. Take

embedded specimen out of mold, transfer to cutting cold plate. Add paraffin to embedding melting pot and clean embedding center.
Retrieve paraffin block from freezer and place on ice tray at microtome. Place paraffin block in microtome. Change and insert knife. Rough-cut block. Place block on ice. Retrieve block and section. Place section on water bath. Confirm specimen ID. Label microscopic slides with slide labeler and place section on microscopic slide from water bath. Put on drain tray. Put in staining basket and put staining basket in oven. Remove from oven, set clock for cool time, and put handle on basket.

Prepare automated stainer with solutions and load microscopic slides. Set and confirm stainer program.
Prepare automated coverslipper, remove slides from stainer and place on coverslipper Complete workload recording logs. Collate slides and paperwork. Deliver to pathologist.
Clean grossing station; includes Load dirty cutting board, knives, forceps, etc. (instrument pack) in dishwasher, clean counter, clean sink, dispose of and package trash, restock, set up gross area for next day. Pack specimens for short term storage prior to disposal.

Post-Service Clinical Labor Activities: where applicable.
Thoroughly clean all of the equipment, tissue processor, and embedding and staining areas. Recycle the xylene and dispose of chemicals, specific specimens after designated period and the case is signed out. File the blocks, slides and requisitions.

	A	B	C	D	E	F	G	H	I
1	**88300 - 88309 Direct Practice Expense Recommendation**			**88300**	**88302**	**88304**	**88305**	**88307**	**88309**
2	**Meeting Date: January 2012** **Specialty: Pathology, Dermatology, Urology, Gastroenterology** **TAB 24 - REVISED**	**CMS**	**Staff**	Level I - Surgical pathology, gross examination only	Level II - Surgical pathology, gross and microscopic examination Appendix, incidental…	Level III - Surgical pathology, gross and microscopic examination …	Level IV - Surgical pathology, gross and microscopic examination …	Level V - Surgical pathology, gross and microscopic examination …	Level VI - Surgical pathology, gross and microscopic examination …
3	**LOCATION**	**Code**	**Type**	Non Facility	Non Facility	Non Facility	Non Facility	Non Facility	Non Facility
6									
7	**GLOBAL PERIOD**								
8	**TOTAL CLINICAL LABOR TIME**			**13.00**	**23.50**	**29.50**	**29.50**	**111.00**	**139.00**
9	**TOTAL HISTOTECHNOLOGIST**	L037B	Histotech	**5.00**	**10.00**	**14.00**	**16.00**	**82.00**	**111.00**
10	**TOTAL LAB TECHNICIAN**	L033A	Lab Tech	**8.00**	**13.50**	**15.50**	**13.50**	**29.00**	**28.00**
11	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**-**	**0.50**	**0.50**	**0.50**	**1.00**	**1.00**
12	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**12.00**	**19.00**	**24.00**	**25.00**	**97.00**	**125.00**
13	**TOTAL POST-SERV CLINICAL LABOR TIME**			**1.00**	**4.00**	**5.00**	**4.00**	**13.00**	**13.00**
14	**PRE-SERVICE**		Blocks	0	1	2	2	12	18
15	**Start: When containers/requisitions prepared for physician**								
16	Order, fill, label, restock and distribute specimen containers .	L033A	Lab Tech	-	0.50	0.50	0.50	1.00	1.00
17	**End:When specimen is ready for examination by pathologist**								
18	**SERVICE PERIOD**								
19	**Start: When specimen is ready for examination by pathologist**								
20	Accession specimen in lab computer system including the following: Unwrap and/or remove specimen bottle and requisition slip from plastic bag. Check demographics to ensure they are correct and to ensure proper billing. Check requisition slip against bottle to see If patient name and/or specimen location (s) match each other. Distribute requisition form and specimen to grossing station.	L033A	Lab Tech	6	6	6	6	6	6
21	Prepare tissue cassettes	L037B	Histotech		1	1	1	2	3
22	Photograph gross specimen, download file into lab computer system (88307-9 only)	L037B	Histotech					5	5
23	Obtain and display applicable specimen radiographs.	L033A	Lab Tech					1	
24	Assist pathologist with gross specimen examination	L037B	Histotech	5	1	2	3	15	20
25	Clean grossing area between specimens	L033A	Lab Tech	1	1	1	1	2	2
26	Load solutions into tissue processor. Load and sort cassettes into tissue processor includes drain cassette basket, place basket in processor, put lid on basket, close lid, set processor. Confirm settings. Take requisitions to secretary.	L037B	Histotech		1	1	1	5	5
27	Confirm specimen ID. Embed tissue in paraffin includes: Review applicable gross information (number of fragments, orientation, size) Take cassette out of embedding chamber, open cassette, put paraffin in bottom of embedding mold, embed tissue, put cassette on top of mold and fill mold with paraffin. Put mold on cold plate. Take embedded specimen out of mold, transfer to cutting cold plate. Add paraffin to embedding melting pot and clean embedding center.	L037B	Histotech		2	2	3	15	20
28	Retrieve paraffin block from freezer and place on ice tray at microtome. Place paraffin block in microtome. Change and insert knife. Rough-cut block. Place block on ice. Retrieve block and section. Place section on water bath. Confirm specimen ID. Label microscopic slides with slide labeler and place section on microscopic slide from water bath. Put on drain tray. Put in staining basket and put staining basket in oven. Remove from oven, set clock for cool time, and put handle on basket.	L037B	Histotech		3	6	6	36	54
29	Prepare automated stainer with solutions and load microscopic slides. Set and confirm stainer program.	L037B	Histotech		1	1	1	2	2
30	Prepare automated coverslipper, remove slides from stainer and place on coverslipper	L037B	Histotech		1	1	1	2	2
31	Complete workload recording logs. Collate slides and paperwork. Deliver to pathologist.	L033A	Lab Tech		1	1	1	3	3
32	Clean grossing station includes; Load dirty cutting board, knives, forceps, etc. (instrument pack) in dishwasher, clean counter, clean sink, dispose of and package trash, restock, set up gross area for next day	L033A	Lab Tech		1	1	1	1	1
33	Pack specimens for short term storage prior to disposal	L033A	Lab Tech			1		2	2
34	Other Clinical Activity (please specify)								
35	**End: When specimen examination by pathologist is complete**								
36	**POST SERVICE - PERIOD**								
37	**Start: When specimen examination by pathologist is complete**								
38	Clean tissue processor, embedding and staining area	L033A	Lab Tech		1	1	1	5	5
39	Recycle xylene from tissue processor and stainer	L033A	Lab Tech		1	1	1	2	2
40	Dispose of remaining chemicals	L033A	Lab Tech		1	1	1	2	2
41	Discard remaining specimen after designated period following case sign out	L033A	Lab Tech	1		1		2	2
42	File blocks, slides, and requisitions	L033A	Lab Tech		1	1	1	2	2
43	**End: When specimen, chemical waste and record handling is complete**								

	A	B	C	D	E	F	G	H	I
1	**88300 - 88309 Direct Practice Expense Recommendation**			**88300**	**88302**	**88304**	**88305**	**88307**	**88309**
2	**Meeting Date: January 2012** **Specialty: Pathology, Dermatology, Urology, Gastroenterology** **TAB 24 - REVISED**	**CMS**	**Staff**	Level I - Surgical pathology, gross examination only	Level II - Surgical pathology, gross and microscopic examination Appendix, incidental…	Level III - Surgical pathology, gross and microscopic examination …	Level IV - Surgical pathology, gross and microscopic examination …	Level V - Surgical pathology, gross and microscopic examination …	Level VI - Surgical pathology, gross and microscopic examination …
3	**LOCATION**	**Code**	**Type**	Non Facility	Non Facility	Non Facility	Non Facility	Non Facility	Non Facility
44	**MEDICAL SUPPLIES**		**Unit**						
45	gloves, non-sterile, nitrile	SB023	pair	1	2	2	2	2	2
46	gown, staff, impervious	SB027	item	0.1	0.1	0.1	0.1	0.1	0.1
47	mask, surgical	SB033	item	0.1	0.1	0.1	0.1	0.1	0.1
48	biopsy sponge (Histo-Prep)	SD005	item		-	-	2		
49	blade, microtome	SF004	item		0.10	0.20	0.20	1.20	1.80
50	scalpel with blade, surgical (#10-20)	SF033	item		1	1	1	2	3
51	eye shield, non-fog	SG049	item	0.1	0.1	0.1	0.1	0.1	0.1
52	bleach	SL020	ml	10	10	10	10	10	10
53	cover slip, glass	SL030	item		1	2	6	12	18
54	specimen container 86 oz	SL034	item	1				1	
55	specimen container 163 oz	see invoices 1a #1	item						1
56	cup, biopsy-specimen non-sterile 4oz	SL035	item		1	1	1		
57	embedding cassette	SL058	item		1	2	2	12	18
58	embedding mold	SL060	item		1	2	2	12	18
59	embedding paraffin	SL061	kg		0.008	0.016	0.005	0.096	0.144
60	eosin solution	SL063	ml		4.00	8	8	48	72
61	fixative (for tissue specimen)	SL068	ml		50	100	50	500	750
62	fixative processing (buffered formalin)	SL070	ml		14	28	28	170	252
63	histology freezing spray (Freeze-It)	SL078	oz		0.10	0.10	0.20	0.20	0.20
64	label for microscope slides	SL085	item		1	2	6	12	18
65	mold release agent, liquid	SL093	ml		0.10	0.20	0.20	1.20	1.80
66	mounting media (Histomount)	SL095	ml		1	1	2	4	6
67	slide, microscope	SL122	item		1	2	6	12	18
68	stain, hematoxylin	SL135	ml		16	32	32	192	288
69	xylenes solvent	SL151	ml		30	60	60	360	540
70	formaldehyde spill control	SM017	grams		5	10	5	15	15
71	wipes, lens cleaning (per wipe) (Kimwipe)	SM027	item		1	1	2	15	20
72									
73	specimen, solvent, and formalin disposal cost	see invoices 2a/ cost calc/ specimen disp. Invoices	dollars	-	-	-	-	-	-
74	marking dyes	see invoices 1a #4	ml				3	5	3
75	acetic acid 5%	SH001	ml			2	1	5	3
76	paraffin repel	see invoices 1a #5	ml		1	1	1	2	2
77									
78	clarifier	see invoices 1a #7	ml		2	4	4	24	36
79	Q-tips	see invoices 1a #8	item				3	3	1
80	towel, paper (Bounty) (per sheet)	SK082	item	2	2	2	2	8	10
81	gauze, non-sterile 4in x 4in	SG051	item		2	4	4	8	10
82	Courier transportation costs	see invoices 2a/ cost calc	dollars	-	-	-	-	-	-
83	100% alcohol	SL189	ml		30	60	60	360	540
84	95% alcohol	SL248	ml		18	36	36	216	324
85	70% alcohol	SL190	ml		4	8	8	48	72
86	**Equipment**								
87	balance, scale	EP005	minutes			1		2	3
88	grossing station w-heavy duty disposal	EP015	minutes	6	2	5	2	16	30
89	microscope, compound	EP024	minutes		5	10	20	24	60
90	paraffin dispenser (two-gallon)	EP032	minutes		1	2	2	12	18
91	slide coverslipper, robotic	EP033	minutes		1	2	6	12	18
92	tissue embedding center	EP039	minutes		1	2	2	12	18
93	water bath, general purpose (lab)	EP043	minutes		3	6	6	36	54
94	instrument pack, basic ($500-$1499)	EQ137	minutes		5	10	10	40	50
95	equipment maintance cost	see invoices 2a/ invoice #9	dollars	-	-	-	-	-	-
96	microtome	ER041	minutes		3	6	6	36	54
97	slide dryer	EP034	minutes		1	1	1	1	1
98	slide stainer, automated high-volume throughput	EP036	minutes		2	4	12	24	36
99	tissue processor	EP040	minutes		5	10	10	234	351
100	solvent recycling system	EP038	minutes		2	4	4	24	36
101	Freezer	see invoice #10	minutes		1	1	1	2	2
102	automated cassette labeler	see invoice #11	minutes		1	1	1	2	2
103	camera, digital system, 12 megapixel (medical grade)	ED005	minutes					5	5
104	hood, fume	EP017	minutes		1	1	1	2	2
105	Copath System with maintenance contract	see invoices #12-14/LabInfoSys	minutes	-	-	-	-	-	-
106	Copath software	see invoices #12-14/LabInfoSys	minutes	-	-	-	-	-	-
107	loupes, standard, up to 3.5x	EQ176	minutes				1		
108	slide labeler	see invoices 2a	minutes		1	1	1	5	5

	A	B	C	D	E	F	G	H	I
1	**88300 - 88309 Direct Practice Expense Recommendation**			**88300**	**88302**	**88304**	**88305**	**88307**	**88309**
2	**Meeting Date: January 2012** **Specialty: Pathology, Dermatology, Urology, Gastroenterology** **TAB 24 - REVISED**	**CMS**	**Staff**	Level I - Surgical pathology, gross examination only	Level II - Surgical pathology, gross and microscopic examination Appendix, incidental…	Level III - Surgical pathology, gross and microscopic examination …	Level IV - Surgical pathology, gross and microscopic examination …	Level V - Surgical pathology, gross and microscopic examination …	Level VI - Surgical pathology, gross and microscopic examination …
3	**LOCATION**	**Code**	**Type**	Non Facility	Non Facility	Non Facility	Non Facility	Non Facility	Non Facility
6									
7	**GLOBAL PERIOD**								
8	**TOTAL CLINICAL LABOR TIME**			**13.00**	**23.50**	**29.50**	**29.50**	**111.00**	**139.00**
9	**TOTAL HISTOTECHNOLOGIST**	L037B	Histotech	**5.00**	**10.00**	**14.00**	**16.00**	**82.00**	**111.00**
10	**TOTAL LAB TECHNICIAN**	L033A	Lab Tech	**8.00**	**13.50**	**15.50**	**13.50**	**29.00**	**28.00**
11	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**-**	**0.50**	**0.50**	**0.50**	**1.00**	**1.00**
12	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**12.00**	**19.00**	**24.00**	**25.00**	**97.00**	**125.00**
13	**TOTAL POST-SERV CLINICAL LABOR TIME**			**1.00**	**4.00**	**5.00**	**4.00**	**13.00**	**13.00**
14	**PRE-SERVICE**		Blocks	0	1	2	2	12	18
15	**Start: When containers/requisitions prepared for physician**								
16	Order, fill, label, restock and distribute specimen containers .	L033A	Lab Tech	-	0.50	0.50	0.50	1.00	1.00
17	**End:When specimen is ready for examination by pathologist**								
18	**SERVICE PERIOD**								
19	**Start: When specimen is ready for examination by pathologist**								
20	Accession specimen in lab computer system including the following: Unwrap and/or remove specimen bottle and requisition slip from plastic bag. Check demographics to ensure they are correct and to ensure proper billing. Check requisition slip against bottle to see If patient name and/or specimen location (s) match each other. Distribute requisition form and specimen to grossing station.	L033A	Lab Tech	6	6	6	6	6	6
21	Prepare tissue cassettes	L037B	Histotech		1	1	1	2	3
22	Photograph gross specimen, download file into lab computer system (88307-9 only)	L037B	Histotech					5	5
23	Obtain and display applicable specimen radiographs.	L033A	Lab Tech					1	
24	Assist pathologist with gross specimen examination	L037B	Histotech	5	1	2	3	15	20
25	Clean grossing area between specimens	L033A	Lab Tech	1	1	1	1	2	2
26	Load solutions into tissue processor. Load and sort cassettes into tissue processor includes drain cassette basket, place basket in processor, put lid on basket, close lid, set processor. Confirm settings. Take requisitions to secretary.	L037B	Histotech		1	1	1	5	5
27	Confirm specimen ID. Embed tissue in paraffin includes: Review applicable gross information (number of fragments, orientation, size) Take cassette out of embedding chamber, open cassette, put paraffin in bottom of embedding mold, embed tissue, put cassette on top of mold and fill mold with paraffin. Put mold on cold plate. Take embedded specimen out of mold, transfer to cutting cold plate. Add paraffin to embedding melting pot and clean embedding center.	L037B	Histotech		2	2	3	15	20
28	Retrieve paraffin block from freezer and place on ice tray at microtome. Place paraffin block in microtome. Change and insert knife. Rough-cut block. Place block on ice. Retrieve block and section. Place section on water bath. Confirm specimen ID. Label microscopic slides with slide labeler and place section on microscopic slide from water bath. Put on drain tray. Put in staining basket and put staining basket in oven. Remove from oven, set clock for cool time, and put handle on basket.	L037B	Histotech		3	6	6	36	54
29	Prepare automated stainer with solutions and load microscopic slides. Set and confirm stainer program.	L037B	Histotech		1	1	1	2	2
30	Prepare automated coverslipper, remove slides from stainer and place on coverslipper	L037B	Histotech		1	1	1	2	2
31	Complete workload recording logs. Collate slides and paperwork. Deliver to pathologist.	L033A	Lab Tech		1	1	1	3	3
32	Clean grossing station includes; Load dirty cutting board, knives, forceps, etc. (instrument pack) in dishwasher, clean counter, clean sink, dispose of and package trash, restock, set up gross area for next day	L033A	Lab Tech		1	1	1	1	1
33	Pack specimens for short term storage prior to disposal	L033A	Lab Tech			1		2	2
34	Other Clinical Activity (please specify)								
35	**End: When specimen examination by pathologist is complete**								
36	**POST SERVICE - PERIOD**								
37	**Start: When specimen examination by pathologist is complete**								
38	Clean tissue processor, embedding and staining area	L033A	Lab Tech		1	1	1	5	5
39	Recycle xylene from tissue processor and stainer	L033A	Lab Tech		1	1	1	2	2
40	Dispose of remaining chemicals	L033A	Lab Tech		1	1	1	2	2
41	Discard remaining specimen after designated period following case sign out	L033A	Lab Tech	1		1		2	2
42	File blocks, slides, and requisitions	L033A	Lab Tech		1	1	1	2	2
43	**End: When specimen, chemical waste and record handling is complete**								

	A	B	C	D	E	F	G	H	I
1	**88300 - 88309 Direct Practice Expense Recommendation**			**88300**	**88302**	**88304**	**88305**	**88307**	**88309**
2	**Meeting Date: January 2012** **Specialty: Pathology, Dermatology, Urology, Gastroenterology** **TAB 24 - REVISED**	**CMS**	**Staff**	Level I - Surgical pathology, gross examination only	Level II - Surgical pathology, gross and microscopic examination Appendix, incidental…	Level III - Surgical pathology, gross and microscopic examination …	Level IV - Surgical pathology, gross and microscopic examination …	Level V - Surgical pathology, gross and microscopic examination …	Level VI - Surgical pathology, gross and microscopic examination …
3	**LOCATION**	**Code**	**Type**	Non Facility	Non Facility	Non Facility	Non Facility	Non Facility	Non Facility
44	**MEDICAL SUPPLIES**		**Unit**						
45	gloves, non-sterile, nitrile	SB023	pair	1	2	2	2	2	2
46	gown, staff, impervious	SB027	item	0.1	0.1	0.1	0.1	0.1	0.1
47	mask, surgical	SB033	item	0.1	0.1	0.1	0.1	0.1	0.1
48	biopsy sponge (Histo-Prep)	SD005	item		-	-	2		
49	blade, microtome	SF004	item		0.10	0.20	0.20	1.20	1.80
50	scalpel with blade, surgical (#10-20)	SF033	item		1	1	1	2	3
51	eye shield, non-fog	SG049	item	0.1	0.1	0.1	0.1	0.1	0.1
52	bleach	SL020	ml	10	10	10	10	10	10
53	cover slip, glass	SL030	item		1	2	6	12	18
54	specimen container 86 oz	SL034	item	1				1	
55	specimen container 163 oz	see invoices 1a #1	item						1
56	cup, biopsy-specimen non-sterile 4oz	SL035	item		1	1	1		
57	embedding cassette	SL058	item		1	2	2	12	18
58	embedding mold	SL060	item		1	2	2	12	18
59	embedding paraffin	SL061	kg		0.008	0.016	0.005	0.096	0.144
60	eosin solution	SL063	ml		4.00	8	8	48	72
61	fixative (for tissue specimen)	SL068	ml		50	100	50	500	750
62	fixative processing (buffered formalin)	SL070	ml		14	28	28	170	252
63	histology freezing spray (Freeze-It)	SL078	oz		0.10	0.10	0.20	0.20	0.20
64	label for microscope slides	SL085	item		1	2	6	12	18
65	mold release agent, liquid	SL093	ml		0.10	0.20	0.20	1.20	1.80
66	mounting media (Histomount)	SL095	ml		1	1	2	4	6
67	slide, microscope	SL122	item		1	2	6	12	18
68	stain, hematoxylin	SL135	ml		16	32	32	192	288
69	xylenes solvent	SL151	ml		30	60	60	360	540
70	formaldehyde spill control	SM017	grams		5	10	5	15	15
71	wipes, lens cleaning (per wipe) (Kimwipe)	SM027	item		1	1	2	15	20
72									
73	specimen, solvent, and formalin disposal cost	see invoices 2a/ cost calc/ specimen disp. Invoices	dollars		0.18	0.35	0.35	1.85	1.85
74	marking dyes	see invoices 1a #4	ml				3	5	3
75	acetic acid 5%	SH001	ml			2	1	5	3
76	paraffin repel	see invoices 1a #5	ml		1	1	1	2	2
77									
78	clarifier	see invoices 1a #7	ml		2	4	4	24	36
79	Q-tips	see invoices 1a #8	item				3	3	1
80	towel, paper (Bounty) (per sheet)	SK082	item	2	2	2	2	8	10
81	gauze, non-sterile 4in x 4in	SG051	item		2	4	4	8	10
82	Courier transportation costs	see invoices 2a/ cost calc	dollars	2.02	2.02	2.02	2.02	2.02	2.02
83	100% alcohol	SL189	ml		30	60	60	360	540
84	95% alcohol	SL248	ml		18	36	36	216	324
85	70% alcohol	SL190	ml		4	8	8	48	72
86	**Equipment**								
87	balance, scale	EP005	minutes			1		2	3
88	grossing station w-heavy duty disposal	EP015	minutes	6	2	5	2	16	30
89	microscope, compound	EP024	minutes		5	10	20	24	60
90	paraffin dispenser (two-gallon)	EP032	minutes		1	2	2	12	18
91	slide coverslipper, robotic	EP033	minutes		1	2	6	12	18
92	tissue embedding center	EP039	minutes		1	2	2	12	18
93	water bath, general purpose (lab)	EP043	minutes		3	6	6	36	54
94	instrument pack, basic ($500-$1499)	EQ137	minutes		5	10	10	40	50
95	equipment maintance cost	see invoices 2a/ invoice #9	dollars		0.61	0.61	0.61	0.61	0.61
96	microtome	ER041	minutes		3	6	6	36	54
97	slide dryer	EP034	minutes		1	1	1	1	1
98	slide stainer, automated high-volume throughput	EP036	minutes		2	4	12	24	36
99	tissue processor	EP040	minutes		5	10	10	234	351
100	solvent recycling system	EP038	minutes		2	4	4	24	36
101	Freezer	see invoice #10	minutes		1	1	1	2	2
102	automated cassette labeler	see invoice #11	minutes		1	1	1	2	2
103	camera, digital system, 12 megapixel (medical grade)	ED005	minutes					5	5
104	hood, fume	EP017	minutes		1	1	1	2	2
105	Copath System with maintenance contract	see invoices #12-14/LabInfoSys	minutes	3	3	5	4	10	12
106	Copath software	see invoices #12-14/LabInfoSys	minutes	3	3	5	4	10	12
107	loupes, standard, up to 3.5x	EQ176	minutes				1		
108	slide labeler	see invoices 2a	minutes		1	1	1	5	5

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Harvard Valued-Utilization over 30,000 and
CMS High Expenditure Procedural Codes

January 2012

Fluorescein Angiography

In April 2011, CPT code 92235 *Fluorescein angiography (includes multiframe imaging) with interpretation and report* was identified through the Harvard Valued-Utilization over 30,000 screen and recently through the CMS High Expenditure Procedural Codes screen.

The RUC reviewed the survey results from 104 ophthalmologists and determined that the physician work had not changed. The RUC recommends the work RVU of 0.81 should be maintained. The RUC noted that currently, this service has a total time of 28 minutes Harvard time. It was surveyed in 2005, for the Third Five-Year Review, which yielded the same result of 15 minutes intra-service time, however the Harvard time was maintained. The RUC determined that the specialty society recommendation pre-service time of 3 minutes, intra-service time of 15 minutes and post-time of 5 minutes appropriately accounts for the physician time required to this service. The specialty society confirmed and the RUC agreed that the 3 minutes of pre-service time is not duplicative with what may occur with an Evaluation and Management service. The pre-evaluation time accounts for the physician informing the patient and reviewing the risks of anaphylactic shock each time this service is performed. Additionally, the specialty society recommended and the RUC agreed that the immediate post-service time should be reduced from 10 minutes to 5 minutes to remove any duplication of time already accounted for in the Evaluation and Management service.

The RUC compared 92235 to key reference service 92240 *Indocyanine-green angiography (includes multiframe imaging) with interpretation and report* (work RVU=1.10) and determined that the surveyed service required less physician work, time, technical skill and physical effort than 92240. The RUC compared 92235 to similar services CPT code 99213 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 0.97 and 15 minutes intra-service time), 76816 *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* (work RVU = 0.85 and 15 minutes intra-service time) and MPC code 76700 *Ultrasound, abdominal, real time with image documentation; complete* (work RVU = 0.81 and 10 minutes intra-service time) and determined that these services required similar physician work and time to perform. **The RUC recommends a work RVU of 0.81 for CPT code 92235.**

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
92235	Fluorescein angiography (includes multiframe imaging) with interpretation and report	XXX	0.81 (No Change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:92235 Tracking Number

Original Specialty Recommended RVU: **0.81**
Presented Recommended RVU: **0.81**
RUC Recommended RVU: **0.81**

Global Period: XXX

CPT Descriptor: Fluorescein angiography (includes multiframe imaging) with interpretation and report

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 82 year old woman with age related macular degeneration noted blurred vision and on examination was found to have a hemorrhage in the macula. Fluorescein angiography is ordered to determine the cause.95

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

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

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

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The indications, risks and benefits of the angiography are explained to the patient and family.

Description of Intra-Service Work: The fluorescein angiogram is interpreted and diagnosis is determined. Angiographic findings are compared with previous studies and other diagnostic modalities to determine disease progression. The angiographic findings are reviewed and discussed with the patient.

Description of Post-Service Work: Representative images are chosen for archiving for future comparison. The report is prepared and dictated. Referring physicians are informed of the outcome.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012					
Presenter(s):	Stephen A. Kamenetzky, M.D. and Cameron Javid, M.D.					
Specialty(s):	ophthalmology/retina					
CPT Code:	92235					
Sample Size:	600	**Resp N:**	104	**Response:** 17.3 %		
Sample Type:	Random **Additional Sample Information:** Random sample of members from the AAO who indicate an interest in retina and ASRS were pooled.					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	20.00	176.00	**300.00**	550.00	650.00
Survey RVW:	0.85	1.10	**1.10**	1.20	4.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	2.00	10.00	**15.00**	20.00	90.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	92235	**Recommended Physician Work RVU: 0.81**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**3.00**	**0.00**	**3.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
92240	XXX	1.10	**RUC Time**

CPT Descriptor Indocyanine-green angiography (includes multiframe imaging) with interpretation and report

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
20551	000	0.75	**RUC Time**	156,000

CPT Descriptor 1 Injection(s); single tendon origin/insertion

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
76816	XXX	0.85	**RUC Time**	14,000

CPT Descriptor 2 Ultrasound, pregnant uterus, real time with image documentation, follow-up (

Other Reference CPT Code	Global	Work RVU	Time Source
76700	XXX	0.81	**RUC Time**

CPT Descriptor Ultrasound, abdominal, real time with image documentation; complete

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 97 **% of respondents:** 93.2 **%**

TIME ESTIMATES (Median)	**CPT Code: 92235**	**Key Reference CPT Code:** 92240	**Source of Time RUC Time**
Median Pre-Service Time	3.00	30.00	
Median Intra-Service Time	15.00	30.00	
Median Immediate Post-service Time	5.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**23.00**	**80.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.42	4.32
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.13	4.15
Urgency of medical decision making	4.41	4.35
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.22	4.23
Physical effort required	3.41	3.43
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.00	3.90
Outcome depends on the skill and judgment of physician	4.41	4.39
Estimated risk of malpractice suit with poor outcome	3.91	3.91

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.50	3.60
Intra-Service intensity/complexity	3.96	4.10
Post-Service intensity/complexity	4.00	4.00

Additional Rationale and Comments

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

CPT 92235, *Fluorescein angiography (includes multiframe imaging) with interpretation and report* was chosen for review because it is on Table 7 in the 2012 NPRM which deals with high volume codes that have not been reviewed in the past five years . This code, 92235, was on a list of high-volume, non-RUC-reviewed (Harvard valued) codes although the code was reviewed during the Third Five Year Review in 2005 (08/05). The RUC rationale for the 2005 review indicates that the survey

validated the work value. It also states that the RUC "did not accept the survey results or any of the physician time data". The old Harvard time was retained without further explanation.

Fluorescein angiography (FA) is used to define the vascular structure of the retina and choroid. Dye is injected intravenously and multiple images using a camera with special filters are obtained over a 15-minute time period. These images are reviewed sequentially to examine the integrity and filling of the choroidal and retinal vascular. Microvascular anatomy can be defined in exquisite detail using this technology and information about the surrounding retina inferred.

Our survey had over 100 respondents, 95% of whom felt that the vignette was typical. The median WRVU was 1.10 with a 25th percentile of 1.10 and a 75th percentile of 1.20. Median intraservice time was 15 minutes with a total preservice time of 25 minutes and an immediate postservice time of 10 minutes. The primary reference code chosen was 92240 *Indocyanine-green angiography (includes multiframe imaging) with interpretation and report* with a WRVU of 1.10. Fluorescein angiography is typically done with an EM visit. Both codes have an XXX global period.

The AAO expert consensus panel, which included representatives from the American Society of Retinal Specialists familiar with both the RUC method and the performance of the test, reviewed the results of this survey as well as the Five Year Review from 2005. The panel agreed that the test had changed little over this time interval. That finding was confirmed by the fact that the current survey and the survey from 2005 produced virtually identical results. The median intraservice time and immediate postservice time were identical in the two surveys. The 25th percentile WRVU value was 1.08 in 2005 and 1.10 in 2011.

The panel decided that 3 minutes of preservice time should be added to account for the additional time beyond the EM visit typically accompanying the test that it takes to discuss the procedure and answer the quesitions of the patient and their family directly related to the procedure. The times recommended are 3/15/5 minutes.

The panel felt that the 25th percentile of the survey overestimated the physician work and that the current value of 0.81 is correct. There are many imaging codes and diagnostic tests with similar times that have WRVU in this range. For example, CPT 76700 Ultrasound, *abdominal, real time with image documentation; complete* (RUC 2005, MPC, 3/10/4) has a value of 0.81. CPT 76816 *Ultrasound, abdominal, real time with image documentation; complete* (RUC 2002, 6/15/10) has a WRVU of 0.85. CPT 70547 *Magnetic resonance angiography, neck; without contrast material(s)* which was reviewed in 2000 has a WRVU of 1.2 and times of 5/10/10.

The society therefore recommends that the current WRVU of 0.81 be maintained. We also recommend that times of 3/15/5 minutes be accepted.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

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

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

☐ Historical precedents.
☒ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. E/M or the ophthalmologic exam codes1.

		CPT Code	Pre-	Intra-	Post-	Total Time	Work RVU	Global Period
3.								
4.		92002	5	15	5	25	.88 XXX	
5.		92004	5	25	10	40	1.82 XXX	
6.		92012	5	15	5	25	.92	XXX
7.		92014	5	24	8	37	1.42 XXX	
8.	7.	99213	3	15	5	23	.97 XXX	

FREQUENCY INFORMATION

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

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

Specialty How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,472,186 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC db

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 92235

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

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN
3																																								
4	**ISSUE:** 92235																																							
5	**TAB:** 26																																							
6						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office					Prolonged			
7	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57
8	REF	92240	Indocyanine-green angiography (includes multiframe imaging) with interpretation and report	16	-0.001			1.10			80	30					30			20																				
9	CURRENT	92235	Fluorescein angiography (includes multiframe imaging) with interpretation and report		0.029			0.81			28						28																							
10	SVY			104	0.031			1.10			50	10	5	10	2	10	15	20	90	10																			
11	REC				0.042			0.81			23	3					15			5																			

	A	B	C	D	E	F
1	**Tab 26: REVISED**			**92235**		**92235**
2	**Meeting Date: January 2012** **Specialty: Ophthalmology**	**CMS**	**Staff**	**Fluorescein angiography (includes multiframe imaging) w/**		
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**OLD**
4	**GLOBAL PERIOD**			**xxx**	**xxx**	
5	**TOTAL CLINICAL LABOR TIME**			**62.0**	**0.0**	**67.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**2.0**	**0.0**	
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**60.0**	**0.0**	
8	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	
9	**PRE-SERVICE**					
10	**Start: Following visit when decision for surgery or procedure made**					
11	Complete pre-service diagnostic & referral forms	L038A	COMT/COT/RN CST	**2**		
12	Coordinate pre-surgery services					
13	Schedule space and equipment in facility					
14	Provide pre-service education/obtain consent					
15	Follow-up phone calls & prescriptions					
16	Other Clinical Activity (please specify)Review chart					2
17	**End: When patient enters office/facility for surgery/procedure**					
18	**SERVICE PERIOD**					
19	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**					
20	Greet patient, provide gowning, ensure appropriate medical records are available					2
21	Obtain vital signs					
22	Provide pre-service education/obtain consent	L039A	Certified retinal angiographer	**5**		5
23	Prepare room, equipment, supplies	L039A	Certified retinal angiographer	**2**		10
24	Setup scope (non facility setting only)					
25	Prepare and position patient/ monitor patient/ set up IV	L039A	Certified retinal angiographer	**2**		incl in 23
26	Sedate/apply anesthesia					
27	**Intra-service**					
28	Assist physician in performing procedure	L039A	Certified retinal angiographer	**40**		40
29	**Post-Service**					
30	Monitor pt. following service/check tubes, monitors, drains	L038A	COMT/COT/RN CST	**5**		5
31	Clean room/equipment by physician staff	L039A	Certified retinal angiographer	**3**		
32	Clean Scope					
33	Clean Surgical Instrument Package					
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	Discharge day management					
38	Other Clinical Activity (please specify)Label & archive images	L039A	Certified retinal angiographer	**3**		3
39	**End: Patient leaves office**					
40	**POST-SERVICE Period**					
41	**Start: Patient leaves office/facility**					
42	Conduct phone calls/call in prescriptions					
43	*Office visits:*					
44	*List Number and Level of Office Visits*					
45	99211 16 minutes		16			
46	99212 27 minutes		27			
47	99213 36 minutes		36			
48	99214 53 minutes		53			
49	99215 63 minutes		63			
50	99238 12 minutes		12			
51	*Total Office Visit Time*			**0**	**0**	**0**
52	Other Activity (please specify)					
53	**End: with last office visit before end of global period**				**0**	0
54	**MEDICAL SUPPLIES**		**Unit**			
55	I.V. infusion set	SC018		**1**		1
56	Gloves, sterile, pr	SB024		**1**		
57	needle 18-19g, filter	SC027		**1**		1
58	needle 19-25g, butterfly	SC030		**1**		1

	A	B	C	D	E	F
1	**Tab 26: REVISED**			**92235**		**92235**
2	**Meeting Date: January 2012** **Specialty: Ophthalmology**	**CMS**	**Staff**	**Fluorescein angiography (includes multiframe imaging) w/**		
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**OLD**
59	film, tri-X 35mm, BW (per exposure)*	SK030		**24**		24
60	paper, photo printing (8.5 x 11)*	SK058	sheet	**2**		2
61	photographic stop bath*	SK065		**8**		0.125 gal
62	syringe 5-6ml	SC057		**1**		1
63	Povidone solution (Betadine)	SJ041	ml	**10**		1
64	Fluorescein inj (5ml)	SH033		**1**		1
65	Applicator, cotton-tipped, non-sterile 6in	SG008		**2**		2
66	Bandage, strip 0.75 in x 3 in (Bandaid)	SG021		**1**		2
67	post myd spectacles	11121	pr			1
68	pad, chin rest	11110	item			1
69	swab, alcohol	31101				2
70	gloves, non-sterile	11302	pr			2
71	mylofrin 2%	53076	ml			0.1
72	mydriacil 1%	53065	ml			0.1
73	**Equipment**					
74	Camera, retinal	ED008		**60**		1
75	Table, motorized (for camera)	EF030		**60**		1
76	screening lane	EL005		**60**		
77	Exam Lane	E71109				1
78						
79						
80						
81						
82	* Denote line items that need future review as the Film to Digital Workgroup completes it considerations					

	A	B	C	D	E	F
1	**Tab 26: REVISED**			**92235**		**92235**
2	**Meeting Date: January 2012** **Specialty: Ophthalmology**	**CMS**	**Staff**	**Fluorescein angiography (includes multiframe imaging) w/**		
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**OLD**
4	**GLOBAL PERIOD**			**xxx**	**xxx**	
5	**TOTAL CLINICAL LABOR TIME**			**61.0**	**0.0**	**67.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**4.0**	**0.0**	
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**57.0**	**0.0**	
8	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	
9	**PRE-SERVICE**					
10	**Start: Following visit when decision for surgery or procedure made**					
11	Complete pre-service diagnostic & referral forms	L038A	COMT/COT/RN CST	**2**		
12		L039A	Certified retinal angiographer	**2**		
13	Coordinate pre-surgery services					
14	Schedule space and equipment in facility					
15	Provide pre-service education/obtain consent					
16	Follow-up phone calls & prescriptions					
17	Other Clinical Activity (please specify)Review chart					2
18	**End: When patient enters office/facility for surgery/procedure**					
19	**SERVICE PERIOD**					
20	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**					
21	Greet patient, provide gowning, ensure appropriate medical records are available					2
22	Obtain vital signs					
23	Provide pre-service education/obtain consent	L039A	Certified retinal angiographer	**5**		5
24	Prepare room, equipment, supplies	L039A	Certified retinal angiographer	**2**		10
25	Setup scope (non facility setting only)					
26	Prepare and position patient/ monitor patient/ set up IV	L039A	Certified retinal angiographer	**2**		incl in 23
27	Sedate/apply anesthesia					
28	**Intra-service**					
29	Assist physician in performing procedure	L039A	Certified retinal angiographer	**40**		40
30	**Post-Service**					
31	Monitor pt. following service/check tubes, monitors, drains	L038A	COMT/COT/RN CST	**2**		5
32	Clean room/equipment by physician staff	L039A	Certified retinal angiographer	**3**		
33	Clean Scope					
34	Clean Surgical Instrument Package					
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	Discharge day management					
39	Other Clinical Activity (please specify)Label & archive images	L039A	Certified retinal angiographer	**3**		3
40	**End: Patient leaves office**					
41	**POST-SERVICE Period**					
42	**Start: Patient leaves office/facility**					
43	Conduct phone calls/call in prescriptions					
44	*Office visits:*					
45	*List Number and Level of Office Visits*					
46	99211 16 minutes		16			
47	99212 27 minutes		27			
48	99213 36 minutes		36			
49	99214 53 minutes		53			
50	99215 63 minutes		63			
51	99238 12 minutes		12			
52	*Total Office Visit Time*			**0**	**0**	**0**
53	Other Activity (please specify)					
54	**End: with last office visit before end of global period**				**0**	0
55	**MEDICAL SUPPLIES**		**Unit**			
56	I.V. infusion set	SC018		**1**		1
57	Gloves, sterile, pr	SB024		**1**		

	A	B	C	D	E	F
1	**Tab 26: REVISED**			**92235**		**92235**
2	**Meeting Date: January 2012** **Specialty: Ophthalmology**	**CMS**	**Staff**	**Fluorescein angiography (includes multiframe imaging) w/**		
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**OLD**
58	needle 18-19g, filter	SC027		**1**		1
59	needle 19-25g, butterfly	SC030		**1**		1
60	film, tri-X 35mm, BW (per exposure)*	SK030		**24**		24
61	paper, photo printing (8.5 x 11)*	SK058	sheet	**2**		2
62	photographic stop bath*	SK065		**8**		0.125 gal
63	syringe 5-6ml	SC057		**1**		1
64	Povidone solution (Betadine)	SJ041	ml	**10**		1
65	Fluorescein inj (5ml)	SH033		**1**		1
66	Applicator, cotton-tipped, non-sterile 6in	SG008		**2**		2
67	Bandage, strip 0.75 in x 3 in (Bandaid)	SG021		**1**		2
68	post myd spectacles	11121	pr			1
69	pad, chin rest	11110	item			1
70	swab, alcohol	31101				2
71	gloves, non-sterile	11302	pr			2
72	mylofrin 2%	53076	ml			0.1
73	mydriacil 1%	53065	ml			0.1
74	**Equipment**					
75	Camera, retinal	ED008		**60**		1
76	Table, motorized (for camera)	EF030		**60**		1
77	screening lane	EL005		**60**		
78	Exam Lane	E71109				1
79						
80						
81						
82						
83	* Denote line items that need future review as the Film to Digital Workgroup completes it considerations					

AMA/Specialty Society RVS Update Committee Summary of Recommendations
High Volume Growth / CMS Fastest Growing

January 2012

Laser Treatment

In 2002, three CPT codes were created to describe and report laser treatment for inflammatory skin diseases: 96920 *Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm,* 96921 *Laser treatment for inflammatory skin disease (psoriasis); total area 250 sq cm to 500 sq cm* and 96922 *Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm.* In February 2008, these codes were identified by the High Volume Growth and CMS Fastest growing screens. At that time the RUC recommended that these services be assessed again in two years. In October, 2011, the RAW re-reviewed these codes and recommended that the specialty society resurvey for work and practice expense for January 2012.

The RUC considered the typical patient who presents with chronic plaque psorasis over 3-8% of their body and requires 6-8 treatments every 5-7 days. This treatment is typical performed once a year and is not reported with an Evaluation and Management code. Additionally the specialty societies indicated, and the RUC agreed that handheld UVB devices are never used for this procedure.

96920
The RUC reviewed the survey results from 49 dermatologists for CPT code 96920 and recommends to maintain the current work RVU of 1.15. The RUC compared 96920 to key reference service 11303 *Shaving of epidermal or dermal lesion, single lesion trunk, arms or legs; lesion diameter over 2.0 cm* (work RVU = 1.24) and noted that these services require similar intra-service time, 23 minutes for 96920 and 20 minutes for 11303, but 11303 is a more intense procedure and should be valued higher. In addition, the RUC reviewed CPT code 12002 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm* (work RVU=1.14) and noted that although the more total time compared to the reference code, 35 minutes and 27 minutes, respectively, the services should be valued similarly because the intensity is greater for 12002. Therefore, maintaining the current value of 1.15 for CPT code 96920 appropriately accounts for the physician work required to perform this service relative to the reference services. **The RUC recommends a work RVU of 1.15 for CPT code 96920.**

96921
The RUC reviewed the survey results from 49 dermatologists for CPT code 96921 and recommends to increase the current work RVU from 1.15 to 1.30 which is both the survey 25th percentile and median. The specialty society presented compelling evidence and the RUC agreed that there was a significant change in physician work since the code was first surveyed. In 2002, the typical patient was 35 years old compared to 65 years old today, the introduction of new technology has increased the complexity of decision making during the physician work. Specifically, the

physician is treating sensitive skin areas and must adjust laser fluence throughout the session to avoid risk of burning/blistering skin. The RUC compared 96921 to key reference service 11303 *Shaving of epidermal or dermal lesion, single lesion trunk, arms or legs; lesion diameter over 2.0 cm* (work RVU = 1.24) and determined that 96921 required more intensity and time and should be valued higher. In addition, the RUC reviewed CPT code 91022 *Duodenal motility (manometric) study* (work RVU=1.44) and noted that these services require the same intra service time of 30 minutes; however, total time for 91022 (61 minutes) is higher compared to total time for 96921 (42 minutes) and should be valued higher. The RUC also reviewed CPT code 90935 *Hemodialysis procedure with single physician evaluation* (work RVU=1.48) and noted that the intra service time for these services is similar, 30 minutes for 96921 and 25 minutes for 90935, but total time is higher for 90935 (45 minutes) compared to 96921 (42 minutes) and 90935 is a more complex procedure and should be valued higher. **The RUC recommends a work RVU of 1.30 for CPT code 96921.**

96922

The RUC reviewed the survey results from 50 dermatologists for CPT code 96922 and recommends to maintain the current work RVU of 2.10, which was also the survey 25th percentile work RVU. This is the most complex patient in this family of services, with multiple lesion sites. The RUC compared 96922 to 12015 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm* (work RVU=1.98) 12006 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 20.1 cm to 30.0 cm* (work RVU=2.39) and determined that these services were similar with regards to physician work, time, intensity and complexity. Therefore, maintaining the current value of 2.10 for CPT code 96922 appropriately accounts for the physician work required to perform this service relative to the key reference service. **The RUC recommends a work RVU of 2.10 for CPT 96922.**

Practice Expense:

The RUC approved the practice expense inputs as modified and submitted by the Practice Expense Subcommittee.

CPT Code (●New)	CPT Descriptor	Global Period	Work RVU Recommendation
96920	Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm	000	1.15 (No Change)
96921	250 sq cm to 500 sq cm	000	1.30

96922	over 500 sq cm	000	2.10 (No Change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:96920 Tracking Number Original Specialty Recommended RVU: **1.15**
Presented Recommended RVU: **1.15**
Global Period: 000 RUC Recommended RVU: **1.15**

CPT Descriptor: Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is a 65 year-old Caucasian male with a history of moderate plaque psoriasis. In spite of multi-drug topical therapy, the patient has still less than 250 sq cm of chronic plaques on the elbows, knees, sacrum, and hips resistant to topical therapy. The severity of the disease is documented and the decision is made to utilize laser treatment for recurrent and recalcitrant psoriatic plaques.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 100%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

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. Pain or blistering from previous therapy or treatment is also discussed with the patient to ensure the physician can properly adjust for treatment of lesions of newly healed skin, where blisters are no longer present. He verifies positioning of patient and checks laser equipment.

Description of Intra-Service Work: The lesion site(s) are identified and confirmed, the areas are prepped with a clarifying agent such as mineral oil or other moisturizing agent. Each sequential lesion to be treated is assessed by the physician for thickness, redness, scale and shape. The physician also assesses for prior treatment complications including redness, scale crust and residual blistering of each of the lesions. Treatment fluence is selected for each part of each individual plaque, depending on the thickness of that part of the plaque and its response to previous treatment(s). The physician evaluates and examines then sequentially treats each individual plaque section of all plaques with the laser, (as needed) adjusting spot size and treating each targeted area with various fluences, again depending on the individual plaque(s) thickness and previous treatment response(s). Often, individual plaque(s) are treated with different fluences within the plaque itself depending on the degree of clearance and/or the blistering/scabbing that has occurred in individual plaques. Calculations and adjustments to the laser strength are sequentially determined and treatment continues, being careful to avoid overlapping by checking sequential positioning of the instrument, and modifying joules delivered. If there is overlap or more than 1 pass is planned, appropriate blocking templates are used to avoid treating uninvolved areas and to deal with geometric lesion configurations which would preclude overlap avoidance . The physician monitors for pain as well as skin surface reaction throughout the process. This is repeated and modified for each subsequent lesion to be treated. At the end

of each lesion treatment the site is reassessed for adequacy of treatment and for any signs of excessive overlap which might need post treatment therapy such as topical cortisone cream.

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

RUC Meeting Date (mm/yyyy)	01/2012					
Presenter(s):	Lawrence Green, MD; Mark Kaufman, MD; Brett Coldiron, MD; Fitzgeraldo Sanchez, MD					
Specialty(s):	Dermatology					
CPT Code:	96920					
Sample Size:	80	**Resp N:**	49	**Response:** 61.2 %		
Sample Type:	Panel	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	10.00	80.50	**225.00**	500.00	1000.00
Survey RVW:	1.00	1.24	**1.25**	1.38	1.80
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**2.00**		
Pre-Service Scrub, Dress, Wait Time:			**2.00**		
Intra-Service Time:	3.00	20.00	**23.00**	25.00	36.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	96920	**Recommended Physician Work RVU: 1.15**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**7.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**23.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
11303	000	1.20	**RUC Time**

CPT Descriptor Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11755	000	1.31	**RUC Time**	27,209

CPT Descriptor 1 Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
56605	000	1.10	**RUC Time**	27,933

CPT Descriptor 2 Biopsy of vulva or perineum (separate procedure); 1 lesion

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 23 **% of respondents:** 46.9 **%**

TIME ESTIMATES (Median)	**CPT Code: 96920**	**Key Reference CPT Code:** 11303	**Source of Time RUC Time**
Median Pre-Service Time	7.00	10.00	
Median Intra-Service Time	23.00	20.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**35.00**	**35.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.16	2.41
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.00	2.27
Urgency of medical decision making	1.77	1.75
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.54	2.39
Physical effort required	3.02	2.43
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	1.97	1.95
Outcome depends on the skill and judgment of physician	2.64	2.02
Estimated risk of malpractice suit with poor outcome	2.06	2.52

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	1.70	1.62
Intra-Service intensity/complexity	2.52	2.41
Post-Service intensity/complexity	1.60	1.56

Additional Rationale and Comments

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

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 96920

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

Specialty Dermatology How often? Commonly

Specialty Physician Assistants How often? Rarely

Specialty Nurse Practitioners How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 85826
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Dermatology Frequency 80476 Percentage 93.76 %

Specialty Physician Assistant Frequency 4500 Percentage 5.24 %

Specialty Nurse Practitioner Frequency 850 Percentage 0.99 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 46,873 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare Claims Data in RUC Data Base

Specialty Dermatology Frequency 43021 Percentage 91.78 %

Specialty Physician Assistants Frequency 2047 Percentage 4.77 %

Specialty Nurse Practitioners Frequency 454 Percentage 1.05 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 96920

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:96921 Tracking Number Original Specialty Recommended RVU: **1.30**
Presented Recommended RVU: **1.30**
Global Period: 000 RUC Recommended RVU: **1.30**

CPT Descriptor: Laser treatment for inflammatory skin disease, (psoriasis); between 250 sq cm to 500 sq cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is a 65 year-old Caucasian male with a history of moderate plaque psoriasis. In spite of multi-drug topical therapy, the patient has between 250 sq cm to 500 sq cm of chronic plaques on the elbows, knees, sacrum, and hips resistant to topical therapy. The severity of the disease is documented and the decision is made to utilize laser treatment for recurrent and recalcitrant psoriatic plaques.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 100%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The physician reviews treatment options including systemic therapy, phototherapy, additional topical therapy and laser treatment. Pain or blistering from previous therapy or treatment is also discussed with the patient to ensure the physician can properly adjust for treatment of lesions of newly healed skin, where blisters are no longer present.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 lesion site(s) are identified and confirmed, the areas are prepped with a clarifying agent such as mineral oil or other moisturizing agent. Each sequential lesion to be treated is assessed by the physician for thickness, redness, scale and shape. The physician also assesses for prior treatment complications including redness, scale crust and residual blistering of each of the lesions. Treatment fluence is selected for each part of each individual plaque, depending on the thickness of that part of the plaque and its response to previous treatment(s). The physician evaluates and examines then sequentially treats each individual plaque section of all plaques with the laser, (as needed) adjusting spot size and treating each targeted area with various fluences, again depending on the individual plaque(s) thickness and previous treatment response(s). Often, individual plaque(s) are treated with different fluences within the plaque itself depending on the degree of clearance and/or the blistering/scabbing that has occurred in individual plaques. Calculations and adjustments to the laser strength are sequentially determined and treatment continues, being careful to avoid overlapping by checking sequential positioning of the instrument, and modifying joules delivered. If there is overlap or more than 1 pass is planned, appropriate blocking templates are used to avoid treating uninvolved areas and to deal with geometric lesion configurations which would preclude overlap avoidance . The physician monitors for pain as well as skin surface reaction throughout the process. This is repeated and modified for each subsequent lesion to be treated. At the end

of each lesion treatment the site is reassessed for adequacy of treatment and for any signs of excessive overlap which might need post treatment therapy such as topical cortisone cream.

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

RUC Meeting Date (mm/yyyy)	01/2012		
Presenter(s):	Lawrence Green, MD; Mark Kaufman, MD; Brett Coldiron, MD; Fitzgeraldo Sanchez, MD		
Specialty(s):	Dermatology		
CPT Code:	96921		
Sample Size:	80	**Resp N:** 49	**Response:** 61.2 %
Sample Type:	Panel	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	25.00	**117.00**	200.00	500.00
Survey RVW:	1.14	1.30	**1.30**	1.71	3.61
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**1.00**		
Pre-Service Scrub, Dress, Wait Time:			**1.00**		
Intra-Service Time:	10.00	25.00	**30.00**	37.50	60.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	96921	**Recommended Physician Work RVU: 1.30**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**7.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
11303	000	1.24	**RUC Time**

CPT Descriptor Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11755	000	1.31	**RUC Time**	27,209

CPT Descriptor 1 Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
56605	000	1.10	**RUC Time**	27,933

CPT Descriptor 2 Biopsy of vulva or perineum (separate procedure); 1 lesion

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 21 **% of respondents:** 42.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 96921**	**Key Reference CPT Code:** 11303	**Source of Time RUC Time**
Median Pre-Service Time	7.00	10.00	
Median Intra-Service Time	30.00	20.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**42.00**	**35.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.16	2.35
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.04	2.27
Urgency of medical decision making	1.79	1.83
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.56	2.47
Physical effort required	3.04	2.47
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.02	1.95
Outcome depends on the skill and judgment of physician	2.62	2.04
Estimated risk of malpractice suit with poor outcome	2.08	2.52

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	1.73	1.69
Intra-Service intensity/complexity	2.65	2.55
Post-Service intensity/complexity	1.65	1.59

Additional Rationale and Comments

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

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 96921

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

Specialty Dermatology How often? Commonly

Specialty Family Practice How often? Sometimes

Specialty Plastic & Reconstructive Surg How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 34870
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Dermatology Frequency 25849 Percentage 74.12 %

Specialty Family Practice Frequency 3103 Percentage 8.89 %

Specialty Plastic & Reconstructive Frequency 1742 Percentage 4.99 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 14,562 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare Claims Data in RUC Data Base

Specialty Dermatology Frequency 12846 Percentage 88.21 %

Specialty Family Practice Frequency 1553 Percentage 8.90 %

Specialty Plastic & Recnstructive Frequency 863 Percentage 4.94 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 96921

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:96922 Tracking Number Original Specialty Recommended RVU: **2.10**
Presented Recommended RVU: **2.10**
Global Period: 000 RUC Recommended RVU: **2.10**

CPT Descriptor: Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is a 65 year-old Caucasian male with a history of moderate plaque psoriasis. In spite of multi-drug topical therapy, the patient has more than 500 sq cm of chronic plaques on the elbows, knees, sacrum, and hips resistant to topical therapy. The severity of the disease is documented and the decision is made to utilize laser treatment for recurrent and recalcitrant psoriatic plaques.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 100%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

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. Pain or blistering from previous therapy or treatment is also discussed with the patient to ensure the physician can properly adjust for treatment of lesions of newly healed skin, where blisters are no longer present. He verifies positioning of patient and checks laser equipment.

Description of Intra-Service Work: The lesion site(s) are identified and confirmed, the areas are prepped with a clarifying agent such as mineral oil or other moisturizing agent. Each sequential lesion to be treated is assessed by the physician for thickness, redness, scale and shape. The physician also assesses for prior treatment complications including redness, scale crust and residual blistering of each of the lesions. Treatment fluence is selected for each part of each individual plaque, depending on the thickness of that part of the plaque and its response to previous treatment(s). The physician evaluates and examines then sequentially treats each individual plaque section of all plaques with the laser, (as needed) adjusting spot size and treating each targeted area with various fluences, again depending on the individual plaque(s) thickness and previous treatment response(s). Often, individual plaque(s) are treated with different fluences within the plaque itself depending on the degree of clearance and/or the blistering/scabbing that has occurred in individual plaques. Calculations and adjustments to the laser strength are sequentially determined and treatment continues, being careful to avoid overlapping by checking sequential positioning of the instrument, and modifying joules delivered. If there is overlap or more than 1 pass is planned, appropriate blocking templates are used to avoid treating uninvolved areas and to deal with geometric lesion configurations which would preclude overlap avoidance . The physician monitors for pain as well as skin surface reaction throughout the process. This is repeated and modified for each subsequent lesion to be treated. At the end

of each lesion treatment the site is reassessed for adequacy of treatment and for any signs of excessive overlap which might need post treatment therapy such as topical cortisone cream.

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

RUC Meeting Date (mm/yyyy)	01/2012		
Presenter(s):	Lawrence Green, MD; Mark Kaufman, MD; Brett Coldiron, MD; Fitzgeraldo Sanchez MD		
Specialty(s):	Dermatology		
CPT Code:	96922		
Sample Size:	80	**Resp N:** 50	**Response:** 62.5 %
Sample Type:	Panel	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	10.00	**56.50**	100.75	1100.00
Survey RVW:	1.17	2.10	**2.15**	2.25	6.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**1.00**		
Pre-Service Scrub, Dress, Wait Time:			**1.00**		
Intra-Service Time:	15.00	35.00	**45.00**	50.00	65.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	96922	**Recommended Physician Work RVU: 2.10**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**7.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
11313	000	1.62	**RUC Time**

CPT Descriptor Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52000	000	2.23	**RUC Time**	920,676

CPT Descriptor 1 Cystourethroscopy (separate procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
43235	000	2.39	**RUC Time**	408,630

CPT Descriptor 2 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
20205	000	2.35	**Harvard Time**

CPT Descriptor Biopsy, muscle; deep

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 28 **% of respondents:** 56.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 96922**	**Key Reference CPT Code:** 11313	**Source of Time** **RUC Time**
Median Pre-Service Time	7.00	10.00	
Median Intra-Service Time	45.00	24.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**57.00**	**39.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.28	2.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.04	2.34
Urgency of medical decision making	1.79	1.81
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.04	2.65
Physical effort required	3.77	2.65
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.12	2.14
Outcome depends on the skill and judgment of physician	2.71	2.16
Estimated risk of malpractice suit with poor outcome	2.10	3.06

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	1.91	1.79
Intra-Service intensity/complexity	3.14	2.69
Post-Service intensity/complexity	1.69	1.67

Additional Rationale and Comments

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

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 96922

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

Specialty Dermatology How often? Commonly

Specialty Physicians Assistant How often? Rarely

Specialty Internal Medicine How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 15910
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Dermatology Frequency 14844 Percentage 93.29 %

Specialty Physicians Assistant Frequency 476 Percentage 2.99 %

Specialty Internal Medicine Frequency 149 Percentage 0.93 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 8,904
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare Claims Data in RUC Data Base

Specialty Dermatology Frequency 8078 Percentage 90.72 %

Specialty Physician Assistant Frequency 238 Percentage 2.99 %

Specialty Internal Medicine Frequency 75 Percentage 0.94 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 96922

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

CPT Code: 96920-96921-96922
Specialty Society('s): American Academy of Dermatology

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

CPT Long Descriptor:

96920 Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm

96921 Laser treatment for inflammatory skin disease, (psoriasis); between 250 sq cm to 500 sq cm

96922 Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm

Global Period: **000** Meeting Date: **January 2012**

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

The AAD RB/RVS committee has reviewed the RUC approved PE direct inputs for these codes as well as determined from industry data that there are no significant additions or changes to these inputs. The AAD Coding & Reimbursement Task Force as well as the RUC advisors for AAD, ASDS, ACMS and SID serve on the AAD RB/RVS committee.

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

Please describe in detail the clinical activities of your staff:

Please see PE Direct input spreadsheet.

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

	A	B	C	D	E	F	G	H	I
1	**Presenters:** Lawrence Green, MD; Mark Kaufman, MD; Brett Coldiron, MD			**96920**		**96921**		**96922**	
2	**Meeting Date:** January 2012 **Specialty:** American Academy of Dermatology	**CMS**	**Staff**	**Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm**		**Laser treatment for inflammatory skin disease, (psoriasis); between 250 sq cm to 500 sq cm**		**Laser treatment for inflammatory skin disease, (psoriasis); over 500 sq cm**	
3	**LOCATION: In-Office**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**			**0**	**0**	0	0	0	0
5	**TOTAL CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**39.0**	**0.0**	**42.0**	**0.0**	**52.0**	**0.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**39.0**	**0.0**	**42.0**	**0.0**	**52.0**	**0.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
9	**PRE-SERVICE**								
10	**Start: Following visit when decision for surgery or procedure made**								
11	Complete pre-service diagnostic & referral forms								
12	Coordinate pre-surgery services								
13	Schedule space and equipment in facility								
14	Provide pre-service education/obtain consent								
15	Follow-up phone calls & prescriptions								
16	Other Clinical Activity (please specify)								
17	**End: When patient enters office/facility for surgery/procedure**								
18	**SERVICE PERIOD**								
19	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**								
20	Review Charts			0		0		0	
21	Greet patient, provide gowning, ensure appropriate medical records are available			3		3		3	
22	Obtain vital signs			3		3		3	
23	Provide pre-service education/obtain consent			3		3		3	
24	Prepare room, equipment, supplies			5		5		5	
25	Prepare and position patient/ monitor patient/ set up IV			2		2		2	
26	**Intra-service**								
27	Assist physician in performing procedure			17		20		30	
28	**Post-Service**								
29	Monitor pt. following service/check tubes, monitors, drains			1		1		1	
30	Clean room/equipment by physician staff			2		2		2	
31	Complete diagnostic forms, lab & X-ray requisitions			0		0		0	
32	Review/read X-ray, lab, and pathology reports			0		0		0	
33	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions			3		3		3	
34	**POST-SERVICE Period**								
35	**Start: Patient leaves office/facility**								
36	Conduct phone calls/call in prescriptions								
37	*Office visits:*								
38	*List Number and Level of Office Visits*			**pre**		**post**		**post**	
39	99211 16 minutes		16						
40	99212 27 minutes		27						
41	99213 36 minutes		36						
42	99214 53 minutes		53						
43	99215 63 minutes		63						
44	99238 12 minutes		12						
45	*Total Office Visit Time*			**0**	**0**	**0**	**0**	**0**	**0**
46	Other Activity (please specify)								
47	**End: with last office visit before end of global period**				**0**		0		0

	A	B	C	D	E	F	G	H	I
1	**Presenters:** Lawrence Green, MD; Mark Kaufman, MD; Brett Coldiron, MD			**96920**		**96921**		**96922**	
2	**Meeting Date:** January 2012 **Specialty:** American Academy of Dermatology	**CMS**	**Staff**	**Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm**		**Laser treatment for inflammatory skin disease, (psoriasis); between 250 sq cm to 500 sq cm**		**Laser treatment for inflammatory skin disease, (psoriasis); over 500 sq cm**	
3	**LOCATION: In-Office**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
48	**MEDICAL SUPPLIES**		**Unit**						
49	M/S Minimum Supply Package *	SA048	pack	1		1		1	
50	drape-towel, sterile 18in x 26in	SB019	item	1		2		4	
51	drape, non-sterile, sheet 40in x 60in	SB006	item	1		1		1	
52	sanitizing cloth-wipe (surface, instruments, equipment)	SM022	item	3		3		3	
53	towel, paper (Bounty) (per sheet)	SK082	item	6		6		6	
54	gown, staff, impervious	SB027	item	2		2		2	
55	gloves, sterile	SB024	pr	2		2		2	
56	eye shield, splash protection	SM016	item	2		2		2	
57	skin marking pen, sterile (Skin Skribe)	SK075	item	1		1		1	
58	cotton balls, sterile	SG082	item	6		6		6	
59	petroleum jelly	SJ038	oz	1		1		1	
60	sunscreen lotion (spf15) 4 oz	SK078	oz	1		1		1	
61	mineral oil, 3.5 oz	SJ035	ml	2		4		8	
62	tape, surgical paper 1in (Micropore)	SG079	inch	1		1		1	
63	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	2		3		4	
64	bacitracin oint (15gm uou)	SJ008	item	1		1		1	
65	alcohol, ethyl, denatured	SL006	ml	1		1		1	
66	Eucerin cream	SJ026	oz	12		12		12	
67	goggles, uv-blocking	SJ027	item	1		1		1	
68	underpad 2ft x 3ft (Chux)	SB044	item	2		2		2	
69	laser tip (single use)	SF028	item	1		1		1	
70	triamcinolone acetonide 0.1% cream	SH072	gm	1		1		1	
71	ice pack, instant	SJ029	Item	4		4		4	
72	lidocaine 4% soln, topical (Xylocaine)	SH050	ml	1		1		1	
73	drape, sterile, fenestrated 16in x 29in	SB011	item	2		2		2	
74	**Equipment**								
75	Power Table	EF031		20		23		33	
76	EXAM Light	EQ168		17		20		30	
77	Excimer Laser	EQ161		20		23		33	
78	Digital Camera Pkg - 12 megapixel medical grade	ED005		3		4		5	
79	Items included in Annual Laser Service Package - Pend Inv and review by CMS			1		1		1	

	A	B	C	D	E	F	G	H	I
1	**Presenters:** Lawrence Green, MD; Mark Kaufman, MD; Brett Coldiron, MD			**96920**		**96921**		**96922**	
2	**Meeting Date:** January 2012 **Specialty:** American Academy of Dermatology	**CMS**	**Staff**	**Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm**		**Laser treatment for inflammatory skin disease, (psoriasis); between 250 sq cm to 500 sq cm**		**Laser treatment for inflammatory skin disease, (psoriasis); over 500 sq cm**	
3	**LOCATION: In-Office**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**			**0**	**0**	0	0	0	0
5	**TOTAL CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**42.0**	**0.0**	**45.0**	**0.0**	**55.0**	**0.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**42.0**	**0.0**	**45.0**	**0.0**	**55.0**	**0.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
9	**PRE-SERVICE**								
10	**Start: Following visit when decision for surgery or procedure made**								
11	Complete pre-service diagnostic & referral forms								
12	Coordinate pre-surgery services								
13	Schedule space and equipment in facility								
14	Provide pre-service education/obtain consent								
15	Follow-up phone calls & prescriptions								
16	Other Clinical Activity (please specify)								
17	**End: When patient enters office/facility for surgery/procedure**								
18	**SERVICE PERIOD**								
19	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**								
20	Review Charts			0		0		0	
21	Greet patient, provide gowning, ensure appropriate medical records are available			3		3		3	
22	Obtain vital signs			3		3		3	
23	Provide pre-service education/obtain consent			3		3		3	
24	Prepare room, equipment, supplies			5		5		5	
25	Prepare and position patient/ monitor patient/ set up IV			2		2		2	
26	**Intra-service**								
27	Assist physician in performing procedure			17		20		30	
28	**Post-Service**								
29	Monitor pt. following service/check tubes, monitors, drains			3		3		3	
30	Clean room/equipment by physician staff			3		3		3	
31	Complete diagnostic forms, lab & X-ray requisitions			0		0		0	
32	Review/read X-ray, lab, and pathology reports			0		0		0	
33	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions			3		3		3	
34	**POST-SERVICE Period**								
35	**Start: Patient leaves office/facility**								
36	Conduct phone calls/call in prescriptions								
37	*Office visits:*								
38	*List Number and Level of Office Visits*			**pre**		**post**		**post**	
39	99211 16 minutes		16						
40	99212 27 minutes		27						
41	99213 36 minutes		36						
42	99214 53 minutes		53						
43	99215 63 minutes		63						
44	99238 12 minutes		12						
45	*Total Office Visit Time*			**0**	**0**	**0**	**0**	**0**	**0**
46	Other Activity (please specify)								
47	**End: with last office visit before end of global period**				**0**		0		0

	A	B	C	D	E	F	G	H	I
1	**Presenters:** Lawrence Green, MD; Mark Kaufman, MD; Brett Coldiron, MD			**96920**		**96921**		**96922**	
2	**Meeting Date:** January 2012 **Specialty:** American Academy of Dermatology	**CMS**	**Staff**	**Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm**		**Laser treatment for inflammatory skin disease, (psoriasis); between 250 sq cm to 500 sq cm**		**Laser treatment for inflammatory skin disease, (psoriasis); over 500 sq cm**	
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48	**MEDICAL SUPPLIES**		**Unit**						
49	M/S Minimum Supply Package *	SA048	pack	1		1		1	
50	drape-towel, sterile 18in x 26in	SB019	item	1		2		4	
51	drape, non-sterile, sheet 40in x 60in	SB006	item	1		1		1	
52	sanitizing cloth-wipe (surface, instruments, equipment)	SM022	item	3		3		3	
53	towel, paper (Bounty) (per sheet)	SK082	item	6		6		6	
54	gown, staff, impervious	SB027	item	2		2		2	
55	gloves, sterile	SB024	pr	2		2		2	
56	eye shield, splash protection	SM016	item	2		2		2	
57	skin marking pen, sterile (Skin Skribe)	SK075	item	1		1		1	
58	cotton balls, sterile	SG082	item	6		6		6	
59	petroleum jelly	SJ038	oz	1		1		1	
60	sunscreen lotion (spf15) 4 oz	SK078	oz	1		1		1	
61	mineral oil, 3.5 oz	SJ035	ml	2		4		8	
62	tape, surgical paper 1in (Micropore)	SG079	inch	1		1		1	
63	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	2		3		4	
64	bacitracin oint (15gm uou)	SJ008	item	1		1		1	
65	alcohol, ethyl, denatured	SL006	ml	1		1		1	
66	Eucerin cream	SJ026	oz	12		12		12	
67	goggles, uv-blocking	SJ027	item	1		1		1	
68	underpad 2ft x 3ft (Chux)	SB044	item	2		2		2	
69	laser tip (single use)	SF028	item	1		1		1	
70	triamcinolone acetonide 0.1% cream	SH072	gm	1		1		1	
71	ice pack, instant	SJ029	Item	4		4		4	
72	lidocaine 4% soln, topical (Xylocaine)	SH050	ml	1		1		1	
73	drape, sterile, fenestrated 16in x 29in	SB011	item	2		2		2	
74	**Equipment**								
75	Power Table	EF031		20		23		33	
76	EXAM Light	EQ168		17		20		30	
77	Excimer Laser	EQ161		20		23		33	
78	Digital Camera Pkg - 12 megapixel medical grade	ED005		3		4		5	
79	Items included in Annual Laser Service Package - Pend Inv and review by CMS			1		1		1	

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
Practice Expense Subcommittee
Ultrasound Equipment Workgroup
December 14, 2011

Members: *Doctors William Gee (Chair), David Han, Lee Mills, Chad Rubin, John Seibel, Richard Wright, Michael Main, Geraldine McGinty, Harvey Nisenbaum*

CMS Request for Review of Ultrasound Equipment

I. **Ultrasound Equipment**
CMS received comments that there may be potential inconsistencies with the inputs and the prices related to ultrasound equipment in the direct PE database, specifically there are 17 different ultrasound related equipment items (including ultrasound rooms) associated with 110 CPT codes ranging in price from $1,304.33 to $466,492.00. CMS requested that the RUC review the clinical necessity of the ultrasound equipment as well as the way the equipment is described for individual codes. Staff reminded the PE Subcommittee that it is not in the Subcommittee's purview to make recommendations related to specific prices.

II. **Ultrasound Equipment Workgroup**
The Chair of the PE Subcommittee established a workgroup to review this issue and offer recommendations to the Subcommittee. The workgroup was charged with two tasks: 1) review the details for the 17 ultrasound CMS direct PE input equipment items to determine if the level of distinction is appropriate; and 2) review the list of 110 CPT codes that use the various ultrasound equipment to determine if the equipment is appropriately identified. The workgroup met via conference call on Wednesday, November 8th and Wednesday Dec. 14th to review the equipment and associated codes. On the first call, the workgroup established that they will review the types of equipment, descriptions and assignment of CPT codes. The group believed that the 17 ultrasound equipment codes were still typical for the CPT codes, but that the specialties expertise would have to be solicited to verify.

III. **Specialty Recommendations**
Feedback was solicited and received from the specialties, and then reviewed and finalized by the workgroup. In general, if there was disagreement between specialties, the recommendation of the dominant specialty for the CPT code was utilized. The review of the list of 110 CPT codes that use the various ultrasound equipment are listed in the table below. Please refer to the attached excel workbook tab 1 for more detail regarding the specialty recommendations. In addition the results of the review of the 17 ultrasound equipment codes and the ultrasound rooms are included in the attached excel workbook, under the appropriate tabs.

Ultrasound Equipment by CPT Code

CPT Code	CMS Code	Committee Recommendation
19105	EQ250	Portable ultrasound unit typical, however unit listed is not appropriate. See Invoice Folder 1 for recommended equipment. Recommended description: ultrasound unit, portable, breast procedures
19296	EL015	Portable ultrasound unit typical, however unit listed is not appropriate. See Invoice Folder 1 for recommended equipment. Recommended description: ultrasound unit, portable, breast procedures
19298	EL015	Portable ultrasound unit typical, however unit listed is not appropriate. See Invoice Folder 1 for recommended equipment. Recommended description: ultrasound unit, portable, breast procedures

CPT Code	CMS Code	Committee Recommendation
28890	EQ250	Typical equipment
31620	ES014	Typical equipment, specialty society invoice provided for updates to equipment (please Invoice Folder 2)
31620	ES015	Typical equipment, specialty society invoice provided for updates to equipment (please Invoice Folder 2)
31620	ES016	Typical equipment, specialty society invoice provided for updates to equipment (please Invoice Folder 2)
31620		Missing equipment, specialty society invoice provided for missing equipment (please Invoice Folder 2)
31620		Missing equipment, specialty society invoice provided for missing equipment (please Invoice Folder 2)
36475	EL015	Typical equipment
36476	EL015	Typical equipment
36478	EL015	Typical equipment
36479	EL015	Typical equipment
37191	EQ250	Portable ultrasound unit is typical, specialty society to provide invoices for appropriate unit
37192	EQ250	Portable ultrasound unit is typical, specialty society to provide invoices for appropriate unit
37193	EQ250	Portable ultrasound unit is typical, specialty society to provide invoices for appropriate unit
49083	EL015	Typical equipment
49418	EQ250	Typical equipment
51798	EQ255	Typical equipment
52649	EQ255	Change to EQ250 (portable ultrasound unit) per dominant specialty recommendation
53850	EQ250	Typical equipment
55873	EQ250	Typical equipment
58356	EQ249	Typical equipment
59070	EQ249	Typical equipment
59074	EQ249	Typical equipment
76376	EL015	Remove from list, procedure does not require ultrasound input
76506	EL015	Typical equipment
76536	EL015	Typical equipment
76604	EL015	Typical equipment
76645	EL015	Typical equipment
76700	EL015	Typical equipment
76705	EL015	Typical equipment
76770	EL015	Typical equipment
76775	EL015	Change to EQ250, per dominant specialty recommendation
76776	EL015	Typical equipment
76800	EL015	Typical equipment
76801	EL015	Typical equipment
76802	EL015	Typical equipment
76805	EL015	Typical equipment
76810	EL015	Typical equipment
76811	EL015	Typical equipment
76812	EL015	Typical equipment

CPT Code	CMS Code	Committee Recommendation
76813	EL015	Typical equipment
76814	EL015	Typical equipment
76815	EL015	Typical equipment
76816	EL015	Typical equipment
76817	EL015	Typical equipment
76818	EF034	Typical equipment
76818	EQ249	Typical equipment
76819	EF034	Typical equipment
76819	EQ249	Typical equipment
76820	EQ249	Change to EL015, per dominant specialty recommendation
76821	EL015	Typical equipment
76825	EQ252	Typical equipment
76825	EQ254	Typical equipment
76826	EQ252	Typical equipment
76826	EQ254	Typical equipment
76827	EQ254	Typical equipment
76828	EQ254	Typical equipment
76830	EL015	Typical equipment
76831	EL015	Typical equipment
76856	EL015	Typical equipment
76857	EL015	Change to EQ250, per dominant specialty recommendation
76870	EL015	Change to EQ250, per dominant specialty recommendation
76872	EL015	Change to EQ250, per dominant specialty recommendation
76873	EL015	Typical equipment
76881	EL015	Typical equipment
76882	EQ250	Typical equipment
76885	EL015	Typical equipment
76886	EL015	Typical equipment
76936	EL015	Typical equipment
76937	EQ250	Portable ultrasound unit is typical, specialty society to provide invoices for appropriate unit
76942	EL015	Change to EQ250, per dominant specialty recommendation
76946	EQ250	Typical equipment
76948	EQ250	Typical equipment
76950	EQ250	Equipment identified is not appropriate, specialty society to identify appropriate equipment
76965	EQ250	Portable ultrasound unit is typical, specialty society to provide invoices for appropriate unit
76970	EL015	Typical equipment
76977	ER022	Typical equipment
77600	ER035	Typical equipment
77620	ER036	Retain, specialized equipment
93303	EQ253	Equipment identified is not appropriate, specialty society proposes Cardiovascular Ultrasound Room (please see ultrasound room spreadsheet for equipment inputs)
93303	EQ254	Equipment identified is not appropriate, specialty society proposes Cardiovascular Ultrasound Room (please see ultrasound room spreadsheet for equipment inputs)

CPT Code	CMS Code	Committee Recommendation
93303	EQ252	Equipment identified is not appropriate, specialty society proposes Cardiovascular Ultrasound Room (please see ultrasound room spreadsheet for equipment inputs)
93304	EQ252	Equipment identified is not appropriate, specialty society proposes Cardiovascular Ultrasound Room (please see ultrasound room spreadsheet for equipment inputs)
93304	EQ253	Equipment identified is not appropriate, specialty society proposes Cardiovascular Ultrasound Room (please see ultrasound room spreadsheet for equipment inputs)
93304	EQ254	Equipment identified is not appropriate, specialty society proposes Cardiovascular Ultrasound Room (please see ultrasound room spreadsheet for equipment inputs)
93306	EQ253	Equipment identified is not appropriate, specialty society proposes Cardiovascular Ultrasound Room (please see ultrasound room spreadsheet for equipment inputs)
93306	EQ254	Equipment identified is not appropriate, specialty society proposes Cardiovascular Ultrasound Room (please see ultrasound room spreadsheet for equipment inputs)
93306	EQ252	Equipment identified is not appropriate, specialty society proposes Cardiovascular Ultrasound Room (please see ultrasound room spreadsheet for equipment inputs)
93307	EQ252	Equipment identified is not appropriate, specialty society proposes Cardiovascular Ultrasound Room (please see ultrasound room spreadsheet for equipment inputs)
93307	EQ253	Equipment identified is not appropriate, specialty society proposes Cardiovascular Ultrasound Room (please see ultrasound room spreadsheet for equipment inputs)
93307	EQ254	Equipment identified is not appropriate, specialty society proposes Cardiovascular Ultrasound Room (please see ultrasound room spreadsheet for equipment inputs)
93308	EQ252	Equipment identified is not appropriate, specialty society proposes Cardiovascular Ultrasound Room (please see ultrasound room spreadsheet for equipment inputs)
93308	EQ253	Equipment identified is not appropriate, specialty society proposes Cardiovascular Ultrasound Room (please see ultrasound room spreadsheet for equipment inputs)
93308	EQ254	Equipment identified is not appropriate, specialty society proposes Cardiovascular Ultrasound Room (please see ultrasound room spreadsheet for equipment inputs)
93312	EQ253	Equipment identified is not appropriate, specialty society proposes Cardiovascular Ultrasound Room (please see ultrasound room spreadsheet for equipment inputs)
93312	EQ252	Equipment identified is not appropriate, specialty society proposes Cardiovascular Ultrasound Room (please see ultrasound room spreadsheet for equipment inputs)
93312	EQ256	Equipment identified is not appropriate, specialty society proposes Cardiovascular Ultrasound Room (please see ultrasound room spreadsheet for equipment inputs)

CPT Code	CMS Code	Committee Recommendation
93312	EQ254	Equipment identified is not appropriate, specialty society proposes Cardiovascular Ultrasound Room (please see ultrasound room spreadsheet for equipment inputs)
93314	EQ254	Equipment identified is not appropriate, specialty society recommends review for possible miscoding
93314	EQ256	Equipment identified is not appropriate, specialty society recommends review for possible miscoding
93314	EQ252	Equipment identified is not appropriate, specialty society recommends review for possible miscoding
93314	EQ253	Equipment identified is not appropriate, specialty society recommends review for possible miscoding
93320	EQ252	Equipment identified is not appropriate, specialty society proposes Cardiovascular Ultrasound Room (please see ultrasound room spreadsheet for equipment inputs)
93320	EQ253	Equipment identified is not appropriate, specialty society proposes Cardiovascular Ultrasound Room (please see ultrasound room spreadsheet for equipment inputs)
93320	EQ254	Equipment identified is not appropriate, specialty society proposes Cardiovascular Ultrasound Room (please see ultrasound room spreadsheet for equipment inputs)
93321	EQ252	Equipment identified is not appropriate, specialty society proposes Cardiovascular Ultrasound Room (please see ultrasound room spreadsheet for equipment inputs)
93321	EQ254	Equipment identified is not appropriate, specialty society proposes Cardiovascular Ultrasound Room (please see ultrasound room spreadsheet for equipment inputs)
93325	EQ252	Equipment identified is not appropriate, specialty society proposes Cardiovascular Ultrasound Room (please see ultrasound room spreadsheet for equipment inputs)
93325	EQ253	Equipment identified is not appropriate, specialty society proposes Cardiovascular Ultrasound Room (please see ultrasound room spreadsheet for equipment inputs)
93325	EQ254	Equipment identified is not appropriate, specialty society proposes Cardiovascular Ultrasound Room (please see ultrasound room spreadsheet for equipment inputs)
93350	EQ252	Equipment identified is not appropriate, specialty society proposes Cardiovascular Ultrasound Room (please see ultrasound room spreadsheet for equipment inputs)
93350	EQ253	Equipment identified is not appropriate, specialty society proposes Cardiovascular Ultrasound Room (please see ultrasound room spreadsheet for equipment inputs)
93350	EQ254	Equipment identified is not appropriate, specialty society proposes Cardiovascular Ultrasound Room (please see ultrasound room spreadsheet for equipment inputs)
93351	EQ254	Equipment identified is not appropriate, specialty society proposes Cardiovascular Ultrasound Room (please see ultrasound room spreadsheet for equipment inputs)
93880	EL016	Typical equipment
93882	EL016	Typical equipment

CPT Code	CMS Code	Committee Recommendation
93886	EL016	Typical equipment
93888	EL016	Typical equipment
93890	EL016	Typical equipment
93892	EL016	Typical equipment
93893	EL016	Typical equipment
93922	EL016	Typical equipment
93923	EL016	Typical equipment
93924	EL016	Typical equipment
93925	EL016	Typical equipment
93926	EL016	Typical equipment
93930	EL016	Typical equipment
93931	EL016	Typical equipment
93965	EL016	Typical equipment
93970	EL016	Typical equipment
93971	EL016	Typical equipment
93975	EL016	Typical equipment
93976	EL016	Typical equipment
93978	EL016	Typical equipment
93979	EL016	Typical equipment
93980	EL015	Change to EQ249, per dominant specialty recommendation
93981	EL015	Change to EQ249, per dominant specialty recommendation
93990	EL016	Typical equipment
97035	EQ251	Typical equipment
G0365	EL016	Typical equipment
G0389	EL015	Typical equipment

IV. **Other Issues**

The Ultrasound Workgroup discussed adding a crash cart to both the vascular and cardiovascular ultrasound rooms, however after the second conference call it was determined that this is against CMS policy because a crash cart is considered an indirect expense. Based on this information, a crash cart was not added to the equipment inputs for these ultrasound rooms.

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
Practice Expense Subcommittee
Ultrasound Equipment Workgroup
February 28, 2012

Members: *Doctors William Gee (Chair), David Han, Lee Mills, Chad Rubin, John Seibel, Richard Wright, Michael Main, Geraldine McGinty, Harvey Nisenbaum*

CMS Request for Review of Ultrasound Equipment – Description of Submission

CMS requested that the RUC review 17 different ultrasound related equipment items (including ultrasound rooms) associated with 110 CPT codes ranging in price from $1,304.33 to $466,492.00. CMS requested that the RUC review the clinical necessity of the ultrasound equipment as well as the way the equipment is described for individual codes. The Chair of the PE Subcommittee established a workgroup to review this issue and offer recommendations to the Subcommittee. The recommendations of the workgroup were reviewed and accepted by the PE Subcommittee at the January 2012 RUC Meeting. The final recommendations of the RUC Practice Expense Subcommittee are enclosed.

1. Ultrasound Workgroup PE Subcommittee Report
2. Final Compiled 2012 CMS Ultrasound Equipment_CPT codes_PE inputs_rooms
    a. Tab 1: Ultrasound Equipment CPT Codes
    This spreadsheet is a list of the 110 CPT codes that CMS requested be reviewed. There are some recommended changes to the descriptions indicated in red, The specialties that perform the code are listed and if the dominant specialty reviewed the code it is highlighted in yellow. The spreadsheet indicates whether or not the equipment is used in a nonfacility setting, the specialty comments and the committee recommendations
    b. Tab 2: Direct PE Equipment Inputs
    New equipment is highlighted in yellow
    c. Tab 3: Ultrasound Rooms
    This spreadsheet includes equipment inputs that specialties recommend be added to the existing ultrasound rooms as well as the recommended addition of an ultrasound room (cardiovascular), with equipment inputs
3. General Ultrasound Room Invoice
    Invoice submitted by ACR including equipment inputs for the general ultrasound room
4. Invoice Folder 1
    Submitted by ASBS and ACS for recommended new equipment
5. Invoice Folder 2
    Submitted by ACCP for recommended new and revised equipment
6. Invoice Folder 3
    Submitted by ASE for inputs to recommended new cardiovascular ultrasound room

In addition, ACP brought a subset of these codes to the attention of the Workgroup because they are potentially being misreported by internal medicine physicians. The specialty suspects the miscoding results from reports more advanced equipment than is typically found in a general practice office today. The PE Subcommittee recommends that ACR and ACP work together to determine an appropriate way to handle this issue and report back to the PE Subcommittee at the April 2012 meeting.

AMA
AMERICAN MEDICAL ASSOCIATION

American Medical Association
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Chicago, Illinois 60654

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312.464.5000

March 6, 2012

Marilyn Tavenner
Acting Administrator
Chief Operating Officer
Center for Medicare
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: HCPAC Recommendations

Dear Ms. Tavenner:

The RUC Health Care Professionals Advisory Committee (HCPAC) Review Board submits the enclosed recommendations for work and direct practice expense inputs to the Centers for Medicare and Medicaid Services (CMS). These recommendations are a component of the RUC's consideration of services that were identified as potentially misvalued. The RUC and HCPAC are fully committed to this ongoing effort to improve relativity in the work, practice expense, and professional liability insurance values.

The enclosed recommendations result from the HCPAC's review of services from the January 27, 2012 meeting and include: CPT code 11719 *Trimming of nondystrophic nails, any number,* identified by CMS through the Low Value-High Volume screen and CPT code 97150 *Therapeutic procedure(s), group (2 or more individuals*), identified by the Relativity Assessment Workgroup through the CMS/Other – Utilization over 500,000 screen.

The HCPAC appreciates the opportunity to provide recommendations related to the 2013 Medicare Physician Payment Schedule. If you have any questions regarding this submission. Please contact Susan Clark (202) 789-7495 or Susan.Clark@ama-assn.org at the AMA for clarification regarding these recommendations.

Sincerely,

Arthur Traugott, MD
HCPAC Chair

Anthony Hamm, DC
HCPAC Co-Chair

cc: HCPAC Participants

Attachments

AMA/Health Care Professionals Advisory Committee
Summary of Recommendations
Low Value-High Volume Screen

January 2012

Trimming of Nails

CPT code 11719 *Trimming of nondystrophic nails, any number* was identified by CMS through the Low Value-High Volume screen. The HCPAC noted that in September 2011, CPT code 11719 was surveyed with codes 11720 and 11721, however the American Podiatric Medical Association (APMA) indicated, and the HCPAC agreed, that the previous survey data appeared inconsistent with the service and therefore recommended a resurvey.

In January 2012, the HCPAC reviewed the survey data from 37 podiatrists for CPT code 11719 and determined that the physician work involved in the service has not changed. The HCPAC agreed 11719 is similar to 11720 *Debridement of nail(s) by any method(s); 1 to 5* (HCPAC recommended work RVU = 0.32 and 5 minutes intra-service time). However, 11720 is more intense in order to debride and reduce the size and girth of 4 nail plates compared to trimming 10 nails as described in CPT code 11719 and therefore requires more work. The HCPAC also compared 11719 to MPC code 73620 *Radiologic examination, foot; 2 views* (work RVU=0.16 and 3 minutes intra-service time) and determined these services require similar work and time to perform. For additional support the HCPAC compared 11719 to 99211 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 0.18 and 5 minutes intra-service time) and determined these services are also similar in work and time. The HCPAC recommends 5 minutes pre-time, 5 minutes intra-service time and 2 minutes post-service time for CPT code 11719. **The HCPAC recommends to maintain a work RVU of 0.17 for CPT code 11719.**

Practice Expense
The HCPAC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
11719	SS7	Trimming of nondystrophic nails, any number	000	0.17 (No Change)
11720		Debridement of nail(s) by any method(s); 1 to 5	000	0.32 (No Change) (HCPAC Recommendation from Sept 2011)
11721		Debridement of nail(s) by any method(s); 6 or more	000	0.54 (No Change) (HCPAC Recommendation from Sept 2011)
G0127		Trimming of dystrophic nails, any number	000	0.17 (Direct Crosswalk to 11719)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11719 Tracking Number Original Specialty Recommended RVU: **0.17**
Presented Recommended RVU: **0.17**
Global Period: 000 RUC Recommended RVU: **0.17**

CPT Descriptor: Trimming of nondystrophic nails, any number

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 76-year-old obese diabetic female presents for trimming of 10 elongated nails.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

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

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

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Review chart with general medical and surgical history update including current medications and allergies. Discusses the procedure with the patient. Verify that all required instruments and supplies are available in the treatment room. Position patient in the treatment room and examine both feet.

Description of Intra-Service Work: After feet have soaked to soften nails and periungual tissue, inspect the length and thickness of nails and periungual tissue. Trim all ten toenails, taking care to avoid injuring the hyponychium and lateral folds. Apply antiseptic to the nails and periungual tissue

Description of Post-Service Work: Instruct patient and/or care giver on appropriate home care. Discuss future management of the condition. Instuct on proper selection and sizing of footwear. Instruct on importance of controlling concomitant medical conditions. Complete medical record. Communicate with primary care physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012		
Presenter(s):	Seth Rubenstein, DPM		
Specialty(s):	podiatry		
CPT Code:	11719		
Sample Size:	100	**Resp N:** 37	**Response:** 37.0 %
Sample Type:	Random	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	10.00	50.00	**225.00**	500.00	250.00
Survey RVW:	0.23	0.30	**0.45**	0.78	1.20
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**1.00**		
Pre-Service Scrub, Dress, Wait Time:			**1.00**		
Intra-Service Time:	2.00	5.00	**10.00**	10.00	15.00

Immediate Post Service-Time:	**2.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	11719	**Recommended Physician Work RVU: 0.17**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**4.00**	**7.00**	**-3.00**
Pre-Service Positioning Time:		**1.00**	**0.00**	**1.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**5.00**		

Immediate Post Service-Time:	**2.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99212	XXX	0.48	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99211	XXX	0.17	**RUC Time**	8,731,118

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93010	XXX	0.17	**RUC Time**	19,219,718

CPT Descriptor 2 Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only

Other Reference CPT Code	Global	Work RVU	Time Source
29540	000	0.32	**RUC Time**

CPT Descriptor Strapping; ankle and/or foot

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 14 **% of respondents:** 37.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 11719**	**Key Reference CPT Code:** 99212	**Source of Time** **RUC Time**
Median Pre-Service Time	5.00	2.00	
Median Intra-Service Time	5.00	10.00	
Median Immediate Post-service Time	2.00	4.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**12.00**	**16.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	1.71	2.36
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.86	2.29
Urgency of medical decision making	1.50	1.93
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.29	2.21
Physical effort required	1.64	1.71
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.00	2.29
Outcome depends on the skill and judgment of physician	2.21	2.36
Estimated risk of malpractice suit with poor outcome	2.21	2.29

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	1.69	1.77
Intra-Service intensity/complexity	2.21	2.50
Post-Service intensity/complexity	1.31	1.46

Additional Rationale and Comments

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

The RUC recommended that code 11719 be surveyed as a family code when CPT 11721 was identified by the MPC List screen. Code 11719 was last reviewed in 1997 when code M0101 *Cutting or removal of corns, calluses and/or trimming*

of nails, application of skin creams and other hygienic and/or preventive maintenance care (excludes debridement of nail(s) (RVW = 0.43) was deleted. The survey median of 0.17 RVW was recommended by the HCPAC and accepted by CMS with pre/intra/post survey times of 2/2/5.

The APMA conducted a RUC survey and received 37 surveys. The work performing this service has not changed. **The APMA recommends maintaining the current work RVU of 0.17 for 11719.**

Pre-time package 5 (office procedure without sedation/anesthesia care) is appropriate: Total pre-time recommended is 5 minutes, which is less than the survey median pre-time and less than the standard pre-time of seven minutes for package 5. An E/M is not typically reported on the same day. Therefore, four minutes is recommended for evaluation, including an interval history, medication update, and exam of both feet. Because this service is typically performed on elderly (73% over 75 y.o. / 34% over 85 y.o.), obese, diabetic, arthritic patients who do not ambulate well without assistance, one minute is recommended to assist with positioning the patient in the treatment room and preparing the foot for the procedure.

Intra-time: An intra-time of five minutes is recommended. This is less than the survey median and is based on consensus by our expert panel of approximately 30 seconds per nail. Toenails of the elderly are often thick, curved, and may be discolored. Trimming involves nipping at the nail and requires care to avoid injuring the hyponychium and lateral folds. Trimming is followed by application of antiseptic.

Work reflects both time and intensity/complexity. Although it takes the same time to trim **10** nails as debride **4** nails, the intensity is lower for trimming nails as shown in the table below. This table also shows an appropriate relationship between this set of codes.

CPT		STAT	RVW	IWPUT	Total time	pre	intra	post
11719	trim 10 nails	R	0.17	0.003	12	5	5	2
11720	debride 4 nails	A	0.32	0.024	14	7	5	2
11721	debride 8 nails	A	0.54	0.034	19	7	10	2

Codes 20600-20610 (reviewed in 2010) present this same fact (work = time x intensity). It takes the same time to inject a joint, but the bigger and deeper the joint, the more intense/complex the work.

CPT	DESC	RVW	iwput	Total time	pre	intra	post
20600	Drain/inject joint/bursa	0.66	0.075	21	11	5	5
20605	Drain/inject joint/bursa	0.68	0.079	21	11	5	5
20610	Drain/inject joint/bursa	0.79	0.101	21	11	5	5

Another example: It takes the same time to perform an anoscopy as inject the occipital nerve, but there is clearly an appropriate difference in intensity/complexity.

CPT	DESC	RVW	iwput	Total time	pre	intra	post
46600	Anoscopy; diagnostic	0.55	0.034	22	7	5	10
64405	Injection, occipital nerve	0.94	0.112	22	7	5	10

Post-time: The survey median post-time of two minutes is recommended for follow-up discussion with the patient on proper foot care, documentation of the procedure, and communication with the patient's primary care physician.

Code 99212 was chosen as the key reference by 14 respondents and code 29540 was chosen by 11 respondents.

	CPT	DESC	STAT	GLOB	IWPUT	RVW	Total Time	eval	posit	s,d,w	INTRA	post
	11719	Trimming of nondystrophic nails, any number	R	000	**0.003**	**0.17**	12	4	1		5	2
Key Ref	**99212**	Office/outpatient visit, established	A	XXX	**0.035**	**0.48**	16	2			10	4
Oth Ref	**29540**	Strapping; ankle and/or foot	A	000	**0.013**	**0.32**	18	7			9	2

There are no MPC codes with a 0-day global period in this low range of work RVUs. Below are the data for two XXX-global MPC codes with similar work RVUs.

	CPT	DESC	STAT	GLOB	RVW	IWPUT	Total Time	eval	posit	s,d,w	INTRA	post
	11719	Trimming of nondystrophic nails, any number	R	000	**0.17**	0.003	12	4	1		5	2
MPC	**93010**	Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only	A	XXX	**0.17**	0.037	5				4	1
MPC	**99211**	Office/outpatient visit, established	A	XXX	**0.18**	0.027	7				5	2

For additional perspective on the relativity of 11719 in the physician fee schedule, below are 20 low work RVU codes reviewed by the RUC in 2011 and approved by CMS for CY 2012

CPT	DESC	STAT	GLOB	RVW	IWPUT	Total Time	eval	posit	sdw	INTRA	post
95015	Id allergy titrate-drug/bug	A	XXX	**0.06**	0.065	**1.25**	0.4			0.8	0.2
95010	Percut allergy titrate test	A	XXX	**0.11**	0.057	**2.72**	1			1.4	0.29
93321	Doppler echo exam heart	A	ZZZ	**0.15**	0.015	**10**				10	
73620	X-ray exam of foot	A	XXX	**0.16**	0.038	**5**	1			3	1
72170	X-ray exam of pelvis	A	XXX	**0.17**	0.026	**7**	1			4	2
94729	C02/membane diffuse capacity	A	ZZZ	**0.17**	0.034	**5**				5	
94781	Car seat/bed test add'l 30 min	A	ZZZ	**0.17**	0.034	**5**				5	
11719	Trimming of nondystrophic nails, any number	R	000	**0.17**	0.003	**12**	4	1		5	2
73030	X-ray exam of shoulder	A	XXX	**0.18**	0.028	**7**	1			4	2
72100	X-ray exam of lower spine	A	XXX	**0.22**	0.051	**6**	1			3	2
72120	X-ray exam of lower spine	A	XXX	**0.22**	0.051	**6**	1			3	2
88313	Special stains group 2	A	XXX	**0.24**	0.018	**13**				13	
29583	Apply multlay comprs upr arm	A	000	**0.25**	0.012	**16**	4			10	2
94060	Evaluation of wheezing	A	XXX	**0.26**	0.017	**14**	3			8	3
94726	Pulm funct tst plethysmograp	A	XXX	**0.26**	0.007	**15**	5			5	5
94727	Pulm function test by gas	A	XXX	**0.26**	0.007	**15**	5			5	5
94728	Pulm funct test oscillometry	A	XXX	**0.26**	0.007	**15**	5			5	5
72110	X-ray exam of lower spine	A	XXX	**0.31**	0.049	**8**	1			5	2
72114	X-ray exam of lower spine	A	XXX	**0.32**	0.051	**8**	1			5	2
15272	Skin sub graft t/a/l add-on	A	ZZZ	**0.33**	0.033	**10**				10	
95904	Sense nerve conduction test	A	XXX	**0.34**	0.037	**12**	4			5	3

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

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

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) Other foot care services may be reported in addition to 11056, however, there is no single typical code reported.

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 11719

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

Specialty podiatry How often? Commonly

Specialty How often?

Specialty How often?

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

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,488,242 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC database 2010 Medicare utilization

Specialty podiatry Frequency 1458480 Percentage 98.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 11719

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

ISSUE: Trimming of Nails

TAB: 32

Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD
					MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
KEY REF	99212	Office or other outpatient visit for the evaluati	38%	0.035			0.48			16	2					10			4
Oth REF	29540	Strapping; ankle and/or foot	30%	0.013			0.32			18	7					9			2
HVD	11719	Trimming of nondystrophic nails, any numbe		0.007			0.17			9	2					2			5
SVY	11719	Trimming of nondystrophic nails, any numbe	37	0.026	0.23	0.30	0.45	0.78	1.20	19	5	1	1	2	5	10	10	15	2
REC		*current rvw*		0.003			0.17			12	4	1	0			5			2

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

CPT Long Descriptor:
Trimming of nondystrophic nails, any number

Global Period:_000_ Meeting Date: ___01/2012__

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
Consensus committee reviewed current PE details developed in March 2001 and updated the details as appropriate.

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:
Consensus committee reviewed current PE details developed in March 2001 and updated the details as appropriate.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

N/A

Intra-Service Clinical Labor Activities:

Staff will greet patient, assist with positioning (patients are typically, obese and do not ambulate well), ensure appropriate medical records are available, provide pre-service education, prepare room, equipment, supplies, assist physician in performing procedure, and clean room/equipment.

Post-Service Clinical Labor Activities:

N/A

	A	B	C	D	E	F	G
1	**Trimming of Nails**		**CPT Code**	**CURRENT 11719 (March 2001)**		**11719**	
2	**Meeting Date: February 2012 Specialty: APMA**	**CMS**	**Staff**	**Trimming of nondystrophic nails, any number**		**Trimming of nondystrophic nails, any number**	
3	**GLOBAL PERIOD**			**000**		**000**	
4	**LOCATION**	**Code**	**Type**	**OFF**	**FAC**	**OFF**	**FAC**
5	**TOTAL CLINICAL LABOR TIME**	L037D	RN/LPN/MA	**17**	**0**	**5**	**0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MA	**0**	**0**	**0**	**0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L037D	RN/LPN/MA	**17**	**0**	**5**	**0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MA	**0**	**0**	**0**	**0**
9	**PRE-SERVICE**						
10	**Start: Following visit when decision for surgery or procedure made**						
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MA	**0**	**0**	**0**	**0**
12	Coordinate pre-surgery services	L037D	RN/LPN/MA	**0**	**0**	**0**	**0**
13	Schedule space and equipment in facility	L037D	RN/LPN/MA	**0**	**0**	**0**	**0**
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MA	**0**	**0**	**0**	**0**
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MA	**0**	**0**	**0**	**0**
16	**End: When patient enters office/facility for surgery/procedure**						
17	**SERVICE PERIOD**						
18	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**						
19	review charts			**2**	**0**		
20	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MA	**2**	**0**	**1**	**0**
21	Obtain vital signs	L037D	RN/LPN/MA	**3**	**0**		
22	Provide pre-service education/obtain consent	L037D	RN/LPN/MA	**2**	**0**	**1**	**0**
23	Prepare room, equipment, supplies	L037D	RN/LPN/MA	**2**	**0**	**1**	**0**
24	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MA	**2**	**0**		
25	Sedate/apply anesthesia	L037D	RN/LPN/MA				
26	**Intra-service**						
27	Assist physician in performing procedure	L037D	RN/LPN/MA	**1**	**0**	**1**	**0**
28	**Post-Service**						
29	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MA				
30	Clean room/equipment by physician staff	L037D	RN/LPN/MA	**3**	**0**	**1**	**0**
31	Clean Surgical Instrument Package	L037D	RN/LPN/MA				
32	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MA				
33	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MA				
34	Check dressings & wound/ home care instructions	L037D	RN/LPN/MA				
35	Discharge day management	L037D	RN/LPN/MA				
36	**End: Patient leaves office**						
37	**POST-SERVICE Period**						
38	**Start: Patient leaves office/facility**						
39	Conduct phone calls/call in prescriptions			**0**	**0**	**0**	**0**

	A	B	C	D	E	F	G
1	**Trimming of Nails**		**CPT Code**	**CURRENT 11719 (March 2001)**		**11719**	
2	**Meeting Date: February 2012 Specialty: APMA**	**CMS**	**Staff**	**Trimming of nondystrophic nails, any number**		**Trimming of nondystrophic nails, any number**	
3	**GLOBAL PERIOD**			**000**		**000**	
4	**LOCATION**	**Code**	**Type**	**OFF**	**FAC**	**OFF**	**FAC**
50	**MEDICAL SUPPLIES**	**Code**	Desc				
51	paper, exam table	SB036	foot	**7**	**0**	**7**	**0**
52	underpad 2ft x 3ft (Chux)	SB044	item			**1**	**0**
53	towel, non-sterile	SB042	item				
54	gloves, non-sterile	SB022	pair	**2**	**0**	**2**	**0**
55	slippers, paper	SB040	pair	**1**	**0**		
56	blade, surgical (Bard-Parker)	SF007	item	**2**	**0**		
57	blade, surgical chisel 81-86 (Beaver)	SF009	item	**1**	**0**		
58	hydrogen peroxide	SJ028	ml	**10**	**0**	**0**	**0**
59	povidone swabsticks (3 pack uou)	SJ043	item	**1**	**0**	**1**	
60	swab-pad, alcohol	SJ053	item	**2**	**0**	**0**	**0**
61	applicator, cotton-tipped, non-sterile 6in	SG008	item	**2**	**0**		
62	gauze, non-sterile 4in x 4in	SG051	item	**2**	**0**	**2**	**0**
63							
64							
65							
66	**Equipment**						
67	table, power	EF031		**17**	**0**	**11**	**0**
68	light, exam	EQ168		**17**	**0**	**11**	**0**
69	dust extractor	EQ109		**17**	**0**	**0**	**0**

	A	B	C	D	E	F	G
1	**Trimming of Nails**		**CPT Code**	**CURRENT 11719 (March 2001)**		**11719**	
2	**Meeting Date: February 2012 Specialty: APMA**	**CMS**	**Staff**	**Trimming of nondystrophic nails, any number**		**Trimming of nondystrophic nails, any number**	
3	**GLOBAL PERIOD**			**000**		**000**	
4	**LOCATION**	**Code**	**Type**	**OFF**	**FAC**	**OFF**	**FAC**
5	**TOTAL CLINICAL LABOR TIME**	L037D	RN/LPN/MA	**17**	**0**	**11**	**0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MA	**0**	**0**	**0**	**0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L037D	RN/LPN/MA	**17**	**0**	**11**	**0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MA	**0**	**0**	**0**	**0**
9	**PRE-SERVICE**						
10	**Start: Following visit when decision for surgery or procedure made**						
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MA	**0**	**0**	**0**	**0**
12	Coordinate pre-surgery services	L037D	RN/LPN/MA	**0**	**0**	**0**	**0**
13	Schedule space and equipment in facility	L037D	RN/LPN/MA	**0**	**0**	**0**	**0**
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MA	**0**	**0**	**0**	**0**
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MA	**0**	**0**	**0**	**0**
16	**End: When patient enters office/facility for surgery/procedure**						
17	**SERVICE PERIOD**						
18	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**						
19	review charts			**2**	**0**		
20	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MA	**2**	**0**	**3**	**0**
21	Obtain vital signs	L037D	RN/LPN/MA	**3**	**0**		
22	Provide pre-service education/obtain consent	L037D	RN/LPN/MA	**2**	**0**	**2**	**0**
23	Prepare room, equipment, supplies	L037D	RN/LPN/MA	**2**	**0**	**2**	**0**
24	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MA	**2**	**0**		
25	Sedate/apply anesthesia	L037D	RN/LPN/MA				
26	**Intra-service**						
27	Assist physician in performing procedure	L037D	RN/LPN/MA	**1**	**0**	**1**	**0**
28	**Post-Service**						
29	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MA				
30	Clean room/equipment by physician staff	L037D	RN/LPN/MA	**3**	**0**	**3**	**0**
31	Clean Surgical Instrument Package	L037D	RN/LPN/MA				
32	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MA				
33	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MA				
34	Check dressings & wound/ home care instructions	L037D	RN/LPN/MA				
35	Discharge day management	L037D	RN/LPN/MA				
36	**End: Patient leaves office**						
37	**POST-SERVICE Period**						
38	**Start: Patient leaves office/facility**						
39	Conduct phone calls/call in prescriptions			**0**	**0**	**0**	**0**

	A	B	C	D	E	F	G
1	**Trimming of Nails**		**CPT Code**	**CURRENT 11719 (March 2001)**		**11719**	
2	**Meeting Date: February 2012 Specialty: APMA**	**CMS**	**Staff**	**Trimming of nondystrophic nails, any number**		**Trimming of nondystrophic nails, any number**	
3	**GLOBAL PERIOD**			**000**		**000**	
4	**LOCATION**	**Code**	**Type**	**OFF**	**FAC**	**OFF**	**FAC**
50	**MEDICAL SUPPLIES**	**Code**	Desc				
51	paper, exam table	SB036	foot	**7**	**0**	**7**	**0**
52	underpad 2ft x 3ft (Chux)	SB044	item			**1**	**0**
53	towel, non-sterile	SB042	item				
54	gloves, non-sterile	SB022	pair	**2**	**0**	**2**	**0**
55	slippers, paper	SB040	pair	**1**	**0**		
56	blade, surgical (Bard-Parker)	SF007	item	**2**	**0**		
57	blade, surgical chisel 81-86 (Beaver)	SF009	item	**1**	**0**		
58	hydrogen peroxide	SJ028	ml	**10**	**0**	**10**	**0**
59	povidone swabsticks (3 pack uou)	SJ043	item	**1**	**0**	**1**	
60	swab-pad, alcohol	SJ053	item	**2**	**0**	**2**	**0**
61	applicator, cotton-tipped, non-sterile 6in	SG008	item	**2**	**0**		
62	gauze, non-sterile 4in x 4in	SG051	item	**2**	**0**	**2**	**0**
63							
64							
65							
66	**Equipment**						
67	table, power	EF031		**17**	**0**	**11**	**0**
68	light, exam	EQ168		**17**	**0**	**11**	**0**
69	dust extractor	EQ109		**17**	**0**	**0**	**0**

AMA/Health Care Professionals Advisory Committee
Summary of Recommendations
CMS/Other - Utilization over 500,000 screen

January 2012

Group Therapeutic Procedure

In April 2011, the Relativity Assessment Workgroup identified CPT code 97150 *Therapeutic procedure(s), group (2 or more individuals)* through the CMS/Other – Utilization over 500,000 screen and recommended it to be resurveyed. In January 2012, the HCPAC determined that there was compelling evidence that the physician work has changed for this service since the code was created and valued in 1995. This service was never surveyed by the HCPAC, however CMS staff imputed a value for this service not based off any survey results. Therefore, the HCPAC determined that incorrect assumptions were made by CMS at the time of valuation.

The HCPAC reviewed the survey results from 23 physical therapists and 11 occupational therapists and determined that the survey respondents overestimated the work required to perform this group service. The HCPAC compared 97150 to 92508 *Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals* (work RVU = 0.33 and 17 minutes intra-service time) and determined that 92508 requires more work and intensity than the surveyed code. The HCPAC compared 97150 to timed codes 97530 *Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15* minutes (work RVU = 0.44) and 97110 *Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility* (work RVU = 0.45) and determined that for a half hour of 97530 and 97110 would total 0.89 and 0.90 work RVUs which is similar to the 30 minutes total required to perform 97150. Further, if 0.89 is divided by 3, the typical number of patients in the group therapy session as confirmed by CMS claims data, the resulting value is 0.29. The HCPAC agreed that this work value is appropriate for this service. **The HCPAC recommends a work RVU of 0.29 for CPT code 97150 and 10 minutes intra-service time.**

Practice Expense:
The HCPAC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
97150	BW2	Therapeutic procedure(s), group (2 or more individuals)	XXX	0.29

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:97150 Tracking Number BW2 Original Specialty Recommended RVU: **0.29**
Presented Recommended RVU: **0.29**
Global Period: XXX RUC Recommended RVU: **0.29**

CPT Descriptor: Therapeutic Procedure(s), Group (2 or more individuals)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The therapeutic group involves three patients, including a 66 year old female who received a total knee replacement, a 70 year old male post rotator cuff repair surgery, and a 58 year old female with low back pain. Group procedure includes instruction, with return demonstration, in functional therapeutic activities (transfers from lying to sit to stand and initiation of gait) and self care home management techniques (functional reach to access cabinets, doors, windows) to be able to perform Activities of Daily Living safely in an independent home setting. Group session is completed with participant reflection and therapist wrap-up with individual and group feedback on performance.

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

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

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

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Pre-service work is included in the other services (typically in the 97000 series) that are delivered during the same visit.

Description of Intra-Service Work: Provider initiates communication with individuals in group by providing verbal instruction and demonstration in group procedures, including reviewing concepts of joint protection, body mechanics, instruction in safety, postures, patient demonstration and therapist assessment of return demonstration newly learned or previously instructed techniques. Individuals participating in the group are instructed by therapist to observe other group members responses to interventions for additional feedback and reinforcement of learned movements and techniques included in the of group interventions.

Description of Post-Service Work: Post-service work is included in the other services (typically in the 97000 series) that are delivered during the same visit.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2012				
Presenter(s):	Steve Levine, PT, DPT, MSHA; Mary Foto, OT, CCM. FAOTA				
Specialty(s):	American Physical Therapy Association; American Occupational Therapy Association				
CPT Code:	97150				
Sample Size:	314	**Resp N:**	34	**Response:** 10.8 %	
Sample Type:	Panel	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		5.50	**20.00**	145.00	2000.00
Survey RVW:	0.30	0.45	**0.47**	0.55	237150.00
Pre-Service Evaluation Time:			**9.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	15.00	**30.00**	48.75	120.00

Immediate Post Service-Time:	**9.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	97150	**Recommended Physician Work RVU: 0.29**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**10.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
97530	XXX	0.44	**RUC Time**

CPT Descriptor Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

KEY MPC COMPARISON CODES:

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
97110	XXX	0.45	**RUC Time**	42,100,000

CPT Descriptor 1 Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
97535	XXX	0.45	**RUC Time**

CPT Descriptor Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes

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

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

Number of respondents who choose Key Reference Code: 15 **% of respondents:** 44.1 **%**

TIME ESTIMATES (Median)	**CPT Code: 97150**	**Key Reference CPT Code:** 97530	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	1.00	
Median Intra-Service Time	10.00	15.00	
Median Immediate Post-service Time	0.00	2.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**10.00**	**18.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.13	3.87
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.93	3.67
Urgency of medical decision making	3.60	3.67
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.87	3.93
Physical effort required	3.73	3.93
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.07	3.07
Outcome depends on the skill and judgment of physician	4.20	4.20
Estimated risk of malpractice suit with poor outcome	3.00	2.80

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.93	3.13
Intra-Service intensity/complexity	4.00	4.13
Post-Service intensity/complexity	2.87	3.13

Additional Rationale and Comments

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

An expert panel of representatives of the American Physical Therapy Association and the American Occupational Therapy Association met by conference call to discuss the results of the survey. The expert panel reviewed the survey RVW values and determined that these values were not appropriate for the surveyed code.

Both the median value of 0.47 and the 25th percentile (0.45) were believed to be too high. The expert panel attributed these faulty survey results to the difficulty of using a code with a 15 minute parameter as the reference code. While the reference service list included six codes that did not have a timed parameter, no survyee selected any of these codes (five codes on the reference service list did have time parameters and were included because of the volume of services these codes represent). There were data available to the expert panel which supported an intraservice time of 30 minutes. This data were the result of a random survey conducted earlier in the year, unrelated to the HCPAC RUC activities, to gather information regarding the group code, and which found a mean length of service to be 32.2 minutes.

The expert panel also believed that the group code is typically used in conjunction with other services delivered at the same visit. In such a case, the pre and post service times would already be accounted for in the other services. The survey results showed a total time of 48 minutes, with pre time of 9 minutes, intra time of 30 minutes, and post time of 9 minutes. Thus the pre and post service times constituted 37.5% of the total time (18/48). The expert panel then reduced the median survey value of 0.47 by 37.5% and this resulted in a value of 0.29.

The expert panel then reviewed codes with similar value to the calculated 0.29. Codes reviewed included:

1. The current 97150, group code, has a value of 0.27 indicating a historical validity to the calculated value.
2. The value of 97110, Therapeutic exercise, 15 minutes, is 0.45. For 30 minutes, that value would be 0.90. In the group code, the typical vignette is three patients and the intraservice time is 30 minutes. If the 0.90 associated with 30 minutes of therapeutic exercise was applied to three patients, each patient would receive a value of 0.30. This further supports the recommended value of 0.29.
3. Another way to look at the group code value relative to the common value of a one-on-one 15 minute code (0.45) would be to reduce the intraservice time to 10 minutes by dividing the total intraservice time of 30 minutes by the three patients, resulting in an intraservice time of 10 minutes per patient. This is 2/3 of the minutes in a 15 minute code and the 2/3s of the value of a 15 minute code would be 0.30. In order to reflect that 30 minutes of services were delivered to three patients, the intraservice time in the RUC data base should be 10 minutes (30minutes divided by 3 patients).

A brief review of the IWPUT finds the 97110 (Therapeutic exercise) code at 0.0255. The 97150 Group code with zero pre and post service time and a work value of 0.29 has a IWPUT of 0.00967. Since time is already addressed in the IWPUT, it does not need to be further adjusted; but the number of patients (3) will affect the payment. Multiplying the Group IWPUT of 0.00967 by the three patients results in a "total" IWPUT of 0.0290, very similar to the Therapeutic exercise value of 0.0255.

When societies request a work value for a service/code that currently has a work value, and the proposed work value is higher than the current work value, a compelling argument must be presented that the published relative value for a service is inappropriately valued. The RUC provides guidelines in creating a compelling argument, one of which is:

Evidence that incorrect assumptions were made in the previous valuation of the service, as documented, such as:

- o a misleading vignette, survey and/or flawed crosswalk assumptions in a previous evaluation;

The Group code, 97150 has not been previously surveyed; additionally there is no previous or current vignette for the service. Since this is the first time a vignette has been established and the first time the code has been surveyed, there is a compelling argument to consider the proposed work value versus a value that was established without survey or vignette.

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SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

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

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.

☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
☐ Multiple codes are used to maintain consistency with similar codes.
☒ Historical precedents.
☒ Other reason (please explain) The codes in the Physical Medicine and Rehabilitation Section (97000) are primarily 15 minute codes and are designed to be used in combination.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. A typical scenario where the group code might be used with other codes would be a visit to a therapist that involved thirty minutes of one-on-one therapeutic exercise followed by a group session with other patients (as described in the typical vignette). The visit would be reported as two units of 97110 and a single unit of 97150. The 97110 Therapeutic exercise service has an XXX global period, a RVW of 0.45, and pre, intra and post service times of 1, 15, and 2 minutes, respectively. As noted in the previous item, the codes in the Physical Medicine and Rehabilitation Section (97000) are primarily 15 minute codes and are designed to be used in combination

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FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 97150 is an existing code. It is being reviewed/surveyed as a high expenditure code at CMS' request.

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

Specialty Physical Therapists How often? Commonly

Specialty Occupational Therapists How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1800000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This data is based on the current data on the RUC data base for 2010 which shows 89.1% of the volume of services delivered by physical therapists and 1.44% delivered by occupational therapists

Specialty Physical Therapy Frequency 1603800 Percentage 89.10 %

Specialty Occupational Therapy Frequency 25920 Percentage 1.44 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 674,472 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The source is the RUC data base for 2010.

Specialty Physical Therapy Frequency 618600 Percentage 91.71 %

Specialty Occupational Therapy Frequency 9994 Percentage 1.48 %

Specialty Frequency 0 Percentage 0.00 %

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

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 97150

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

CPT Code: 97150

Specialty Society('s) The American Occupational Therapy Association
The American Physical Therapy Association

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

CPT Long Descriptor: Therapeutic Procedure(s), Group (2 or more individuals)

Global Period: XXX Meeting Date: Jan. 26-29, 2012

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

> Information was solicited from therapists in private practice and directors of therapy outpatient clinics. The data were reviewed by members of AOTA's and APTA's coding committees. Recommendations are based on feedback and analysis of data.

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

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

In a group session, the therapy assistant offers additional individualized attention to specific impairments and functional deficits. This may include

- Providing verbal, tactile, or visual cues and correcting performance techniques
- Providing direct supervision or safety assistance
- Gathering items and modifying therapeutic environment to meet goal as specified by therapist
- Providing verbal feedback to encourage goal attainment
- Providing progressive exercise instruction
- Reinforcing and augmenting the therapist's instructions or educational interventions
- Providing written instructions to the patient as directed by the therapist

Post-Service Clinical Labor Activities:

	A	B	C	D	E
1	**Tab 32: Group Therapeutic Procedure REVISED**			**97150**	
2	**Meeting Date: Jan. 26-29, 2012** **Specialty: The American Occupational Therapy Asst. The American Physical Therapy Asst.**	**CMS**	**Staff**	**The therapeutic group involves three patients, including a 66 year old female who received a total knee replacement, a 70 year old male post rotator cuff repair surgery, and a 58 year old female with low back pain. Group procedure includes instruction, with return demonstration, in functional therapeutic activities (transfers from lying to sit to stand and initiation of gait) and self care home management techniques (functional reach to access cabinets, doors, windows) to be able to perform Activities of Daily Living safely in an independent home setting. Group session is completed with participant reflection and therapist wrap-up with individual and group feedback on performance. ****	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	
4	**GLOBAL PERIOD**				
5	**TOTAL CLINICAL LABOR TIME**			**5.00**	
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.00**	
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L039B**	**Assist.**	**5.00**	
8	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.00**	
9	**Intra-service**				
10	Assist physician in performing procedure	**L039B**	**Assist.**	**5.00**	
11	Assist physician in performing procedure	**L023A**	**Aide**		
12	**MEDICAL SUPPLIES**		**Unit**		
13	Cooking activitiy ingredients	SA007	kit	**1**	
14	Disinfectant	SM013	oz	**1**	
15	Non-sterile towels	SBO42	item	**1**	
16	Gloves	SB022	pair	**1**	
17	Antibacterial lotion	SMO20	oz	**1**	
18	Antibacterial Soap	SMO24	oz	**1**	
19	Drape	SB006	item		
20	Gown	SB026	item		
21	Pillow case	SB037	item		
22	Therabands (6"width)	SJ056	item		
23	Sanitizing cloth-wipe	SM021	item		
24	**Equipment**				
25	Environmental module - Kitchen	EL002	min		
26	Blood pressure monitor, ambulatory, w-battery charger	EQ269	min	**1**	
27	Treadmill	EQ248	min	**10**	
28	Exercise mat- hi-lo table	EF028	min		
29					
30					
31					
32	**** Please note: Supplies and equipment have been calculated per participant in the group.**				